Post Traumatic Stress Disorder:

Predisposed Careers, Therapy, and Positive Support

by

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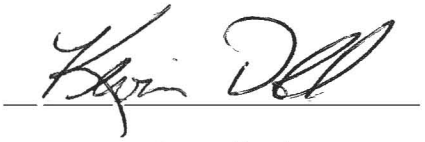

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Abstract

Some occupations have the predisposition for high-risk stress factors and exposure to traumatic incidents. These occupations, such as law enforcement, emergency medicine, corrections, firefighters, and combat military veterans may inevitably experience or be exposed to significant psychological distress by virtue of their job. In some instances, a traumatic experience may invariably create uncontrollable stress or depression and treatment will be prescribed for the victim. The treatment for these disorders is characteristically focused on the individual, their willingness to accept therapy, and any related experiences from their past.

The high-risk occupations identified in this paper may be predisposed to experiencing trauma but by virtue of the presumptive "toughness" of their position, they tend to decline counseling/therapy. Many people experiencing symptoms of posttraumatic stress or other related

disorders will use their social network as a sounding board for their troubles. It is important that the social network, family, friends, and peers are not only positive but they do not give inappropriate advice to the victim.

Coupled with the treatment by a qualified therapist, the victim may assume additional coping strategies through positive support. The support must be an encouraging influence without exasperating the disorder by abrogating the treatment through unspecified and negative connotations. If the social network is not educated on what to expect when working with a victim from trauma, they may fail to provide a positive influence. Unfortunately, without positive support, victims may not only have difficulty with the therapy, but may turn to other coping mechanisms such as drugs or alcohol.

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Chapter I: Posttraumatic Stress for Specific Occupations

There are specific occupations with an inherently higher rate of stress because of the frequency of exposure to various traumatic events such as death. Occupations such as law enforcement, emergency medical services, corrections, firefighters, and combat military personnel are susceptible of being exposed to trauma at a higher frequency than most other occupations. In many cases, the witnessed traumatic event may be a violent and portentous episode dealing with a near death experience or a fatality. These exposures to trauma, or frequent high stress events, may ultimately lead to a diagnosis of acute stress disorder, posttraumatic stress syndrome, or a more simplified version of depression.

With many stressors in life, a positive support system of family, peers, and friends may be needed to help cope with the trauma. In addition, the victim may ultimately change their ostensibly routine daily functions and roles within the family structure. It is difficult to sustain the daily rituals we endear when emotional strife consumes most of our thought process.

The family systems theory essentially identifies these various extemporized roles within family organization. These undefined responsibilities have a preconceived process of organizing harmony in the relationship. The identifiable functions may be more symbolic than absolute, but will deviate periodically to help better define the member's position. These functions within the family will marinate over time and fundamentally become the basis for any communication in that family. The nuclear family with all of its intricacies and tribulations can be a delicate configuration easily destroyed when a member becomes dysfunctional due to their experience with a traumatic event.

According to the American Psychiatric Association, the rate of posttraumatic stress increases substantially due to the expectations connected with high-risk occupations. This rate is relatively low for the general population and most careers. However, professions within emergency services or combat veterans as identified within this document, have an increased risk of developing symptoms for posttraumatic stress due to the precariousness of their job.

When seeking treatment for these stressors or symptoms such as posttraumatic stress, it is important that outside influences do not differ from any treatment. The influence received from any social support cannot provide inappropriate advice that although innocent, will ultimately exasperate the treatment period for a stress disorder. By integrating the family or positive support system in with the treatment plan through education and suitable feedback, it may generate a more complete map toward a faster recovery or stabilization.

Statement of the Problem

Emergency services and combat veterans tend to have a more susceptible capacity for developing issues from exposure to traumatic events. The expectations of the job, ultra masculine portrayal of the position, and unwillingness to seek treatment may exacerbate proper care for coping with the stress. In addition, support systems may be incorrectly used or provide inaccurate and inappropriate advise. Treatment for stress disorders such as posttraumatic stress, depression, or a form of acute stress should incorporate the family support system to insure proper care. If the support system is a well-known axiom that people use to vent to or receive advice during extreme stress or traumatic experiences, it should be given the guidance to provide information.

Purpose of the Study

The goal of this study was to find available research in support of using family and friends as a coping mechanism within treatment programs. In addition, the research was to identify what programs are available for emergency services during traumatic events.

Assumptions of the Study

Most treatment programs do not integrate the family support system into their therapy or provide education to the family to assist them in helping their loved one in crisis.

Definition of Terms

Emergency services – is typically agencies and organizations that respond to emergencies for public safety or have a duty to control public safety such as police, firefighters, emergency medical services, and corrections.

Combat Military Personnel- are personnel in a branch of the service such as Marines, Army, Air Force, Navy, Coast Guard, or their affiliates that are exposed to combat.

Family Systems Theory- Considering that each family is unique based on the many variables and characteristics within the family and the viewpoints and cultures that exist, a system is formed. The system incorporates all the personalities of those in the family and builds a unique interaction arrangement. As time progresses and additions or developments are revealed, this system can be fluid and change. The family system may loosely define unspecified roles of its members and allow the family to determine care and quality of life for its components.

Posttraumatic stress disorder- This disorder may start at different stages for each person-experiencing trauma in their life but can adversely affect a person through reliving the event that created the stress. It is primarily an emotional sickness classified as an anxiety disorder and is the result of a frightening, life-threatening, or otherwise highly traumatic experience. It is more defined in Chapter II of his document.

Social Support System- A social support network can be co-workers, friends, family, and other peers. It is a significant people in our lives that we tend to lean on when distress is overwhelming. The social support system is typically those people we are comfortable with but can also be people we turn to during those times of need in helping us cope with stress or traumatic events.

Traumatic Event - A traumatic event is usually a stressful experience that may cause physical, emotional, psychological distress, or harm to us. The event may be something that happens to you or something you witness that is terrifying or life threatening. It could also be a horrific traumatic event that was witnessed and resulted in death.

Chapter II Literature Review

Would therapy for posttraumatic stress disorder benefit more if therapists would integrate with the victim's positive support network?

Occupations Predisposed to Trauma

There are occupations by virtue of their existence that have established parameters that may include exposure to outside stressors and a high potential of experiencing traumatic events. Rescue workers are defined as emergency service professionals (law enforcement, fire fighters, paramedics, and EMTs, correctional officers, health care professionals, and search and rescue teams) who respond to disasters. In many cases, this will include military in combat situations or those assigned duties specifically related to those listed here.

These occupations within emergency services as well as combat veterans tend to carry expected stressors and the possibility of traumatic exposure. Rescue workers have the added experiences that include the odor of decomposed bodies or viewing bodies mutilated from a disaster. These selected occupations are inclined not only to have the expectation of exposure to trauma, but repeated exposure to various traumatic incidents. Emergency workers who may deal with an incident involving the death of a child or adolescent may invariably have increased symptoms associated with stress, especially if they are parents and have children within the same age group. Unvarying within these high-stress service professions there exists controversy of which career may bear more susceptibility to posttraumatic stress disorder.

Most professions dealing with distressing violent death may have a higher vulnerability to tension leading into posttraumatic stress disorder. Stress is universal in most careers but the level of the strain and the manner of acceptance and tolerance is the contradictory factor when referring to "stressful professions." (Jeannette, 2008) In many cases, the emergency professionals balance their stressors of death by saving a life or accomplishing a difficult task. Unfortunately, many feel a sense of helplessness when they are commonly dealing with death and disaster far more often than a rewarding experience.

Law Enforcement - A law enforcement officer is generally a government employee held responsible for various preventive measures in criminal activity and as a community caretaker. They normally investigate, arrest, and detain suspected or convicted offenders that violate laws enacted by legislation. Law enforcement officers include state troopers, deputy sheriffs, city police officers, federal marshals, and a variety of state agencies. Law Enforcement officers and military personnel in combat zones have a unique process of hypervigilance: a technique that tends to place them in an entire different mode than many other emergency services. (Gilmartin, 2004)

Law Enforcement officers from their initial training through their years in their career tend to look at the world for its potential hazardous and dangerous possibilities. This mechanism is a learned trait to survive on the street and seek the "what if" scenarios for preparedness. (Page 33,Gilmartin, 2002) Unfortunately, law enforcement officers cannot easily shut off their "alert state" and commonly practice it whether on duty or off duty.

Colonel John Boyd established a system believing that soldiers in combat, which pertains to law enforcement in combative situations, need to Observe, Orient, Decide, and Act. (Howe, 2005) His system commonly referred to as the OODA Loop was attributed to the manner of mindset within the soldiers when confronted with a rapidly changing combative environment. It was Boyd's way of trying to have you look within the mind of the opponent so you could be fluid as the situation changes and stay focused on the mission.

This manner of thinking is related to the hypervigilance that soldiers and police officers need to remain in to stay focused and ready for any situation, regardless of its changing environment.

Corrections – A correctional officer or jailer is someone working in a prison or jail with offenders awaiting trial or convicted inmates. This job requires an extreme guarded role and the person may need additional strength in their mind. Within their work environment, correctional officers seem to become weakened to outside influences unless they establish a structured psychological strength. This weakness may cloud their judgment and entrap their empathetic or sympathetic senses allowing them to be more trusting of the inmates and form an unaccepted "friendship" or "bond" with them. Perhaps, in many respects, it could be compared with the "Stockholm Syndrome," coined from a hostage situation in 1973 in Sweden.

Note: *The name "Stockholm Syndrome" derives from a 1973-hostage incident in Stockholm, Sweden where four hostages were held for a week. The hostages later became emotionally attached to the capturers. Although viewed as a psychological response of a*

hostage situation or an individual in similar circumstances, in many cases it predicates on the emotions of authority with self-proclaimed victims at the time. (De Fabrique, 2007)

The correctional officer maintains order within their assigned facility and must enforce the various rules and regulations for that institution. Much of their work requires contact with the inmates/prisoners, a dangerous posture for many. Officers are required to search inmates and their assigned cells for contraband or other dangerous weapons. Many prisoners have nothing to lose because they are adjudicated with a life sentence. During an inmate's stay in a facility, privileges can be revoked or suspended and sanctions can be imposed depending on various rules within the facility. This alone creates a very distrusting relationship for those serving several years to life in an institution. Correctional officers must remain alert when handling inmates that have a lifetime sentence or potential adjudication of any long-term sentence. More importantly, inmates have every moment of their incarceration to study their environment and fantasize about escape. The sentenced inmates will test the complacency of officers and force them to establish a mechanism of survival by remaining vigilant. (Parent, 2004)

Correctional officers create defensiveness to inmate threats by imposing a vigilance for dangers that is impossible to shut off when off duty. Correctional officers therefore do not have the luxury to become complacent and tend to carry this "learned behavior" during most intervals of their lives.

Most of these correctional officers will generate stress while working with inmates during the daily operations. This includes the routine and tedious contacts with inmates, rule violations or their fighting coupled with the daily logs, reports, and handling of inmates while unarmed. One of the most devastating issues, outside of fearing their own confrontation with inmates, is

witnessing suicides or murder while in the prison systems. Correctional officers have a high propensity for developing posttraumatic stress disorder based solely on their response to a self-inflicted death of an inmate while in custody. This proclivity for the disorder following a death response is predicated on factors such as experience, prior response to a suicide, problem solving ability, optimistic views, and the level for which they were involved in the incident. The unfortunate information is that it is more common for staff to be affected by the death response. (Wright, 2006)

Firefighters - Although a rewarding career, most of their time is not spent fighting fires or using their skills, but when called to action are subjected to the stress of fighting the fire. Firefighters are called on periodically to rescue people from a burning building, administer any medical care, and combat fires in a home or business. The stress of this is not just the work, but anticipating the next call for service and then imagining if they will do it right.

This job does not have the burden of constant stress but still has a sense of hypervigilance while on-duty. The hypervigilance is created by maintaining a prepared mind for that call to action for a dangerous situation. The downfall of helping people as this job entails, is losing a life while working or incapable of rescuing someone from a burning building. This traumatic experience of witnessing death or the unsuccessful resuscitation of a human life may be devastating for a firefighter. Fortunately, firefighters are less susceptible to regular stress unlike a combat veteran, or law enforcement and corrections officers. Firefighters may not always be required to maintain hypervigilance such as police do, but their stress is acquired through anticipation and response. This stress is typically easy to shut off when not working which is opposite from law enforcement as they cannot.

Paramedics - The Paramedic is a medical care worker on wheels and their ability likely can exceed that of a nurse. The equipment in coalesce with the skill of the paramedic allows exceptional care to patients before ever arriving at a hospital. However, the added stress of their job is that they are personally responsible, legally, ethically and morally, for each drug that they administer to a patient. They also have to use correct protocols and techniques when working with patients and then properly document the effects of the medical services provided. The comprehensive ability of the paramedic mixed with their drive to save lives can easily create unprecedented stress when life is lost in their hands. These traumatic events are what may impregnate their unique exposure to witnessing death and the connection to stress. Although their work may in fact create a stress in reference to their responsibilities while on the job, the hypervigilance is less likely while no longer on the job.

Military – When identifying the military as an occupation susceptible to traumatic situations, the position held and the combat campaign at the time would dictate the propensity for traumatic events. The present war in the Mid East has forced many military personnel into combat and heightened their vulnerability to traumatic events. Despite the fact the term "military" is used for this report, it would truly depend on the position and assignment.

Many career positions, such as those in a high-stress role have a tendency to create additional stress within the family. Family members may bear the burden of the stress exhibited by the member of the family in a stressful environment or experiencing a traumatic event. The strength of the family is predicated on the communication within and on the family systems theory.

Overview of Family Systems Theory

This theory relies on establishing very general or symbolic roles within the structure of the family while building a bridge for communication. The family system enables each member to develop these hypothetical roles and styles as they form their family as a whole. The family recognizes and accepts this formula because of the process by which each member develops their role and how it interconnects with each other. However, the creation of these roles for unity may manufacture a rather nebulous pattern of expectations.

This family communication system is a manner of cultivating traditional boundaries through an almost distinctive household style that is rather unique to each family. The rituals that are maturated by the family by their own various reinforcing methods are not always accepted from family to family, especially by generation to generation. However, as the family develops specific and expected patterns, they tend to safeguard their private functions and routines. (Murray, 2006)

The idea of a traumatic event, or an experience that may establish emotional distress, will tend to shuffle the recognized symbolic classifications outlining family roles. When witnessing or experiencing any traumatic event, other family members will become concerned for their kindred's mental health. The remaining family members cannot completely understand how this quandary has influenced the fraternal member. This lack of knowledge may incorporate misunderstandings and unknowingly exasperate the crisis. The remaining familial body, without

understanding the stressful effects of such an event, may be more inclined to continue, without interruption, their routine or symbolic duties at home.

This continuation of life "as it was" by the remaining family will create more confusion and the appearance of inappropriate or dispassionate behavior as witnessed by the victim. While the remaining family normalizes to pre-trauma events, the trauma victim is still cognitively imagining the event and holding negative feelings. This disconnect becomes the barrier for misconception and lack of appropriate communication. The trauma victim's inability to have previously accepted what had initially occurred may be another factor to consider. The member that has suffered the stressful episode may feel that others are unwilling to discuss the events and their feelings regarding it.

Subsequent to a traumatic event, the person experiencing the disorder will need time, support, and a sense of assurance that they can justly reconnect with family. Military personnel witnessing or having a direct involvement in a war zone may have serious reactions to the experience. (Paul J. Antonellis jr., 2006) As with many traumatic events, the family member will be affected by the event, while others display misinterpreted disconcerting gestures. This may construct fear, dismay, or helplessness within the mind of the victim that is connected with posttraumatic stress. They may have difficulty sleeping because of disturbing memories that create anxiety, irritability, and emotional numbing. Unfortunately, one of the common disinterested activities is turning to drug use and alcohol as a coping mechanism.

Fundamentally, the interruption caused from a traumatic event will dramatically affect the entire family system. The event may disrupt and sequentially redefine the normal symbolic roles and functions of the family requiring new communication methods or altering roles.

(Erbes, 2008) A single-family member involved with a traumatic experience can materialize change induced from the symptoms of posttraumatic stress disorder that directly influenced the remaining family members. This change will develop further various unexpected problems with the communication and family cohesiveness. The unfortunate result is that the family members begin to feel alienated from feelings of frustration and irritation that the victim is "not the same."

Family change, especially by disruption, can be systemic rather than individually focused. (Becvar, Research on Social Work Practice, 1994). The emotional process influences the individual; however, the emotional make-up of the individual within the family is actually the framework of the entire system. Ultimately, this directly correlates with the family component of becoming emotionally disturbed when a single element is affected. In conclusion, this shows that a traumatic episode creating an emotional instability even from a single element of the family will impinge on the emotions of all. This change is difficult because we tend to believe working with the individual and not the family system will resolve most issues.

This emphasizes that these changes when working with posttraumatic stress disorder may not allow a "fix one, fix all," style of treatment and may require the entire family, when positive, to be included in the treatment process of an individual family component. (Murray, 2006) The theory further suggests that when individuals isolate themselves from their family, it may be misunderstood. The family, or those that are involved within that system, have a better understanding and comprehension for the many roles or functions of their family. Families, or more definable as contemporary families, are systems that are connected to one another and mutually dependent on the rules and responsibilities they establish.

It is important to establish a positive family structure when working with members of the family that may be distressed through trauma. Although the family network may be the first contact when a sibling is under stress, it is important the family be formed in a positive manner to avoid additional problems.

Positive Family Support

Those that experience a life-altering traumatic event, will likely use, or try to use their primary source of support, which is typically their family. Victims that have experienced trauma that exposed them to untypical distress will inevitably seek family members to assist them during the sorrow. This is invariably due to their feelings of trust and knowing their family may understand them more in depth than other friendships. The avenue of concern is that although family may be the first choice for assistance, they also have the influence to incense the problem through misunderstanding and incorrect approach. Family members will seemingly provide comfort and recommendations similar to counseling, but lacking any foundation beyond the typical intuitive conviction.

The trauma victim will become vulnerable to their social network and in some way enable them with a sense of unwritten authority for helping. The family and friends, with every good intention, will provide their view including their extemporaneous way of lessening the traumatic experience by sharing a similar occurrence with a past trauma in their life. This tends to be a common theme when given that entitlement to help; unfortunately, the victim may not interpret it as intended. Victims are not necessarily interested in hearing the personal stories of others or how the traumatic event could have been worse. The trauma is affecting the victim in a

manner that cannot be thoroughly understood and their concentration to the trauma is an emotional roller coaster. Without using a more empathetic manner of exchanging words, the hollow attempt may be received as more of an insult than commiseration. This in some respect, is a support system saying, "I know how you feel," which is not at all likely.

The unfortunate side effect to inappropriate words or acts is that if the victim does not feel any comfort or true acceptance, they may withdraw or disassociate from their selected social arrangement. This withdrawal may actually add to the propensity for victims of trauma becoming depressed. The uneducated venture may actually increase the normal recovery process or interfere with some of the therapeutic practices. With a more informed support network, the anguish experienced by the victim may actually decrease during the recovery process of the treatment.

It is impossible to assume that because a person may have experienced a similar past traumatic event, or have an empathetic understanding for people; they may have the full benefit of appreciating the pain suffered by someone else. In addition, two people witnessing the exact same traumatic event at the same time will presumably not fully understand what the other person is experiencing. (Antonellis , 2006)

Conceivably, treatment programs may need to include a process for educating family on some of the complications and misunderstandings when interacting with a victim suffering from depression or posttraumatic stress syndrome. This education could include some of the important factors to avoid but also guidance that would connect them with their depressed family

member and provide support and comfort. This could merely be the "what to do" and "what not to do" book to follow during the victim's stress treatment and symptoms of distress.

Posttraumatic Stress symptoms are identified in the Diagnostic and Statistical Manual of Mental Disorder.

Posttraumatic Stress Disorder

This disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorder (DSM), Fourth Edition ,is the development of specific characteristics after being exposed to a traumatic stressor. The stressor, according to the DSM-IV must *involve direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person.* The DSM-IV recognizes that it may also include *learning about an unexpected or violent death, serious harm or threat or death or injury experienced by a family member or other close associate.* The true connection to these events is that the occurrence or exposure should involve intense fear, helplessness, or horror. (Rosen, 2004)

The specifiers that may identify the onset or duration of these symptoms is acute, chronic, or with delayed onset. The close companion to posttraumatic stress disorder is the acute stress disorder that is similar but usually has an onset of symptoms within one month. This immediate, short-term response to a traumatic incident usually lasts between a few days to a few weeks and is distinctively different from posttraumatic stress disorder. The other difference of acute stress disorder, depending on the circumstances, is that acute stress disorder is more linked with dissociative symptoms, such as emotional disconnection, temporary amnesia, or a feeling of

being detached from their traumatic experience. In some studies, an examination was made of various combinations of symptoms including symptoms of acute stress disorder as predictors of posttraumatic stress disorder. (Zoellner, 2003)

Both these disorders may be the body's natural response to the traumatic event as an instinctive coping mechanism. Some symptoms of posttraumatic stress disorder can be categorically identified in one of the following:

1. Unexpected and perhaps unwanted memories of the traumatic incident can regress in the mind whereas these episodes are referred to as "flashbacks."
2. Internal and external reminders during periods of thoughts, feelings, conversations, activities, etc
3. Sleep deprivation or a sleep disorder from the consistent manner of thinking about the incident identified as traumatic. (Antonellis Jr., 2006)

Posttraumatic stress disorder is a psychological disturbance that is the sum of all the emotional conflicts resulting from exposure to a traumatic event. (Laufer, 2006) The effects or identifiable conditions of posttraumatic stress disorder will invariably take its toll on others that are associated with the victim. . (Antonellis Jr., 2006) Although one of the beneficial aspects in the healing process of the stress is positive social support; however, those associated with the victim may eventually isolate themselves from the victim of the disorder due to the increase in anger

The disorder relating to posttraumatic stress symptoms is recognized more easily now than years ago, regardless of the fact it still carries the stigma of being a disease of combat war.

(Paul J. Antonellis jr., 2006) In fact, historically the common name used to identify posttraumatic stress disorder in previous cases of those in combat was “shell shock” or “battle fatigue.”

In 1980, the formal recognition of posttraumatic stress disorder in the DSM-III, was as a diagnostic category for discussion during combat in our nation’s wars. (Rosen, 2004) However, regardless of the location or category of the traumatic experience, the connection with life-threatening traumatic events and psychiatric issues is profound. This would imply that depending on the circumstances, any stressor that evokes these symptoms of distress could actually involve nearly anyone.

Another study suggests that there is a genetic predisposition to posttraumatic stress disorder attained from within the family. (True, 1993) However, most of the literature on this topic is inconsistent. These studies were originally conducted during wartime about family relationship issues. These other disorders could actually be indicators toward the development of posttraumatic stress disorder. The conclusion of these reports suggested ample evidence that the symptoms correlated to posttraumatic stress disorder in the family might actually increase the risk of the diagnoses. (Watson, 1996)

Emergency personnel may essentially become the “hidden victims” to posttraumatic stress disorder during their recurring response to these tragedies. In research conducted by Jeannette and A. Scoboria, they discovered that there is an obscure perspective regarding emergency personnel responding to a traumatic incident. The study was specifically directed toward emergency personnel developing symptoms of posttraumatic stress disorder when they are merely after-action responders. (Jeannette, 2008) The theory identified that it is not just the

number of occurrences for which emergency personnel respond, but rather how the event is perceived within the principles and personal experiences of the person involved. Oddly, the person does not even need to know that they have these preconceived thoughts or beliefs in order for it to apply.

The regrettable belief continues to be the portrayal that since emergency personnel have been trained to handle these stressful circumstances; it should be like switching to autopilot when a high-stressed situation occurs. (Jeannette, 2008) It is not necessarily the reaction of the person while involved with a traumatic incident, but rather the emotions that come into play following the incident. It is possible that emergency responders will create a link with their family and the distressing incident. This emotional thought tends to cause the incident to become even more embedded in the psychological stress. (Wright, 2006)

Some of these negative social difficulties may include the expectation of a community that believes certain occupations should have anticipated they would be exposed to traumatic events. This implies that because people choose a certain career knowing it will include exposure to trauma, any emotional strife or unfavorable reaction from this exposure is merely a weakness. It is unfortunate that this perception exists entailing that specific professions experiencing affliction should be able to handle it with little distress. This implied stigmatism is one of the main reasons that these identified occupations feel they cannot report their emotional turmoil from a traumatic event for fear of disgrace.

Within these high-tension careers, a stress debriefing was designed to allow officers to speak freely regarding the explicit details and emotional feelings following a traumatic event. (Robinson, 2004) The design of the Critical Incident Stress Debriefing was a means to provide a

distinct intervention technique allowing all emergency personnel to attend. This style of group therapy in some respect obligated those experiencing the traumatic event to show and shattering the stigma of the "tough guy."

Many in those dangerous careers have a common manner of self-identifying their machismo or "warrior mentality" due to the "toughness" of the profession such as police, firefighters, etc. (Paul J. Antonellis jr., 2006)

The screening process for emergency services following trauma and their identified masculine position has been identified as the primary resistance for refusing to report symptoms to a mental health professional. If the victim has concerns about their peer perception, they tend to avoid requesting help in fear of how they may be acknowledged. In many cases, those mostly avoiding it are likely to be those with the greatest need to report their symptoms or seek mental health assistance. (Hoge, C., Castro, C., Messer, S., McGurk, D., Cotting, D., & Koffman, R, 2008).

Research seems to focus on the predictors of posttraumatic stress symptom severity and the reactions to it. (Ullman, 2001) It is difficult to view these predictors without adequately addressing the variances for unknown history for each individual. The previous experiences and other history may determine the severity and susceptibility for gaining symptoms for posttraumatic stress disorder. In some of the cases, using a coping mechanism appropriate for the situation coupled with a positive support system could prevent some of the symptoms related to posttraumatic stress disorder. The research has examined negative and positive social reactions such as blaming, treating the victim differently, distraction, and other negative

connotations. When the results are more negative, the victim is more likely to increase posttraumatic stress disorder symptom severity.

Treatment for posttraumatic stress syndrome may occasionally mystify therapists because it is not always a one-size-fits-all treatment plan. Some of the treatments for posttraumatic stress disorder include:

1. Eye movement desensitization and reprocessing. This treatment is where the patient visualizes the reoccurring traumatic event and the therapist moves a finger rapidly back and forth in front of them. The rapid movement in conjunction with tapping of the hands or alternating noise in their ears will trigger the senses of both sides of the brain. (Antonellis Jr., 2006)

2. Neuro-Linguistic Programming. This treatment process is dependent on how we perceive things through our five senses and treatment is adjusted accordingly. (Antonellis Jr., 2006)

3. Thought Field Therapy. This is a method of blocking the flow of energy that is created by the disturbing thoughts of the event. It is more immediate relief for anxieties and fears associated with the trauma. (Antonellis Jr., 2006)

4. Trauma Incident Reduction: This treatment is specific to a one on one plan that is highly structured and designed to eliminate the negative effects of the trauma. (Antonellis Jr., 2006)

5. Prolonged Exposure: Prolonged exposure (PE) to stimuli associated with the original trauma experience is a method of treatment provided to the patient as a willing

participant. The flexible and perhaps very individualized use of this treatment has been successful when relationship patterns are considered. (KRAMER, 2009)

6. Cognitive-Behavioral Treatment: The CBT is a model for assessment and treatment planning while taking into account the person and distinctive aspects of their personality and life circumstances. This treatment requires a plan analysis and determining the best method toward the individual rather than a customary subjective process created by the therapist. (CASPAR, 2009)

It is not any more unusual for emergency personnel to feel a sense of helplessness or an intense fear following the tragedy than anyone that may witness or experience traumatic events. (Robinson, 2004) Emergency personnel cannot always win in a situation that has a tragic ending and commonly blame themselves for the results. It is difficult for these career personnel during those moments that their efforts to help are shattered by violent death where the outcome may be an emotional rollercoaster.

Posttraumatic stress disorder is typically the failure to adapt to the traumatic event from symptoms cultivated immediately after the occasion. These symptoms may continue for weeks or months and increase if not managed adequately. One of the single most suggested coping mechanisms is for the person to talk about the events, their feelings, to their supportive network (family, friends, and health professionals).

Regardless of many of the stress issues that may be preventable when referring to posttraumatic stress disorder, there are some careers that tend to have a more susceptibility of trauma related stress.

Susceptibility to Posttraumatic Stress Disorder

Risk factors associated with developing symptoms of posttraumatic stress disorder are invariably greater when dealing with 1) superior trauma severity, 2) lack of social support, and 3) more subsequent life stress. However, most studies identified that these risk factors are not uniform for predicting the propensity of posttraumatic stress symptoms. (Brewin C. R., 2000) The awkward study to analyze the risk for predisposition of posttraumatic stress disorder was directed toward politics, attorneys, and ethics. This study was trying to theorize that the predisposition for the disorder was based on financial issues and the retention of an attorney. (Harris, 2008) Unfortunately, the research was not trying to identify the predictors that were discovered.

The best question about posttraumatic stress disorder is why many witnessing or involved in traumatic incidents do not have symptoms that lead to its development. The common nature to distinguish some of these concerns is the extreme thoughts of dangers lurking in our world and perhaps the fear of a person's ability to cope. (Bryant, 2007) When trauma variables that predict posttraumatic stress cannot adequately show uniform results, the theory is likely to be misleading. More in question would be the issue of completing self-appraisals that provide an unexpected or doubted result.

Treatment Considerations

One of the primary discoveries regarding the research is that, although possible, rarely are proactive management actions taken to anticipate the predecessor that drives the potential risk for posttraumatic stress disorder. (Alexander C., 2007) The challenge to agencies that employ the "at risk" service professional is to minimize the injury to the victim and lessen costs associated with it to the organization.

Organizations of emergency services should consider screening those involved in traumatic exposure immediately following a traumatic incident. Unfortunately, many agencies rely solely on a debriefing after an incident and assume that is a sufficient for employee. The benefits of early intervention necessitate more evidenced-based treatment and prevention practices than the common "debriefing" practiced by so many. (Leonard, 1999) Emergency service professionals must confront many hazardous critical incidents that create acute stress reactions and dissolve the stability of those involved. The stress symptoms from the incident can continue for a long period and deflect a person's mental capacity to handle it.

A critical incident stress debriefing is a semi-structured process during which those involved in the traumatic incident can emotionally react to the trauma and learn more of what happened from others present on scene. (Bisson, 1997) The program was developed as a group session and designed to normalize the emotions that follow the affliction. This process was designed to allow the victims to more readily accept the reactions experienced and how to manage them properly.

The critical incident stress debriefing was provided as an educational tool following the emotional release so the responders knew more about their symptoms. Some of the complications with the stress debriefings are when the information is exposed during the session, it is not protected, and the facilitator is commonly a worker not working in one of the emergency services. Regardless of its continued use, many of these responders are not easily dissauded that the signs or symptoms of stress are nothing more than something associated with weakness.

The critical incident stress debriefing is likely the most popular means for intervention and yet no evidence exists for its success. Although both the employer and employee have a great deal to gain for the success of the program or any intervention that is triumphant, they may need to research more for a better solution. Emergency responders are not unique to stress in the field, but many other workplaces that may be at risk for stress do not entail the devastation of death as often as emergency services and combat military.

It has been shown that a single episode of witnessing a horrific or graphic violent death, mutilation, or a threat of death to oneself can generate difficulty in coping. (Alexander C., 2007) The mechanics of trying to witness and then manage death and suffering by these professions at crime scenes and accidents continues to burden them. The uniqueness of combat military and emergency personnel is that they are exposed to multiple traumatic episodes, which is far more complicated for treatment than working with someone involved in a single event.

Some of the factors when dealing with posttraumatic stress disorder are the number of times the person is exposed to an event of death or other traumatic event. The claim is that law enforcement or other emergency personnel become more callous over time while contending with trauma or these horrific disturbing events. Lt. Colonel Grossman, a psychology professor

and former military ranger, has published books on military conditioning concerning classical methods of teaching soldiers. Lt Colonel Grossman contends that soldiers need conditioning to teach them how to by-pass the normal instinct of not wanting to kill---even in combat.

The contention is that during World War II, the Japanese would train young soldiers to kill prisoners of war with their rifle-attached bayonet. The new soldiers would approach an alleged war criminal tied to a post and repeatedly use their bayonet until death. The victim to this punishment would scream and plea during their death. This unimaginable training style continued while other young Japanese soldiers would cheer on their comrade. Following the event, the new soldiers were treated very respectably to a fine meal and the enjoyment of a young woman.

Lt Col Grossman stated in his book, "On Killing," that this was a training technique that, although morally reprehensible, would inculcate soldiers to kill. The soldiers were capable of killing without the moral values and psychological repercussions of coping with death. It was bread into them. (Grossman & DeGaetano, "On Killing"1999).

In retrospect to Lt Colonel Grossman's research about Japanese soldiers, this egregious theory was merely a way to prevent the psychological effects of killing or symptoms comparable to posttraumatic stress disorder following the event. (Wright, 2006) Emergency service personnel and combat soldiers continue to witness unspeakable traumatic events without any conditioning. In many cases, they learn to accept the traumatic episode and develop a tolerance after being repeatedly exposed to it. Perhaps this is the reason some research refers to their manner of coping with these tragedies as a "John Wayne" syndrome. This is because some

cannot understand their numbness to the incident or perceived lack of serious symptoms of stress coupled with their unwillingness to receive any assistance when exposed.

The critical stress debriefings, although the accepted manner for dealing with stress and trauma in emergency service careers may paradoxically induce distress in those who may have otherwise been unaffected. Organizations need an evidence-based solution for early intervention for employees while considering limited resources. In many instances, the social network for employees is presumed to be co-workers while families are seldom considered.

Early intervention should require a full evaluation but 'non-invasive' support. (Bisson, 1997) The intervention to prevent undue future health issues may require coordination with close positive family relationships, their primary healthcare physician, social services, emergency planners, and mental health professionals.

A screening process designed in the form of a questionnaire or brief interview could potentially help detect those workers in need of more intricate help and avoid the delays in adequate treatment. (Alexander C., 2007) Ultimately, the ideal process for dealing with these events is to have a system in place that anticipates the outcome of the exposure to some individuals. Supervisors should be trained to detect symptoms and manifestations indirectly displayed and institute appropriate health assessments.

This does not suggest having supervisors badger their subordinates with a barrage of questions about the incident, but rather have unrelated conversations while drawing some conclusions. The supervisor's skill training would allow a better assessment before seeking additional help from a clinical professional. In addition, keep family apprised of any concerns

and provide the social network with the required tools to prevent long-term issues similar to posttraumatic stress disorder.

People suffering from an emotional wound prefer talking about the incident as part of their therapeutic recovery. This single conviction has rapidly expanded the idea for managers to allow the practice of critical incident stress debriefing. However, without the empirical data to confirm its success coupled with the fear that it may invariably be a 'quick fix' to get officers back in the game (so to speak), it may not be the best selection of a therapy practice. (Leonard, 1999) The concept of talking about traumatic issues was the purpose J.T. Mitchell designed the popular stress debriefing technique used by emergency services. This style of group therapy allowed the stressed employees the ability to speak freely and it was presumed to be effective in combining symptoms for areas of stress-related issues. It addressed maladaptive coping strategies and the anger that may accompany it.

The design of the Critical Incident Stress Debriefing is a 7-phase structured process identified as:

1. Introduction – This is a means to get the attendees to become more comfortable by providing them with ground rules, a confidentiality statement, and urged to open up.

2. Facts—the attendees are asked to describe what occurred from their perspective.

3. Thoughts—The attendees speak candidly about what they first thought when the incident occurred.

4. Emotions—Each person can describe their emotions.

5. Assessment—This is a time where the facilitator begins to identify the physical and psychological symptoms from those in the group and then it is discussed.

6. Teaching—The facilitator will discuss stress reaction and coping strategies.

7. Re-entry---this is when the group asks questions and the facilitator summarizes what happened. (Campfield, 2001)

The practice of using critical incident stress debriefing in the United Kingdom has changed to an alternative method of a three-stage model comprising of facts, feelings, and future. It is merely an introduction to their feelings of stress. The methods used in the United Kingdom emulate that which is used in the United States. (Regel, 2010) The agency is then developing support teams to work with those in stressful incidents and monitor their performance and actions following the event.

The process of critical incident stress debriefing articulates one important fact regarding the phases addressed by Camfield. People working in emergency services tend to place a high regard for their fellow co-workers and commonly refer to them as their "family." Although this "family" is generally not considered, even with a stretch of the imagination, within the definition for nuclear family, it still has a strong practical application. Critical incident stress debriefings do provide education for the "employment family," but fail to move outside the agency to the victim's support network to help prevent additional complications with stress.

When using group discussion therapy such as critical incident stress debriefing, it is important to follow up with the victims after the initial group contact. In addition, if a person

elects not to attend the debriefing it is not indicative of their need for help. The group discussion is a great method for allowing those in attendance to better understanding others with similar emotional suffering. However, to undrape the full potential of having an intervention program, the employee's family must be included in the evaluation.

The follow-up process should include screening personnel for additional needs and educating family or close friends on signs of stress. Some of the group sessions may unintentionally mold responding participants in believing there is a "correct" method for handling their issues and emotions. (Jeannette, 2008) There cannot be, nor should it be suggested, that there is only one-way to manage and cope with stress related incidents.

Some pre-trauma factors may exist that raise concerns about emergency responders involved in a traumatic incident. (McFarlane, 2007) Some of these considerations may be prior traumatic exposures, previous psychiatric or physical injury, and the manner of thinking prior to exposure to a traumatic incident.

A Critical Incident Stress Debriefing should not be exploited as a stand-alone program for trauma victims. At best, it may display an understanding that the employee's agency is trying to prevent them from long-term issues caused from the traumatic experience. However, without adequate follow-up, appropriate screening practices, or supervisor evaluation, the job is not complete. Unfortunately, many health officials performing the debriefing are aware of many aspects of grieving but lack full understanding of posttraumatic stress disorder. (Regel, 2010) Managers should not use it as their only means of stress intervention for posttraumatic stress disorder and then "wash their hands" of any further obligation. All agencies should evaluate the

program and continue to strive for a method or standard for evaluating the mental health of their employees. (Robinson, 2004)

Most of those suffering from the stress of an incident will need some interaction with a friend or family member for their release of the emotions they are experiencing. At times, that release of emotions will begin to irritate those listening to the information. . (Irving, 2001) Without proper instruction or edification, these appointed support groups (families and friends) might inadvertently make compelling statements or improper advice that may ultimately be damaging to the recovery process. After all, any unexpected traumatic life experience is best understood through the eyes of the beholder rather than anyone that may "think" they understand

The traumatic experience can be such that it may overcome a person's normal ability to cope. Without a systemic way to address the anger, maladaptive coping, and family support evaluation, the process may fail in retaining the emergency worker. (Leonard, 1999) The critical incident stress debriefing process has not been convincing enough through studies to gain full support of the analyst reviewing the outcome for participants. Additionally, it seems the strongest support group identified for serious incidents is the participants loved ones.

Commonly, those respected and loved are the first to assume the role of supporter for the anguished victim. With this frequent selection for support, it seems logical to incorporate family and close friends into the therapeutic process. If the therapy includes educating and guiding these appointed support system members, it may prove beneficial for effective encouragement without exasperating the healing.

As noted in the lists for treatment for posttraumatic stress disorder, a range of possibilities exists that extend beyond a simple solution or a single program for all. Clinicians must consider various aspects for treating posttraumatic stress disorder including the spiritual aspects of health and outside influences. Trauma survivors have a five to eleven percent possibility of developing posttraumatic stress disorder. Since many of the trauma victims may seek spiritual means for resolving their agony, they could benefit from spiritual assessment and intervention as part of their overall treatment plan. Spirituality and religion are defined differently and are not considered the same.

It is a common belief that life-threatening events and psychological trauma have a tendency to prompt spiritual questioning. A traumatic experience has a broad definition that may include combat, a natural disaster or terrorist attack, sexual assault, witnessing or involved in violent death, loss of a life you feel obligated to protect or save medically, or any experiences where individuals fear that their life or psychological integrity are threatened. (Sigmund, 2003) When the trauma includes a violent or hostile nature where the victim cannot control the outcome, it can provoke a process of existential questioning. These "why me?" questions may be best served by at least including spirituality in the treatment planning.

Research has supported the theory that social reinforcement buffers the impact of a critical incident on a person. (Palmans, 2006) Although the data may imply that social support alone may not be enough to prevent the development of posttraumatic stress disorder, it suggests that it has a place in the treatment. When treating a possible posttraumatic stress victim, therapy should not discount family involvement. The family may be key to the success of the treatment, providing their involvement is controlled.

Family Involvement

The impact of the relationship prior to the traumatic experience will likely dictate the degree of support that is accepted from social and family involvement.. The idea is to include positive social and family support. However, if there were any complications and negative contacts with family prior to the event, using their support may counter the treatment goal.

The empirical survey results in some studies have shown that not all exposures to critical incidents will result in posttraumatic stress disorder. (Palmans, 2006) In addition, a study done by the British Psychological Society argued that individuals with perceived encouraging social support are less likely to develop posttraumatic stress disorder. The social support seems to provide a specific safeguard from the impact of their traumatic encounter.

Although social support is a prime factor in therapeutic recovery for posttraumatic stress disorder victims, there may be some gender differences concerning the social support. It appears that women are more likely to carry an instinct of nurturing than the male gender. This key nurturing comfort may be the reason women appear more sensitive to negative support while conversely deriving more benefit from positive support. (Andrews, 2003) However, there was no documenting evidence or research regarding gender difference in social support levels for trauma victims. Research did identify that the effect of social support for posttraumatic stress disorder appeared to be greater with military personnel rather than the civilian counterparts.

The theory about the military connection is that most of the research was completed using military personnel. This research with military personnel was accomplished primarily due to

their increased episodes of posttraumatic stress disorder during combat situations. Most of this research for posttraumatic stress disorder was accomplished shortly after the Vietnam Conflict.

Victims of posttraumatic stress disorder may occasionally blame another person or obstruction for their demise. In opposition, the victim may also be blamed by their social support for the manner of the way they are reacting to the traumatic event. One of the collateral aspects of posttraumatic stress disorder is the increased consumption of alcoholic beverages. This increase is mainly a coping mechanism and studies have shown an increase in the use of alcohol following deployment from a combat zone. (Hoge, C., Castro, C., Messer, S., McGurk, D., Cotting, D., & Koffman, R, 2008)

The method and manner of treatment for those suffering the emotional pain of a graphic event may affect how quickly they recover. (Maercker, 2004) Many that are suffering symptoms of posttraumatic stress disorder following a traumatic event may have an increased sensitivity on how others react to them. The emotional turmoil may intensify their quandary by their perception of others blaming them for being weak. Many victims with posttraumatic stress symptoms seek validation for what they have experienced and incorrectly recognize some statements from their perceived support. This is why positive social support and family are so effective in the recovery process.

Nonetheless, a negative social network has been more indicative of poor recovery or the development of posttraumatic stress disorder, than in the absence of positive support. (Ullman, 2001) This may also be evident regarding the fluid transformation of symptoms of posttraumatic stress disorder. The social support provided to the victim may be directly responsible or in some manner influence the symptomology. (Andrews, 2003)

Traumatized victims do not always agree on what defines positive social support. A group of researchers while reviewing the results of a cruise ship disaster developed a Crisis Support Scale. (Joseph, 1992) This instrument was designed to measure elements of support effecting specific trauma. The scale is composed of six questions concerning the availability of others, confiding in others, emotional support, practical support, negative response, and satisfaction with support.

The crisis support scale was developed by asking participants to think of family members and friends that they have used for support following a crisis. The scale was developed from answers provided by the participants to question about the support they received. (Joseph, 1992) A scale of this significance could be an evaluation or assessment of the social support available to many victims following a traumatic event. Depending on the information attained, adjustments could be made to the social support for victims to insure they are receiving adequate encouragement during their therapy.

However, as much as there is evidence that therapy and treatment may need positive social support, yet that support alone is not enough. The balance of using both support and treatment may result in a more effective treatment plan. The key element to social support is that it is perceived as optimal or emotionally meeting the needs of the person effected by a trauma. If social interaction or family environment is not a positive paradigm, it may be as damaging to the therapeutic work as when family displays irritability when regularly used for support by the victim. During the study by the British Psychological Society if social support was less than desirable and did not meet the needs of the victim (negative interaction), the result were more probable to lead to posttraumatic stress disorder. (Palmans, 2006)

The social network has a variety of different pockets for the victim to reveal or reach. This includes those that are closest to the victim such as family and friends, but also includes significant persons such as co-workers, clergy, and local authorities. The positive social support is typically the unconditional consoling and understanding received by the victim or survivor of a life event. Included in the negative social support would be people who may have provided hurtful feedback, including ignorance, rejection, avoidance, or blaming the victim.

Some of the common social conditions of rejecting, commenting on, or disapproval may cause a traumatized person to feel unsupported, misunderstood, or feel cut off from their social network. In many cases, the remarks are made without forethought to the impact to the trauma victim's treatment. Many people do not know what to say during those trying times of emotional strife, yet feel obligated to say something. Unfortunately, in many cases, uninformed people will make statements or comments interpreted inappropriately. (Maercker, 2004) These comments are merely the result of untrained, misinformed people without the guidance needed to make such comments.

There have been incidents where people traumatized by being a hostage were ultimatrely blamed for their own carelessness for getting into that predicament in the first place. Negative social support like this may lead to a much longer treatment process trying to explain why their comments were inaccurate. . (Maercker, 2004) Social acknowledgement and social support are defined differently. The difference between the two is merely the degree of social support received.

Unlike the scale for social support, nothing exists that defines different types of trauma. Considering that, some people respond differently to specific traumatic experience, it may

convolute any attempted means of defining trauma. However, considering the DSM-III defines a traumatic event as an "*actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person,"* it may be unnecessary to use any scale for trauma.

Most of the information contained within this report is related to the traumatic event witnessed or involving emergency services. (Vickerman, 2007) Considering there are a few identified treatment plans for posttraumatic stress disorder, the re-exposure treatment may not work in all cases of trauma. This may be prevalent not only in treatment of children exposed to family violence, but also in instances where an emergency service worker responds to trauma that they associate with an event that occurred to them as a child. It may also be ineffective for someone with poor social skills.

When observing some of the posttraumatic stress disorder issues with returning veterans, social support and acknowledgement has been more available during the current war than any other previous conflicts. Military personnel involved in combat face adversaries in a new perspective now compared to some of the first declared conflicts. (Sammons & Batten, 2008) Soldiers will suffer additional stress with the unconventional wars where enemy identification is difficult. In other words, the enemy may be dressed exactly like innocent civilians. As soldiers' return uninjured physically from war, the burden of combat may have taken more of a toll on their mental state that had been predicted.

The regrettable and often overlooked subsidiary effects of war when parents are military combatants, is that their children commonly acquire the same residual symptoms of depression associated with posttraumatic stress disorder. Children tend to see changes in their parents that

they dislike and form their own defense of disassociation and sadness. (Punamäki, 2006) It may be an expected outcome when dealing with the family systems theory that members will have different reactions to psychological distress. However, children may develop symptoms of posttraumatic stress disorder not from the experiences of their parents but through their experiences relived.

Combat veterans have added stress with the profound appreciation and admiration upon returning to their home state. This rise in ego, although commendable, can be deflated the next time the soldier is standing in line at a department store absent his uniform. The soldier, without the symbolic uniform, feels he is no longer recognizable as an idol and the newly proclaimed hero status is diminished. This heroic status given solely by the design of the uniform and the commitment to a military service branch does not depend on an act of valor but merely the location of service. Unfortunately, this generic form of identifying bravery to all rather than those involved on the front line may have weakened the term and divided those that have served in a combat area from those in support of it.

The soldier in a combat zone has increased vigilance as a safety precaution for their welfare. This vigilance referred to as 'hypervigilance' is common among police officers as well. Military in combat and law enforcement officers have the same difficulties with hypervigilance and the process of trying to shut it down while off-duty or away from combat.. (Gilmartin, 2002) The brain has a set of structures referred to as the reticular activating system that determines the level of alertness in any given situation; this alertness is typically for potential threats or risks for safety. This alertness is common in law enforcement (on or off duty) and while in a combat war zone.

Most emergency service personnel have the distinct ability to shut off their active mind and state of alertness when off duty and many times when they are on duty. (Gilmartin, 2002) This is typically because there is not any threat to their lives and there is not any need to increase the functioning of the sympathetic branch of the autonomic nervous system. Unfortunately, soldiers in a combat area or law enforcement, off and on duty, rarely feel safe enough to function without this pattern of responsiveness. In most cases, this hypervigilance provides the people with a more advanced means of heightened functions. The downside is the inability to relax beyond the scope of employment even when not working or on vacation.

The aforementioned hypervigilance may increase the possibility of stress symptoms in situations where they feel helpless following the loss of a life. Law enforcement as well as combat soldiers demonstrate remarkable resilience in the face of adversity and may not develop symptoms of posttraumatic stress. (Sammons & Batten, 2008) However, the diagnosis for this disorder is not rendered in a vacuum and these highly alert people still need to be evaluated sufficiently and have adequate social support. There are still concerns of readjustment for soldiers returning from combat and for law enforcement following a traumatic event or moving to retirement.

The social support system becomes invaluable for soldiers and law enforcement. Unfortunately, most emergency services employees become less confident in engaging in conversation merely under the assumption that those not involved with law enforcement will not understand their issues. More now than at any other previous time, mental health awareness has increased as the operations across this country continue to become more complex and military personnel being at greater risk of psychological distress than before. It is difficult to find an

acceptable solution for the majority of those under care. (Gould, 2007) These same complications facing our military in combat are parallel in law enforcement with the increasing fatality rates.

Social networks should be examined by understanding how often the victim has used this social network and what resources are available. In some cases, what could be perceived as inadequate support may truly be a positive network in relative terms. The negative support continues to identify persons that may take control of the conversation rather than active listening, blaming the victim for the feelings, treating them differently during their depressive state, telling the victim to get over the problem and move on, and egocentric behavior that is a focus of their own needs rather than that of the victim. (Ullman, 2001) Unfortunately, many of these negative features are inadvertent and may impair current treatment practices.

Chapter III: Results

Summary

Social support is a very prevalent means for coping with the stress of trauma. However, it is extremely important that this support is positive and the advice given is cautiously provided with extreme care and proper empathy. Emergency personnel and combat veterans are more susceptible to suffer the residual mental effects of trauma due to the frequency of exposure and perhaps the environment for which they work. Therapy for trauma should consider integrating the treatment with educating the victim's social support. The didactic instruction to the support group should provide proper techniques when dealing with victims to insure there is not any attenuation to their current treatment process.

Conclusion

Treatment for acute stress disorder or posttraumatic stress is not only about therapy but also education. If the patient is more aware of what the prognosis entails, they become more stable in trying to work toward recovery. (Regel, 2010) Social support is a major factor following a life-altering event such as experiencing trauma and the recovery process may be informative, practical, and emotional. People generally prefer to have a basic understanding of what they are experiencing and unfortunately may accept inaccurate advice while on this quest to know.

It is common that anything leading to acute stress or posttraumatic stress symptoms following a traumatic event will typically lead to a support network. A patient's therapist should not merely assume the available support network is a positive influence or provides beneficial encouragement. In some instances, the support being used may be less than desirable for the treatment. The expectation for therapy is that it is progressive; therefore, having a positive social support system is paramount in the recovery. Therapists need to recognize that providing the support network with the right tools may accelerate the anticipated results of therapy. This may include educating them with what should be done and what should be avoided when working with the patient outside the parameters of therapy.

The family systems theory, reflective of the complexity of families as a whole, organizes the system by the daily challenges and tasks of each member within the family. However, these daily challenges are put to task when the emotional turmoil following a crisis begins to detach one of the family members from their symbolic role. In some instances of posttraumatic stress

symptoms, the family member completely disassociates from other family members and isolates from their involvement. It is difficult for anyone experiencing a traumatic episode to regain normalcy in their social relationship. (Irving, 2001) Depending on the extent of the traumatic event and if they were involved rather than merely witnessing the event, the results could be more of a brain injury and not just posttraumatic stress disorder. Therapists may spend an unidentifiable amount of time trying to diagnose posttraumatic stress disorder when it is traumatic brain injury (TBI).

With literature and logical assertion inculcating the psychological challenges following a traumatic experience, the subsequent concern is the profound effects on families and couples. (Erbes, 2008) A form of therapy that exists for many situations is referred to as couple therapy. This therapy is designed to increase social support, decrease interpersonal conflict, and address the pragmatic restraints associated with posttraumatic stress disorder.

Since it remains important to adopt a system that correlates prolonged stresses of trauma with emotional turmoil within the family, therapy must incorporate family systems therapy into its treatment plans. When posttraumatic stress symptoms prevent a family member from intimacy and beneficial conversation, incorporating the family keeps communication advantageous. (Erbes, 2008) Couple therapy provides education, a key factor when treatment involves a family member experiencing a traumatic incident.

The benefits seem well established for keeping the positive support systems informed and skilled during the treatment of victims of posttraumatic stress disorder. Confirming positive or negative support systems and assessing the results could be time consuming for the therapist. However, assuring positive care outside the therapist's office may increase the results as well as

build a better environment for the victim seeking help. Posttraumatic stress disorder has criteria that include disassociation and withdrawal; perhaps given hints to a family member would allow the victim to find a subsidy to the therapy beyond that perceived.

The use of a group remedy, such as the critical incident stress debriefing, is a great tool for keeping the work family together and validating each of their concerns, but it cannot become a lone treatment plan for managers. (Laffaye, 2008) The gathering of the group and validation of feelings may actually distance the members further from their family with the belief that at home "they will not understand." It is important to keep a positive social support during those imperative moments when stressors are driving emotions and logic is a bleeding entity.

It is apparent that the perceived social support is a significant factor in reference to the intensity of posttraumatic stress disorder. Therefore, it is important to build a broad network of support that encapsulates those affected to insure they attain the necessary helpers. (Milenković, 2010) The support system is paramount to the recovery process and that network should know the essence of the disorder and the included manifestations of behavior. Without the proper education input, the support system is only working within the parameters of what they believe, rather than what is proper and substantial for the victim.

Another impact to the development of posttraumatic stress disorder symptoms is the exposure to violence, which can also benefit from social support for a better resilience during recovery. (Salami, 2010) The suggested therapy for exposure to violence is Cognitive-Behavior Therapy (CBT) as it may enhance self-esteem and supports a social network.

Some studies completed with veterans from the Vietnam War recognized the importance of social support in reference to posttraumatic stress disorder. Veterans with weak social support

or a lower index of support had more symptoms of posttraumatic stress disorder even 10-years following their traumatic war experience. Another prevalent factor associated with social support is the residual effects of the disorder such as suicide and the use of drugs and alcohol.

Most symptoms include the belief that others will not understand what they are feeling and they begin to alienate from others. Unfortunately, the emotional turmoil associated with stress may change their outlook with the world as they lose connection with others. (Milenković, 2010) Social support, properly skilled, could be a preventative measure for these residual problems including the impulsivity and tendency of anxiety attacks. The support should not just be a the victim's sounding board for when anxiety perks the most, but as a soothing protector for those occasions, especially holidays, when alcohol abuse used for self-medication is at its highest.

In a paper by Milenkovic, there was added information about a strong connection between a patient with posttraumatic stress disorder and their surroundings, such as family, parents, partners, work, and friends. The unfortunate issue regarding a positive support system is that many times the patient will push the support away regardless of the purpose of the disorder. In many cases, as posttraumatic stress symptoms continue, the patient starts provoking a resistance toward friends and family and it begins to erode the social support. (Laffaye, 2008) When the support network is unprepared or incapable of managing the changes exhibited by the victim, it creates a barrier in the healing process.

The combination of their own resistance, unpreparedness from support, and irrepressible stress symptoms, will commonly add to the trauma by creating collateral problems such as job loss, divorce, or losing close relationships.

Most of the literature has identified that there is a relationship between posttraumatic stress disorder and social support. (Laffaye, 2008) However, most of this shows that the relationship is customary during the onset of the disorder and is not as dominant in recognizing the source type or its effect of chronic symptoms. The support also identifies family as a stronger mechanism for reinforcement than a mere friendship.

Recommendations

Therapy should use social support and some of the benefits may need further examination to contend with the affects of posttraumatic stress symptoms at various stages. These high-stress vulnerable jobs cannot continue to survive without better prevention techniques for long-term stress disorders. Incorporating the trauma victim's positive support group, even minimally with exposure to information, may ultimately prevent further complications.

Treatment may be able to stand alone without convoluting the therapy by incorporating family and friends to assist with treatment. However, without considering integrating the social support with the treatment, the entire process may be prolonged due to the many outside negative influences contradicting what occurs in therapy. The family system and social network, similar to couple therapy, could be a vast benefit for therapist while treating their patients with posttraumatic stress disorder.

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