

PSYCHOLOGICAL TRENDS IN THE TREATMENT OF PTSD

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Abstract: *This paper explores the evolution of PTSD management, encompassing its historical background, evidence-based therapies, and the latest advancements. The study examines various therapeutic approaches and technological integrations, individual strategies, challenges, ethical considerations, and future directions, providing insight into current practices and potential advancements in the field.*

Keywords: *PTSD, trauma therapy, evidence-based treatments, personalized medicine, cultural competence, technology in mental health*

PTSD is a complex mental health condition that can develop following exposure to traumatic events, affecting individuals differently based on their life stage and personal experiences. Early experiences of loss and trauma, such as the death of a significant loved one during childhood, can significantly influence later psychological outcomes. Research by Krasteva – Ivanova (2023) highlights the relationship between the experience of significant adult loss and the development of existential fears in preschool children, underscoring the importance of addressing early trauma in PTSD treatment frameworks. PTSD is characterized by persistent intrusive thoughts, avoidance behaviors, negative alterations in cognition and mood, and heightened arousal and reactivity.

The investigation of trends in psychological treatment for PTSD has long been of immense importance to mental health. As our understanding of trauma and its effects on the human psyche evolves, so do the approaches to treating this disabling condition. By studying these trends, health care providers and researchers will gain a better understanding of the effectiveness of treatment modalities, allowing them to more accurately identify areas needing improvement and develop better interventions for individuals suffering from PTSD. This paper tries to discuss the historical and current trends in the treatment of PTSD with a special focus on developments made across Europe and the United States. Studying how treatment practices developed over time, and across

these regions, could give an important insight into the cultural, scientific, and practical factors that shaped current best practice in PTSD treatment.

In this research paper, we will consider the course of development of PTSD treatment from the time of early recognition and the first attempts at managing trauma-related symptoms. We will then go on to look at the development of evidence-based therapies, the inclusion of pharmacological interventions, and the very latest in treatment techniques. Then we will compare and contrast the Europeans with the Americans, showing not simply similarities and differences but cross-pollination of ideas between these two important centers of psychological research and practice.

The notion of trauma-related psychological suffering has been acknowledged for many centuries; however, a formal diagnosis of PTSD is relatively modern. The history of PTSD treatment is closely linked to the understanding and recognition of the disorder itself.

In the late 19th century, physicians started documenting symptoms in soldiers that today we refer to as PTSD. They called these conditions by terms like "soldier's heart," "combat fatigue," and "shell shock." Treatment during this period was often limited to rest and return to non-combat duties. More severe treatments included electro-shock therapy in some instances. In general, the treatment reflects the poor understanding at that time of the psychological basis of the condition.

The massive scale of World Wars I and II brought increased attention to combat-related psychological trauma. Although some military psychiatrists recognized the psychological nature of war neurosis during World War I, it was during this period that treatment strategies began to focus on the psychological aspects of trauma, with a special emphasis on immediate treatment near the frontlines. "PIE" principles—Proximity, Immediacy, Expectancy—were introduced in treating combat stress during this period. This set pace for proper understanding of combat-related trauma. Later thinkers, such as World War I treating psychiatrist Abram Kardiner, set the stage with their work for a wider view of trauma treatment. One of Kardiner's influential books was "The Traumatic Neuroses of War" (1941), and his understanding of trauma responses shaped later developments.

There was increased research into trauma and its treatment following World War II. The psychoanalytic approach mainly focused on unearthing repressed traumatic memories. However, such techniques were of little use to most of the traumatized. Another major advancement in the

history of PTSD treatment occurred during the Vietnam War. The unique nature of the war and its impact on servicemen significantly contributed to chronic psychological problems that persisted long after their service. The development of such interventions among the veterans were rap groups and peer support — crucial avenues that enabled the inception of group therapy in later PTSD therapies.

In the 1970s, the mental health community began to see a need for a separate disorder category for trauma-related disorders, and this eventually led to the adoption of PTSD by the third edition of the Diagnostic and Statistical Manual of Mental Disorders in 1980. This was an important moment in the deliberation and treatment of PTSD as an official disorder. This historical progression set the stage for development of more specialized and effective treatments that would emerge in the following decades and be explored in subsequent sections of this paper.

The formal recognition of PTSD as a distinct diagnosis in the DSM-III in 1980 catalyzed a new era of research and treatment development. This period was the period in which a number of evidence-based treatments and alternative approaches were developed, which would become paramount in the treatment of PTSD.

Cognitive-Behavioral Therapy emerged as a major powerful treatment for PTSD in the 1980s. The focus of CBT is to help identify and change thoughts and behaviors related to trauma. Two key CBT techniques are used for PTSD: cognitive restructuring and exposure therapy. Edna Foa's refinement of Prolonged Exposure (PE) therapy, another form of CBT, also gained much popularity and acceptance around this time.

Invented by Francine Shapiro in 1987, EMDR was a controversial but extensively studied intervention for PTSD. The intervention involves the recounting of the traumatic incident while undergoing "bilateral stimulation" of one type or another, most frequently as a result of tracking the movement of one's finger. Although research on the effectiveness of EMDR was met with skepticism in 1998, sufficient empirical evidence emerged by the late 1990s to establish it as an effective treatment. Today, most major health organizations consider EMDR to be empirically supported.

Patricia Resick and associates developed CPT (Cognitive Processing Therapy) in the late 1980s as a treatment for rape victims. The basic premise is that individuals' appraisals of what they believed before, during, and after trauma are associated with their PTSD symptoms. CPT is a cognitive therapy that helps patients identify and change negative beliefs (called stuck points) that

they have from their trauma. By doing so, the patient will develop more balanced thinking and experience a reduction in his or her PTSD symptoms.

In the 1990s, Gary Craig created Emotional Freedom Techniques (EFT), commonly known as "tapping." EFT is a form of alternative therapy that integrates concepts from cognitive therapy with acupuncture. The approach focuses on the tapping of acupuncture sites while addressing traumatic memories or negative emotions. Even though mainstream psychology initially exhibited reluctance, EFT found acceptance among some practitioners and clients, likely as a supplement to the treatment of PTSD. Over time, scientific studies have begun to support its efficacy. For instance, a systematic review and meta-analysis published in the *Frontiers in Psychology* demonstrated significant and large effect sizes for EFT in treating PTSD, showing it to be as effective as other established therapies (Stapleton et al., 2023). Additionally, guidelines from EFT International and research by Church et al. (2018) further validate its effectiveness, confirming its value in reducing PTSD symptoms.

Pharmacological treatment of PTSD increased significantly during the 1980s and 1990s. Selective Serotonin Reuptake Inhibitors (SSRIs) emerged as the first-line medication for managing symptoms. The FDA approved sertraline (Zoloft) in 1999 and paroxetine (Paxil) in 2001 as the first drugs specifically indicated for PTSD treatment.

The acceptance and advocacy of trauma-informed care also gained momentum later in this period. This approach involves understanding, recognizing, and responding to the effects of all types of trauma by integrating this knowledge into policies, procedures, and practices within care systems. This shift towards evidence-based therapies and alternative approaches marked a significant change in PTSD treatment, moving from generalized to targeted trauma-specific interventions. These developments laid the groundwork for novel treatment strategies and increased precision in the new century, as discussed in the following.

The first decade of the 21st century has seen significant progress in the treatment of PTSD, characterized by increased precision and novel interventions incorporating the neurobiological basis of trauma.

Existing evidence-based therapies were further refined and validated. Prolonged Exposure (PE) saw research supporting its efficacy, with protocols adapted for a broad range of trauma types and clients. Cognitive Processing Therapy (CPT) was also further refined, with versions created

for various cultural groups and trauma types. Additional research bolstered the empirical base of EMDR, making it more widely accepted in standard treatment protocols.

New approaches were developed during this period. Narrative Exposure Therapy (NET), created by Maggie Schauer, Frank Neuner, and Thomas Elbert, combines exposure therapy with testimonial therapy and was initially designed for war and torture survivors but has since been expanded to other trauma forms. Mindfulness-based therapies, including Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT), began being applied to PTSD treatment, focusing on present-moment awareness and non-judgmental acceptance of thoughts and feelings. Virtual Reality Exposure Therapy (VRET) uses the latest technological advances to create computer-generated environments for safe, immersive exposure therapy.

The early 2000s saw increased interest in the neurobiology of PTSD, leading to several treatment breakthroughs. Prazosin, an alpha-1 adrenergic antagonist initially developed for hypertension, was found to improve sleep and nightmares associated with PTSD. Studies also explored propranolol, a beta-blocker, for preventing the development of PTSD when administered shortly after trauma exposure. Additionally, D-cycloserine, a partial NMDA agonist, was studied as an adjunct designed to augment the effects of exposure therapy.

Understanding the multi-component nature of PTSD saw the development of more integrative treatment approaches. There was increasing interest in Complementary and Alternative Medicine (CAM) therapies, like acupuncture, yoga, and meditation, as adjunctive treatments for PTSD. Somatic experiencing and sensorimotor psychotherapy were also developed to focus on the role of the body in trauma processing. With greater recognition of the impact of PTSD on relationships, couple and family therapy protocols specifically for PTSD have been developed.

In the early 21st century, there was a significant increase in the dissemination and implementation of evidence-based treatments for PTSD. Large-scale training initiatives were launched to educate clinicians in military and veteran health systems on these treatments. Throughout the first two decades, the use of technology in delivering PTSD treatments became increasingly common, thereby expanding access to services for individuals in rural and underserved areas.

These advancements were followed by continuous innovations and refinements in PTSD treatment, which persisted and evolved over the next decade. Several of these developments will be explored in the following section.

In the last decade, since the first innovation in the treatment of PTSD was developed, there has been an evolution in models, new technologies, and growing interest in a personalized-medicine approach.

Written Exposure Therapy, developed by Denise Sloan and colleagues, is a brief, exposure-based treatment in which traumatic experiences are written about. Accelerated Resolution Therapy utilizes EMDR, guided eye movements, and voluntary memory/image replacement to rapidly resolve traumatic memories. Cognitive Behavioral Conjoint Therapy, developed by Candice Monson, is a treatment for PTSD provided within the context of an intimate relationship. Brainspotting, created in 2003 by David Grand, has gained significant attention. It's a tool for identifying, processing, and releasing core neurophysiological sources of emotional and body pain, trauma, dissociation, and other challenging symptoms. In its direct access to the autonomic and limbic systems within the body's central nervous system, it works with the deep brain and body.

Internet-delivered CBT (iCBT) has emerged as an innovative approach, utilizing online platforms to deliver CBT for PTSD, thereby increasing accessibility. Numerous mobile applications have been created to support PTSD treatment, providing tools for symptom tracking and relaxation exercises. More sophisticated virtual reality (VR) systems have further enhanced the potential of Virtual Reality Exposure Therapy (VRET), enabling more immersive exposure experiences.

Research has explored the potential of ketamine in rapidly reducing PTSD symptoms, particularly in treatment-resistant cases. Clinical trials have shown promising results for MDMA-assisted psychotherapy in treating PTSD. Additionally, there is growing interest in the potential of cannabinoids, particularly CBD, in alleviating PTSD symptoms.

Advances in pharmacogenomics have spurred explorations into how genetic factors might influence treatment responses. Functional MRI and other brain imaging techniques are being used to better understand individual differences in PTSD. Furthermore, AI and machine learning algorithms are being developed to potentially identify optimal treatment approaches for individual patients.

There is an increased focus on building resilience in high-risk populations before trauma exposure, known as pre-trauma interventions. Early interventions are being refined to be delivered immediately post-trauma, aiming to prevent the development of PTSD.

There is increased awareness of the need to therapeutically adapt evidence-based treatments to be applicable across cultural differences. Additionally, there is growing interest in culturally adapting traditional healing practices with Western psychotherapies for PTSD treatment in indigenous populations. These recent developments reflect the trend toward a more personal, accessible, and integrative approach to PTSD treatment. The inclusion of innovative therapies like Brainspotting alongside established treatments indicates that the field continues to evolve. As research continues, more targeted treatment options are likely to emerge, potentially improving outcomes for those suffering from PTSD.

While there have been significant advances in the treatment of PTSD in both Europe and the United States, differences exist in the approach, priorities, and implementation of strategies.

In the USA, the development and promotion of evidence-based practices for PTSD have been significant. Organizations like the Department of Veterans Affairs have strongly pushed for implementing EBPs such as Prolonged Exposure and Cognitive Processing Therapy. In contrast, European countries also recognize the importance of EBPs but remain more open to integrative paradigms, combining EBPs with other therapeutic modalities. For instance, narrative exposure therapy, developed in Germany, has gained significant traction across Europe.

The use of psychotropic medications in PTSD treatment is higher in the United States, where the FDA has authorized two SSRIs (sertraline and paroxetine) specifically for PTSD treatment. In European countries, drug treatment is generally considered a second-line treatment, with much more emphasis placed on psychotherapeutic approaches. When medications are used, there is a preference for shorter prescribing durations.

There is growing recognition in the USA that treatments must be culturally adapted, especially for minority groups and veterans. However, the implementation of culturally specific interventions is still under development.

In Europe, there has been a longer-standing emphasis on culturally adapted treatments due to its diverse cultural landscape. Countries like the Netherlands and Sweden have been particularly active in developing culturally sensitive approaches for immigrant and refugee populations.

In the USA, the country has been leading the way in developing and implementing technology-enhanced treatments, including virtual reality exposure therapy and mobile apps for PTSD management. While European countries also embrace technology, they have generally been more cautious in its implementation, focusing on thorough evaluation before widespread adoption.

In the USA, there is a strong focus on PTSD treatment, particularly within military and veteran populations. Recent years have seen increased attention to prevention and resilience-building programs. European countries, on the other hand, have traditionally placed greater emphasis on prevention and early intervention strategies, particularly in civilian settings. There is also more focus on addressing complex PTSD resulting from prolonged trauma exposure.

In the USA, PTSD treatment is often integrated within mental health services or specific programs like VA healthcare. However, integration with primary care remains an ongoing challenge. In contrast, many European countries have more integrated healthcare systems, facilitating better coordination between mental health services and primary care in PTSD treatment.

In the USA, research often focuses on treatment efficacy and effectiveness, with large-scale randomized controlled trials being the gold standard. While European countries also value controlled trials, they tend to place more emphasis on qualitative studies and real-world effectiveness, considering broader contextual factors in PTSD treatment.

Despite these differences, there is significant cross-pollination of ideas between Europe and the USA. International collaborations and conferences facilitate the exchange of knowledge and best practices, contributing to the global advancement of PTSD treatment. Both regions continue to innovate and refine their approaches, working towards the common goal of improving outcomes for individuals suffering from PTSD.

With our increasingly sophisticated understanding of the nature of PTSD, the horizon is being shaped by some emerging trends and potential future directions in treatment.

The scope of treatment for PTSD will likely become more personalized in its approach in the coming years. Advancements in genetics, neuroimaging, and biomarker research are likely to allow clinicians to better target treatments to individual patients. Predictive pharmacogenomic testing may help determine medication responses and side effects. Neuroimaging could be utilized to produce algorithms for selecting treatments based on patterns of neural processes representative

of PTSD subtypes. Machine learning algorithms are being designed to integrate various strands of data and suggest optimal treatment plans.

New pharmacological treatments in development include psychedelic-assisted therapies. Beyond MDMA, psilocybin and ayahuasca are currently under study for PTSD treatment. Neuropeptide-Y (NPY) and oxytocin, natural hormones, are being explored for boosting resilience and social bonding. Medications targeting the endocannabinoid system may also be explored further in the future for specific PTSD symptoms.

Non-invasive brain stimulation techniques currently under study include Transcranial Magnetic Stimulation (TMS), which is FDA-approved for depression but is now also being studied for PTSD. Transcranial Direct Current Stimulation (tDCS) is another method being tested to determine whether it can enhance the effectiveness of exposure therapy.

The use of technology in treating PTSD is expected to increase. AI chatbots may be used for symptom monitoring and on-the-fly support. VR systems could provide much more advanced and individualized exposure therapy. Wearable devices could be used for real-time monitoring of symptoms and for providing interventions as needed.

There is growing awareness that the scope of PTSD treatment should be broadened to include organizational trauma-informed practices in the delivery of healthcare, schools, and social services. Community-based interventions could foster collective healing after mass adversity and increase community-level resilience.

Future treatments may include evidence-based therapies combined with complementary approaches. Mind-body interventions such as yoga and tai chi could be added to standard treatment protocols. Nutritional approaches and exercise could serve as adjuncts to psychotherapy and medication.

As complex PTSD gains recognition, particularly with its inclusion in ICD-11, more specialized treatments for this condition are likely to emerge. Phase-based approaches could address emotional regulation and interpersonal difficulties alongside trauma processing. Additionally, longer-term treatment models may be developed to better accommodate the nuances of developmental trauma.

Increased attention to PTSD in low and middle-income countries could bring culturally adapted, scalable interventions that can be delivered by non-specialists. Integrating traditional healing practices with evidence-based treatments could also be beneficial.

Future approaches may place greater emphasis on preventing PTSD through pre-trauma interventions for high-risk populations and early interventions immediately following trauma exposure. Public health campaigns could increase trauma awareness and reduce stigma.

As research in these areas improves, we can look forward to a far wider and more sophisticated set of PTSD treatments. The challenge will be to rigorously test these new approaches and make them available in a practical and efficient manner in routine care. The ultimate goal is to provide more effective, accessible, and personalized care for people suffering from PTSD.

As the field of PTSD treatment advances, it faces several challenges and ethical considerations that need to be addressed. One of the primary issues is access to care. Despite advancements in treatment, many individuals with PTSD still struggle to receive appropriate care due to geographic disparities, economic barriers, and stigma. Rural areas often lack specialized trauma treatment services, while high costs of treatment and limited insurance coverage can prevent access for many. Additionally, fear of stigma may deter individuals from seeking help, particularly in certain cultures or professions. Potential solutions to these issues include expanding telehealth services, increasing mental health coverage in insurance plans, and implementing public education campaigns to reduce stigma.

Treatment resistance presents another significant challenge. A considerable proportion of individuals with PTSD do not respond adequately to current evidence-based treatments. This necessitates the identification of predictors for treatment response to better match patients with effective interventions. It also calls for the development of new approaches for treatment-resistant PTSD and exploration of combination treatments that may be more effective than single modalities.

Iatrogenic effects pose a concern in PTSD treatment. Some treatments, particularly exposure-based therapies, can potentially exacerbate symptoms if not properly administered. Ensuring proper training and supervision for clinicians, developing clearer guidelines for patient selection and treatment implementation, and vigilant monitoring for adverse effects are crucial steps in mitigating these risks.

As PTSD treatment expands globally, ensuring cultural competence becomes increasingly important. This involves adapting evidence-based treatments for different cultural contexts,

incorporating indigenous healing practices where appropriate, and training clinicians in cultural humility and cross-cultural communication.

The integration of technology into PTSD treatment raises several ethical issues. These include concerns about data privacy and security in digital mental health interventions, ensuring equitable access to technology-enhanced treatments, and maintaining the therapeutic alliance in virtual treatment settings.

The use of psychotropic medications and novel substances in PTSD treatment also presents ethical questions. Clinicians and researchers must balance the benefits and risks of long-term medication use, consider the ethical implications of psychedelic-assisted therapies, and address potential conflicts of interest in pharmaceutical research.

There's ongoing debate about the necessity of directly addressing traumatic memories in treatment. This involves weighing the potential benefits of trauma processing against the risk of retraumatization and developing clearer guidelines for when to use trauma-focused versus present-centered approaches.

Healthcare providers treating PTSD patients are at risk of secondary traumatization. Implementing support systems and self-care strategies for clinicians while balancing the need for empathic engagement with professional boundaries is crucial.

The evolving understanding of trauma-related disorders presents diagnostic challenges. Clinicians must navigate the complexities of differentiating between PTSD, complex PTSD, and other trauma-related disorders, while also addressing potential over-diagnosis or under-diagnosis in different settings.

Finally, as new treatments are developed and tested, maintaining ethical standards in research is paramount. This includes ensuring informed consent, particularly in vulnerable populations, balancing the need for rigorous research with minimizing risk to participants, and addressing the ethical implications of withholding potentially effective treatments in control groups.

Addressing these challenges and ethical considerations will be crucial for the continued advancement of PTSD treatment. It requires ongoing dialogue among clinicians, researchers, policymakers, and individuals with lived experience of PTSD. By navigating these complex issues thoughtfully, the field can continue to evolve in ways that best serve those affected by trauma.

As this review of psychological trends in the treatment of PTSD has demonstrated, the field has undergone significant evolution since the formal recognition of the disorder. From early approaches that often misunderstood the nature of trauma to today's evidence-based, neurobiologically-informed treatments, our ability to address PTSD has greatly improved. However, challenges remain, and the field continues to evolve rapidly.

The understanding and treatment of PTSD have progressed from early recognition of combat stress to a comprehensive biopsychosocial model of trauma response. Cognitive-Behavioral Therapy (CBT), Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR) have emerged as gold standard treatments, supported by robust empirical evidence. While SSRIs remain the primary pharmacological intervention, research into novel compounds like ketamine and MDMA shows promise for treatment-resistant cases. Advances in neuroscience have deepened our understanding of PTSD's biological underpinnings, informing new treatment approaches and refining existing ones. The incorporation of virtual reality, mobile applications, and telehealth has expanded the reach and capabilities of PTSD treatment. There's growing recognition of the need to adapt treatments for diverse cultural contexts and to integrate traditional healing practices where appropriate. The field is moving towards more individualized treatment approaches, leveraging genetic, neuroimaging, and other data to tailor interventions.

As we look to the future of PTSD treatment, several key areas warrant continued attention and research. Further development of personalized treatment approaches based on individual biological, psychological, and social factors is essential. Increased focus on preventive interventions and resilience-building strategies, particularly for high-risk populations, is necessary. Refinement of treatment approaches for complex PTSD is crucial, addressing the unique needs of individuals with prolonged trauma exposure. The expansion of culturally-adapted, scalable interventions to address PTSD in low and middle-income countries is needed. Continued exploration of how AI, machine learning, and advanced neuroimaging can enhance PTSD assessment and treatment is important. Bridging the gap between neuroscientific discoveries and clinical applications to develop novel interventions is vital. Increased emphasis on studying the long-term effectiveness of treatments and developing strategies for maintaining gains and preventing relapse is crucial.

In conclusion, while significant strides have been made in the treatment of PTSD, much work remains. The complex nature of trauma and its effects on the human psyche continue to challenge clinicians and researchers alike. However, the rapid pace of scientific discovery, coupled with growing public awareness and destigmatization of mental health issues, provides hope for continued improvements in PTSD treatment.

As we move forward, it is crucial to maintain a balance between innovation and empirical rigor, always keeping the needs and experiences of trauma survivors at the forefront of our efforts. By doing so, we can continue to enhance our ability to help individuals recover from trauma and reclaim their lives.

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