

Trauma Competency: An Active Ingredients Approach to Treating Posttraumatic Stress Disorder

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Meta-analytic studies have extracted 4 common elements among effective posttraumatic stress disorder treatments: cognitive restructuring and psychoeducation, a deliberate and continually improving therapeutic relationship, relaxation and self-regulation, and exposure via narrative of traumatic experiences. The authors present a clinical treatment structure catalyzing these active ingredients into discrete therapeutic tasks that counselors can focus on to maximize treatment effectiveness. The 4 tasks represent an attempt to identify critical competencies and baseline standards for the field of trauma counseling.

Keywords: traumatic stress, PTSD, active ingredients, treatment, trauma competency

In the 37 years since posttraumatic stress disorder (PTSD) was conceptualized as a diagnosis (American Psychiatric Association, 1980), researchers and counselors have labored to develop and refine treatments for survivors of trauma. In 2010, a significant milestone was passed with the publication of the Department of Veterans Affairs (VA) and Department of Defense (DoD) treatment guideline for PTSD (Management of Post-Traumatic Stress Working Group, 2010), which presented clear evidence that trauma-focused treatment works best for clients with trauma-related symptoms. If a competent professional follows these guidelines, clients with PTSD can reasonably expect relief from their acute trauma symptoms and, with continued engagement, their more chronic symptoms as well (Baranowsky & Gentry, 2014; Briere & Scott, 2014; Cahill, Rothbaum, Resick, & Follette, 2009).

Since then, empirical meta-analytic research has produced additional sets of best practices and treatment guidelines to help counselors manage trajectories of treatment with trauma survivors and their families (Baranowsky & Gentry, 2014; Cahill et al., 2009; Cloitre et al., 2011, 2012; Forbes et al., 2007; Ursano et al., 2004). The discipline of trauma counseling has matured beyond determining whether treatment is effective and toward integrating the most effective methods of treatment. Now, the field is approaching another evolutionary leap in the understanding and prescription of treatment for posttraumatic conditions. Four *active ingredients* have been identified as common to all effective treatments for survivors of trauma and hypothesized to be primary mechanisms for

the effects demonstrated by evidence-based treatments. We have identified these active ingredients, and in this article we present a generic clinical structure for treating posttraumatic conditions that infuses these active ingredients into a phasic model. By using the phasic structure of the model, counselors will be able to efficiently complete these four therapeutic tasks while still using the evidence-based trauma resolution methods of their choice. The ability to complete these four tasks should represent minimal competency for trauma-focused counselors.

Identifying Effective Treatments for Trauma Survivors

In 2010, the VA and DoD, using 56 professional reviewers, created a comprehensive clinical practice guideline for the management of posttraumatic stress (Management of Post-Traumatic Stress Working Group, 2010). This guideline may be the most comprehensive documentation to date for understanding effective treatment of posttraumatic conditions. Its authors conducted a thorough literature review regarding psychotherapeutic and psychopharmacological treatments that had demonstrated effectiveness in studies from 2002 to 2009, evaluated the evidence for each method, and assigned them to categories based on the strength of evidence (Management of Post-Traumatic Stress Working Group, 2010). Their categorization of psychotherapeutic treatments is summarized in Table 1. The methods most strongly recommended were “evidence-based trauma-focused

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TABLE 1

**Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline
Classification of Psychotherapies for Posttraumatic Stress Disorder (PTSD)**

Category and Recommendation	Treatment Method
A: Strongly recommended for first-line treatment of PTSD; trauma-focused methods	Exposure-based therapies such as prolonged exposure therapy, brief eclectic psychotherapy, narrative therapy, and written exposure therapies Cognitive-based therapies such as cognitive processing therapy Stress inoculation training Eye movement desensitization and reprocessing
C: No recommendation for or against	Patient education Imagery rehearsal therapy Psychodynamic therapy Hypnosis Relaxation techniques Group therapy Family or couples therapy
I: Insufficient evidence to recommend for or against	Web-based cognitive behavior therapy Dialectical behavior therapy Acceptance and commitment therapy Complementary and alternative medicine approaches such as yoga, acupuncture, mindfulness, and massage

Note. Adapted from *VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress*, by Management of Post-Traumatic Stress Working Group, 2010, pp. 115–118. In the public domain.

psychotherapeutic interventions that include components of exposure and/or cognitive restructuring; or stress inoculation training” (Management of Post-Traumatic Stress Working Group, 2010, p. 117).

The authors of the VA/DoD guideline established the cornerstone of trauma recovery as the use of evidence-based trauma-focused interventions, which are more effective with clients and are strenuously indicated over nonspecific treatment (Alvarez et al., 2011), up to 86% better than no treatment (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). However, in a published analysis of seven existing guidelines for treating PTSD (Forbes et al., 2010), a panel of expert authors indicated that current evidence was insufficient to drive most of the recommendations in the guideline. While Forbes et al. (2010) supported use of the recommended first-line treatments for posttraumatic stress, they concluded that these treatments cannot resolve traumatic stress by themselves; they remain “embedded in broader clinical care that includes . . . building a therapeutic alliance, comprehensive assessment, case formulation, and treatment planning. . . it is unrealistic to assume that every aspect of care will be guided by Level I empirical data” (p. 551). This passage supports the importance of trauma counselors’ good clinical judgment, as well as implementation of the active ingredients of these evidence-based treatments in myriad contexts.

Identifying Active Ingredients of Effective Treatments

Benish, Imel, and Wampold (2008) published a meta-analytic study that directly compared evidence-based, trauma-focused

treatments to determine which, if any, were better than the others and reported, “The primary analysis revealed that effect sizes were homogenously distributed around zero for measures of PTSD symptomology, and for all measures of psychological functioning, indicating that there were no differences between psychotherapies” (p. 746). In other words, they found no discernible differences in the levels of relief provided by the trauma-focused treatments. These results have been replicated elsewhere (Bisson et al., 2007; Foa, Hembree, & Rothbaum, 2007; Forbes et al., 2010; Karatzias et al., 2011; Management of Post-Traumatic Stress Working Group, 2010; Powers et al., 2010).

Prior to the study by Benish et al. (2008), models and methods of treatment competed to be considered evidence-based and the best treatment for PTSD. This competitive climate led many clinicians and academicians to become strictly faithful to certain methods, which fractured the field of traumatic stress treatment into separate and distinct groups. However, the findings of Benish et al. indicate that although trauma-focused therapy works, the outcome has little to do with the particular method used. Instead of asking “Which treatment is better?” the question becomes “What makes all these treatments effective?” If common elements that are central to change can be extracted from the effective treatments, further important questions can be asked, including “How do trauma counselors integrate what works across these models into treatment with all survivors of trauma?” and “How do educators train clinicians to become effective at treating traumatic stress instead of simply implementing ‘evidence-based’ practice?” Benish et al. suggested helping trauma clinicians develop mastery by implementing factors common to all effective treatments for traumatic stress.



S. D. Miller, Hubble, Chow, and Seidel (2013) argued that the primary factors accounting for change among clients are not model-specific. Instead, citing previous studies (Duncan, Miller, Wampold, & Hubble, 2010; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Wampold, 2005), they reported that the variance of outcomes attributable to variability among treatments was a very low 0%–1%. This result contrasts sharply with therapeutic alliance (5%) and therapist variables (5%–9%) explaining significantly more of the variance in outcomes. The same authors reported that the nonspecific common factors in effective treatments were much more potent for achieving client outcomes than any specific model or method of treatment. This nascent shift away from evidence-based treatment toward empowering counselors with what actually works is representative of a movement in the field of trauma treatment.

Figley and Carbonell (1995) hosted a clinical demonstration project at Florida State University in 1995 and 1996, designed to extract the active ingredients from several treatments for traumatic stress. They invited developers and practitioners of new therapies to demonstrate their treatments with volunteer clients before a live audience (Carbonell & Figley, 1996, 1999). The project showcased methods such as eye movement desensitization and reprocessing (EMDR), traumatic incident reduction, thought field therapy, visual-kinesthetic dissociation, and other energy-focused treatments; it also provided a forum for attendees to discuss the factors that were common to these treatments. It was found that all the treatments paired some form of exposure with some form of relaxation to help survivors desensitize the negative effects of their trauma memories (Gallo, 1996).

Reciprocal inhibition (Wolpe, 1968)—the pairing of exposure and relaxation—has always been central to effective treatment of trauma. Cloitre et al. (2011) surveyed 50 expert trauma clinicians and found that 84% endorsed phase-based or sequenced therapy as the most appropriate treatment approach, with interventions tailored to specific symptom sets. First-line interventions they matched to specific symptoms included (a) emotion regulation strategies, (b) narration of trauma memories as an exposure process, (c) cognitive restructuring, (d) anxiety and stress management, and (e) interpersonal skills development. The survey results provide a strong rationale for conducting research focused on the relative merits of traditional trauma therapies and sequenced multicomponent approaches applied to different populations (Cloitre et al., 2011). The 2010 VA/DoD Clinical Practice Guideline also points out exposure, cognitive restructuring, anxiety management, and psychoeducation as key components of recommended evidence-based treatments and emphasizes the importance of the therapeutic relationship in treating trauma survivors (Management of Post-Traumatic Stress Working Group, 2010). Therefore, based on these meta-analytic studies, the following four primary active ingredients of effective PTSD treatments are identified:

- Cognitive restructuring: restructuring cognition, with a focus on psychoeducation about the neurological, physical, and psychological effects of trauma.
- Therapeutic relationship: establishing, maintaining, and enhancing an excellent therapeutic relationship through the use of feedback-informed treatment (FIT; Duncan & Miller, 2000; S. D. Miller et al., 2013; Seidel, 2012).
- Self-regulation and relaxation: teaching survivors to monitor and autonomously regulate autonomic arousal through ongoing relaxation.
- Exposure or narrative: using exposure or narrative approaches to integrate and desensitize repressed, suppressed, and dissociated traumatic memories and memory fragments.

Psychoeducation/Cognitive Restructuring

Psychoeducation/cognitive restructuring is a primary tenet of cognitive behavior therapy and an early intervention in treating PTSD (National Association of Cognitive-Behavioral Therapists, 2014). It can serve to establish the credibility of the counselor, generate positive expectancy, make treatment seem immediately helpful to the client, frame and reframe the symptoms, and prepare the client for the next steps. Psychoeducation is a central element of effective treatment and can significantly enhance outcomes (Yeomans, Forman, Herbert, & Yuen, 2010). Teaching clients about the impact of trauma can help ameliorate the debilitating posttraumatic shame and guilt many survivors carry (Beck et al., 2011; Robinson & McNally, 2010). Effective cognitive restructuring can be administered in brief discussions when the client has questions, and more systematically as a formal activity; it can be delivered to individuals or to groups. Because people with PTSD often have difficulties with concentration and memory, it is important to repeat information and provide it in writing. For an example of client-friendly discussions on this topic, see Baranowsky and Lauer (2013). PTSD-related education can cover topics such as (a) emotional and physical PTSD symptoms; (b) positive and negative coping skills and their differences; (c) recovery as an ongoing daily gradual process; and (d) treatment options, including evidence-based treatments (Wampold et al., 2010).

Therapeutic Relationship via FIT

Since Eysenck's (1952) formative research on variables leading to effective treatment outcomes, evidence has supported the therapeutic relationship as one of the most important factors leading to positive outcomes (Duncan et al., 2010; Hubble, Duncan, & Miller, 1999; Strupp, 2013; Strupp, Wallach, Wofan, & Jenkins, 1963). The therapeutic relationship continues to emerge in meta-analyses and deconstruction studies as a crucial component of effective

treatment (Arnow et al., 2013). Knerr et al. (2011) found that to develop, maintain, and enhance therapeutic relationships, counselors should possess the following traits: (a) a strong differentiated self-concept; (b) ability to regulate their own emotions and behaviors; (c) awareness of their own beliefs, preferences, and needs; (d) ability to manage stress; and (e) ability to maintain relaxation when working with clients. The last two traits are especially crucial, because a primary generator of clients' symptoms and distress is a dysregulated autonomic nervous system, and a counselor's relaxed demeanor can help reduce this arousal. A meta-analysis by Karver, Handelsman, Fields, and Bickman (2006) found several other counselor skills that contributed to clinical success with adolescents and their families: (a) having interpersonal skills, such as empathy, positive regard, warmth, and genuineness; (b) engaging clients in treatment; (c) delivering information clearly and concisely; and (d) giving a believable and reasonable rationale for information. In addition, Fife, Whiting, Bradford, and Davis (2014) explored integrations of multiple models of client treatment and suggested that three factors relate directly to treatment outcomes: the creation of a therapeutic alliance, the ability to use interventions that fit the client, and the counselor's personal character or way of being. These studies suggest that effective counselors are emotionally mature and self-regulating individuals who exhibit compassion and charity.

The most important occurrence in the psychotherapy field over the past decade has been the emergence of feedback-informed treatment, or FIT (Anker, Duncan, & Sparks, 2009; Duncan & Miller, 2000; Duncan, Miller, & Sparks, 2004; S. D. Miller et al., 2013; Seidel, 2012). FIT significantly evolves and accelerates the way in which counselors develop, maintain, and enhance therapeutic relationships. Before FIT, to enhance a therapeutic relationship, counselors would likely attempt to apply the characteristics recommended by Rogers (1966): empathy, warmth, compassion, authenticity, and so forth. However, this one-size-fits-all approach to relationship building has been demonstrated to be significantly less effective in generating positive outcomes, and counselors frequently overestimate the quality of relationships with their clients (S. D. Miller et al., 2013).

In 2013, the International Center for Clinical Excellence reported that FIT was included in the Substance Abuse and Mental Health Services Administration's (SAMHSA, 2014) National Registry of Evidence-Based Programs and Practices, and according to S. D. Miller (2015), FIT doubled clinician effectiveness. In addition to providing a structured, empirically validated method for enhancing therapeutic relationships and improving outcomes, FIT funnels counselors into a process of developing deliberate collaborative practice with their clients as a pathway for maturation (S. D. Miller et al., 2013). For these reasons, we strongly advocate that FIT become a required component of trauma-focused counseling.

Self-Regulation and Relaxation

With a good therapeutic relationship established, the next task of treatment is to help clients learn the workings of their autonomic nervous systems and the importance of regulating this system (Ford & Russo, 2006). Virtually every effective treatment for posttraumatic stress, especially cognitive behavioral methods, includes some strategy for achieving and maintaining relaxation (Foa, Keane, Friedman, & Cohen, 2008; Management of Post-Traumatic Stress Working Group, 2010). Wolpe (1961, 1968) discovered that when people with anxiety disorders confronted things that made them anxious while keeping their bodies relaxed, they were able to resolve their symptoms of anxiety. This reciprocal inhibition (Wolpe, 1954) is the primary tool for desensitizing trauma memories in effective treatments for PTSD (Foa et al., 2008; Management of Post-Traumatic Stress Working Group, 2010).

Many cognitive behavioral treatments, such as prolonged exposure, cognitive processing therapy, and stress inoculation training, explicitly prescribe teaching relaxation strategies before addressing traumatic memories with clients (Foa & Kozak, 1998). Techniques such as diaphragmatic breathing, guided visualization, progressive relaxation, and autogenics are indicated for use in treatment manuals and writings on cognitive behavior therapy protocols (Foa et al., 2008; Foa & Kozak, 1998; Pole, 2007). EMDR integrates a "safe-place" exercise into the preparation phase of treatment to help clients develop capacity for relaxation (Shapiro, 2001), and the bilateral stimulation central to EMDR may produce a modicum of relaxation (Corrigan, 2002). Hypnotic protocols use hypnotic induction as a relaxation strategy to prepare the survivor to confront, integrate, and desensitize trauma memories (Kirsch, Capafons, Cardeña, & Amigó, 1998; Lynn & Cardeña, 2007). Developing skills for relaxation is key to effective treatment of traumatic stress (Ford, Courtois, Van der Hart, Nijenhuis, & Steele, 2005).

One result of recent upheavals in health care services has been the systematic and institutional attempt to take a "trauma-informed approach" (SAMHSA, 2014, para. 1). With this evolution away from "What is wrong with you?" and toward "What happened to you?" (Bloom, 1997), more efforts are being made to understand the effects of past trauma on current physical symptoms (Felitti et al., 1998; Putnam, Harris, & Putnam, 2013). One adaptation that past trauma produces is a sensitive and overly active autonomic nervous system (L. E. Miller, 2014). Trauma survivors perceive a more frequently and intensely dangerous world than those without histories of trauma. Increased perceived threat, coupled with an overly developed threat response system, is at the core of the survivor's dysregulation (Ford, 2005).

Training clients to perform ongoing monitoring and self-regulation of their anxiety symptoms can serve as both a treatment and a resiliency tool (Ford, 2005; Ford & Blaustein,



2013; Ford et al., 2005; Najavits, 2002; van der Kolk, 1996). Developing this capacity for self-regulation can ameliorate distress associated with anxiety disorders and lessen symptoms across the mental disorders spectrum (Shah, Klainin-Yobas, Torres, & Kannusamy, 2014).

Exposure or Narrative

Reciprocal inhibition (Wolpe, 1954, 1968) is at the center of effective treatments for PTSD; it desensitizes hyperarousal effects and integrates dissociated, suppressed, or repressed trauma memories (Boudewyns & Hyer, 1990; Foa et al., 2008; Rauch, Eftekhari, & Ruzek, 2012). There is also evidence that exposure therapy helps trauma survivors regain optimal brain functioning (Roy, Constanzo, Blaire, & Rizzo, 2013).

The Category A treatments for PTSD identified by the Management of Post-Traumatic Stress Working Group (2010) are primarily exposure-based methods. Treatment manuals for prolonged exposure (Foa et al., 2007) and cognitive processing therapy (Resick, Monson, & Chard, 2008) articulate exposure as a central component of their effectiveness. Cognitive processing therapy has become more popular for treating trauma in the past decade, especially among providers working with combat veterans; it facilitates exposure by helping survivors construct and reconstruct narratives of their traumatic experiences. Increasingly, clinicians and researchers are advocating the use of narratives to help survivors confront, desensitize, and integrate charged trauma memories (Adenauer et al., 2011; Cloitre et al., 2012).

Exposure interventions focus on safely working through unresolved traumatic memories without overstimulating clients. Outcome research (Bisson & Andrew, 2009; Foa et al., 2008) has consistently demonstrated the effectiveness of exposure-based methods in lessening trauma-related symptoms and improving quality of life for those completing these treatments over time. Exposure is an essential component of effective trauma treatment.

Five criteria establish that a client is ready to begin exposure work: (a) resolving danger, (b) distinguishing being safe from feeling safe, (c) developing self-regulation and self-rescue skills, (d) demonstrating self-regulation and self-rescue from abreaction, and (e) using a negotiated contract and informed consent for resolution of trauma memories (Gentry, 1998).

Proposed Phasic Treatment Structure

The field of trauma counseling has struggled to mature past divided loyalties to particular treatment models. One way to bypass this conflict is to build treatment structures that embrace any model of treatment while focusing on competence in the four active ingredients. S. D. Miller et al. (2013) suggested that counselors should be taking three main steps toward excellence and mastery in psychothera-

peutic principles: (a) improve domain-specific knowledge and learn to apply it correctly; (b) refine skills and processes using a feedback system that enables them to better meet client needs while enhancing performance; and (c) keep a deliberate, intentional focus on reaching a higher standard as a counselor. The field of trauma treatment can lead the way into the future of counseling and psychotherapy by implementing these concepts more broadly.

A synthesis of research indicates that the common factors in successful trauma treatment are found in many areas of counseling. Although not enough data have been collected to suggest a universal metamodel of treatment, there is a gathering body of evidence that a treatment structure including the four active ingredients would be highly productive and increase positive clinical outcomes. The next step becomes identifying attitudes, skills, strategies, and a learning process to facilitate this broader implementation in the maturing view of trauma treatment.

If the field of trauma treatment does not build new structures, it is likely that rigid clinical pathways will become as commonplace in mental health services as they are in the medical community (Campbell, Hotchkiss, Bradshaw, & Porteous, 1998). Rather than moving to a model-dependent clinical pathway, we suggest using a structure based on competency in the four active ingredients. Our proposed structure is a developmental maturation of Herman's (1992) triphasic model for the 21st century, integrating new empirical and practice-based learning in the field. This structure enables counselors to manage the treatment trajectory with trauma survivors by applying the active ingredients to any treatment protocol (Rhoton & Gentry, 2016). It consists of four stages: relationship building, psychoeducation and self-regulation, recovery and resolution, and posttraumatic resiliency building.

Stage 1: Relationship Building

The first part of the relationship-building stage is orientation or acculturation to treatment. The counselor introduces topics such as the healing process, his or her counseling philosophy, FIT, and the session experience and limitations of the setting. Then, to build the therapeutic relationship, the counselor follows the following steps with the client:

- Discuss and prepare survivor for transitions in treatment
- Discuss the importance of being able to self-regulate before tackling resolution work
- Model self-regulation, verbalizing how it is done and the benefit of the experience
- Distinguish perceived and real safety
- Create ritual and predictability
- Conduct psychoeducation that normalizes so-called problem behaviors and beliefs

In Stage 1, the counselor also helps the client set treatment goals and learn about helpful approaches to reaching those goals. Finally, the counselor goes over any documentation requirements, such as concurrent documentation and the forms associated with the FIT process.

Stage 2: Psychoeducation and Self-Regulation

At this stage, the counselor can teach clients rudimentary brain and autonomic nervous system functioning, helping them to understand and demystify their threat response system (Porges, 1995, 2007, 2014). This is a safe teaching method because it does not require clients to implement any action. The counselor can also bring up the impact of environment and family epigenetics and explore meanings of the clients' behaviors as adaptive strategies for coping with their developmental challenges.

Metaphors can be used to help the client understand and digest information, creating a common language to enhance ease of discussion and relational connection. The counselor should also refer to physiological dysregulation rather than anger, sadness, or fear, which allows the client to understand his or her behavior as a predictable reaction rather than an intentional behavior. It is important to normalize that clients' internal negative messages; perceptions of self; worldviews; and relationship, emotional, and cognitive patterns are being influenced as predictable reactions to an overactive and dysregulated threat response system.

Stage 3: Recovery and Resolution

This stage involves the application of evidence-based (e.g., prolonged exposure, EMDR, cognitive processing therapy) and other protocols that assist the survivor in revisiting, integrating, and desensitizing their trauma memories. This process utilizes the combination of exposure and relaxation (i.e., desensitization) and the creation of an explicit narrative sequencing of the microevents of the trauma, with particular focus on all the sensory fragments associated with the trauma memory (i.e., integration).

During this stage, the counselor should create narratives that expand, as needed, and lessen reactivity to the traumatic event, but be ready to put the brakes on if necessary. The counselor should work to (a) normalize difficulties, unwanted emotions, thoughts, behaviors, and beliefs; (b) focus on discovering and highlighting strengths and capacity; and (c) assist the client to mourn or work through grief.

Stage 4: Posttraumatic Resiliency Building

During this stage, the counselor helps the client consolidate the three domains of change in posttraumatic growth: perception of self, interpersonal relationships, and philosophy of life. The five core factors for posttraumatic growth are relating to others, new possibilities, personal strength, spiritual change and maturity, and appreciation of life.

Conclusion

Traumatic events are the great human equalizer. Every one of us must face the trials and fragility of life, and we may suffer and need assistance along the way to cope, but recovery is our birthright. If we are willing to apply our natural inclination for curiosity, self-reflection, and growth, any set of steps that includes the four basic elements for posttraumatic growth and recovery will result in a beneficial outcome. Frankl (1959) captured it well in *Man's Search for Meaning*: "Everything can be taken from a man but one thing: the last of the human freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way" (p. 65). This capacity determines the outcome of trauma therapy and aids survivors in navigating treatment.

Today, trauma-focused treatment models demonstrate gold standard outcomes with survivors. The maturation of informed trauma care must focus on the application of proven components of approaches that allow for trauma recovery and growth. The four active ingredients discussed in this article represent an early attempt to identify critical competencies and baseline standards for the field of trauma counseling. Competent counselors can use the structure laid out here to aid in the skilled application of care and make a difference to clients recovering after trauma.

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