Trauma in Adults

AMY B. MULLENS; GOVIND KRISHNAMOORTHY; JOHN GILMOUR; AND INDIA BRYCE

ABSTRACT

Clients with trauma-related presentations seeking counselling are a unique sub-population with specific needs and challenges. The nature of this work can be both challenging and rewarding and have significant potential to affect the individual's life trajectory in positive ways. Counselling can provide a forum to assist with support, validation, meaning-making and processing of trauma to assist people to live to their potential. Therefore, this chapter will provide an overview of types of trauma and the psychological effects of trauma. It will identify relevant screening and distress assessment tools relevant to trauma, as well as an overview of possible evidence-based interventions. The chapter then discusses considerations for counsellors when working with trauma-affected clients.

Learning Objectives

- Describe the nature and types of trauma and possible psychological effects.
- Identify screening tools relevant to trauma across the lifespan.
- Understand risk and protective factors among individuals and priority groups.
- Increase awareness of post-traumatic growth and resiliency.
- Consider relevant professional issues when working with trauma-affected clients.
- Gain awareness of possible interventions.

INTRODUCTION

The term 'trauma' represents an aggregate grouping of salient, negative life events and their associated psychological sequelae. This chapter is intended to provide a broad overview of the nature and types of trauma, and the ways in which counsellors can assist individuals and groups to recognise trauma, provide support/psychoeducation, and refer/support clients with assessment and therapeutic interventions. This chapter is not intended to provide an exhaustive account of all traumas nor intended to be a compendium for the treatment of severe/chronic/pervasive/complex trauma. This is highly specialised area requiring further training and under ongoing clinical supervision to ensure safety, wellbeing, and duty of care for both the client and practitioner. Counsellors may work with clients with trauma in a range of trauma-specific settings (e.g., domestic and family violence), however given the high rates of lifetime prevalence (estimated at 71.1% and 80.7% for lifetime prevalence for any potential trauma) Knipscheer et al. (2020) and de Vries and Olff (2009)

argue that trauma is likely to be a common feature of client presentations and history within any counselling setting/context.

A trauma response is something that one experiences that is typically out of the ordinary and may initially be life 'shattering'. Some traumatic events may be anticipated (e.g., knowing that a flood may occur at some time in a specific region, but not knowing exactly when this may occur; or the death of a loved one after a long and arduous battle with cancer). A traumatic event, however, is often unexpected, whereby the individual experiences a range of predictable and typical reactions to something highly atypical and potentially life threatening. Traumatic events can be 'one off', acute isolated events (e.g., earthquake, sexual assault, house fire, accident) or experienced as ongoing (e.g., repeated childhood sexual abuse, torture/trauma due to political circumstances); likewise, they may have been recent or historical, including from childhood (Bromfield et al., 2007; Higgins & McCabe, 2000; Finkelhor et al., 2005; Price-Robertson et al., 2013).

People may also experience a range of distinct traumatic events throughout their lifetime, which may result in cumulative and confounding trauma reactions/effects and potentially poorer prognoses. Trauma reactions are most commonly experienced by those directly exposed to the incident/s; however, vicarious trauma can also occur as a result of being exposed to other people's traumatic stories/experiences (e.g., as counsellors) or based on the viewing of repetitive media images (such as after 9/11 occurred in the USA) (Lowell et al., 2018). Other examples of traumatic events include: climactic (e.g., cyclone, floods), domestic and family violence, political (e.g., terrorism), and trauma associated with hate crimes (e.g., discrimination, assault or persecution based on gender, sexuality, or ethnicity). People may experience trauma in relation to distressing birth events or a diagnosis of a chronic health condition (e.g., fear of cancer recurrence or stigma associated with HIV) (Mullens et al., 2004; Mullens et al., 2018; Strodl et al., 2015). Trauma may also coincide with public health emergencies (e.g., COVID-19 pandemic) and disaster responses (e.g., bushfires), both directly and vicariously and with cumulative effects due to repeated exposure, other predisposing factors and/or salience of the trauma. Mental Health First Aid may be provided to assist with psychosocial support after such events (Jacobs & Meyer, 2005). The wide range of examples provided here regarding trauma is intended to demonstrate the heterogeneity of trauma and those associated with individual experiences and help you to build a context and terminology regarding trauma when working with future clients. Within an Australian context it is estimated a lifetime prevalence of 57–75% of a potentially traumatic event (Mills et al., 2011; Rosenman, 2002). Further, the majority of Australians will experience at least one traumatic event during their lifespan, however, individual reactions and adjustment processes vary tremendously. Australian research suggests that the most common traumatic events experienced by Australians are: experiencing an unexpected death of a close loved one; witnessing a person critically injured or killed, or finding a body; and being in a life-threatening car accident (Phoenix Australia (PA), 2019).

Like the wide range of trauma examples, the individual effects and trajectories post-trauma can vary significantly—even if two or more people have experienced the same event at the same time. Reactions and adjustment to trauma can also be heavily influenced by how a trauma was 'dealt with' at the time and the extent to which the individual felt sufficiently supported, as well as pre-morbid psychological factors (de Munter et al., 2020). For example, if an adolescent has been sexually assaulted and then attempts to seek support from their parents and is not believed, and/or experiences a negative interaction with police when trying to make an official report, these subsequent experiences will likely have further compounding cognitions (e.g., sense of injustice, vulnerability) and negative self-evaluation (e.g., defectiveness, helplessness) associated with the incident/s—as compared to if the individual had felt well supported after the incident (see Lorenz et al., 2019). Seeking support and not receiving it can result in further trauma or secondary victimisation.

PREVALENCE OF TRAUMATIC LIFE EVENTS IN ADULTS

Most people will encounter a traumatic life-event at some point. Exposure to a potentially traumatic event (PTE) is a common experience, with large community surveys in Australia and internationally revealing that 50–75% of people report at least one traumatic event in their lives (Benjet et al., 2016). PTEs include any threat,

actual or perceived, to the life or physical safety of a person, their loved ones or those around them. While PTEs are not uncommon experiences, only a small number of people who encounter trauma will go on to develop post-traumatic stress disorder (PTSD) (Shalev et al., 2017). Overall, the prevalence rate of PTSD in the general population ranges from 1.3% to 12.2% (Shalev et al., 2017). Some groups may be predisposed to PTSD, as relevant to social determinants of health and minority stress theory, and these predispositions may include childhood environment, prior exposure to trauma, pre-trauma psychopathology, and pre-trauma life stress (Carlson et al., 2016). Additionally, demographic variables like gender, race, and socioeconomic status can be risk factors for developing PTSD following a PTE (Carlson et al., 2016) and intersectionalities. Further, people who experience discrimination and marginalisation (e.g., migrants, members of sexually and gender diverse commuities) may be less likely to engage with formal help-seeking due to past negative experiences or fear of future mistreatment and may require more innovative health promotion approaches (see Mullens et al., 2020) and staff training (see Mullens et al., 2017) to more appropriately meet the needs of these at risk, priority communities.

While there is a chance that the majority of people will encounter a PTE in their lifetimes, there are some jobs that pose increased risk. Emergency service professionals (ESPs), such as police, firefighters, paramedics, emergency nurses and doctors, defence force personnel, and State Emergency Services, are frequently exposed to PTEs as part of their everyday work that may be considered traumatic. In unique and challenging work environments, ESPs are often required to provide immediate and urgent interventions in crisis situations and operate under conditions that may present some personal danger. Consequently, the prevalence of PTSD is higher among ESPs than the general population, ranging from 16.5% to 20.9% (Dobson et al., 2012; Forbes et al., 2016; Marmar et al., 2015; O'Toole et al., 1996; Shalev et al., 2017).

COURSE OF TRAUMA REACTIONS, DIFFERENTIAL DIAGNOSES, AND CASCADE OF COMORBIDITY IN ADULTS

Trauma, as described above, is a psychological and emotional response to a distressing event or experience, such as an accident, an assault, or a natural disaster (American Psychological Association, 2021). Such traumas may be singular or multiple in nature, and the research suggests that repeated and chronic trauma is more common through multitype maltreatment, poly-victimisation, and re-victimisation (Higgins & McCabe, 2000; Finkelhor al., 2005). Multi-type maltreatment has been proposed as a theoretical framework for understanding the interrelatedness of the five childhood abuse types (i.e. sexual, physical, emotional, neglect, witnessing domestic and family violence), however poly-victimisation is a model which focuses on traumatisation in childhood in the broader sense, taking into account other forms of victimisation, including but not limited to, bullying, neighbourhood conflict and crime which might co-occur in childhood (Price-Robertson et al., 2013). Re-victimisation is also a broader model, exploring the same adversities as poly-victimisation, although from a 'whole of lifespan' perspective (Bryce, 2018). To acknowledge the multiplicity of trauma, the term complex trauma is used to conceptualise the complexity of traumatic outcomes for survivors of repeated traumas across the lifespan. Two diagnosable conditions are recognised as possible outcomes of trauma and complex trauma, acute stress disorder (ASD) and post traumatic stress disorder. It is important to acknowledge that all presentations of ASD and PTSD are caused by trauma or complex trauma, but not all trauma results in these diagnosable conditions. This highlights that these two terms speak to the heterogeneity of traumatic outcomes—multifinality and equifinality. In the case of multifinality, similar initial conditions may lead to dissimilar outcomes, depending on the mix of ecological risk and protective factors. Equifinality holds that multiple causal pathways can result in the same outcome, in this case maltreatment.

In the acute phases after a traumatic event, it is expected and typical for individuals to experience a wide and variable range of anxiety (e.g., hypervigilance), stress, and depressive (e.g., low mood) symptoms (American Psychiatric Association, 2022). This can initially manifest as an acute stress reaction or an adjustment disorder (as per the DSM-5-TR), which over time and after a longer duration of course may be better accounted for by a diagnosis of PTSD. Beyond the symptoms of PTSD, those with PTSD are 80% more likely to have another mental health condition, in comparison with those without PTSD (O'Donnell et al., 2004; Rytwinski et al., 2013).

The most common include mood and anxiety conditions, such as major depressive disorder, which has a co-morbidity with PTSD of 50% (Rytwinski et al., 2013). Further, among people within inpatient substance abuse treatment centres, it is estimated that approximately 50% meet criteria for PTSD (Souza & Spates, 2008). In an attempt to self-manage symptoms, individuals exposed to trauma may also develop substance-related conditions associated with hazardous/harmful use or substance dependence (van Dam et al., 2012). This indicates that a serious disorder such as PTSD can have a significant flow-on effect, which may adversely impact many aspects of a person's life.

TRAUMA SYMPTOMS AND DIAGNOSTIC CRITERIA IN ADULTHOOD

Diagnosis, whilst not typically in the scope of a counsellor's role, is critical knowledge which informs practice and assists the practitioner to engage with multidisciplinary professionals to holistically support the client. There are two main models of post-traumatic stress disorder (PTSD) in the mental health diagnostic sphere of understanding: the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) model (American Psychiatric Association, 2022) and the World Health Organization's International Classification of Diseases (ICD-11) model (WHO, 2022). Both models require an individual to have encountered a PTE, however, there are some differences in symptomology between these models. A comparison of the diagnostic criteria in each model is presented below in Table 1.

The DSM-5-TR diagnostic criteria of PTSD list 20 symptoms separated into four factors or symptom clusters (American Psychiatric Association, 2022). The first factor, 'intrusion' (Criterion B), focuses on five symptoms of intrusion (memories and flashbacks), including the distress the intrusive thoughts can cause. The second factor, 'avoidance' (Criterion C), represents two symptoms that relate to the active avoidance of reminders of the traumatic event, both internal (memories) and external (places, people, or situations). The third factor, 'negative alterations in cognitions and mood' (Criterion D), is comprised of seven symptoms that relate to poor mood and negative beliefs and feelings. The fourth factor, 'alterations in arousal and reactivity' (Criterion E), is comprised of six symptoms that relate to poor functioning (e.g., sleep issues, concentration problems, aggressive behaviour).

The ICD-11 model has six symptoms across three symptom clusters (WHO, 2022). The first factor, 're-experiencing', focuses on two symptoms that relate to re-experiencing the traumatic event (i.e., upsetting dreams and flashbacks). The second factor, like the DSM-5-TR model, is 'avoidance', and relates to two symptoms: avoidance of reminders of the traumatic event including internal (memories) and external (places, people, or situations) aspects. The third factor, 'sense of 'threat', is focused on feelings and perceptions of threats that are disproportionate to the actual stimuli (i.e., hypervigilance to threats and perceived threats). The ICD-11 has classified an additional model of PTSD—complex PTSD. This model of PTSD has the symptoms previously mentioned, and includes additional symptoms of disorganised self organisation across three symptom clusters. These clusters include affective dysregulation (i.e., emotional reactivity/numbing), negative self-concept (i.e., feelings of worthlessness/failure), and disturbances in relationships (i.e., feeling disconnected from others).

Table 1: PTSD symptom mappings for the DSM-5-TR, ICD-11, and ICD-11 (Complex PTSD) diagnostic criteria

DSM-5-TR symptoms	ICD-11 symptoms (PTSD)	ICD-11 symptoms (Complex PTSD)
A. Exposure to trauma	Exposure to Trauma	Exposure to Trauma
Intrusion	Re-experiencing	
B1. Distressing memories	1. Upsetting Dreams	
B2. Distressing dreams	2. Flashbacks	
B3. Flashbacks	Avoidance traumatic reminders	
B4. Psychological distress	3. Avoidance of internal reminders (memories)	3. Avoidance of internal reminders (memories)
B5. Physical reactivity	4. Avoidance of physical reminders	4. Avoidance of physical reminders
Avoidance	Sense of threat	
C1. Avoidance of internal reminders (distressing memories, thoughts, feelings)	5. Hypervigilance	5. Hypervigilance
C2. Avoidance of external reminders (people, places, conversations, activities, objects, situations)	6. Hyperarousal	6. Hyperarousal
Negative alterations in cognitions and mood		Affective dysregulation
D1. Inability to recall key features		7. Emotional Reactivity
D2. Exaggerated negative thoughts		8. Emotional Numbing
D3. Distorted cognitions leading to blame		Negative self-concept
D4. Negative emotional state		9. Failure
D5. Diminished interest in significant activities		10. Worthless
D6. Feelings of detachment or estrangement		Disturbances in relationships
D7. Inability to experience positive affect		11. Cut-off from people
Alterations in arousal and reactivity		12. Hard to stay close to people
E1. Irritability or angry outbursts		
E2. Risky or self-destructive behaviour		
E3. Hypervigilance		
E4. Exaggerated startle reaction		
E5. Problems with concentration		
E6. Sleep disturbance		

SCREENING AND ASSESSMENT TOOLS FOR ADULTS FOR TRAUMA INDICATORS AND COMORBID CONDITIONS

Counsellors can work within a vast range of government and community-based organisations and settings (e.g., child safety, substance use, domestic and family violence), where they may be required to administer standardised measures to determine eligibility for engagement with services, assess severity of symptoms, and measure changes in distress and coping over time. Such measures may also be required to meet the organisation's funding or clinical governance requirements or as part of the organisation's 'minimum data set' regarding clients and service engagement. Examples of brief screening and assessment tools are available within the public domain and can assist with screening for symptoms of trauma and PTSD include: Patient Check List-5: Civilian Version (PCL-5; Weathers et al., 2014) and the Impact of Events Scale-Revised (IES-R; Weiss & Marmar, 1997). Further, other psychometrically validated scales can be used by mental health practitioners to screen for frequently occurring co-morbidities post trauma, including for: alcohol and other substance use (e.g., Alcohol Use Disorders Identification Test (AUDIT); Drug Use Disorders Identification Test (DUDIT), Severity of Dependence Scale (SDS) and the Depression, Anxiety and Stress Scale-21 (DASS-21; Lovibond & Lovibond, 1995). Diagnostic clarification can be further provided by a qualified mental health professional, psychologist, doctor, or psychiatrist. Counsellors (as with all professionals/clinicians) must check whether or not measures

are freely available within the 'public domain' or require prior permission or purchase for use, and must confirm prior whether they meet the requirements for administration of measures based on training and qualifications.

INTERVENTIONS FOR TRAUMA WITH ADULTS: AN OVERVIEW

The following section will provide a brief overview for counsellors regarding commonly utilised evidence-based interventions for trauma, which are typically provided by psychologists, psychiatrists, and counsellors with specific training in trauma. It is not intended to provide a comprehensive treatment guide, but rather to provide readers with a working knowledge of approaches to interventions their clients may be exposed to. The following useful summary from Phoenix Australia (PA), a research centre in Melbourne, provides a useful summary of information they have developed in relation to the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2017).

The first-line evidence-based interventions for trauma are psychological in nature and includes:

- trauma-focussed cognitive behavioural therapy (TF-CBT)
- eye movement desensitization & reprocessing (EMDR)
- cognitive processing therapy (CPT)
- structured writing therapy (SWT).

These therapies include common elements:

1. narrative exposure (e.g., writing about the trauma and its symptoms) and/or gradual exposure to reminders of the trauma
2. unlearning the fearful responses to distressing reminders
3. changing how a person thinks about themselves, the future, or the world around them. This is particularly important for people who blame themselves or others for their trauma.
4. relaxation techniques, including breathing activities, to help manage the distress caused by memories or flashbacks
5. psychoeducation that helps to explain to a client how and why they are experiencing these symptoms. This helps them to take control of their own recovery.

The second-line or adjunct interventions include medication—selective serotonin reuptake inhibitors (SSRIs, i.e., antidepressants). These are normally only used to stabilise a person enough so that therapy can begin to be effective and are prescribed by a psychiatrist or other qualified physician.

TRAUMA-FOCUSED COGNITIVE BEHAVIOURAL THERAPY (TF-CBT)

TF-CBT is the gold-standard intervention for PTSD. Normal CBT focuses on challenging negative cognitions and emotions, and changing behaviours (de Arellano et al., 2014). In this case, TF-CBT is similar, but with a focus on the trauma-based thoughts, feeling and behaviours (de Arellano et al., 2014). Many individuals who have experienced trauma hold unhelpful beliefs about their trauma (e.g., they are responsible for their trauma), and this can result in destructive behaviours (e.g., anger or numbing). TF-CBT aims to reframe these negative self-beliefs, and identify behavioural coping mechanism and goals (de Arellano et al., 2014). From an evidence perspective, it has relatively strong post-intervention outcomes for PTSD. This is supported by, for example, 29 studies that compared TF-CBT to waitlist or control conditions and a further 38 studies that compared TF-CBT to 'treatment as usual' or another intervention (PA, 2019).

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

EMDR is a therapy that focuses on using eye movements and other types of stimuli, like hand tapping, to unblock the mental processes associated with memory (Shapiro & Solomon, 2010). A client focuses on a traumatic memory, and the therapist evaluates the client's eye movements to see how the rapid eye movements are intensified by traumatic memories. These traumatic memories are often avoided by the client and remain unprocessed. Once a memory is found that is significantly distressing, the therapist will explore the memory in more detail and provide coping mechanisms (Shapiro & Solomon, 2010). Six studies compared EMDR to waitlist, and a further 9 studies compared EMDR to 'treatment as usual' or another intervention (PA, 2019), showing EMDR to be efficacious.

COGNITIVE PROCESSING THERAPY (CPT)

CPT is another type of therapy that assists a person to identify unhelpful thoughts & beliefs '('stuck 'points'), challenge them and replace with rational alternatives. CPT typically includes psychoeducation about trauma and mental health and will focus on allowing the client to reframe the traumatic event (PA, 2019). The reframing process begins with the client writing a narrative about the trauma, and then the therapist assists in challenge unhelpful beliefs, like self-blame (Resick et al., 2016). This type of therapy can also include artificially creating exposure to distressing circumstances. CPT is a relatively young therapy, but it has been shown to be highly effective in Australian veterans (Resick et al., 2016).

STRUCTURED WRITING THERAPY (SWT)

SWT utilises the act of writing about a client's memories of trauma, as well as the thoughts and feelings that the trauma invokes, to process the trauma itself (Schoutrop et al., 2002; Smyth & Pennebaker, 1999). By writing about a traumatic event, the client is processing the negative feelings associated with the trauma, and these negative feelings will begin to ease. It has been found that SWT can be beneficial for both the mental and physical health of a client (Schoutrop et al., 2002; Smyth & Pennebaker, 1999). This therapy can be delivered in online, distance, or in-person, making it an effective form of therapy for clients who wish to remain anonymous or live some distance from a mental health clinic.

SOCIAL AND FAMILIAL SUPPORTS

One of the major things that can help a person recover more effectively and completely is support from friends and family. A person cannot undertake the PTSD recovery process solo—both professional and personal support are typically needed. It is often families/partners/children that witness the full spectrum of symptoms before the recovery process, so encouraging family to be involved in the recovery process and their own self care is vital. Social support is crucial for persons with PTSD, as it reduces the feelings of isolation, and increases life satisfaction (Taylor, 2011). Additionally, education and support from both professionals and the community are very helpful. Education for understanding PTSD, how to take care of themselves, and how to get both practical and emotional support for the whole family can often make a huge difference for effectiveness of interventions (PA, 2019). Psychoeducation also provides family members with greater understanding and compassion for the person experiencing PTSD. Additionally, incorporating aspects of the recovery model into therapeutic interventions can promote healing by supporting the individuals to regain a sense of meaning, support, and normalisation (e.g., Sarkadi et al., 2018), as well as supporting them through processing associated grief and existential issues. Sufficient investment in building rapport and therapeutic alliance is also vital in relation to creating a sense of safety for your client and are relevant to outcomes of intervention.

RISK FACTORS FOR TRAUMA AMONG ADULTS

There is strong evidence to suggest that a person's genetics play a role in the development of PTSD, with approximately 30% of the variance within PTSD diagnosis being accounted for by genetic factors (Skelton et al., 2012; True et al., 1993). Studies into twins exposed to combat in the Vietnam War found that monozygotic twins (identical twins) were more likely to both have developed PTSD than dizygotic twins (non-identical twins) (Skelton et al., 2012; True et al., 1993). It has been found that genetic predisposition to other mental health concerns, such as anxiety or panic disorders, can also predict genetic predisposition to developing PTSD (Skelton et al., 2012). Further, we know that environmental stress can permanently influence genes that can contribute to trauma-related vulnerabilities and resilience via epigenetic factors. This supports the notion of the interaction between environment and biology via the diathesis-stress model—that biology can influence environment, and conversely, environment can also influence biology.

Protective factors for trauma among adults

There are several factors that can be protective for developing PTSD following exposure to a PTE:

- resilience: people who have high levels of psychological resilience report lower levels of PTSD symptomology following a PTE
- social support: high levels of support from friends/family is a strong protective factor against developing PTSD/symptomology
- disclosure following trauma: individuals who 'open up' about their traumatic event are less likely to develop PTSD
- self-efficacy: the belief in one's abilities to take control of their engagement with therapeutic intervention and recovery
- health coping mechanisms: people who have healthier ways of coping with mental health concerns (e.g., seeking help) and who avoid unhelpful coping mechanisms (e.g., excessive alcohol/drug use) have a greater chance of not developing PTSD or recovering once being diagnosed
- general healthy lifestyle choices: exercise and a good diet are further protective measures against PTSD (Carlson et al., 2016; Weisaeth, 1998).

Individuals' who possess strong self-belief or resilience are less likely to develop PTSD, or experience lower levels of distress following a PTE (Bonanno & Mancini, 2012). This is likely related to the adaptability associated with resilience. Additionally, individuals with strong and diverse social support networks are more buffered from the negative effects of PTEs than individuals with lower levels of social support, following self-disclosure of thoughts and feelings around the event to trusted friends and family (Campbell & Renshaw, 2013; Tsai et al., 2012). The support provided by an individual's social network, as well as the feeling of being heard with regards to the PTE can be a buffer between the stress of the event and mental health. Individuals' who experience high levels of self-efficacy and translate this self-efficacy into healthy coping and help-seeking behaviours are also less likely to develop PTSD following a PTE (Adams et al., 2020; Greenberg et al., 2009). This is due to the belief that one can overcome a traumatic event, as well as the belief that one can get help and succeed in maintaining healthy functioning and behaviours. It is also worth noting that exercise and healthy diet has also been shown to buffer and individual from the stress of PTEs and the effects this can have on health (Adams et al., 2020). As trauma can have a negative effect on physical health, it is important that individuals who experience trauma maintain a healthy lifestyle (Ryder et al., 2018).

SUMMARY

There are a wide range of trauma experiences that can result in subsequent significant and varied symptomatology associated with distress and/or impaired functioning for an individual. Comorbidities may also be common, including hazardous and harmful substance use. The symptomatology, course, prognosis,

and process of recovery can vary considerably from person to person; and is influenced by a wide range of biopsychosocial factors. The role of the mental health professional can help to provide psychosocial support, psychoeducation, and counselling to assist the individual to more effectively cope with their traumatic experiences and develop adaptive coping strategies.

POST-TRAUMATIC GROWTH AND RESILIENCY

While the development of PTSD significantly impacts a person's life in many negative ways, a number of people who encounter trauma can experience positive psychological changes. These changes, known as posttraumatic growth (PTG), come from the successful processing and navigation of adverse life events (see Calhoun & Tedeschi, 2013). This PTG has been supported by recent epigenetic studies (Mehta et al., 2020). Following a traumatic event, a person can experience intrusive thoughts and feelings about the event, which can be distressing. However, it has been found that deliberately ruminating on the traumatic event, and seeking to understand and process the feelings around the event, can lead to PTG (Henson et al., 2021). If an individual reframes their personal narrative to see the PTE as a potential catalyst for positive changes in their life, this can result in improved mental and physical health outcomes. This can lead to greater resilience when encountering future stressful or difficult life events. PTG can also result in positive spiritual or personal growth, improved relationships with loved ones, improved life directions, stronger self-belief, and a greater appreciation for life (see Brown, 2017). Other factors that have been associated with greater PTG among those who have experienced a traumatic event include sharing negative emotions, positive coping strategies (e.g., positive reappraisal), and personality traits (e.g., agreeableness) (Henson et al., 2021).

CONSIDERATIONS FOR COUNSELLORS WHEN WORKING WITH TRAUMA-AFFECTED INDIVIDUALS

Given the prevalence of counsellors entering the helping profession with a personal history of trauma, as well as the nature of the work itself, it is critical for counselling practitioners to maintain their own well-being when working with people affected by trauma. Vicarious trauma is defined as the permanent transformation in the inner experience of the clinician that comes about as a result of empathic engagement with clients' trauma material (Didham et al., 2011) and secondary traumatisation refers to the experience of trauma-related symptoms from learning others' stories (Davidson 2017).

Chenoweth and McAuliffe (2015) identify that it is often those who do this work well who are the most vulnerable to what is known as secondary traumatic stress, vicarious trauma, or compassion fatigue. Counsellors are exposed to traumatic stories and want to assist their clients. This exposure and desire to assist lead to a specific form of stress that creates compassion fatigue (Figley, 1995). Given the nature of the work of counsellors, with the risk of vicarious trauma or secondary traumatic stress high, the need for proactive self-care is imperative.

Self-care is a strategy that has been found to reduce vicarious trauma and burnout while promoting compassion satisfaction (Radey & Figley, 2007; Ruysschaert, 2009). Self-care is often difficult for counsellors to prioritise but it is vital to mitigating the risk of vicarious trauma, and thereby sustaining the capacity to continue helping. It is necessary that when counsellors are suffering and may sense they need to take action; seek counselling, support, or therapeutic intervention.

A counsellor's motivation to enter the helping professions to heal their own wounds, may diminish their capacity for effectiveness with clients (Ford, 1963). Briere (1992) hypothesised that issues related to child abuse, including counter transference, may adversely affect the competency of helping professionals. Some researchers have argued that experiencing an accumulation of childhood maltreatments, especially emotional abuse and neglect, can increase the risk of helping professionals experiencing secondary traumatic stress (Figley, 1995; Nelson-Gardell & Harris, 2003). This is also reflected in literature which asserts poor mental

health contributes significantly to a lack of career success, including acquiring and maintaining employment (McIlveen, 2014; Olesen et al., 2013).

Whilst a counsellor's own experience of adverse experiences in childhood may increase the risk of bias or counter transference and impair or diminish objectivity, a personal history of trauma can also provide strengths that may support an individual's professional capacity (Calhoun & Tedeschi, 2006). This reflects post traumatic growth and trauma-sensitive resiliency. If counsellors are resilient and remain positively connected to their work there is potential for growth, also known as compassion satisfaction (Figley, 1995; Ruysschaert, 2009).

Clinical supervision is an important strategy for mitigating the impact of working with clients who have experienced trauma. Supervision forms a central tenet of ethical and effective professional practice, invaluable in assisting helping professionals to acquire the knowledge and skills necessary to achieve a high standard of professional performance (Joubert et al., 2013; Kadushin & Harkness, 2002; Shulman, 2010). Supervision offers practitioners the opportunity to debrief and challenge assumptions and biases, explore alternative perspectives, and make informed decisions (Joubert et al., 2013).

Legal issues may emerge during engagement with intervention related to the client's experiences of trauma. A client, for instance, could seek to prosecute a perpetrator of trauma (e.g., for domestic violence) or to sue for damages sustained in an accident or natural disaster. The counsellor's role is not to provide legal advice, but to offer support during the process and, if needed, refer the client to appropriate legal help. Legal matters may permeate the counselling experience and a client's progress may be intimately associated with the trajectory and resolution of a legal matter. The impact of the legal context is an important consideration in working with trauma survivors.

Given the relational origins and complications of trauma one of the most important considerations in working with trauma-affected individuals is the therapeutic alliance and the building of rapport. Successful intervention with traumatised individuals is significantly influenced by a strong therapeutic relationship (Eltz et al., 1995; Kearney et al., 2010; Lawson, 2009). The therapeutic alliance, commonly defined as agreement on goals, task collaboration, and an emotional bond (Bordin, 1979), has been shown to be linked with outcome in individual child, adolescent, and adult therapy (Horvath et al., 2011; Ormhaug et al., 2014; Shirk et al., 2011). It is recommended the counsellors develop and hone their skills in rapport and the therapeutic relationship to maximise engagement and outcomes of intervention.

Given the nature of the counselling role, the prevalence of trauma-affected individuals entering the helping professions, and the emotional toll counselling can take on the practitioner, important considerations must be acknowledged to ensure a safe and effective therapeutic experience for client and counsellor. To prevent burnout, secondary trauma or retraumatisation, self-care, supervision and self-awareness form imperative considerations for counsellors and support the development of a safe and positive therapeutic relationship.

CONCLUSION

In summary, there are a range of experiences that can result in post-traumatic stress reactions for individuals. However, the likelihood of developing clinically significant trauma responses varies significantly from person to person, and may manifest somewhat differently for affected individuals—with DSM-5-TR and ICD-11 providing a useful framework for substantiating diagnostic threshold. This chapter has presented a range of evidence-based interventions, along with risk and protective factors. Further it is well documented that post-traumatic growth can occur concurrently with trauma responses. Finally, it is important to maintain optimal self-care and supervision to promote well-being and longevity in the profession when counselling those who have experienced traumas.

LEARNING ACTIVITIES

Learning Activity 1

Please take 5 to 10 minutes to sit in a quiet space and reflect on your memories and experiences regarding 9/11 in the USA or a similar event. What do you recall about this event? Where were you at the time that you heard about this event? What images did you see on TV? What sorts of psychological impacts did these events have on those who were directly involved and the broader community (including internationally)? What were your thoughts/feelings/reactions at the time? What are your own thoughts/feelings/reactions now?

Learning Activity 2

Consider the following case study:

Your client, James, has sought therapy for issues with alcohol abuse over the last 12 months. After a number of sessions, James discloses to you that he was the victim of a violent robbery 5 years ago. He describes being unable to watch television that portrays criminal acts, has memories surface from that event at seemingly random times, and has mood issues that he needs to numb.

Is it possible that James' issues with alcohol are related to this trauma? Clients will often take time to build a therapeutic relationship before disclosing trauma.

Reflect on how clients can present with an immediate issue, like alcohol abuse, but may have trauma in their past that could be related.

Learning Activity 3

Please watch the following recording regarding nature and impacts of trauma among first responders [11:47]:

One or more interactive elements has been excluded from this version of the text. You can view them online here:
https://usq.pressbooks.pub/counselling/?p=71#oembed-1

Reflect on the following questions:

- What are some reported challenges of working as a first responder?
- How do individuals attempt to cope who work in this field?
- What are some of the unique stressors associated with these roles?
- How can the nature of this work impact upon vicarious trauma, cumulative trauma, and susceptibility to poorer/better coping with trauma?

Learning Activity 4

Please read this article on growth after trauma:

- How does your personal values, beliefs and experiences influence your thoughts and feelings about posttraumatic growth?
- Do you believe that negative, traumatic experiences can be beneficial to a person?
- When does posttraumatic stress move into growth?
- Can the two happen at the same time?

Learning Activity 5

Please watch the following recording regarding self-care for counsellors and mental health professionals [5:51]:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://usq.pressbooks.pub/counselling/?p=71#oembed-2

- What are some ways in which you can nurture your own wellbeing on a regular basis, now and throughout your work and career in mental health?
- What are the elements of your daily, weekly, and monthly 'self-care' plan?

RECOMMENDED RESOURCES

- Psychological first aid
- Mental health resources: COVID-19
- Negative experiences with the justice system post-sexual assault
- The Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder

ADDITIONAL SUGGESTED READINGS

Calhoun, L. G., & Tedeschi, R. G. (Eds.). (2006). *Handbook of posttraumatic growth: Research & practice.* Lawrence Erlbaum Associates Publishers.

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GLOSSARY OF TERMS

CPT—cognitive processing therapy (for veterans), a recent therapy found to be effect in veterans

DSM-5-TR—the American Psychiatric Association's Diagnostic and statistical manual of mental disorders: Text revised version (DSM-5-TR)

EMDR—eye movement desensitization and reprocessing, a front-line therapy for PTSD

ESP—emergency service professionals (e.g., police, fire fighters, paramedics)

High risk professions—employment in which encountering potentially traumatic events are to be expected as a part of the job

ICD-11—the World Health Organisation's international classification of diseases (ICD-11)

PTEs—potentially traumatic event, an event in which the individual feels that they or someone else is at risk (e.g., assault or car accident)

PTG—posttraumatic growth, or positive psychological changes that can come from processing traumatic events

PTSD—posttraumatic stress disorder

SSRI—selective serotonin reuptake inhibitors (i.e., antidepressants)

TF-CBT—trauma-focussed cognitive behavioural therapy, the gold standard of PTSD interventions

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AUTHOR INFORMATION

Amy B. Mullens, BA, MSc, PhD, MAPS, University of Southern Queensland

Professor Mullens is a clinical and health psychologist in the School of Psychology and Wellbeing at the University of Southern Queensland. She has worked for over twenty years across public and private sectors working with client who experience mental and physical health comorbidities. Professor Mullens' research and clinical experience focusses on trialling novel health promotion initiatives to reduce health disparities in partnership with priority communities.

Govind Krishnamoorthy, PhD, University of Southern Queensland

Dr. Krishnamoorthy is a clinical psychologist and senior lecturer in the School of Psychology and Wellbeing at the University of Southern Queensland. He has worked for over a decade in both public and private sectors offering child and adolescent mental health services. As a co-developer of the Trauma Informed Positive Behaviour Support (TIPBS) program, Dr. Krishnamoorthy's research and clinical experience has focused on addressing the social emotional needs of children and adolescents impacted by child maltreatment.

John Gilmour, PhD, University of Queensland

Dr Gilmour is a Postdoctoral Research Fellow at the University of Queensland's School of Social Sciences. His research focus is on program evaluations for evidence-based policing interventions, and the use of statistics and research methodology in modern policing research. Dr Gilmour also focuses on the application of statistical techniques to diagnostic criteria for a number of developmental and mental health concerns, including autism and PTSD. Dr Gilmour has also published work on the use of statistics in modern sociological and psychological research.

India Bryce, B Ed, M Guid Cous, MSW (*Forensic Studies*), MSW (*Qual*), PhD, University of Southern Queensland

Dr India Bryce is a Senior Lecturer and Academic in the School of Counselling, at the University of Southern Queensland and a member of the USQ Centre of Health Research (Health and Social Justice). India's current research explores the lived experience of cumulative harm and its influence on life course development, including career choice, trauma informed pedagogy in higher education, and trauma narratives and health. India has published books, book chapters, and journal articles from her research including two co-edited reference books, *Child abuse and neglect: Forensic issues in evidence, impact and management* and *Child sexual abuse: Forensic issues in evidence, impact and management.* India has presented on topics related to her research nationally and internationally. She is also specialist consultant in the field of child maltreatment, specialising in cumulative harm. She has worked closely with government and non-government agencies in the design and implementation of family intervention, prevention and preservation programs and has delivered training in child maltreatment and cumulative harm to a broad range of helping professionals across the forensic sector.

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