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Cognitive-Behavior Strategies Applied to the Treatment of PTSD: A review of Clinical Reports

Juliana Margarida Carneiro[1], Rosangela Bertelli[1]

ABSTRACT

Post-traumatic stress disorder (PTSD) is a highly prevalent psychopathological condition that may develop after exposure to a single or to a series of threatening or traumatic events. In the absence of treatment, its course can be chronic causing significant distress. In this sense, psychotherapeutic interventions would allow for the relief of some symptoms with the improvement of one's cognitive and behavior functioning. The aim of the present study was to identify, through a review of clinical reports, the choice of strategies made by psychologists and/or other health professionals for the psychotherapeutic treatment of PTSD. A review of clinical reports published in journals indexed in the Online Library of Knowledge (B-on) was carried out following specific criteria. Twenty-two publications that met the inclusion criteria were identified and the results pointed to the presence of strategies in line with the principles of the cognitive-behavior model of learning. The present narrative review of the literature provides a clear picture of choices being made, in terms of specific approaches and derived strategies, in the field of psychological clinical practice.

Keywords: Post-traumatic stress disorder; psychotherapeutic strategies; cognitive-behavior model of learning.
JEL classification: I Health; Education; Welfare; I0 General.

1. Introduction

1.1 PTSD

Post-Traumatic Stress Disorder (PTSD) springs from exposure to a traumatic event that evokes fear, helplessness and horror, with the most common events including the loss of a family member or of a close friend, war, physical or sexual abuse (Jensen, Fjermestad, Granly, & Wilhelmsen, 2015; Jakobsen, Demott, & Heir, 2014; Vervliet et al., 2014). The diagnostic criteria conceive of three groups of symptoms: (1) Re-experiencing, that is, a recurrence of a prior experience, of trauma in the form of nightmares, spontaneous flashbacks or memories elicited by stimuli that resemble the traumatic event; (2) Averting stimuli or circumstances that resemble the traumatic event such as thoughts, people or activities; loss of some memories for aspects of the traumatic event or even emotional numbness allowing for the avoidance of feelings or thoughts about the event; and (3) Persistent symptoms of

[1] Universidade de Trás-os-Montes e Alto Douro, Escola de Ciências Humanas e Sociais, Quinta de Prados, 5001-801, Vila Real, Portugal.

increased arousal that were not present before the trauma, such as exaggerated startle responses, alertness, irritability, difficulty concentrating, and sleep problem (American Psychiatric Association, 2013; World Health Organization, 2018).

1.2 Diagnostic criteria

In the DSM-IV, this psychopathological condition was previously included in the anxiety disorders category and currently it is included in the category of trauma and stress-related disorder. PTSD may also present with symptoms that meet the diagnostic criteria for at least another mental disorder (depressive, bipolar, anxiety, substance use disorders), when compared to individuals without the PTSD. Also, most children with PTSD have at least one other diagnosis, although the pattern of the coexistence of two or more related medical conditions (i.e. comorbidity) is different from that of adults, with predominance of oppositional defiant disorder and separation anxiety disorder. In addition, there is comorbidity between PTSD and mild traumatic brain injury, as well as between the former and major neurocognitive disorder (American Psychiatric Association, 2013).

1.3 Treatment

In the absence of treatment, the course of this disorder can be chronic. PTSD is associated with increased mortality, cardiometabolic diseases, and suicide risk, often leading to fractured relationships and a decrease in the cognitive and psychosocial functioning (Feduccia et al., 2019; Haviland, Banta, Sonne, & Przekop, 2016). A study in the United States also showed that older adults who suffered from PTSD were more likely to have been diagnosed with hypertension, angina pectoris, tachycardia, other heart diseases, stomach ulcer, gastritis and arthritis, compared to individuals who experienced one or more traumatic events but did not meet the diagnostic criteria for the disorder (Pietrzak, Goldstein, Southwick, & Grant, 2012).

1.4 Psychological strategies

During the last decades there has been a great deal of progress in the development of effective treatments for this disorder, such as psychological interventions (Carpenter et al., 2018; Hodges et al., 2011). Currently there is a variety of strategies derived from a number of conceptual views (Kazdin & Rabbitt, 2013; Schnyder et al., 2015; Tortella-Feliu et al., 2016) and thus the aim of this study was to conduct an inquiry or investigation on interventions employed by psychologists and/or other qualified health professionals in the process of psychological treatment of PTSD.

1.5 Objectives

The aim of this review of clinical reports was: a) To recover available knowledge on psychotherapeutic interventions applied to the treatment of PTSD; b) To synthesize the available knowledge recovered; and c) To determine the characteristics (types of approaches and specific strategies) of those psychological treatments reported.

2. Data and methodology

2.1 Participants

The process of reviewing the clinical reports gathered 22 case studies. The sum of the study samples resulted in a total of 25 cases of PTSD under psychotherapeutic treatment. With regard to gender, 12 (48%) were females and 13 (52%) were males. The average age ranged from three to 84 years of age.

2.2 Materials and procedure

2.2.1 Step 1

A review of clinical reports published in journals indexed in the Online Library of knowledge (B-on) about the interventions used by psychologists and/or other health professionals in the psychotherapeutic treatment of PTSD was carried out. The electronic search on the B-on (step 1) was performed from the Google Chrome Internet browser (version 84.0.4147.105) connected to the Virtual Private Network (VPN) service, an encrypted Internet connection from a device to a network (CISCO, 2020), which guarantees the security of the data transmitted. This service allows users of university

computer systems to remotely access university resources, under the same conditions as if they were physically connected to the network on the university campus.

On the homepage of B-on the researcher session was started and the option "Research Service" was selected, followed by "Advanced Search", which allows for the combination of terms and application of limits, which were previously defined. On this second page, the terms "PTSD" (first text field) and "Psychotherapy" (second text field) were inserted, while in the Search modes and expanders section the option "Apply related words" was selected. The search was limited to articles that had full text available, published between 2014 and 2019 in academic journals written in English. This Step 1 was carried out on November 17, 2019, at 16:14 hours.

2.2.2 Step 2

Step 2 consisted of analyzing the titles and abstracts of each of the publications identified by the electronic search strategy in order to, considering its relevance to this review, include or exclude a given article. Due to the enormous amount of articles available, an analysis of the bibliographic references of each of the articles found was not performed.

As inclusion criteria, case studies on the effects of the psychotherapeutic interventions on the cognitive, emotional or behavioral functioning of individuals suffering from PTSD (and its comorbid conditions, if any) were considered for inclusion as well as case studies on the effects of psychotherapy on the neural fields and brain areas of individuals suffering from the disorder in question.

Regarding the exclusion criteria, lack of relationship with the theme of the review, repeated publications, studies unavailable for viewing, studies that were in a language other than English, publications such as systematic literature reviews, meta-analyses, dissertations and theses, symposia, communications, editorials, comments, letters, conferences, studies not included in scientific journals, poorly detailed case studies, study corrections, empirical studies, studies that only addressed the diagnostic criteria of the DSM and ICD, non-empirical studies, studies that addressed the intervention through the opinion of health professionals, studies that addressed the psychometric properties of psychological instruments, case studies that did not refer to PTSD, case studies on the damage in the neural fields and brain areas of individuals who suffer from the disorder in question (but which did not refer to the effects of psychotherapy), case studies on the effectiveness of non-psychological treatments (e.g. pharmacological, biological, chemical, or making use of the Internet and technologies), case studies that focused only on the effects of psychotherapy on the physiological symptoms of the disorder in question, studies carried out with animals, and studies that only referred to risks and protective factors, barriers, symptoms and prevalence of the disorder, all held the article excluded.

Figure 1 presents the flowchart illustrating the selection process.

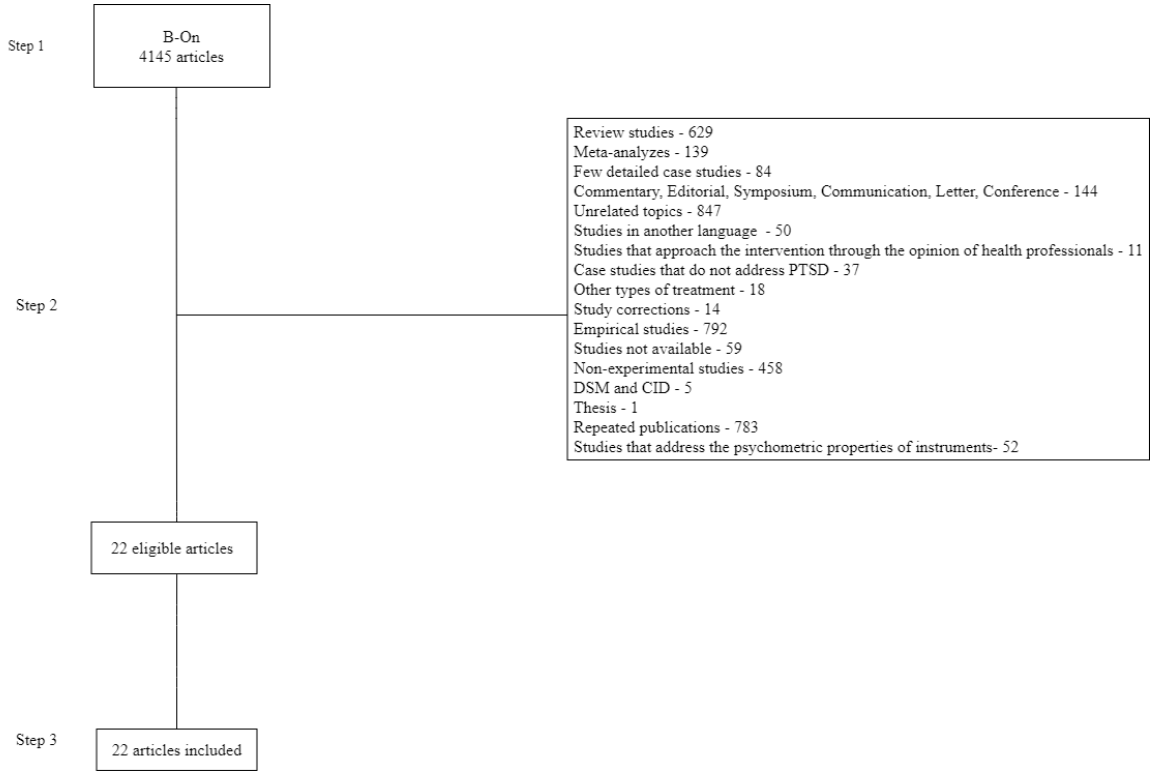

Figure 1. Flowchart illustrating the selection process.

2.2.3 Step 3

In step 3, all eligible articles were read in full and a careful analysis of their content was carried out. In the analysis of each article, the following aspects were observed: (1) authors and year of publication; (2) objectives; (3) sample size; (4) patients clinical characteristics (e.g. gender, age, manifested symptoms, and comorbidity); (5) type of intervention; (6) main results.

3. Results and discussion

3.1 Patients characteristics

The process of reviewing the clinical reports described in the previous sections gathered 22 case studies. Table 1 presents some general characteristics of the patients, their symptoms and their specific comorbidity (when given).

Table 1.

General characteristics of patients with PTSD.

Author(s)	Patient(s)	Symptoms	Comorbidity
Mørkved & Thorp (2018)	Female, 70 years old	a) Hyperexcitation, anxiety, bodily dissociation, severe nightmares, sleep disorders, fatigue and decreased social functioning; b) Avoidance of internal triggers (e.g., thoughts and memories) and external triggers (e.g., sounds and places) related to traumatic experiences; c) Depressed mood and reduced hope for the future; d) Dysfunctional beliefs about her value as a human being and difficulties in controlling her emotions; e) Emotional abuse and emotional neglect from age three, childhood sexual abuse (6-14 years), and multiple traumatic experiences in adolescence and adulthood.	Recurring depressive episodes
Jansen & Morris (2017)	Female, 21 years old	Female (21 years old): a) Sexual abuse at ages 12 and 18; b) Avoidance of things, places or feelings related to events; c) Occasional "paranoid thoughts" (e.g., people watching and following her with bad intentions); d) Anxiety and depressive symptoms, feelings of guilt and shame.	Female (21 years old) schizophrenia (undifferentiated)
	Female, 23 years old	Female (23 years old): a) Childhood sexual abuse; b) Use of hard drugs and alcohol to escape painful feelings; c) Intrusive memories of the events; d) Sexual problematic relations with her boyfriend; e) "Paranoid Thoughts"; f) Anxiety and depressive symptoms, feelings of guilt and shame.	Female (23 years old) unspecified psychosis not due to a known substance or physiological condition; mixed personality disorders
	Male,	Male (27 years old): a) Trauma related to the experience of acute psychosis and forced admission to a psychiatric	Male (27 years old): paranoid

	27 years old	hospital; b) Intrusive memories and deep fear of "losing control of reality" and relapse; c) Auditory hallucinations; d) Anxiety and depressive symptoms.	schizophrenia
Unterhitzenberger & Rosner (2016)	Female, 17 years old	a) Recurrent nightmares, panic reactions as a result of intrusive thoughts, fear of loud noises, aggressive behavior and self-harm; b) Inability to observe oneself in the mirror as this triggers a panic reaction; c) Accelerated thoughts and lack of skills to control subsequent emotions; d) Avoidance of going anywhere alone difficulties separating from her main caregiver in the residential group; e) Concentration problems and feelings of guilt in relation to family; f) Anxiety and depressive symptoms.	No comorbidity
Gielkens, van Alphen, Sobczak, & Segal (2014)	Female, 76 years old	a) Worsening of depressive and anxiogenic symptoms after suffering a stroke; b) Repeated sexual abuse (44 - 47 years old); c) Afraid of own emotions and uncomfortable talking about sexual abuse; d) Feelings of shame and guilt associated with sexual abuse; e) Emotional instability as a result of intrusive memories of abuse; f) Intrusive memories initially at night (presented as nightmares) and later also during the day; g) Flashbacks when seeing a priest on television, church bells ringing, reading about abuse in the newspaper or discussions about the faith; h) Avoiding specific places including churches and anything related to them; i) Sleep disorders, concentration difficulties, irritability and excessive alertness; j) Low social support, low self-esteem, high levels of dependence on others, neuroticism and difficulty in expressing emotions; k) Cognitive decline in executive functioning, with deficits in attention and abstract reasoning.	Anxiety Disorder
McCarthy & Cook (2018)	Male, 58 years old	a) Various sexual assaults, including childhood sexual abuse; b) Intrusive thoughts, avoidance behavior, negative cognitions, moods, and hyperarousal; c) Anxiety symptoms in the face of trauma-related triggers; d) Feelings of being lost, disconnected from others and afraid of relationships; e) No connection to family or any social support outside of	MDD I SAD

		substance abuse treatment programs; e) Three suicide attempts; f) Substance abuse, especially alcohol; g) Feelings of being "dirty" and of guilt as well as thoughts related to paranoia (e.g., people's judgment).	
Woodward, Orengo-Aguayo, Stewart, & Rheingold (2019)	Female, 28 years old	a) Victim of an armed robbery; b) Frequent nightmares and unwanted memories of the incident as well as sleep disturbances; c) Frequent intrusive memories of the gun pointed at her head; d) Extreme fear of leaving the house and of being assaulted in someone else's house; e) She gave up interacting with her friends, several of whom had similar physical characteristics with the robber; f) She stopped performing her usual hobbies due to her fear of being hurt by other people; g) Hesitation going out at night; h) Significant depressed mood, persistent and exaggerated negative beliefs (e.g., people are unreliable), persistent fear, isolation, difficulty concentrating, and excessive alertness; i) Emotional instability and physiological reactions to seeing memories of the incident (e.g., hearing men screaming or raising their voices; difficulty breathing, sweating, and trembling); j) Avoidance of thoughts and feelings about the incident.	Depression
Walker, Kaimal, Koffman, & DeGraba (2016)	Male, 50 years old	a) Significant reduction in cognitive and emotional functioning; b) Difficulty concentrating, depressed mood, sleep disorders, speechless phrases/ideas, hallucinations and flashbacks of traumatic experiences, dysphoria, anxiety symptoms (hypervigilance, increased arousal, reliving and emotional distancing/avoidance), decreased interest, decreased libido, anhedonia; c) War-related traumatic experiences, the most significant of which was the loss of a friend during this period. Feelings of guilt and recrimination associated with the friend's death; d) Traumatic brain injury; e) Alcohol abuse and excessive focus on work as coping strategy; f) Although without suicidal or homicidal ideation, the patient felt that he should put himself in a situation where his life	MDD

		was at risk for the good of his country and to stop his unwanted thoughts.	
Kip, Shuman, Hernandez, Diamond, & Rosenzweig (2014)	Male, 34 years old	a) Nightmares with intrusive anxiety eliciting memories (improvised explosive device that was fired on the patient's vehicle in one of his military missions and the death of the father due to cancer, while the patient was on leave from a trip to Afghanistan); b) Reluctance to relive these memories due to the time and energy invested in "trying not to think about it"; c) Sporadic physical reactions (rapid heartbeat and difficulty breathing); d) Symptoms of anxiety when in the midst of crowds; e) Feelings of distance from the family; f) Problems with concentration and sleep disorders; g) Fear that his PTSD symptoms might prevent him from being a good father and husband.	GAD H PD D N
Wanklyn, Brankley, Laurence, Monson, & Schumm (2017)	Male, 61 years old	a) Physical and emotional abuse in childhood (by his father); b) Not working since his divorce; c) Alcohol abuse and frequent use of cannabis; d) Feelings of detachment on the part of family members; e) Stayed most of the time alone inside his apartment and during Alcoholics Anonymous sessions rarely spoke to other people; f) No romantic relationship for over 20 years.	SUD MDD PD/Agoraphobia SAD
Bergeron (2017)	Female, 3 years old	a) At approximately 18 months of age, the patient was anxious about any object, place or person related to medicine; she cried and screamed as she tried to run away and hide; b) Hypervigilance, difficulties in sleeping and eating, frequent crying, refusal to eat solid foods.	No comorbidity
Luedtke, Davis, & Monson (2015)	Male (no reference to age)	Male: a) Traumatic event: Death of a close friend from mortar fire; b) Frequent dreams about himself and his colleagues being burned and hit by mortars; c) Sleep disturbances, intrusive thoughts about his friend's death, emotional numbness, feeling distant from his wife and others, hypervigilance, and severe depressive symptoms. Female:	No comorbidity

	Female (no reference to age)	a) History of childhood sexual abuse; b) Complaints about husband being absent-minded and forgetful, often leaving kitchen cabinets open and incomplete tasks. The couple presented with: a) Clinical levels of distress in the relationship; b) Little or no physical intimacy for nearly a year.	
Gielkens, Vink, Sobczak, Rosowsky, Van Alphen (2018)	Male, 84 years old	a) Changes in sleep level; b) World War II nightmares eliciting anxiety; c) During adolescence experienced traumatic events at a German labor camp; d) War-related flashbacks; e) Using alcohol to deal with panic attacks; f) Overreaction to fright; g) Deteriorated cognitive functioning (related to brain damage caused by alcohol abuse and transient ischemic attacks).	Alcohol abuse Transient ischemic attacks
Conley, Faleer, & Wu (2018)	Male 57 years old	a) Childhood sexual abuse; b) Avoidance of memories related to that experience until the period in which he was operated on; c) Frequent nightmares, increased fright response, aversion to being touched by someone, maladaptive beliefs related to abuse, feelings of inadequacy, shame, guilt, self-loathing and difficulty in trusting people; d) Hoard behavior; e) Distress when asked to discard items; f) Minimal ability to control acquisition impulses or intrusive thoughts related to possessions and disposal of items; g) Limited social support and significant marital distress; h) Relationship difficulties in the workplace; i) Unemployed during the treatment period.	AD OCD GAD MDD
Benuto & Bennett (2019)	Female, 29 years old	a) Victim of stalking and sexual abuse; b) Feelings of shame; c) Recurring nightmares and intrusive thoughts about the abuse; d) Difficulty in engaging in activities previously enjoyed; e) Difficulties in concentrating and sleep disorders, hypervigilance and fear that the men who attacked her would come after her; f) Adjustment difficulties.	No comorbidity
Katsounari (2015)	Female, 28 years old	a) Sexual assault and torture; b) Torture and death of family, friends, and boyfriend; c) Feelings of skin “burning”	GAD MDD/psychotic features

		and choking sensation when remembering the events; d) Dizziness when breathing; e) Sensation of hair and skin falling out when in close contact with a male figure; f) Feelings of persecution (even when inside her own apartment); g) Verbally and physically attacked anyone she felt was against her; h) Seeing her torturer in every male figure who resembled the man who tortured her; i) Hypervigilance, intrusive thoughts, sleep disorders, nightmares, visual hallucinations, concentration difficulties, anger, fear, sadness, social isolation, avoidance behavior, hatred for male figures, desire for revenge, lack of happiness, lack of positive feelings, pessimistic thoughts about the future, previous suicide attempt and current suicidal ideation without a plan; j) Fear of being arrested and intimidated by the police.	
Mahr, McLachlan, Friedberg, Mahr, & Pearl (2015)	Male, 11 years old	a) Attention difficulties; b) Decreased motivation; c) Increased aggressiveness (mainly in his interactions with colleagues and siblings); d) Severe headaches, lack of energy, memory difficulties; e) Needed frequent reminders to complete daily tasks; f) Feelings of guilt; g) Fear (with physiological arousal such as shaky legs, fast heart rate) of crossing roads and traffic noises (with feelings that the wind might push him onto the road or that a car might hit him from behind); h) Nightmares followed by heading to parent's bedroom; i) Escaping behavior.	No comorbidity
Gurak, Freund, & Ironson (2016)	Female 28 years old	a) Threats of physical abuse (10 - 13 years old), sexual abuse and physical aggression (18 - 21 years old); b) Feelings of guilt about her father's suicide; c) Anxiety and depressive symptoms; d) Lack of motivation for looking and applying for jobs, and making friends; e) Intrusive thoughts about the traumatic events, hyperarousal, avoidance, persistent negative mood swings, hypervigilance, exaggerated startle response, frequent nightmares, inability to remember parts of the sexual abuse, emotional numbness, persistent irritability, maladaptive beliefs, difficulty	MDD ADS

		trusting others, feelings of guilt, vulnerability and discomfort during sexual intimacy with husband.	
Paul et al. (2014)	Male, 27 years old	a) Intrusive thoughts associated to a specific traumatic event (Almost shooting a child during a war); b) Significant guilt-related thoughts associated to a specific event (failure to prevent the detonation of an explosive device that resulted in the death of two soldiers); c) Feelings of shame, guilt and anger associated to a specific event (Becoming aware that his wife had an extramarital affair).	MDD
Carrigan & Allez (2017)	Male, 26 years old	a) Childhood bullying; b) Frequent dissent with parental figures and outbursts of anger (usually with boys of the same age); c) Sexual abuse; d) Avoiding leaving the house and walking outside alone (fear of meeting his aggressors); e) Sleep disorders and frequent nightmares about the traumatic events; f) Intrusive memories difficulty in concentrating, flashbacks, difficulty in trusting others, feelings of guilt and frequent ruminations about what he could have done to prevent the traumatic event (a form of avoidance).	ASD MID
Jørgensen, Cantio, & Elklit (2019)	Male, 6 years old	a) Physical and emotional abuse; b) witnessing domestic violence towards his mother (daily emotional abuse, occasional death threats, beatings and an attempted strangulation; c) Physical and verbal outbursts of anger as well as feelings of annoyance and anxiety; d) Oppositional, defiant, aggressive behaviors (especially towards the 4-year-old sister and the family pets); e) Intense anxiety when someone was too physically close to him; f) Nightmares, sleep disorders, fear of the dark, exaggerated startle response, hypervigilance, attention and concentration difficulties at school; g) intrusive thoughts, avoidant behaviors, feelings of sadness, worthlessness and excessive guilt; h) Abulia; i) Obsessions and concerns for his father.	D ADHD ODD RAD SP
Padmanabhanunni & Edwards	Female, 19 years	a) Sexual abuse at age 10; b) Lack of support from parents and siblings; c)	MDD

(2015)	old	Feelings of sadness, shame, guilt; d) social isolation; abandonment; e) Avoidant behavior; f) Nightmares, flashbacks; g) Feelings of guilt for desiring the death of the perpetrator and beliefs that somehow desires contributed to his death (After hearing about the perpetrator's death).	
Stevens & Michael (2014)	Male 16 years old	a) (While driving the car, an accident occur and one of the passengers died) Depressive symptoms, extreme bad mood, feelings of anger and guilt; b) Difficulty remembering details of the accident; c) Hyperexcitation, difficulty concentrating, avoidance behaviors, hypervigilance, frequent nightmares, difficulty falling asleep, recurrent intrusive memories, intense tantrums directed at the mother, breaking objects, uncontrollable crying, worrying about being accused of murder, suicidal ideation (especially while driving).	Traumatic Grief

Abbreviations: MDD = Major Depressive Disorder; I = Insomnia; SAD = Social Anxiety Disorder; PTSD = Post-Traumatic Stress Disorder; GAD = Generalized Anxiety Disorder; H = Hypochondria; PD = Panic Disorder; D = Depression; N = Narcolepsy; SUD = Substance Use Disorder; AD = Accumulation Disorder; OCD = Obsessive-Compulsive Disorder; ADS = Anxious Distress Specifier; ASD = Autism Spectrum Disorder; MID = Mild Intellectual Disability; ADHD = Attention Deficit Hyperactivity Disorder; ODD = Oppositional Defiant Disorder; RAD = Reactive Attachment Disorder; SP = Specific Phobia.

3.2 Psychological treatments

Table 2 presents specific strategies used in the psychotherapeutic treatment of PTSD.

Table 2.

Specific strategies used in the psychotherapeutic treatment of PTSD and their main effects.

Author(s)	Specific Strategies	Main effects
Mørkved & Thorp (2018)	NET: a) Psychoeducation; b) Narrative Exposure; c) Rereading the written narrative. (Pharmacotherapy: Antidepressants)	a) Post-treatment: PTSD symptoms close to mild levels, while depressive and anxiety symptoms decreased to a mild range. b) Follow-up: Results regarding PTSD and depressive symptoms were maintained, while anxiety symptoms returned to moderate levels.
Jansen & Morris (2017)	ACT: a) Psychoeducation; b) Identification of occasions when each patient's efforts to avoid unwanted private experiences were useless; c) Learning some basic skills "to be with the discomfort" and observe it from a conscious perspective; d) Identification of life goals and personal values; e) Learning skills to develop more flexible behavior patterns when anxiety and fear arise; f) Mindfulness; g) Promotion of	Improvements in PTSD, anxiety and depression symptoms as well as psychological flexibility.

	skills such as being a "self as an experimenter"; h) Exposure exercises. (Pharmacotherapy: Quetiapine (Female, 23 years old); Aripiprazole (Male, 27 years old); Oxazepam (Female, 21 years old)).	
Unterhitzenberger & Rosner (2016)	a) Psychoeducation; b) Creating a list of treatment goals; c) Breathing exercises; d) Use of emotional facial expression imagery; e) Collection of coping strategies; f) Identification of maladaptive thoughts and their replacement by functional alternatives; g) Construction of the patient's narrative; h) Discussion of security strategies.	a) Significant decrease in PTSD symptoms, anxiety and depression; b) At post-treatment and at follow-up, patient did not meet the diagnostic criteria for PTSD.
Gielkens, van Alphen, Sobczak, & Segal (2014)	a) Psychoeducation; b) Relaxation and imagery exposure; c) Experience of "memories"; d) Writing and reading a letter to the perpetrator and to the patient's mother, burying the letter near the grave; e) Considering attachment patterns and help in expressing her needs.	a) Decreased sexual abuse-related nightmares; b) Increased energy level and enjoyment of life, returning to visit the church and cemetery; reading the newspapers without experiencing stress; c) Ability to deal with past experiences and talking in a more comfortable way about the traumatic experiences; d) Awareness of her attachment patterns and ability to convey her needs and feelings; e) Improved self-esteem and confidence; f) Forging new friendships and restoring bonds with her children, g) Disruption of avoidance behaviors and ability to identify and resolve problems underlying PTSD, recognizing dysfunctional interaction patterns; h) Significant decrease in PTSD symptoms that no longer controlled her daily life; i) Rapid recovery within minutes of re-experiencing symptoms; j) Reduction in the frequency of emotional instability as well as reduction in the feelings of shame and guilt; k) All these results were maintained at the 6-month follow-up.
McCarthy & Cook (2018)	PET: a) Psychoeducation; b) Breathing exercises; c) Building a hierarchy of exposures and in vivo exposure exercises; d) Imagery exposure exercises and Imagery Rescripting; e) Homework:	a) Significant decrease in PTSD and depressive symptoms; b) Increased quality of life and general satisfaction with health as well as meaning and purpose in life;

	Breathing exercises; completing the hierarchy of in vivo exposures; in vivo exposure exercises; listening to recordings of exposures; imagery exposure exercises; f) Discussion and creation of a safety plan for relapse prevention and patient progress approach. (Pharmacotherapy: Bupropion, Paroxetine, Buspirone and Trazodone).	c) Continued on outpatient mental health treatment to promote his recovery and to help maintain sobriety during the transition to independent living.
Woodward, Orengo-Aguayo, Stewart, & Rheingold (2019)	a) Psychoeducation; b) Breathing exercises; c) Construction of a hierarchy of in vivo exposures and classification of each one of them; d) In vivo exposure exercises associated with traumatic memories; e) Imagery exposure exercises; f) Homework: Breathing exercises; in vivo exposure exercises; listening to recordings of exposures; imagery exposure exercises.	a) Significant decrease in PTSD and depressive symptoms; b) Stopped avoiding activities and went back to socializing; c) Started working two days a week as a volunteer; d) Reduced frequency of intrusive memories and absence of worries about leaving the house; e) Returned to her level of functioning before the traumatic event and went back to cleaning houses four days a week again; f) Significant reduction in emotional instability and psychological distress; g) Two-week follow-up: Ability to go alone to differing places without any difficulty. Increasingly comfortable being alone at home and intrusive memories of the traumatic event were gone.
Walker, Kaimal, Koffman, & DeGraba (2016)	a) Psychoeducation; b) Construction of a mask that would represent warrior identities; c) Construction of a mask that would represent the patient's recurrent vision of a bloodied face; d) Construction of a box for the mask to be stored or buried; e) Guided Imagery during Acupuncture; f) Creating a painting of the nightmares scene; g) More in-depth approach to traumatic incidents; h) Recreation of the deceased friend through painting; i) Representation of the faces of people he saw during acupuncture treatment (through photocopied image transfer technique) and exploration of the meaning behind faces and memories.	a) Greater openness to share his traumatic experiences; b) Reduction in the frequency of flashbacks and nightmares; c) More relaxed, sleeping better, and reduced anxiety symptoms; d) Symptoms of PTSD continued to be a clinical concern and the patient continued in treatment.
Kip, Shuman, Hernandez, Diamond, & Rosenzweig (2014)	A.R.T.: a) Imagery exposure and Imagery Rescripting; b) Imagine a nicer version of events; c) Processing a new traumatic scene (father's death), using imagery exposure and imagery rescripting; d) Imagine a nicer version of events.	a) Ability to recall the traumatic scenes without physiological and psychological distress; b) Improvements in short-term memory and concentration; c) Reduction of PTSD symptoms

	(Pharmacotherapy: Anxiolytics, Antidepressants).	d) Sleeping without taking any medication; e) At the three-month follow-up: Symptoms of PTSD rose slightly.
Wanklyn, Brankley, Laurence, Monson, & Schumm (2017)	a) Psychoeducation; b) Conflict management strategies; c) Inviting significant others to be part of the recovery process; d) Learning communication and problem solving skills; e) Useful and useless avoidance behaviors; f) In vivo exposure exercises related to the traumatic experience as well as increasing rewarding interpersonal activities; g) Dyadic cognitive technique; h) Construction of a recovery plan and relapse prevention.	a) Reduction of PTSD symptoms as well as the frequency of alcohol consumption; b) Acceptance of traumatic experiences; c) Feelings of happiness and confidence in his ability to refrain from drinking and get along with other people; d) Socializing with family members again and community and interacting with others at Alcoholics Anonymous meetings; e) Incorporating more significant people into his recovery (siblings and friends); f) Not fitting the diagnostic criteria for PTSD, PD, agoraphobia or SAD; g) Three-month follow-up: Both alcohol and cannabis dependence were in early complete remission; h) Beginning of a loving and stable relationship; i) Stable euthymic mood and getting a job.
Bergeron (2017)	a) Psychoeducation; b) Observing the interaction between mother and child; c) Modeling and narrative; d) Learning to solve problems within the family; e) Learning strategies to assist in case of management and crisis intervention; f) Reinforcement of progress made in treatment and preparation for termination.	a) Deeper understanding of the patient's behaviors on the part of the mother; b) Positive reciprocity and a more secure bond between mother and child; c) Reduction of negative interactions between mother and child and the patient was able to recognize her mother as a source of security and support in times of stress; d) The mother failed to see her daughter as a manipulative and misbehaving child; e) The family developed more empathy around the patient's "demanding eating", which eventually eased the tension around meals; f) The mother had some difficulties in adjusting to her daughter's entry into preschool. Even so, she managed to accommodate the changes after seeing progress in her

		child's development, especially in the linguistic domain.
Luedtke, Davis, & Monson (2015)	a) Psychoeducation; b) Written records of positive behaviors practiced by the partner; c) Brief exercise of body awareness mindfulness; d) Filling out a worksheet entitled "Questions of the impact of trauma"; e) Mindful eating exercises and sharing the experience with the group members; f) Peer training to discuss possible concerns and benefits of trauma disclosure; g) Mindfulness exercises focusing on breath awareness; h) "S.T.O.P. and Check In" exercises; i) Creating a list of avoided peoples, places, things and feelings; j) Using the couple's problem-solving skills to pick a slightly distressing topic they avoided talking about; k) Dyadic cognitive intervention "U.N.S.T.U.C.K. process"; l) Guided mindfulness exercises and meditation of love and kindness. Post-retreat sessions (couple only): a) Identification and discussion of barriers that prevented the acceptance of the traumatic event; b) Socratic dialogue; c) Filling in a spreadsheet, using the "U.N.S.T.U.C.K. process" (homework); d) Use of the "U.N.S.T.U.C.K. process" to help the couple challenge their dysfunctional beliefs about trust and control; e) Planning an evening date between the couple that involved having physical intimacy with each other (homework); f) Use of the "U.N.S.T.U.C.K. process" with a focus on post-traumatic growth; g) Completion of the worksheet "Questions of the impact of trauma"; h) Discussion about treatment gains and relapse prevention.	a) Improvements in the male patient's PTSD symptoms as well as anxiety symptoms; b) The male patient did not meet the PTSD diagnostic criteria anymore; c) Increased awareness and communication regarding symptoms by both members of the couple; d) Improvements in the general functioning of both patients as well as in the level of communication between them; e) The female patient said the treatment helped relieve the pressure she was putting on herself.
Gielkens, Vink, Sobczak, Rosowsky, & Van Alphen (2018)	a) Psychoeducation; b) Building a list of target memories. Identification of negative and positive cognitions based on selected target and reported symptoms. Classification of the suffering from each memory; c) Desensitization; d) Motivational techniques and additional psychoeducation on PTSD, EMDR and patient progress; e) Increased credibility of positive cognition; f) Review of progress, clarification of doubts and reinforcement of treatment gains.	a) The patient's nightmares and distress disappeared; b) The patient became able to talk about his traumatic experiences; c) Results were maintained at the 16-month follow-up.
Conley,	CPT: a) Psychoeducation; b) Completing	a) Significant reduction in PTSD and

Faleer, & Wu (2018)	an impact statement to help identify dysfunctional thoughts related to abuse and creating a written register of the worst traumatic incident; c) Socratic questioning. ERP: a) Psychoeducation and cognitive restructuring; b) Building an exposure hierarchy; In vivo exposure exercises; c) Homework: 2-3 hours a day disposing of items, organizing and cleaning the rooms in the house; d) Completing cognitive restructuring worksheets to help reduce the maladaptive thoughts identified when discarding; d) Review of progress and acquired skills and completion of the "Relapse Prevention Package".	AD symptoms; b) Increased self-esteem. The patient also planned to invite friends over to his house; c) Results were maintained at 1-year follow-up.
Benuto & Bennett (2019)	PET: a) Psychoeducation; b) Breathing exercises; c) Construction of a hierarchy of in vivo exposures and their classification; d) Homework: completion of two items from the hierarchy that ranked low; e) Imagery exposure exercises; f) Emotional support and review of treatment justification. WET: a) Written exposure exercises; b) Writing the narrative in the first person and viewing the trajectory of the trauma; c) Sharing thoughts about the experience; d) Cognitive restructuring; e) Homework: Reading the trauma narrative at least 4-5 times a day; Completion of two items from the in vivo exposure hierarchy; f) Verbal review of the trauma narrative.	a) The patient was able to reveal to her family what had happened and received ample emotional support from them; b) Significant decrease in PTSD symptoms; c) Results were maintained at one month follow-up. During this time, the patient reported that she had enrolled in an English program, began working, and regularly attended (no fear) social events with her family (including socializing with men).
Katsounari (2015)	a) Psychoeducation; b) Muscle relaxation; c) Description of all sensory modalities, thoughts and feelings; d) Current physical, emotional and cognitive reactions observed and verbalized by the therapist; e) To avoid flashbacks, the therapist asked the patient to speak slowly about the event and to do the contrast between past and present; d) Grounding techniques; e) Discussing patient's hopes and plans for the future.	a) Decrease in PTSD symptoms and psychotic characteristics; b) Ability to distance herself from the emotional involvement of traumatic memories; c) Decreased emotional and physiological arousal; d) Displaying of positive emotions, increased comfort in interacting with other people, seeking new interests and improving sleep levels; e) She began to address her dreams and aspirations.
Mahr, McLachlan, Friedberg, Mahr, & Pearl (2015)	1st phase of therapy (PTSD): a) Psychoeducation; b) Identification of emotional states; c) Imagery Reliving; d) Cognitive restructuring; e) Discrimination of stimuli; f) Visiting the trauma scene; g) Sleep hygiene; d) Parental training; e)	a) Increased confidence in leaving the house and crossing the roads, especially when exposed to traffic; b) The patient stopped pushing himself to be protective and responsible for his younger siblings

	Development of a trauma script about the accident and relaxation exercises. 2nd phase of therapy (depressive and anxiety symptoms): a) Individual sessions: Problem solving skills; identification of anger activating stimuli, of thoughts and feelings associated with those eliciting stimuli; safe expression of those feelings; relaxation exercises; b) Family sessions: Problem solving within the family context through a reward system; family rules; expression of negative emotions; developing a vocabulary of feelings; encouragement for the parental figures to spend special time with the patient; c) Organization of a school meeting with the presence of parental figures; development of social skills; rearranging the classroom environment in order to improve attention difficulties; informing teachers about the patient's perception of them.	when away from home; c) Ability to structure his thoughts and feelings about the incident; d) Improvements in school behaviors; e) Reduction of PTSD symptoms as well as depressive symptoms; f) Improvements in appetite and sleep.
Gurak, Freund, & Ironson (2016)	PET: a) Psychoeducation; b) Construction and classification of a hierarchy of fears and avoided stimuli; c) Breathing exercises d) Guided meditation; e) Progressive muscle relaxation; f) Discussion of common reactions to trauma as well as common PTSD symptoms; g) Exposure exercises focusing on sexual abuse at age 21; e) Homework: In vivo exposure exercises; f) Sharing suicidal thoughts and creating a safety plan; g) Stress management: Creating and maintaining a "Calm Down Kit" of adaptable and enjoyable activities; h) Coping skills: relaxation techniques; talk to family members; behavioral activation; identification of current stressors; creating realistic to-do lists with reasonable deadlines; organizing weekly responsibilities; learning how to challenge maladaptive thoughts. CPT: a) Written records of three statements to impact her relationship with her father; b) Challenging maladaptive beliefs and identifying counter evidence for negative core beliefs; c) Socratic questioning. PET (continuation): a) Exposure exercises focusing on sexual abuse; b) Cognitive restructuring; c) Building a safety plan in	a) Ability to tell her narrative of traumas with minimal distress; b) Healthy and realistic thoughts about trauma; c) Significant reduction in PTSD symptoms, not meeting the diagnostic criteria for the disorder anymore; d) Significant reduction in depressive and anxiety symptoms; e) Absence of suicidal ideation; f) Found a job during the treatment process.

	case suicidal thoughts resumed; d) Session with the couple: Discussing about the symptoms of PTSD and depression, adaptive coping skills, the husband's supportive role and how to deal with conflicts more effectively; e) Reviewing adaptive coping strategies and patient progress. Creating a relapse prevention plan. (Pharmacotherapy: Effexor-XR / 25 mg/day).	
Paul et al. (2014)	a) Psychoeducation; b) Review of common reactions to trauma; c) Presentation of justification for situational exposure; d) Hierarchy of situational fear and classification of subjective units of discomfort; e) Using those ratings to represent the intensity of negative affect more generally; f) Development of the hierarchy of situational exposures focusing on uncomfortable people, places and things avoided; g) Imagery exposure exercises and processing of discussed events.	a) Significant reductions in PTSD, depression and anxiety symptoms; b) He did not meet the PSPT diagnostic criteria anymore; c) Significant guilt and shame-related cognitions were shifted to more adaptive and functional thoughts; d) Results were maintained at the 6-month follow-up; e) Improvements in the patient's overall functioning and quality of life.
Carrigan & Allez (2017)	a) Psychoeducation on PTSD symptoms through the use of metaphors; b) Anger thermometer; c) Cognitive restructuring of beliefs about others' intentions; d) Cognitive restructuring of guilt beliefs associated with sexual abuse; e) Socratic questioning; f) Imagery reliving; g) Exercising ignoring thoughts about innocuous stimuli; h) Discussing controlling thoughts about abuse; i) Sharing the traumatic experience with parents.	a) Decrease in intrusive thoughts and memories, guilt feelings, avoidant behaviors and flashbacks; b) Sleep improvements; c) Became more affectionate with family members; d) He did not to meet the PSPT diagnostic criteria anymore; e) Decrease in arguments and tantrums.
Jørgensen, Cantio, & Elklit (2019)	a) Psychoeducation; b) Parenting skills; c) Progressive muscle relaxation; d) Controlled breathing; e) Positive imagery; f) Classification of frightening feelings activated by specific circumstances; g) relaxation; h) Identification and expression of feelings; i) Learning (through the use of picture cards and games) how to deal with difficult emotions and feelings; j) Classification of emotions with the patient and the mother; k) Parental training; l) Practicing social skills; m) Developing interpersonal trust; n) Identification of dysfunctional thoughts; o) Developing more adaptive cognitions; p) Using drawings and stories to convey the trauma; q) Psychoeducation on	a) Significant decrease in PTSD intrusive, avoidance, and emotional symptoms; b) Decrease in depressive, attentional and anxiety symptoms; c) He did not meet the PSPT diagnostic criteria anymore, despite the fact that symptoms of arousal were still present without any trauma avoidance symptoms; d) He did not meet the D, SP and ADHD diagnostic criteria anymore, and ODD and RAD symptoms were still present; e) Improvements in sleep level, reduction of nightmares as well as significant improvements in school performance and social functioning;

	exposure to domestic violence; r) Questioning feelings of hatred and anger towards the father; s) Sharing the narrative with the mother; t) Construction of a safety plan; u) Review of skills learned and progress made.	f) Three-week follow-up: Decrease in frequency and intensity of anger outbursts; sleep improvements; absence of fear of the dark; decreased frequency and intensity of conflicts between patient and sister; acceptable levels of concentration and attention at school; better understanding of the impact of trauma on the patient's behavioral reactions and symptoms by the mother.
Padmanabhanunni & Edwards (2015)	a) Psychoeducation; b) Drawing the perpetrator's house and yard; c) reliving the memory through imagery; d) Socratic questioning; e) Emotional support; f) Guided Discovery; f) Roleplaying.	a) Significant reduction in depressive, anxiety and PTSD symptoms; b) Confidence in handling traumatic memories; c) Reduction of intrusive memories and avoidance behaviors; d) Ability to tell her parents how she felt and how her support made her feel loved; e) Ability to building some close relationships with university colleagues; f) Results were maintained after five months;
Stevens & Michael (2014)	CBTFT a) Psychoeducation; b) Written registers of feelings present before the flow of suicidal ideation; c) Reinforcement of protective factors; d) Creation of a safety plan together with parents; e) Sleep hygiene; f) Learning parenting and communication skills; g) Learning to deal with overreactions to fright, restlessness, and irritability; h) Written registers for identification, monitoring, labeling and classification of thoughts, physiological sensations and behavioral reactions for each of the intense emotions experienced; i) Written registers of automatic thoughts, behaviors, feelings and alternative and realistic thoughts; j) Imagery exposure exercises and cognitive restructuring; k) Roleplaying; l) Mourner's Bill of Rights. (Pharmacotherapy: Prozac - 10 mg/day).	a) Significant reduction in PTSD, anxiety and depressive symptoms; b) Improvement in the patient's self-esteem, self-confidence, relationships with parents and peers, and in the quality of sleep; c) Decrease in concentration difficulties, suicidal ideation and intrusive thoughts as well as absence of nightmares, hypervigilance or overreaction to fright; d) He did not meet the criteria for diagnosing the disorder; e) Adequate levels of irritability and antagonism for developmental and age group; f) Ability to make the grieving process.

Abbreviations: NET = Narrative Exposure Therapy; PTSD = Post-Traumatic Stress Disorder; ACT = Acceptance and Commitment Therapy; PET = Prolonged Exposure Therapy; A.R.T. = Accelerated Resolution Therapy; SUD = Substance Use Disorder; PD = Panic Disorder; SAD = Social Anxiety Disorder; EMDR = Eye Movement Desensitization and Reprocessing; CPT = Cognitive Processing Therapy; ERP = Exposure and Response Prevention; AD = Accumulation Disorder; WET = Written Exposure Therapy; D = Depression; SP = Specific Phobia; ADHD = Attention Deficit Hyperactivity Disorder; ODD = Oppositional

Defiant Disorder; RAD = Reactive Attachment Disorder; CBTFT = Cognitive-Behavioral Therapy Focused on Trauma.

Note: Psychoeducation connotes imparting knowledge about the disorder and about the designed treatment.

3.3 Discussion

The results of this review of clinical reports (or a narrative review of the literature) presented in the section above allowed one to expand knowledge regarding psychological strategies used by psychologists and/or other health professionals in the psychotherapeutic treatment of post-traumatic stress disorder (PTSD). According to the data obtained, it was possible to determine or establish a wide range of psychotherapeutic strategies derived mainly from the cognitive-behavior model of learning (Beck, 2011).

The cognitive-behavior model of learning springs from two central principles. One of these principles states that our operant behaviors exert a controlling influence over our symptoms (subjective sensations) and over our thoughts (cognitive flows). The other principle states the other way around, that is, our thoughts exert a controlling influence over our symptoms and over our behaviors. An important element in these tours is the circumstance in which a behavior is emitted or in which a cognitive flow is activated. Written registers of circumstances, behaviors, symptoms, and of automatic thoughts are essential in the psychotherapeutic process of learning the relationship that exists amongst these four elements and of becoming aware of one's mental schemata (Beck, 2011; Bertelli, 2017a; Bertelli, 2017b; Carneiro & Bertelli, 2021).

Despite the enormous diversity of specific strategies employed, it was possible to verify that all of them produced at least some degree of lessening of the symptoms of PTSD as well as of the comorbid symptoms.

4. Conclusions and policy implications

The present study constitutes a significant contribution to the psychological clinical practice, even when one takes into account that it is possible that some relevant studies on the subject were not included in this review due to the fact that the bibliographic search was carried out only in the databases indexed by B-on and published between 2014 and 2019. As for policy implications, engaging in the application of any of those strategies should require skillfulness by virtue of possessing detailed knowledge and specialized training in any of those ideas and actions intended to deal with cognitive, emotional or behavioral problems.

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