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Effective Counseling Through Identification of Trauma Patients' Coping Strategies and Pressing Concerns

Posttraumatic stress disorder (PTSD) is a pertinent issue today. Events on the world stage and at the community level are causing people to experience traumatic injuries and stressors. The consequences are impairments in general functioning especially in relationships and on the job. There is a decrease in productivity on the personal level and community level. This impacts communities by decreased productivity and diminishing human resources. Discussion on effectively treating PTSD includes early intervention and patient centered care and responding to the victims' pressing concerns (Bisson, Brayne, Ochberg, & Everly, 2007; Tsay, Halstead & McCrone, 2000; Zatzick et al. 2007).

In 1980, PTSD was included in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (*DSM-III*).* Lasiuk & Hegadoren (2006) posit that this was an extremely significant event. The effects of horrific life events were named and a framework was created to use in studying PTSD. The development of PTSD was attributed to an external cause, a traumatic event, rather than to an inherent weakness in the individual. It validated and legitimized the experiences of trauma victims. It also placed them in the context of reciprocal interaction between the individual and environment, both influencing and being influenced by the other. This was significant because it encouraged healthcare providers to view disorders as human experience rather than human weakness (Lasiuk & Hegadoren).

The DSM IV specified stressor criteria for the trauma experience and the individual's response to it. It resulted in an increase in the number of events that would be considered stressors for PTSD (Lasiuk & Hegadoren, 2006). In the DSM IV-RT (American Psychiatric Association, 2000), PTSD is listed as an anxiety disorder. In order for a person to be diagnosed with PTSD the entire experience that triggered the anxiety must include certain features. The first set of features involves the nature of the event or immediate experience. The person must have experienced what the DSM IV-TR refers to as an extreme traumatic stressor. It may have been a direct threat of death or serious injury, or threat to his or her physical integrity. It could also have been the witnessing of a threat of death or serious injury, or threat of physical integrity to another person. Another extreme traumatic stressor is learning that a family member or close associate has experienced one or more of those events or that they had unexpectedly died a violent death. The next set of features involves the person's response. It could be intense fear, a sense of extreme helplessness, or horror. The features of the symptoms include re-experiencing the event, avoiding stimuli associated with the trauma, numbed responsiveness, and increased arousal such as being easily startled. The symptoms must persist for more than one month. The person must experience distress and impairment in their social, occupational, and personal life. Events that are considered traumatic include military combat, violent personal assault, kidnapping, being taken hostage, a terrorist attack, torture, being a POW or prisoner in a concentration camp, natural or manmade disasters, severe vehicle accidents, and diagnosis of a life threatening disease (American Psychiatric Association, 2000).

Not all trauma victims experience PTSD (Bisson et al. 2007). In their review of trauma studies, Tsay et al. (2000) stated that between 27% and 46% of trauma victims reported post traumatic stress syndrome (PTSS) symptoms. Tsay et al. identified several factors which

contribute to this phenomenon. The perception of the severity of the injury was directly related to the development of PTSS. Also related to symptom development was the victim's perceived stress and perceived controllability, which affected coping strategies. Tsay et al. discussed emotion focused coping (EFC) and problem focused coping (PFC). EFC is a coping style based on avoidance, wishful thinking, and self blame. PFC is characterized by taking direct action to solve the problem. Wishful thinking and avoidance led to higher rates of PTSS. A person using EFC is more likely to see himself or herself as inadequately handling the injury related stressor. Perceived controllability and PFC led to lower rates. Trauma patients who perceived having some control over stressors tended to use PFC and were more effective in dealing with their injuries. Having a sense of control changes the meaning associated with the traumatic event (Tsay et al.). Another important factor in trauma recovery is social support, which helps moderate the stress response to trauma. It has a stress buffering effect, which influences the effectiveness of a person's coping style. Social support accounted for the wide variance, 27%-46%, in the development of PTSS. Tsay et al. concluded that an intervention program that includes assessing coping skills and training in developing these coping styles would be more effective in PTSS cases.

Another study by Zatzick et al. (2007) asserted that identifying and understanding trauma patients' immediate and pressing concerns should happen early in trauma care and treatment. This should be done before a psychological assessment. They believe that doing so strengthens the patient-provider relationship and will lead to treatment that is more effective.

Zatzick et al. (2007) asserted that patient centeredness is the core of high quality healthcare. The central feature of quality care is identifying the patient's individual needs, concerns, and values. This stance is based on the assumption that patients' perspectives can be

identified, understood, and integrated into medical decision making. Attending to trauma patients' most pressing concerns is the key to a strong patient-provider relationship. In their studies, Zatzick et al. found that engaging and retaining acutely traumatized patients in long term intervention protocols is difficult. Early provider-initiated psychosocial interventions such as psychological debriefing were associated with worse PTSD outcomes. A need was identified for early in-depth study of patients' posttraumatic needs and concerns in order to develop a strong patient-provider relationship early in treatment.

Patient centered assessment strategies were developed to focus on patients' concerns rather than symptomatic outcomes such as PTSD. Zatzick et al (2007) list three brief open-ended questions to determine patients' concerns and the degree of severity in these concerns. The questions were as follows: "1) Of all the things that have happened to you since you were injured, what concerns you're the most? 2) What about this worries you? 3) How concerning is this to you?" (p. 263). Severity levels were measured on a scale of 1-5 with one being not at all concerned and five being extremely concerned. Major concerns that were expressed in order of severity were (a) physical health such as the ability to carry out normal physical activities, (b) work and finances such as the ability to return to work and fulfill financial obligations, (c) social such as how the trauma will affect social relationships, and (d) psychological concerns. It was found that PTSD symptoms were more likely to emerge during the year after trauma when three severe concerns were expressed immediately after the trauma. The greater the severity of the initial concern, the more likely PTSD symptoms would persist 12 months after the trauma (Zatzick et al.).

Zatzick et al. (2007) found that focusing on symptoms was associated with difficulties in patient follow up. It was suggested that there is a tension between patients' concerns after trauma

and the goals and limitations placed on medical providers and healthcare systems. By initially attending to non-symptom concerns, a stronger therapeutic relation was established. Care providers should be aware that patients at risk of PTSD might have more pressing concerns than their own injuries or developing PTSD. An example given was a parent who was more concerned about their children after they both had been injured in a serious auto accident. The study found that first addressing concerns not associated with PTSD enhanced the patient and provider relationship. This suggested that the enhanced relationship would lead to more effective health related decisions regarding care (Zatzick et al.).

Determining trauma patients' immediate pressing concerns and their coping styles are concrete guidelines for the counselor serving this population. It will help set the foundation of a client based counseling relationship and lead to a strong client-provider relationship. The emphasis on identifying and addressing trauma patient concerns before determining a psychological diagnosis supports the counseling focus on the necessity to develop rapport with a client before engaging in therapy. The patient-centeredness that Zatzick et al. (2007) describe reflects the counseling relationship based on unconditional positive regard for the client. Remembering to identify and respond to trauma client concerns before focusing on diagnostic guidelines to identify psychological problems will convey empathy and establish a relationship of trust. This will enhance the patient-provider relationship and lead to positive therapeutic outcomes.

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