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THE EFFECTIVENESS OF THERAPEUTIC INTERVENTIONS ON SYMPTOMS OF POST TRAUMATIC STRESS DISORDER

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THE EFFECTIVENESS OF THERAPEUTIC INTERVENTIONS ON SYMPTOMS
OF POST TRAUMATIC STRESS DISORDER

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Sean Michael Howell

June 2019

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Approved by:
Dr. Thomas Davis, Faculty Supervisor, Social Work
Janet C. Chang, Research Coordinator

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ABSTRACT

Despite a plethora of research documenting the effectiveness of various therapeutic interventions on the symptoms of Post Traumatic Stress Disorder (PTSD), there continues to be ambiguity insofar as which approaches or combination thereof are most effective at improving adverse manifestations of this disorder. This lack of clarity is further confounded when other variables and nuances pertaining to variations of PTSD (i.e. military, sexual trauma, childhood abuse, etc.) are factored into these comparisons. Therefore, the purpose of this study was to explore the impact of various interventions on improving the symptoms of PTSD. This study also examined the variances which stand in need of recognition when determining which interventions are most appropriate and meaningful in improving the quality of life and functionality of individuals with this disorder. This has significance in both macro and micro social work practices due to the potential for improvements in policies, allocation of resources, and enhancements in micro-level interventions. The research design involved qualitative interviews with clinicians devised to identify gaps, areas of agreement, and dissent among the research. Data analysis will be qualitative and will be guided by assessing the impact of interventions on the 17 symptoms which, according to the DSM-5 are associated with PTSD.

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Dr. Davis

Thank you for your guidance, optimism, and reassurance. Your inclination toward being spiritually guided and connecting with other human service professionals was just what I needed at the just the right time.

Professors and Faculty

I believe that valuable parts of who you are now a part of who I am. I will do my best to carry that forward with me and do some good with it.

Participants

Time is the most valuable resource we have. I am grateful for the donation of your time and sharing of your invaluable experiences, without which this project design would not have been possible.

Family

There simply are no words that describe how thankful I am for you and your support. I would not be here without you. I love you and appreciate you.

DEDICATION

To my Dad

Who taught me to have goals

and never give up.

To Sharon, Jocelyn, and Megan

For the love and inspiration

to reach those goals.

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CHAPTER ONE

PROBLEM FORMULATION

Post Traumatic Stress Disorder (P.T.S.D.) is a condition caused by an unresolved traumatic event(s) which can manifest in an array of symptoms including; intrusive vivid memories, social isolation, emotional incapacitation, apathy, depression, anger, sleep disturbances, and a feeling of being constantly on guard (Veterans Affairs, 2017). It is not uncommon for clients who are being treated for alcohol and drug problems, homelessness, depression, or anger issues to disclose symptoms and circumstances which are congruent with PTSD. In fact, the National Center for Post-Traumatic Stress Disorder estimates that between 25 and 75 percent of people who survive abuse and or violent trauma develop issues relating to drug and alcohol abuse (Rosenthal, 2015). Furthermore, there is a robust body of evidence indicative of a strong correlation between PTSD and increased suicide rates and suicidal ideation. This is especially evident among survivors of military trauma and trauma associated with childhood sexual abuse (Veterans Affairs, 2017). Given these points, it is imperative that social workers and other human service professionals commit to perpetual growth and increased insight regarding their comprehension of PTSD.

. The types of agencies which typically provide referrals or direct services for persons with PTSD are the VA's Office of Mental Health Services, Real

Warriors Campaign, and the National Child Traumatic Stress Network. Other traditional human service providers that are involved in ameliorating the consequences of PTSD may include behavioral health hospitals, alcohol and drug rehabilitation programs, psychiatrists, Licensed Clinical Social Workers, or Marriage and Family Therapists.

Tension from both macro and micro perspective are part of addressing the needs of individuals with PTSD. Differences in opinion often occur as a result of people and/or agencies who may place a disproportionate preference on one or another. Social workers at the micro level simply aim to assist individuals with the disorder who are in dire need, whereas the macro perspective focus on policies and environmental conditions that support this population (Brown, 2014).

The role of Social Workers providing services to individuals of PTSD may be in the form of direct service providers (i.e. therapist, counselors), case managers, or interventionists. These are often clinicians who conduct assessments, treatment planning, and implementation of treatments. For this reason it is essential that social workers treating this population are educated and current regarding the most appropriate and effective treatments in order to most effectively manage the disorder (Jones, 2017).

Purpose of the Study

The purpose driving the proposed study is to improve the quality and depth of insight regarding the therapeutic interventions that are most impactful

and beneficial to populations suffering with PTSD. Upon examination of rates of suicide, chemical dependency, and divorce there is a undeniable correlation in the increased proportion of individuals with PTSD who endure these hardships (Veterans Affairs, 2017). Social workers and human service providers often provide services to remedy these conditions, hence advancement of knowledge and skills to address these problems should be considered of utmost importance. Individuals with PTSD, whether it be from military service or being the victim of some form of life altering violence, often suffer impaired functioning (Veterans Affairs, 2017). This often leads to dysfunctional forms of coping and self-medicating which in turn creates additional problems. Although the root causes of these problems are well understood, the appropriate combination of therapeutic interventions that best serves this population is less clear. Hence, this study aims to improve the treatment planning and interventions in a way that will produce more favorable outcomes for this population.

The primary research method being utilized for this research study are qualitative interviews with experienced clinician's. This study will also use a methodized research question to guide a review of the pertinent literature that meets specific benchmarks. The basis for using qualitative interviews for this study lies in the availability of skilled clinicians with direct experience and detailed findings regarding their experience treating individuals with PTSD.. Therefore, ramifications derived from these interviews can be expored in a manner that will contribute additional depth and insight. By comparing where these studies are in

agreement, difference, or containing gaps this study will add to the comprehension regarding interventions most effective to address PTSD in light of varying circumstances.

Significance for Social Work Practice

The enhancement of comprehension derived from this study stands to serve as a compass which can guide improvements on both a micro and macro level. From a micro perspective, these findings can help social workers, therapists, and other service providers calibrate their efforts and improve their interventions through a deeper understanding of the nuances of their client's specific form of P.T.S.D. This would include improved ability to conduct assessments that provide more accurate depiction of the obstacles of clients. , This would in turn lead to developing treatment plans that are more tailored to the nuances of individuals suffering with PTSD. Therefore, there would ideally be a continuity of care that is reflective of and tailored to the individuals suffering from various forms of P.T.S.D. This could increase the likelihood that the appropriate intervention(s) (i.e. CBT, EMDR, group therapy, etc.) or combination of interventions is chosen and implemented. Insofar as macro social work, the evaluation of information from this study

may yield valuable insight regarding more effective and beneficial allocation of resources of the various agencies and organizations which treat and provide services to this population (Cloitre,2017). This includes Veterans

Affairs, behavioral health hospitals, and a myriad of other service providers. Furthermore, this research may illuminate deficits of information which may provide research opportunities for social workers specializing in the field of research. This will then create significant opportunities in the evolution of approaches for treating PTSD.

As the next generation of social workers continues to progress and enrich their understanding and education regarding P.T.S.D. and the conditions associated with this disorder, the quality of services and opportunities for favorable outcomes also has potential to evolve. Consequently, there is an opportunity to fine tune the approaches to delivering individualized treatment and therapeutic interventions to this vulnerable population. Hence, the driving purpose of this project is to ask better questions in order to get better answers. This fundamental question is: In what ways do various therapeutic interventions (CBT, EMDR, or group therapy) impact the symptoms of P.T.S.D.?

CHAPTER TWO
LITERATURE REVIEW
Introduction

The following chapter will provide an overview of reputable research as it relates to PTSD. This will include the intervention needs associated with this population, as well as key indicators and statistics accentuating the need for research and advances in treating this disorder. This will incorporate an examination of common evidenced based interventions used for PTSD and well as theories guiding conceptualization.

Intervention Needs for Population with P.T.S.D

Individuals suffering with P.T.S.D. experience symptoms and consequences that have far reaching detrimental implications for not only the afflicted individuals, but for their family members, and society at large. In addition to high rates of suicide and substance abuse among this population, there is also an array of lesser know adverse symptoms indicative of this disorder. Disassociation, self-injurious behaviors, problematic interpersonal functioning, emotional regulation difficulties, and low self-concept are some of the symptoms which are common among this population (Cloitre, 2011). Therefore, increasing the effectiveness of interventions and improving practitioner's ability to choose the appropriate approach will have the potential to improve the outcomes

associated with the healing process. As this wholeness and healing increases, self-destructive coping strategies diminish and in some cases may be reversed completely (Rosenthal, 2017).

Suicidal Association with P.T.S.D

Among the noteworthy evidence to support the need for improving interventions for individuals with P.T.S.D., is the disproportionate occurrence of suicidality among this population. 24% of the Army population who had been diagnosed with P.T.S.D. reported suicidality within the previous year. This is in stark contrast to the six percent of the general Army population reporting suicidality within the same study (Ramsawh, Fullerton, Mash, Kessler, Stein, Ursano, 2014). Furthermore, when P.T.S.D. and depression are combined, this study showed 45% suicidality among participants. Despite limitations of subjectivity that this self report design is susceptible to, numerous studies report similar findings (Ramsawh, 2014).

Sexual assault victims with P.T.S.D. also experience suicidal ideation and suicide attempts at levels considerably higher than average. Caruso (2017) from Suicide.org reports that 33% of these rape victims have suicidal thoughts, and 13% have suicide attempts. Caruso also emphasized that these suicide attempts often occur years after the actual sexual assault. This accentuates the long lasting nature of the mental and emotional scarring, further validating the need for perpetual improvement in interventions.

Substance Abuse and P.T.S.D.

In an attempt to anesthetize their suffering and retrieve some degree of control, people suffering with P.T.S.D. often resort to drug and alcohol abuse (Stout, 2017). In fact 52 percent of males and 28 percent of females meet the criteria for alcohol abuse or dependence. According to Stout, the same study showed comparable findings for drug abuse with 35 percent of men and 27 percent of women meeting this criteria (2017). This abuse of substances is often indicative of “avoidance” which is one the three generalized categories of symptoms related to P.T.S.D. These maladaptive coping strategies tend to culminate in legal problems, health issues, incarceration, chronic unemployment, and divorce. Hence, choosing appropriate interventions and formulating more appropriate treatment plans could make the difference in individuals living relatively healthy and content lives versus further deterioration due to self-medicating with alcohol and drugs.

Therapeutic Interventions for P.T.S.D.

P.T.S.D. is inherently imbedded with nuances and complexities that present challenges to the generation of treatments and interventions (Dossa, Hatam, 2012). Hence, the interventions or combinations thereof may not consistently fall into specific classifications, but may be integrated combinations of treatments tailored to the individual. Comprehensive bio-psycho-social factors

must be taken into consideration. This include consideration regarding the type of trauma, and whether one or multiple traumas were experienced (Dossa, Hatam, 2012).

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (C.B.T.) is a form of therapy commonly used for individuals with P.T.S.D. that involves perceptual reframing using a myriad of related techniques such as exposure therapy, cognitive restructuring, anxiety management, and relaxation training. These techniques also address maladaptive thoughts such as shame, inadequacy, and/or beliefs that the world and people in it are essentially unsafe. Dossa and Hatam (2012) identified C.B.T. as the first line of treatment for P.T.S.D. due to a wide-spread of agreement among studies reporting improvement in a range of symptoms. However, this study acknowledged limitations insofar as significant variations in quality and quantity of evidence between programs. Although difficult to quantify, studies have shown similar findings in qualitative accounts of symptom improvement in C.B.T. based programs, especially with a combined approach. Similarly, these cross-sectional studies also contained gaps due to selection of a sub-set of symptoms, as opposed to a more comprehensive spectrum of symptoms indicative of complex P.T.S.D. (Cloitre, et al., 2011). Therefore, this study seeks to contribute insight to some of these informational gaps, thus facilitating more constructive choices of specific interventions.

Eye Movement Desensitization and Reprocessing (E.M.D.R.)

Eye Movement Desensitization and Reprocessing (EMDR) therapy treats PTSD by combining psychotherapeutic techniques with bilateral stimulation using eye movements, tones, or taps. The combination of external stimuli integrated with concentration on past memories and triggers is believed to change associations and memories in a way that reprocesses and alleviates negative reactions (Vitzthum, Mache, Joachim, Quarcoo, Groneberg, 2009). Meta-analysis has shown EMDR to be more beneficial than other forms of psychological interventions with the exception of CBT (Bradley, Greene, Russ, Dutra, and Westen, 2005). However, according to Schnurr (2017), this treatment continues to be controversial due to a lack of clarity regarding exactly how EMDR works. Hence, by improving understanding regarding how this process impacts various symptoms, this study may help practitioners to know which cases are appropriate to apply this treatment.

Group Therapy

Unlike other forms of PTSD therapy, group therapy offers the advantage of fellowship and camaraderie by interacting with others who have shared similar experiences. Tull (2016) points to research which suggests that this altruism and social support of individuals with PTSD helping peers is a strong predictor of sustainable recovery (2016). Be that as it may, relying solely on this approach lacks the individual attention one may receive from a therapist. A comparable

study of 158 male vets with a mean age of 30.9 years showed significant clinical improvements in mental state, hope levels, and functioning when compared to pretreatment baseline after 15 group therapy sessions (Levi, Shoval, Fruchter, Bibi, Bar-Haim, Wald, 2017). However, these studies lacked randomized controlled trials, thus had gaps insofar as inability to soundly establish the benefits compared to other therapeutic approaches. This presents research opportunities to compare other modes of therapy with controlled conditions.

Theories Guiding Conceptualization

The fundamental theories used to guide conceptualization in this study are the Social Cognitive Theory and the Transactional Model for Stress and Coping Theory.

The Social Cognitive Theory as it pertains to PTSD is central to the development and reestablishment of self-efficacy, which is an integral part of multiple interventions, and varieties thereof. When this self-efficacy is deficient, individuals view their environment with a sense of unmanageability. Due to a skewed focus on their coping deficits, they are prone to catastrophizing and distorting possible threats (Benight, 2003). Therefore, this model emphasizes adaptation as opposed to merely reacting or protecting oneself from vulnerabilities. This approach of enablement and development of personal resources is conducive to recovery from PTSD, despite the source of the trauma. Therefore, it is applicable to individuals suffering with PTSD stemming from

military trauma, interpersonal trauma, disasters, or terrorist attacks (Benight, Bandura, 2003).

The Transactional Model of Stress and Coping Theory provides a framework for assessing the processes of managing trauma and stressful events (Glanz, Rimer, 2002). Glanz and Rimer (2002) describe one the essential aspects of this theory as *primary appraisal* which is an individual's perception about the implication of an event. Subsequent to primary appraisal is what is termed *second appraisal* which assesses resources and options used to cope with the event (Glanz, Rimer, 2002). Pursuing this approach is appropriate due to the broad range of therapeutic concepts used for PTSD which are guided by this theory. Interventions which have potential to impact the symptoms of PTSD such as problem management, emotional regulation, and meaning-based coping are all strategies contained within this theory.

Summary

It is noteworthy to acknowledge that although the aforementioned therapies and guiding theories are not an exhaustive summation of the available approaches PTSD, these are the primary evidence based interventions that have yielded significant improvements in symptoms. It is also important to conceptualize that these theories and interventions are often blended in a way that are tailored to the individual, and not necessarily done in an isolated fashion.

CHAPTER THREE

METHODS

Introduction

This research explored the interventions most appropriate and effective for healing individuals with PTSD, as well as identifying the circumstantial nuances that guide clinicians to adjust their approach. Details on implementation of processes used in this research will be discussed in this chapter. These sections will elaborate on methods for study design, sampling, data collection, protecting human subjects, and analysis.

Study Design

This research utilized qualitative interviews with licensed or certified clinicians to gain key discernment by exploring themes, analyzing gaps, and discussing areas of agreement as well as dissent regarding the therapeutic interventions that yield the most favorable results. Due to the nature of interviews approaching clinical questions and subject matter by retrieving viewpoints from experienced clinicians, this study was primarily qualitative in nature. Hence, this approach elicited participant's unique experiences and findings insofar as treating individuals with PTSD. This process utilized open ended questions to search for the most pertinent and effective interventions relevant to the aforementioned research question. The various research then underwent an extraction process where relevant data was taken and combined with other appropriate themes.

Subsequently, this data then yielded an overall pattern or result which can be used to refine clinical practices. These findings can be useful guides for clinicians in the field of social work and human services who provide services for this population.

Some key strengths of the qualitative interview approach is that it provides an opportunity to elicit detailed information regarding specific interventions. In addition to shedding light on social processes, this approach also established a process where two-way dialog between the researcher and clinician can transcend surface discussion and delve deeper into clinical questions that practicing clinicians may struggle with. Therefore, this may have revealed information to enhance the quality of treatment decisions. Furthermore, these findings have potential to lead to the creation of a hypothesis for further investigation and research opportunities.

The qualitative interview design being used for this study does have some innate limitations which the process will aim to minimize. For example, knowledge obtained may not apply to a particular individual with PTSD. As with any qualitative research, the validity of this research will rely significantly on the experience and qualifications of the respondents. Hence, the participants were chosen carefully based on their experience and qualifications in treating this population. Another constitutional limitation of the qualitative interviews is that if combined or interpreted inappropriately they may not yield information that is accurate or beneficial to practitioners.

Sampling

The sample of participants utilized for this research was a non-random purposive sample of 8 clinicians who practice privately or at various agencies. The majority of participants have been or are currently colleagues of this researcher, and are known to be skilled clinicians who have worked with this population. The established criteria for inclusion in this study was based on being licensed or certified in the state of California as a: Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, PsyD., or Certified Alcohol and Drug Counselor. Furthermore, all clinicians chosen were identified to have a minimum of 5 years of clinical experience treating individuals with PTSD usually combined with other co-occurring disorders. Due, to the varied backgrounds of these clinicians, the insights obtained provided a deeper holistic understanding of the considerations involved in treating this population.

Data Collection and Instruments

Data Collection began with an extensive examination of peer reviewed literature pertaining to PTSD, followed by qualitative interviews conducted between January and March of 2019. This collection process encompassed several reputable data bases such as Google Scholar, MEDLINE, Pfau Library and Scholarworks, and involve CSUSB library personnel experienced in literature searches. Interviews were recorded live on a digital audio storage device, and then uploaded to a software service which transcribed the audio into transcripts. After prescreening based on the aforementioned criteria, basic demographics

were collected, including years of experience, type of license or certification, area of practice, and years of education. (see Appendix B.)

The interviews with participants were guided by a sequence of topics and interview questions pertaining to treating individuals with PTSD (see appendix B). These open ended questions were crafted specifically for this study. Subsequently, they were refined and submitted for approval by Dr. Thomas Davis. The purpose of this interview guide was to generate detailed responses from participants which delve deeply into their own years of experiences working with this population. The interview guide contained 12 questions pertaining to some of the most difficult circumstances that occur when treating individuals with PTSD. Some of the issues addressed in the questionnaire include the exploration of interventions for self-harm (“cutting”), establishing rapport with a clients of the opposite sex or different background, and transcending self blame and/or isolative behaviors. This tool allowed for open-ended questions to provoke meaningful dialogue, clarification, and two-way communication. Although there was overlap and common themes which emerged in the participants responses, there were also new insights and alternative therapeutic approaches which could only be obtained using a qualitative interview design.

Limitations associated with this instrument were simply the time constraints which required that questioning be limited in an effort to not overburden the participants with excessive questioning. Therefore, there were

areas of interest pertaining to interventions for PTSD which were left unexplored. However, the literature review contributed to addressing some of these gaps.

Procedures

An initial text message was sent out to approximately 12 clinicians who are part of the researcher's professional network of colleagues and acquaintances. Of these 12 clinicians, 8 participants were selected based on availability and interest in contributing to the research. Participants consented to being recorded via digital audio and the interviews were scheduled.

The interviews (data collection) took place in neutral non-agency locations with adequate privacy. Due to logistics, several interviews were conducted and recorded via speaker phone. Researcher Sean Howell conducted the interviews with the clinicians individually, after assurance of confidentiality. The time needed for the interviews varied, lasting from 20 to 50 minutes.

Protection of Human Subjects

This research design collected basic demographic information pertaining to the profile of the participants, without the collection of signatures on any documentation. Signatures were purposely omitted to ensure protection and confidentiality of the subjects. Participants provided their consent after being

read the informed consent and acknowledging their acceptance of the information communicated on this document (see Appendix C).

Privacy, confidentiality, and safety was maintained due to the construct of this process.

Upon conclusion of the interviews and the stopping of the recorder, the interviewees were informed what transpires with the information they provided. Audio recordings are stored on an encrypted USB drive in a locked desk. A transcribing software, Temi.com, converted the recordings from audio into transcripts. One year after the completion of this study, all recordings will be deleted and destroyed. Participants were thanked for their participation and ensured that they would be provided a final version of the research project upon conclusion.

Data

The culmination of the data collection, transcribing, and review resulted in an analysis of the data which compared various forms of therapeutic interventions on individuals with PTSD. In order to categorize these transcripts and make some assessments, the next step was to code and assign a definitive thematic structure. These tables included variables such as: military and first responders with PTSD, children/adolescents with PTSD, adults with PTSD due to childhood trauma, non-military clinicians establishing rapport with veterans, transcending self-blame in trauma survivors, and reducing isolation and

avoidance behaviors. These themes were then explored in their context to achieve the purpose of delving deeper into elements pertaining to treatment and interventions which may have been neglected or lack sufficient research.

Summary

At the conclusion of this process of identifying participants, conducting qualitative interviews, and analyzing responses , the research concluded with a meaningful communication of results that can enhance clinicians ability to practice with this population. Furthermore, this study will strive to acknowledge and define any biases that may have been introduced, as well as encapsulating characteristics and benefits of the research as a whole. Ultimately, this will conclude with providing clinical significance of the research as well as new insight pertaining to therapeutic interventions for individuals suffering with PTSD.

CHAPTER FOUR

RESULTS

Introduction

The process of conducting qualitative interviews with seasoned professionals regarding their experience providing therapy and other services to individuals with PTSD, revealed some common themes as well as nuanced findings and alternative therapeutic approaches. Despite the fact that the DSM 5 delineates the symptoms of PTSD, it does not delve into the deeper human elements, idiosyncrasies, and circumstances that contribute to these symptoms. These considerations are imperative in formulating individualized interventions and connecting on a human level to help clients suffering with trauma improve their functioning and overall wellness. Hence, this study seeks to explore interventions and identify essential forethoughts by categorizing ideas and people into their respective classifications. Demographics of clinician participants will be presented, followed by elements of persons with PTSD.

Analyses

The participant's demographic information is displayed in Table 1. Participant's years of experience ranged from 5 years to several decades. All have years of clinical experience treating individuals with various forms of PTSD or unresolved trauma. Practice interests ranged from chemical dependency,

trauma informed family therapy, individual therapy, EMDR, and Trama Focused Cognitive Behavioral Therapy. Participants represent a broad professional clinical background and were hand selected due their compassion for their clients and concern for enhancing the human condition.

Tables 2 thru 7 display the components of treating PTSD organized by people, places, and ideas. The ideas section will be further broken down into subcategories for more concise examination. There will be an emphasis on the data containing quotations pertaining to specific topics in order to extract insights from clinicians regarding these topics.

Data Thematic Results

The problem formulation question for this study was: What are the therapeutic interventions most effective at improving the symptoms of PTSD? This was designed to be an exploration into the interventions and considerations which social workers and therapists should consider when treating this population. Furthermore, it is research intended to complement or illuminate gaps in the research available in the known literature. The collection of data culminated in the emergence of three main themes: human connection and trust is an indispensable prerequisite to establish a therapeutic relationship, deconstructing self-blame is an essential step in healing (especially with sexual trauma), and allowing the client to be in control during talk therapy sessions.

Table 1. Demographics of Research Participants

DEMOGRAPHIC	Participant Response
Age:	48,40,35,57,39,43,78,59
License/Cert.:	CADC II, CADC II, LMFT, LCSW, CADCII, PsyD., LMFT, (LMFT, BSN,PHN)
Years of Clinical Experience:	10, 14, 5, 20, 8, 9, 30, 9
Years of Secondary Formal Education:	6,10, 4, 6, 9, 6, 6, 17.5
Practice Interests:	Chemical dependency counseling (acute, residential, and outpatient), mental health therapy, dual diagnosis, adolescent sexual trauma, military/first responder trauma, Eye Movement Desensitization and Reprocessing (EMDR), family therapy, couples counseling, micro social work, and case management.

Table 2. Research Category: People-Military and First Responders with PTSD

Content/Theme
<ul style="list-style-type: none"> • Veterans with PTSD due to combat trauma • First responders with trauma (such as firemen, police, and ambulance). • Veterans with trauma and co-occurring disorders • Military and / or first responders with substance abuse and PTSD • Veterans with trauma and “survivors guilt” • Veterans or first responders coping with divorce or family discord due to symptoms of military or first responder related trauma

Table 3: Research Category: Children or Adolescents with PTSD

Content/Theme
<ul style="list-style-type: none">• Children with PTSD due to witnessing domestic violence.• Children/adolescents with trauma resulting from sexual abuse.• Children/adolescents with trauma due to abuse from parent/caretaker.• Children/adolescents with trauma due to severe neglect .• Children with PTSD due to witnessing a murder or death.• Children/adolescents engaging in self harm or self soothing (i.e. cutting) as a coping mechanism for PTSD.• Suicidal ideation among children/adolescents with PTSD,

Table 4: Research Category: Adults with PTSD from childhood trauma

Content/Theme
<ul style="list-style-type: none">• Adults with co-occurring substance abuse and childhood trauma• Adults who live with or care for a parent who caused childhood trauma• Adults who blame themselves for a portion of their trauma• Adults with resentment and anger management stemming from childhood trauma.• Isolative behavior in adults with trauma.• Suicidal/Homicidal ideation among adults with childhood trauma• Adults with low self esteem and trust issues stemming from PTSD based in childhood trauma.

Table 5: Research Category: Establishing rapport and trust

Content/Theme
(Personal Communication, Participant 2, January 2019) <ul style="list-style-type: none">• “The first thing is for them to trust you and connect with you as a person. Then let them know that ‘I can’t even begin to understand your pain, but if you help me understand, I’d like to help you through it’.”• “Don’t try to make them think you understand something that you really don’t.”
(Personal Communication, Participant 3, January 2019) <ul style="list-style-type: none">• “Get to know the client. Don’t start by digging into their story. They’ll share their story when their ready.”
(Personal Communication, Participant 4, January 2019) <ul style="list-style-type: none">• “You have to be able to establish a safe place for them. Sometimes it takes a long time to gain that trust.”• “Military trauma is a little different, but it’s still trauma and we treat it the same way.”
(Personal Communication, Participant 6, January 2019) <ul style="list-style-type: none">• “If you don’t have military experience just be empathic, listen, and validate their feelings. It’s okay for you to say ‘I don’t know’”.
(Personal Communication, Participant 7, February 2019) <ul style="list-style-type: none">• “I like to convey respect by letting them know that I am truly grateful for people who put themselves in harms way to protect us.”

(Personal Communication, Participant 8, February 2019)

- “Training is important. The VA has videos on how deployment impacts the children and the family. If you can stomach it, there are also videos that give you an idea of what they went through.”

Table 6: Research Category: Ideas-Transcending self blame

Content/Theme

(Personal Communication, Participant #2)

- “You have to realize and acknowledge that it’s scary for them. You’re asking them to no longer be a victim, but to be a powerful survivor. That creates a loss of part of their identity.”

(Personal Communication, Participant #3)

- “It’s about persistent reframing to relieve the client of their fault. I had a client I thought I was going nowhere with for a whole year. They came back and said, ‘I heard what you said. It’s not my fault.’”

(Personal Communication, Participant #4)

- “I had a client who said she deserved it because she was a bad kid. I said, ‘What made you a bad kid?’ She explained something and I said, ‘If your child did that would you bring in his uncle to rape him?’ She said, ‘Of course not. No child deserves that.’ If you bring in someone they love and want to care for and put them in that situation, it helps them to stop being so subjective.”

(Personal Communication, Participant #6)

- “I think it’s to not just tell them it’s not their fault, but to walk them through why it’s not their fault and why it was out of their control.”

(Personal Communication, Participant #7)

- “When they are referencing trauma from when they were a child, they are a child in that moment.”

(Personal Communication, Participant #8)

- “You have to ask them, ‘What is your core belief? What is your core value? When we process it, we can get past it.’”

Summary

Interventions for various circumstances associated with PTSD were deconstructed and classified into people and ideas. These were acquired through thematic analysis of different aspects the therapeutic process of treating PTSD and unresolved trauma. Clinician’s experiences and perceptions regarding the research questions were gathered to provide deeper insight into treating the population suffering with PTSD due to military service, first responder trauma, violence, sexual trauma, or childhood abuse. A comprehensive explanation and analysis of different aspects of treating PTSD will be documented in the next section.

CHAPTER FIVE

DISCUSSION

Introduction

This section will concern itself with the important facets and considerations delineated in Chapter 4 which should be given careful contemplation by social workers providing therapy and services to this population. These discussions aim to extract meaning from these themes in a manner that will enhance a clinician's ability to utilize these concepts and findings to improve their practice and outcomes for clients with PTSD. The points of discussion have been extricated on the basis of their importance from the prior tables presented. These include: Military/first responders with PTSD, children with PTSD due to violence or sexual abuse, adults with PTSD due to childhood trauma, non-military clinicians establishing rapport with veterans, transcending self-blame/third party projection theory. These issues will be further explored to produce insight on opportunities for future research and ramifications to social work policy.

Discussion

Military based PTSD

Military and first responders with PTSD was extracted from the category of people, and deserves special consideration due to some of the nuances

associated with this population. Because these individuals entered into their line of service with an expectation of encountering danger and traumatic situations, their identity is often associated with being resilient, strong, and serving others. Therefore, military and first responders are often taught to detach from emotions. Deviation from this school of thought can often be viewed as a weakness. This often contributes to a “code” or camaraderie which may lend itself toward secrecy or only communicating about trauma with other military or first responder service providers. For this reason it is important for clinicians treating this population to be mindful to not be excessively eager to overcompensate in an effort to get their clients to self-disclose. An ex-military interviewee who also is an MFT explained, “Just focus on the rapport and connection. Don’t try to share the military stories with them or try too hard to relate.” (Personal Communication, Participant 3, January 2019). This quotation suggests then that the process of shedding the emotional armor of military and first responders should be a gradual and unforced process. Furthermore, from a cultural perspective some of the norms within this population (i.e. secrecy, or “the code”) may need to be reevaluated to assess their helpfulness or lack thereof in this population recovering from the symptoms of PTSD.

Understanding contributing systemic dynamics relating to military and first responders with PTSD can also have implications on treating co-occurring disorders such as alcohol and drug abuse and addiction. Due to the inherent suffering, discomfort, and isolation that coincides with PTSD in the military

population with this disorder is at a much higher risk than the general population of anesthetizing their emotions with alcohol or drugs, thus often leading to substance abuse. In fact, approximately 45% of non combat related deaths among military personnel were attributed to alcohol or drug overdose (Tagliareni ,2018). This longing for relief and lack of outlet for discussing emotions creates a perfect storm for making this population especially susceptible to substance abuse. Gabor Mate, M.D. (2008), provided his theory on addiction and its connection to PTSD,

Far more than a quest for pleasure, chronic substance abuse is the addicts attempt to escape distress. Addictions always originate in pain, whether they be felt openly or hidden in the unconscious. They are emotional anesthetics. (p.247)

Therefore understanding substance abuse and addiction, especially with military and first responders requires the clinician to establish a deeper comprehension of what alleviation the individual is obtaining or striving to obtain in their abuse of substances. Without this foundation of understanding among both the client and clinician, recovery from substance abuse and PTSD can be a challenging prospect due to the continued destructive cycle of escapism, avoidance, and shame. One interviewee explained, “Avoiding triggers does not heal triggers. Avoiding triggers keeps you imprisoned.” (Personal Communication, Participant 2, January 2019). This quotation implies that that exposure therapy through gradually discussing the trauma and moving the difficult memories into neutral

territory can also be beneficial by reducing the negative emotions which are contributing to the substance abuse. Furthermore, motivational interviewing can help the client identify the costs and benefits of self-medicating with drugs and alcohol, which can contribute to their movement toward the next stage of change.

Children/Adolescents with PTSD

Due to the potential for long term devastation and adverse manifestations, PTSD based in childhood or adolescent trauma deserves special attention. Maladaptive compensatory responses stemming from childhood trauma due to violence, sexual abuse, neglect, or severe illness disrupt and resets homeostasis during a formative life stage. This in turn causes this “new” homeostasis which consumes more energy than the prior state. Hence there is a mediating stress response which when activated repeatedly can alter a child’s neurochemistry (Perry, 2019). Therefore, it is essential to understand that the child has been impacted at a cellular level. When they are triggered, even if it’s just by memory, as far as their body is concerned the traumatic event is occurring again in the present moment. An interviewee specializing in Eye Movement Desensitization and Reprocessing stated, “One of the things I’ve learned is that with PTSD, your past is your present” (Personal Communication, Participant 8, 2019).

Childhood trauma rooted in abuse or neglect from the parent or guardian tends to be one of the most damaging categories of trauma, hence these situations hold particular implications for the clinician providing therapy and other services. Few forms of betrayal can be more detrimental than when a parent or

guardian that a child depends on for survival and safety violates that trust and compromises their well being. Not only can this type of trauma cause attachment problems which have a long term impact on a child or adolescents ability to trust and form healthy interpersonal relationships later in life, but it can also manifest in a myriad of symptoms which can cause functional impairment. Intrusive negative thoughts, nightmares, irritability, concentration problems, substance abuse, self harm (“cutting”), and exaggerated negative beliefs about themselves are just of few of the expressions which can occur if this disorder goes untreated. Therefore, the clinician’s primary role is to establish trust and rapport by being present, compassionate, and unconditionally supportive to their young clients in order to make them feel valued and safe. Then an individualized treatment plan can be formulated which may integrate a combination of anxiety management techniques (i.e. visualization, grounding, mindfulness), exposure therapy (In-vivo), group therapy, and belief alterations such as Trauma Focused Cognitive Behavioral Therapy. In severe cases, psychiatrist services may also be an appropriate addition to the treatment plan.

An often overlooked component of providing treatment for children with PTSD, is for the clinician to make time for self-awareness and reflection. One interviewee who specializes in Seeking Safety, a module for trauma and substance abuse, accentuated the importance of asking a very simple but vital question, “How are we being affected?” (Personal Communication, Participant 5, February 2015). This perpetual self awareness is a vital skill because emotions

or secondary trauma experienced by the clinician which go unrecognized can cause changes in behavior or body language of the clinician which may negatively impact connection and communication with young clients who are already in a fragile emotional state. Hence, it's important to comprehend the distinction between experiencing counter transference, and allowing ones clinical skills to be altered by those emotions.

Adults with PTSD from Childhood Trauma

The category of adults with PTSD due to childhood trauma emerged as an area of particular interest to this researcher due to the fact that so little is known about the biological effects of adults with trauma history. Hence this is an area of potential opportunity for further research. A noteworthy fact regarding adults with PTSD due to childhood trauma is that they have significantly shorter telomere length (DeBellis, Zisk, 2014). Telomeres are composed of DNA protein that caps and protects the end of chromosomes. Shorter telomeres are associated with higher risk of cancer, cardiovascular disease, autoimmune diseases, and early death (2014).

According to DeBellis and Zisk (2014), social support has been shown to be a buffer against some of the psychological and biological consequences suffered by adults with PTSD stemming from childhood trauma. The adverse impact of psychological stress and dysregulation tend to be lessened when there are healthy social networks and interaction in place. This is especially true when individuals are able to use their experiences to help others, such as in self help

groups or 12 step fellowships. However, isolative behavior is a common behavioral problem among adults with PTSD. Therefore, this population often avoids the very therapeutic social interaction that can help regulate mood, decrease destructive behavior, and improve outcomes. Even within treatment centers which incorporate social support, individuals within this population tend to find ways to isolate. Hence, part of the clinician's role is to find creative ways to improve the clients awareness regarding the underlying reasons for their isolative behavior and gradually increase exposure to positive social support. One interviewee with experience in residential treatment describes her approach to an individual with PTSD who she noticed was isolating, "I try to spark a conversation

just to let them know that someone is noticing and paying attention.

Sometimes I'll give them a job or make them my assistant to get them involved rather than them just sitting in the corner" (Personal Communication, Participant 2, January 2018).

In the more severe cases of isolative tendencies where group therapy or residential treatment is not an acceptable option, one ex military interviewee described his approach stating, "In those cases I like to give homework

assignments like simple people watching. Between sessions have them go to the park and just observe people without necessarily interacting with people. Then they report their experience and escalate to interacting with people" (Personal Communication, Participant 3, January 2019).

It bears mentioning that in either of the aforementioned approaches the prerequisite is that a strong therapeutic bond and rapport has been established between the clinician and client. Without this relationship the likelihood of the client following through with the intervention or the “homework” assignment is minimal.

Unresolved anger and resentment is another common theme that interviewees mentioned during the discussion of adults with PTSD stemming from childhood trauma. Similar to stress, prolonged anger and resentment harbored toward the perpetrator can have negative psychological and biological impact. Aside from known remedies such as exercise and talk therapy, there are some therapeutic interventions such as the “Angry Letter” or “Empty Chair” which can have a cleansing effect. The angry letter is a writing assignment designed to empower the client by expressing unresolved anger and resentment toward the perpetrator and then finishing the letter with the importance of forgiveness. If forgiveness is too strong of a word for the client, then indifference or acceptance can be an appropriate stepping stone to letting go. This angry letter is not necessarily shared with the perpetrator, but is read with the therapist and then perhaps burned or ripped into pieces in a ceremony symbolizing a new beginning. Similarly, the empty chair exercise allows the client to say things left unsaid to an empty chair in order to alleviate anger and resentment. Part of these interventions include psycho education where clients are educated that

anger is often a secondary emotion, with the primary underlying emotions being fear and sadness (or some variation thereof).

Establishing rapport: Non military clinicians gaining trust with military and law enforcement persons with PTSD

Due to the fact that the majority of social workers and clinicians treating combat and first responder related trauma do not have any direct personal experience with these types of traumatic events, building trust and rapport with this population can be one of the seminal challenges of effectively treating these individuals. Furthermore, there is a marked lack of research and attention given to exploring the best techniques and practices to overcome this obstacle.

Despite the fact that there is an abundance of research exploring effectiveness of various theories and interventions to address this form of PTSD, it is noteworthy to mention that in the absence of a sound therapeutic relationship with the clinician who may be orchestrating and/or implementing these interventions, it is unlikely that they will ever be carried out due to lack of buy in from the client. Therefore, the prerequisite for fulfilling potential interventions is to overcome actual and perceived differences between the clinician and client and establish a human connection.

One of the reoccurring themes among the clinicians being interviewed is the notion that knowing what not to do is as important as knowing what to do. In an eagerness to make the client with military or combat based PTSD feel understood, clinicians may act as if they understand something that they really

don't. Though well intentioned, this usually does not prove to be an effective or authentic approach with this population. One interviewee explained, "Let them know that 'I can't even begin to understand your pain, but if you help me understand, I'd like to help you through it.'" (Personal Communication, Participant 2, February 2019).

Offering unconditional positive regard and respect is another common area of consent among the clinicians interviewed. This applies not only to combat veterans, but to first responders such as firemen or emergency medical technicians who witness human tragedy on a regular basis. This researcher recalls facilitating a process group for residential clients recovering from alcoholism and addiction. At one point a client who is a firefighter by profession opened up about what it was like to pull a lifeless infant from the bottom of a swimming pool, and then later have to go home to his family and pretend he was okay. These types of trauma can have transformational conscious and unconscious impact on these individuals. Conveying support, respect, and appreciation can help lay the foundation for the therapeutic relationship. One interviewee stated, "I like to convey respect by letting them know that I am truly grateful for people who put themselves in harms way to protect us." (Personal Communication, Participant 7, February 2019). Expressions of admiration like these help to fulfill the human need to be appreciated and respected.

Perpetual training and development among social workers is an important component of helping social workers establish rapport and connection. One interviewee who specializes in providing EMDR services stated, “Training is important. The VA has videos on how deployment impacts the children and family. If you can stomach it, there are also videos that give you an idea of what they went through.” (Personal communication, Participant 8, February 2019) This implies that training and education regarding PTSD should be a continuous process that goes beyond text books and utilizes different sources and perspectives of training and education.

Transcending self blame

Although it is not included as a symptom in the DSM 5, one of the most difficult and commonly overlooked cognitive distortions among individuals with PTSD is the phenomenon of blaming themselves for the trauma they experienced. This is especially true in the case of victims of violence or sexual abuse, but also occurs in combat related PTSD in the form of “survivors guilt” or some variation thereof. This unhelpful style of thinking lends itself to a maladaptive interpretation of their experiences, thus contributing to shame and often manifesting in self-destructive and/or self defeating behavior. For a survivor of sexual abuse this may take the form of the victim believing that they bear responsibility for all or perhaps a disproportionately large portion of blame for what they endured. For a combat veteran, law enforcement, or first responder with PTSD this self blame may manifest in rumination in past

punishing themselves mentally for not doing enough, or agonizing over how they could have done things differently to produce different outcomes. A common variation of this is called survivors guilt where survivors of a combat or catastrophe feel guilt for having survived where others perished.

Diligent and purposeful identification and replacement of maladaptive thoughts, (i.e. Trauma Focused Cognitive Behavioral Therapy), appears to be one of the most effective strategies to reduce or eliminate self blame and survivors guilt, according to the interviewees. One interviewee explained, “It’s about persistent reframing to relieve the client of their fault. I had a client I thought I was going nowhere with for a whole year. They came back and said, ‘I heard what you said. It’s not my fault’”. (Personal Communication, Participant 3, January 2019). The key word here is “persistent”. Not only is there no harm in repeating an essential concept, but this repetition may be necessary to counteract longstanding irrational belief systems and deconstruct responsibility. Another interviewee expanded on this concept stating, “I think it’s not enough just to tell them it’s not their fault, but to walk them through why it’s not their fault and why it was out of their control.” (Personal Communication, Participant 6 , January 2019)

In cases where there is violence, sexual assault, or abuse it may be helpful to assess for the presence of and/or severity of self blame. A “blame pie” is a simple therapeutic tool where the therapist draws a circle and hands the pen to the client instructing them to illustrate how big a piece of the pie they feel they

are to blame for, and how big of the piece the offender is responsible for. This can create a more accurate picture for the clinician insofar as the severity and magnitude of the self blame and resulting shame based thoughts and beliefs. As one interviewee explained, “You have to ask them, “What is your core belief? What is your core value? When we process it, we can get past it.” (Personal Communication, Participant 8, February 2019)

There are instances where the severity of a clients distorted sense of self blame are so severe that creative interventions may be therapeutic to help the client see reality from a clearer and less subjective perspective by using techniques such as third party projection. An interviewee with an extensive history treating clients with these distortions narrated one such experience with an adult incest survivor with PTSD, “I had a client who said she deserved it

because she was a bad kid? She explained something and I said, ‘If your child did that would you bring in his uncle to rape him?’ She said, ‘Of course not. No child deserves that.’ If you bring in someone they love and care for and put them in that situation, it helps them to stop being so subjective.” (Personal Communication, Participant 4, January 2019)

This technique may appear slightly extreme and such measures should be used sparingly and mindfully. However, it is important to acknowledge that when you are treating a client whose reality is being filtered through shame and self hatred, such measures may be appropriate to help them return to a more accurate depiction of reality and realize their true value as a human being.

This increased awareness can be a stepping stone to the realization that that their past experiences do have to retain power over their present and future, if they choose to make the effort to accept their life as a whole.

Recommendations for Social Work Research, Policy and Practice

Research

As a consequence of the prior literature review and qualitative interview research it is apparent that there is a marked lack of research insofar as specific clinical techniques for clinicians to establish trust and rapport with military and first responders with PTSD. As mentioned, the acceptance and effectiveness of any of the proven interventions is often largely contingent on the strength of this therapeutic relationship. Therefore, one recommendation would be further research that combines both qualitative and quantitative analysis to gain insight on techniques and attributes that assist clinicians in moving their clients to disarm emotionally, and allow vulnerable process that is conducive to the therapeutic process. Future research should include input from individuals with PTSD in an effort to gain their perspective on what would be of most benefit. These findings could then be integrated with what is known about the systemic dynamics relating to military and first responders with PTSD, in order to educate social workers and other clinicians.

Despite the fact that there is ample research on some proven interventions such as Trauma Focused Cognitive Behavioral Therapy, EMDR, and medications, there is little research specifically pertaining to how exercises in

self awareness and self reflection can impact a clinician's ability to improve outcomes with clients with PTSD. Clinician exposure to secondary trauma and the need to be empathically available to clients with PTSD inevitably impact the internal state of social workers. Therefore, this is an intriguing area of potential research to contrast clinicians who practice specific techniques of self awareness, carefully considering transference and counter transference issues with clinicians who are less inclined to rigorous self awareness in their practice.

Policy

As social workers, clinicians, and policy makers strive to further advancements in treating individuals with PTSD, it is significant to mention that policy to shift some emphasis into exploration of non-pharmacological remedies would be beneficial. Side effects and risks of abuse from over prescription of anti-psychotics, opioids, and benzodiazepines has been especially concerning with this population. Because non medicinal interventions do not have the profit potential of pharmacy driven interventions, there has been less research and attention given to these options. For example, a white water rafting program in Montana combines physical activity, socialization, and exposure to nature to provide healing for individuals struggling with PTSD. Therefore, while there is certainly benefits in some instances to medication, self determination should be respected among clients seeking alternatives. This means matching them with preferably evidenced based interventions which are in alignment with their preferences.

Policy at the University level in regards to curriculum and disseminating the knowledge and skills to provide services to individuals with trauma has room for refinement. While theory, vignettes, and general information are usually adequately addressed, there tends to be little in depth discussion or practical exposure to some of these evidence based practices. Hence, having MSW programs include seminars focused on proven treatment strategies for PTSD such as Seeking Safety and Trauma Focused Cognitive Behavioral Therapy, would help the next generation of social workers acquire the skills and knowledge base to provide compassionate and effective treatment to this population.

Social Work Practice and Conclusions

In conclusion , improving and refining interventions for individuals with PTSD are of vital importance not only for the persons suffering with this disorder, but for their families, friends, employers, coworkers, and for society at large. As a stone is cast into a still body of water it is evident to a mindful observer that the ripples from this impact eventually transform every inch of that body of water. Similarly, the potential ramifications of positively influencing the lives of persons with PTSD and providing needed support should be the concern of not only social workers, but of society because of the larger connection to the community. The discussion then evolves to a paradigm shift where perpetual advances and improvements treating individuals and families with unresolved trauma becomes

a driving purpose. The prerequisite for this is establishing human connection and therapeutic relationships with the persons afflicted, because in the end it's not just about them. It's about us.

APPENDIX A
EMAIL AND TEXT INFORMATION

The following template is a general guideline for initial communication with participants in an effort to elicit their contributions to this research project. The majority of participants have been coworkers and professional colleagues of this writer. Therefore, in some instances initial communication was done much more informally.

Hello (Potential Interviewee Name).

“My name is Sean Howell and I am reaching out to you to ask for your participation in my research project. Due to your background and clinical experience with the population struggling with PTSD or unresolved trauma I believe your contribution to this project would be valuable. It involves a 20-40 minute interview exploring your experience providing clinical services to this population. What would be a convenient time for us to meet?
Should you have any questions please do not hesitate to contact me.”

(Developed by Sean Howell)

APPENDIX B
DEMOGRAPHICS AND INTERVIEW QUESTIONS

This interview consists of basic demographic questions and 12 explorative questions crafted to delve into some difficult clinical issues pertaining to providing services to this population. Although thoroughness is encouraged, feel free to omit any information which you do not wish to provide or terminate this interview at any time.

Age: _____

Licensure (Title): _____

Achieved Years of Secondary Education: _____

Years of Clinical Experience: _____

Practice Interests:

Problem Formulation Question

What are the therapeutic interventions most effective at improving the symptoms of PTSD?

Qualitative Interview Questions

- 1) How can a therapist with no personal military background establish rapport and connection with a client suffering with military based PTSD?
- 2) What interventions are most effective at reducing isolative and avoidance behaviors?
- 3) How can a therapist of the opposite gender establish trust and connection with a client who was the victim of sexual trauma?

- 4) What interventions have assisted PTSD clients prone to self-harm/self mutilation, reduce or stop these behaviors?
- 5) Can you describe how exposure therapy can help with symptoms of PTSD? What are its limitations?
- 6) How do you develop trust and rapport with PTSD clients who feel like no one understands?
- 7) Can you describe the combination of interventions which have the most favorable outcome for military or catastrophe based PTSD?
- 8) Can you describe the interventions, or combination thereof, which have the most favorable impact on clients with PTSD based in violence of sexual trauma?
- 9) What nuances need to be considered when treating an adult whose unresolved trauma occurred in childhood?
- 10) What has been the most effective method at helping clients who blame themselves for their trauma?
- 11) Can you describe the treatment methods you've found effective at helping military or service providers who experience survivor's guilt?
- 12) What techniques seem to be most helpful at reducing suicidal ideation in clients suffering with PTSD?

(Developed by Sean Howell)

APPENDIX C
INFORMED CONSENT



California State University, San Bernardino
Social Work Institutional Review Board Sub-Committee
APPROVED 6/21/2018 VOID AFTER 6/20/2019
IRB# SW 1862 CHAIR *Janeilly*

College of Social and Behavioral Sciences
School of Social Work

Informed Consent

The study which you are asked to participate is designed to examine clinicians' views on effective therapeutic interventions at improving the symptoms of PTSD. The study is being conducted by Sean Howell, a graduate student, under the supervision of Dr. Thomas Davis, a professor in the School of Social Work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board Social Work Sub-committee at CSUSB.

PURPOSE: The purpose of this study is to examine clinicians' views on effective therapeutic interventions most at improving the symptoms associated with PTSD.

DESCRIPTIONS: Participants will be asked open-ended questions regarding their experience treating clients with PTSD and the various factors pertaining favorable outcomes.

PARTICIPATION: Your participation in the study is totally voluntary. You can refuse to participate in the study or discontinue your participation at any time without consequences.

CONFIDENTIALITY OR ANONYMITY: Your responses will remain anonymous and data will be reported in group form only.

DURATION: It will take 1-1.5 hours to complete interviews.

RISKS: There are no foreseeable risks to the participants.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Davis at (909) 537-3839.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks database. (<http://scholarworks.lib.csusb.edu/>) at Cal State University, San Bernardino after July 2019.

I agree to be tape recorded: YES NO

This is to certify that I read the above and I am 18 years older

Place an X mark here

Date

909.537.5501 · 909.537.7029

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

The California State University · Bakersfield · Channel Islands · Chico · Dominguez Hills · East Bay · Fresno · Fullerton · Humboldt · Long Beach · Los Angeles
Maritime Academy · Monterey Bay · Northridge · Pomona · Sacramento · San Bernardino · San Diego · San Francisco · San Jose · San Luis Obispo · San Marcos · Sonoma · Stanislaus

APPENDIX D
DEBRIEFING STATEMENT

Thank you for your participation in this interview. Your experiences and input are invaluable. This communication will contribute to a better understanding and implementation of interventions for PTSD within the field of social work and human services. Furthermore, your input may guide advances in University curriculum. All information gathered for the purpose of this study will be available to you in the winter quarter of 2019. If there are any concerns, please contact Dr. Thomas Davis at (909) 537-5501.

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