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Reflections upon the Invitational Model and 5 Powerful P's in Working with Post-Traumatic Stress Disorder (PTSD)

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The author recently spent part of a sabbatical from her university exploring the most current research on treating clients diagnosed with Post-traumatic Stress Disorder (PTSD). During the sabbatical, she was struck by how her own complacency had become unintentionally disinviting to her work with these clients, as she learned that preconceptions she had about treatment were not considered best practice. The article is a personal reflection of the insights she gained about PTSD and a reaffirmation of the relevance of the invitational model (and the 5 Powerful P's) to working effectively with all clients.

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR), Post-traumatic Stress Disorder (PTSD) is defined as an anxiety disorder "characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma" (p. 429). Typically, the client diagnosed with PTSD will be prescribed medications, such as Prozac, Paxil, or Zoloft (Gorman, 1997, p. 91) and encouraged to 'debrief' in small group therapeutic settings (Seligman & Rosenhan, 1998, p. 146-147).

As part of my recent sabbatical, I chose to research appropriate therapies for working with victims of trauma and had targeted a couple of specific interventions I wanted to explore. But my preconceived attitudes about diagnosing (labeling) and intervening

through a combination of medication and small group interventions definitely affected what I presumed would be the outcomes of my research. Not realizing it, I had begun to disinvite my clients by referring to traumatized individuals as though they were all the same; "PTSD", a cluster of symptoms and interventions, not *individual* people for whom places, policies, programs and processes might vary according to their *individual* needs.

Although I pride myself upon being sensitive and invitational with the individual client, I had definitely felt complacent about my current knowledge of PTSD and appropriate interventions. After conducting this research, I feel compelled to share some of my 'discoveries' with other 'invitational types' who may have become equally complacent in their work. In this case, discussion centers upon traumatized individuals, but the problem of complacency is as relevant for work with any population of individuals who have been diagnosed or labeled.

Throughout my efforts to understand and work with PTSD, I have been reminded of Purkey's discussion of the 5 Powerful P's: People, Places, Policies, Programs, and Processes. His discussion of the P's in his book, *What Students Say to Themselves* (2000) came to mind numerous times as I learned more about working with PTSD. Although this book does not deal specifically with mental disorders, Purkey describes internal dialogues that go on within clients and practitioners that may be helpful and harmful. He mentions the "gap between theory and practice" and how that gap may be "difficult to breach" (p. 34). In this particular passage, Purkey is talking about research and practice related to self-esteem, but the point is applicable to this article since my 'practice' was not in step with current 'research' on PTSD.

People

Why do we label? According to the *DSM-IV-TR*, we label in order to assist in formulating an evaluation of the client and to provide an adequate treatment plan (p. xxxiv). Seligman and Rosenhan (1998) add to this by noting that we also use diagnosis in order to receive third–party insurance payment and to provide a common language for clinicians and researchers to use in providing better understanding of clients. But what happens when the label becomes the person, ignoring the uniqueness of the individual?

In regard to PTSD, I've learned that responses to trauma tend to be very unique, as details of the traumatic experience will also be unique. I've also learned that the incidence of trauma is extremely high. Although there are many reports from federal, state, and local sources that are alarming, studies suggest that 10-20% of all boys have been sexually abused in some way (Homes, 1998); and the number apparently quadruples for girls (United States Bureau of Justice, 2002). In other words, the likelihood is great that you, the reader, or someone you know is suffering as the result of direct experience or witnessing a traumatic event.

Policies, Programs, and Processes

Because those with PTSD re-experience the trauma, triggers can vary in type and number for each victim. During group counseling, re-experiencing is more likely to occur because of the sharing that goes on among victims in the group. Because of those individual differences and therapeutic complexity, client-directed, individual interventions are recommended, using a multiple technique/eclectic approach to therapy. (Note: For purposes of this dis-

cussion, the terms counseling/therapy; counselor/therapist will be used interchangeably.)

Appropriate policies, programs, and processes regarding work with PTSD have to be considered within the individual context of the client's trauma. Even when diagnosis has not been complicated by symptoms that may appear to be better associated with another diagnosis, i.e. Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, and other learning disorders, treatment should begin with analysis of the individual's situation. Experts repeatedly warn against prescribing medication with these individuals, as well as the immediate introduction of group counseling or 'de-briefing'.

Instead of pushing the traumatized client to share too many details too soon, experts suggest that the counselor invite the client by first and foremost establishing a trusting relationship. Within that safe haven, details can emerge and their powers to harm become neutralized. Cautioning against the use of psychiatric drugs, group sessions, and 'catch-all' diagnostic labels, experts tell us to be creative in our use of individualized techniques. They also encourage us to ignore or find ways to circumvent insurance company mandates for limiting sessions and directing the modalities we use to treat these clients.

There are many techniques that the counselor can employ to facilitate wellness in therapy with traumatized clients. These techniques may include journaling, art therapy, role plays, dream work, and regression therapy. Experts also recommend that we permit the client to direct the course of therapy in order to regain a sense of control in relationships. Counselors are encouraged to allow therapeutic venues in which the client can explore his/her unique sense of

spirituality; the operative term here being *unique*, rather than counselor-imposed. Personally, I had avoided using some of these techniques because they appeared to be 'anti-mainstream therapy'. Now the experts resoundingly affirm the contrary. For a more complete listing and description of the aforementioned techniques—and others—that may be successfully employed with those diagnosed with Post-Traumatic Stress Disorder, refer to Rothschild (2003), *The Body Remembers: Casebook* or www.PTSDAlliance.org.

Places

For me, the biggest surprise of all—and it probably should not have been because my son has struggled with environmental sensitivities—involved the significance of the place where counseling occurs with trauma victims. Although I may have inadvertently done the 'right' thing because I shun fluorescent lighting in favor of table lamps and try to rid my office of noxious odors, I had not considered the potential triggering effects of those stimuli for traumatized individuals.

Many counseling offices are very clinical-appearing. Fluorescent lighting is generally the norm, and the scent of cleaning fluids or air fresheners (to mask the cleaning fluid smell) permeates the air. Experts on trauma suggest that the glare of fluorescent lighting is counterproductive to sharing. Instead, desk or table lamps with regular frosted or clear light bulbs are recommended. Fluorescent lighting, because of its prevalence, can also be a trigger for re-experiencing. Odors can also elicit strong emotions, as well as trigger allergic reactions in traumatized clients who often re-experience through phobias and allergies (Rapp, 1991).

Too much sensory stimulation can also impede work with clients diagnosed with PTSD; so the place where counseling occurs should be neat, homey, well-lit, well-ventilated, and clear of too much background noise or visual stimulation (i.e. posters, certificates, knick-knacks, etc.).

Summary

What I hope has become apparent to the reader is that the invitational model is very applicable to our work as helping professionals. Sometimes, we may ignore the wisdom of the model because we have become complacent in our knowledge of a label—in this case, an increasingly prevalent mental disorder diagnosis—at the risk of ignoring the individuality of the person we are seeking to help. We can also assume, as I had, that the policies, programs and processes with which we have become familiar over the years are still 'best practice'. Instead, we should continually strive to remain current and avoid feeling professionally smug.

In my case, it was only too easy to conceptualize an individual as a stereotypical diagnosis and proceed to refer for medication and group therapy; in essence, to push the client to share the details of the trauma too soon. Even though my original doctoral training emphasized individual therapy, not group, I had accepted the idea that certain processes regularly followed in the treatment of all clients diagnosed with PTSD.

Inviting the client through the establishment of trust and rapport within the one-on-one relationship between the client and counselor is critical in the treatment of PTSD. During that process, the counselor must be patiently working to recognize and understand

the unique details and reactions of the client to the trauma. As much as possible, the client should feel a regained sense of control through the direction that the therapy takes, while the counselor is considers a broad framework of possible techniques to assist the client in feeling safe. In providing that safe haven for exploration, the client can begin to neutralize the power of the traumatic event and regain control and direction in his/her life.

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