



## CLINICAL APPLICATIONS OF THE STRUCTURED INTERVIEW FOR DISORDERS OF EXTREME STRESS (SIDES)

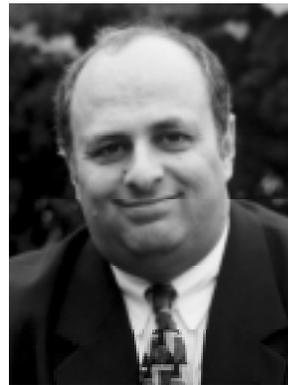
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Bessel van der Kolk, M.D.

During the last two decades the role of trauma on psychological and biological functioning has received an enormous amount of clinical and research attention. This effort has found its organizing principle within the diagnosis of Post Traumatic Stress Disorder (PTSD). The diagnostic criteria for PTSD focus on the intrusive memories and disordered arousal that are distinguishing characteristics of post-traumatic adaptation. Within this

framework the remaining symptoms of PTSD are understood as strategies to ward off the emotions, somatic sensations and personal meanings associated with the trauma. However, the emergence of pure (simple) PTSD following exposure to a traumatic stressor is the exception rather than the rule. Extensive research (e.g., in the Field Trials for PTSD [1-3]) has shown that for a substantial proportion of patients with PTSD this diagnosis only describes a limited dimension of their suffering: the majority of people who respond to a trauma with persistent intrusive and avoidant symptoms also develop a complex set of other, interrelated problems. Many traumatized individuals suffer from difficulties with their regulation of affective arousal, with impaired capacity for cognitive integration of experience (as in dissociation), impairment in the capacity to differentiate relevant from irrelevant information, such as occurs in the misinterpretation of somatic sensations, and with disturbances in relation to self and others. These phenomena have been variously described as "Disorders of Extreme Stress" (1-2) and Complex PTSD (4). These problems associated with traumatic exposure may require clinical interventions different from those proven to be effective in "simple" PTSD.



David Pelcovitz, Ph.D.

Research during the past decade has shown that trauma has a different impact on adaptation at different stages of development, and that trauma early in the life cycle affects subsequent maturational processes (e.g., 5). Early in life, when children primarily depend on their caregivers for modulation of their physiological arousal, they are thought to have two broad ranges of responses to overwhelming stress: hyperarousal and

dissociation. These ways of coping with traumatic processes: originally put to use to cope with traumatic experiences, they may come to be utilized by previously traumatized individuals during periods of subsequent stress. The literature suggests that the impact of trauma on self-regulation, self-concept and interpersonal functioning is most profound in younger victims, and when the source of the trauma is interpersonal, as opposed to natural disasters such as earthquakes or hurricanes (5, 6).

Profound changes in affect regulation and self-identity have not only been observed in traumatized children. Research with rape victims (7), battered women (8), and concentration camp survivors (9) has shown that severe and prolonged trauma can have significant long term impact in the areas of self-regulation and personality development. The ICD-10 (10) recognizes the occurrence of such post-traumatic alterations and includes a diagnostic category of "lasting personality changes following catastrophic stress" which comprises "impairment in interpersonal, social and occupational functioning" including "a hostile or mistrustful attitude towards the world, social withdrawal, feelings of emptiness and hopelessness, a chronic feeling of being "on edge" and constantly threatened and chronic sense of estrangement.

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## FROM THE EDITOR...

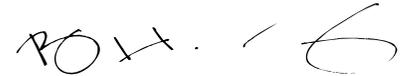
The distinction between clinical subtypes and their respective etiologies may have significant clinical implications related to treatment. The presence of subtypes or complex PTSD, however, remains controversial. Keane (1), for example, posits that PTSD might be the result of a process of conditioned fear effectively transmuting simple acute PTSD to complex chronic PTSD. Others have underscored the relevance of pre-existing vulnerabilities to understand the course of adaptation to trauma, e.g., prior victimization (2) personality characteristics (3), and intergenerational response (4). Pelcovitz et al. (5) suggest that complex PTSD is a specific response to extremely severe traumatic events or events possibly involving interpersonal victimization. In this issue of the *NC-PTSD Clinical Quarterly*, we are pleased to have Bessel van der Kolk and David Pelcovitz present their findings about the psychometric properties and the clinical utility of the Structured Interview for Disorders of Extreme Stress (SIDES). Findings from studies using the SIDES may provide a rationale for inclusion of other symptom types (e.g., dissociation, self-destructive behavior, problems of identity) to the overall traumatic stress response as well as contribute to the development of specific treatment approaches for particular symptom presentations.

Along the same line, Constance Dalenberg provides guidelines for the clinical management of dissociative symptoms and practical suggestions to help clients self-monitor dissociative experiences. Lastly, senior NC-PTSD staff member, Ronald Murphy, and his colleagues describe a treatment model designed to address client ambivalence and increase motivation for behavioral change. Their systematic approach to helping clients more fully engage in treatment may be appreciated by clinicians who encounter clients who have difficulty recognizing and understanding their own resistance to change.

Past issues of the *Clinical Quarterly* have been posted on our NC-PTSD Webpage. Plans are underway to post each of the Quarterly's previously published articles. At this point, a select number of "text only" articles are posted from Volumes 1-7. Please visit our webpage: <http://www.dartmouth.edu/dms/ptsd/>.

### References

1. Keane, T.M., Zimering, R.T., & Caddell, J.M. (1985). A behavioral formulation of posttraumatic stress disorder in Vietnam veterans. *Behavior Therapist*, 8, 9-12.
2. Resnick, H.S., Kilpatrick, D.G., Best, C.L., & Kramer, T.L. (1992). Vulnerability stress factors in the development of posttraumatic stress disorder. *Journal of Nervous and Mental Disorders*, 180, 424-430.
3. Schnurr, P.P., Friedman, M.J., & Rosenberg, S.D. (1993). Preliminary MMPI scores as predictors of combat-related PTSD. *American Journal of Psychiatry*, 150, 479-483.
4. Yehuda, R., Schmeidler, J., Giller, E.L., & Siever, L.J. (1998). Relationship between PTSD characteristics of Holocaust survivors and their adult offspring. *American Journal of Psychiatry*, 155, 841-843.
5. Pelcovitz, D., van der Kolk, B.A., Roth, S.H., Mandel, F.S., Kaplan, S., & Resick, P.A. (1997). Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal of Traumatic Stress*, 10, 3-16.



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## CLINICAL APPLICATION OF THE SIDES

In the DSM-IV Field Trials for PTSD (1, 2, 4) we identified what we considered the seven clinically most relevant issues associated with trauma, which currently are not included in the PTSD diagnosis (see Table 1): a) problems with self-regulation, including self-destructive activities; b) problems with information processing, which is captured, in part, by the phenomenon of dissociation and the diagnosis of dissociative disorder; c) somatic functioning (as captured in the diagnosis of somatization); d) problems with personal identity, such as excessive self-blame, shame and being permanently damaged; e) problems in attachment to the perpetrator; f) problems in interpersonal relationships; and g) alterations in systems of meaning.

The DESNOS workgroup developed a structured interview, the *Structured Interview for Disorders of Extreme Stress* (SIDES) to measure the presence of these criteria. In the DSM IV Field Trial for PTSD this interview was administered to 523 DSM IV Field Trial subjects (1, 2): a treatment seeking sample (n=395), obtained through the assessment of sequential admissions to five outpatient clinics and a non-treatment seeking community sample of 128 subjects. The SIDES proved to be a reliable and valid instrument to assess the alterations in functioning that result from exposure to extreme stress. The inter-rater reliability as measured by Kappa coefficients for lifetime Disorders of Extreme Stress was 0.81. Internal consistency using coefficient alpha ranged from 0.53 to 0.96. In one subset of 395 subjects (1) the correlations ranged from 0.52 for PTSD and Affect Dysregulation and 0.60 for PTSD and Somatization; all SIDES scores correlated with PTSD symptoms at the .0001 level of significance. Subjects who suffered interpersonal trauma as adults had significantly less dissociation and affect dysregulation than those with interpersonal childhood trauma, but significantly more than victims of disasters.

Zlotnick et al. (12) examined the construct validity of the subscales of the SIDES. Using a clinical sample of 74 survivors of childhood sexual abuse with PTSD, this study demonstrated that the subscales of the SIDES correlated highly with instruments hypothesized to measure similar constructs. Divergent validity was established for each of subscales of the SIDES. Findings from this study and other research on the psychometrics of the SIDES supported that the SIDES is a valid measure of the associated features of PTSD in survivors of childhood sexual abuse. In another study Zlotnick et al. (13) found that, compared to 34 women without histories of sexual abuse, 74 survivors of sexual abuse showed increased severity on DESNOS symptoms of somatization, dissociation, hostility, anxiety, alexithymia, social dysfunction, maladaptive schemas, self-destruction, and adult victimization. In addition, a logistic regression found that a complex of symptoms representing DESNOS was significantly related to a history of sexual abuse. The authors concluded that the results of this study provide support for the idea that symptoms of DESNOS characterize survivors of sexual abuse.

In a subsequent analysis (2) subjects were divided into the three "trauma" groups: early onset (age less than or equal to 13 years) interpersonal abuse (physical and/or sexual abuse) [n = 149], late onset interpersonal abuse [n = 87], disaster [n = 58], and other (all

subjects not included above) [n = 226]. The early interpersonal trauma group had significantly higher percent endorsement on all complex PTSD symptoms compared with the disaster group, while the late interpersonal trauma group had significantly higher endorsement on the items of unmodulated anger, suicidal behavior, and somatization. The early and late interpersonal trauma groups differed significantly on the items of unmodulated anger, being self-destructive and suicidal, and on dissociative symptoms. Subjects who had suffered interpersonal abuse before age 14 developed significantly more dissociative problems, as well as difficulties modulating anger, self-destructive and suicidal behaviors, than either the older victims of interpersonal trauma, or the victims of disaster. These patterns of endorsement strongly support the notion that early interpersonal traumatization gives rise to more complex post-traumatic psychopathology than later interpersonal victimization. Exposure to natural disasters tends to be associated with "simple" PTSD, and does not seem to substantially contribute to the development of dissociative symptomatology, somatization or affect dysregulation problems.

In a third analysis (3) 234 participants in the DSM-IV PTSD Field Trial who reported sexual and/or physical abuse were evaluated. Participants were categorized according to type of abuse (physical, sexual, both), duration of abuse (acute versus chronic), and onset of abuse (early versus late). Separate logistic regression analyses examined the relationship between age of onset, duration, abuse type, and the lifetime diagnosis of complex PTSD (CP) for women and men. Sexually abused women, especially those who also experienced physical abuse, had a higher risk of developing CP, although CP symptoms occurred at a high base rate among physically abused women.

As a result of the DSM-IV PTSD Field Trials for PTSD most of the symptoms enumerated in the SIDES are listed as separate diagnoses, such as Dissociative Disorder, Somatization Disorder, and various Axis II disorders, but also under "Associated Features of PTSD" (DSM-IV, p. 425). We propose that in patients with PTSD these symptoms do not constitute separate "double diagnoses", but represent the complex somatic, cognitive, affective, and behavioral effects of psychological trauma, particularly trauma that is prolonged and starts early in the life cycle.

### Utility of the SIDES in Clinical Settings

The concept of Complex PTSD raises important questions about the treatment of people who suffer from PTSD and associated disorders. If the fundamental deficit in people who suffer from the long-term sequelae of trauma consists of unbidden intrusions, against which the sufferer defends himself by avoiding stimuli reminiscent of the trauma, effective treatment needs to focus on desensitization of the traumatic memory, with the goal that the afflicted individual can habituate to the conditioned stimuli that precipitate traumatic reexperiences. Indeed, good treatment results have been reported using such approaches. However, at present it is unclear how various desensitization methods affect the dimensions of traumatization enumerated in the SIDES: dissociation, somatization, affect dysregulation and altered relationships with self and others. If these phenomena represent core features of the post-traumatic response, and reflect problems with self-organization and stimulus discrimination, it becomes an important issue whether desensitization of the traumatic memory also can effectively address those issues.

The SIDES provides clinicians and researchers with a rational way of measuring the associated features of PTSD. The measure allows for further studies to provide empirical support for expanding the current PTSD DSM-IV diagnosis to include an additional category of "Disorders of Extreme Stress" (14, DES, Davidson, 1993). It can also guide clinicians to set priorities in the care of traumatized patients. From a research point of view, it provides a vehicle for the systematic study of post-traumatic changes across different trauma populations. The SIDES has already been used to study treatment outcome. In one study, Zlotnick et al. (15) studied the clinical efficacy of an affect-management group for women with posttraumatic stress disorder and histories of childhood sexual abuse. Subjects who completed the affect-management treatment group reported significantly fewer post-treatment symptoms of both PTSD and a variety of associated features than subjects in the wait list control condition. Similarly, in a study evaluating the efficacy of fluoxetine in PTSD (14), we found that this drug, while not significantly improving PTSD symptoms in a chronic veterans population did have a beneficial effect on interpersonal difficulties, while improving problems with affect dysregulation in the entire sample.

In the Zlotnick et al. study (13), they examined clinical efficacy of an affect management group for women with posttraumatic stress disorder and histories of childhood sexual abuse. Subjects who completed the affect-management treatment group (n=17) reported significantly fewer post-treatment symptoms of both PTSD and a variety of associated features than subjects in the wait list control condition (n = 16). The SIDES was also used in a study to further the understanding of the mechanisms of self-mutilative behavior in female inpatients (15). The study found that self-mutilators (n=103) displayed a greater degree of dissociative symptoms and alexithymia and a greater number of self-injurious behaviors, as well as higher rates of childhood sexual abuse, than non-mutilators (n=45). Both dissociative symptoms and alexithymia were independently associated with self-mutilative behavior.

### Clinical Applications of the SIDES

For the past several years we have used the SIDES in our clinical evaluations of a wide variety of traumatized populations. After taking a careful, developmentally based, trauma history we use the SIDES to elicit information regarding the overall effects of trauma. It has been particularly valuable in identifying the most critical areas of psychological impairment which need to be addressed for effective treatment planning. Post-traumatic patients with high degrees of difficulties on the dimensions of affect regulation, dissociation or somatization may require a different treatment approach than patients who suffer from "simple" PTSD. The significance of these symptoms needs to be examined by a careful investigation of the particular constellation of impairment. The concept of Complex PTSD raises important questions about the treatment of people who suffer from PTSD and associated disorders. If the fundamental deficit in people who suffer from the long-term sequelae of trauma consists of unbidden intrusions, against which the sufferer defends himself by avoiding stimuli reminiscent of the trauma, effective treatment needs to include desensitization of the traumatic memory, with the goal that the afflicted

individual can habituate to the conditioned stimuli that precipitate traumatic reexperiencing symptoms. However, at present it is unclear how such desensitization affects these other dimensions associated with traumatization. If dissociation, problems with attention and stimulus discrimination, affect dysregulation and altered relationships to self and others are core features of the post-traumatic response, desensitization may not be able to effectively address those issues.

Despite the favorable treatment outcome studies using cognitive/behavioral treatments aimed at controlling traumatic intrusion, most clinicians treating traumatized patients continue to practice some form of psychodynamic therapy. This raises the question whether these clinicians are misguided in their choice of interventions, or whether patients who carry the diagnosis of PTSD primarily seek treatment not for their intrusive symptoms, but for dealing with other problems associated with PTSD, such as affect dysregulation, dissociative problems, and difficulties with trust and intimacy, which may respond best to dynamic therapies. No treatment studies of PTSD have as yet addressed those questions.

Disturbances related to arousal, attention and stimulus discrimination may be most usefully addressed by helping patients acquire skills that help them label and evaluate the meaning of sensations and affective states, to discriminate present from past, and to interpret social cues in the context of current realities rather than past events. Linehan (1993) for example, has developed sophisticated programs that address includes the identification and labeling of emotions, the identification and appropriate utilization of social supports, focusing on content, rather than affects; scheduling, planning and anticipating; the judicious use of exercise and food; "mindfulness" training, relaxation and stress inoculation exercises.

Fully effective treatment may require a strategically staged, multimodal treatment approach. On the one hand, a treatment that emphasizes cognitive reorientation to the present, while disregarding past trauma, may insufficiently address the reliving of the trauma in images, feelings, or behavior. On the other hand, a treatment approach that focuses prematurely on exploration of the past may exacerbate, rather than relieve intrusive affective and somatic symptoms. With appropriate timing, however, different treatment modalities might well be employed in complementary fashion. Thus, recognition of the complex nature of adaptation to traumatic life experiences may lead to further developments of a more comprehensive treatment approach to trauma-based psychiatric disorders.

### References

1. van der Kolk, B.A., Pelcovitz, D., Roth, S.H., Mandel, F.S, McFarlane, A.C., & Herman, J.L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. *American Journal of Psychiatry*, *153*, (Festschrift Supplement), 83-93.
2. Pelcovitz, D., van der Kolk, B.A., Roth, S.H., Mandel, F.S., Kaplan, S., & Resick, P.A. (1997). Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal of Traumatic Stress*, *10*, 3-16.

**CLINICAL APPLICATION OF THE SIDES**

**Table I: Sample scoring Report**

*Key: First column: life time present or not.*

*Second column: current severity:*

- 0= none at all, never,*
- 1= sometimes, somewhat*
- 2= often, moderate,*
- 3= severe, all the time*

Name: \_\_\_\_\_

**DES – NOS Results**

	<b>Lifetime</b>	<b>Present Severity</b>
<b>I. Alteration in Regulation of Affect and Impulses</b>		
a) Affect Regulation	Yes	2.0
b) Modulation of Anger	Yes	2.5
c) Self-destructive	No	0.0
d) Suicidal Preoccupation	Yes	1.0
e) Difficulty Modulating Sexual Involvement Preoccupation	Yes	1.5
f) Excessive Risk Taking	Yes	2.0
<b>II. Alterations in Attention or Consciousness</b>	Yes	2.0
a) Amnesia	Yes	2.0
b) Transient Dissociative Episodes and Depersonalization	Yes	2.0
<b>III. Alteration in Self-Perception</b>		
a) Ineffectiveness	Yes	2.0
b) Permanent Damage	Yes	2.0
c) Guilt and Responsibility	Yes	1.5
d) Shame	Yes	2.0
e) Nobody can Understand	Yes	0.0
f) Minimizing	No	0.0
<b>IV. Alterations In Perception Of The Perpetrator</b>	No	0.0
a) Adopting Distorted Beliefs	No	0.0
b) Idealization of Perpetrator	No	0.0
c) Preoccupation with Hurting Perpetrator	No	0.0
<b>V. Alterations in Relationships with Others</b>	Yes	1.5
a) Inability to Trust	Yes	3.0
b) Revictimization	No	0.0
c) Victimizing Others	No	0.0
<b>VI. Somatization</b>	Yes	0.6
a) Digestive System	Yes	0.6
b) Chronic Pain	Yes	3.0
c) Cardiopulmonary Symptoms	Yes	0.0
d) Conversion Symptoms	Yes	0.0
e) Sexual Symptoms	No	0.0
<b>VII. Alterations in Systems of Meaning</b>	No	0.0
a) Foreshortened Future	Yes	0.0
b) Loss of Previously Sustained Beliefs	No	0.0

## VAN DER KOLK &amp; PELCOVITZ

3. Roth, S.H., Newman, E., Pelcovitz, D., van der Kolk, B.A., & Mandel, F.S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: results from the DSM-IV Field Trial for Posttraumatic Stress Disorder. *Journal of Traumatic Stress*, *10*, 539-555.
4. Herman, J. L. (1993). Sequelae of prolonged and repeated trauma: evidence for a complex posttraumatic syndrome (DESNOS). In J.R.T. Davidson & E.B. Foa (Eds.), *Posttraumatic stress disorder: DSM-IV and beyond*, (pp. 213-228), Washington, DC: American Psychiatric Press.
5. Cole, P., & Putnam, F.W. (1992). Effect of incest on self and social functioning: A developmental psychopathology perspective. *Journal of Consulting and Clinical Psychology*, *60*, 174-184.
6. Pynoos, R.S. (1993). Traumatic stress and developmental psychopathology in children and adolescents. In J. Oldham, M. Riba & A. Tasman (Eds.), *Review of Psychiatry*, *12*, (pp. 205-238). Washington, DC: American Psychiatric Press.
7. Burgess, A. & Holmstrom, L. (1974). Rape trauma syndrome. *American Journal of Psychiatry*, *131*, 980-986.
8. Walker, L.E. (1984). *The battered woman syndrome*. New York: Springer Publishing Co.
9. Krystal, H. (1968). *Massive psychic trauma*. New York: International University Press.
10. *International Statistical Classification of Diseases and Related Health Problems*. (1992). World Health Organization: New York.
11. Zlotnick, C., & Pearlstein, T. (1997). Validation of the Structured Interview for Disorders of Extreme Stress. *Comprehensive Psychiatry*, *38*, 243-247.
12. Zlotnick, C., Zakriski, A.L., Shea, M.T., Costello, E., Begin, A., Pearlstein, T., & Simpson, E. (1996). The long-term sequelae of sexual abuse: support for a complex posttraumatic stress disorder. *Journal of Traumatic Stress*, *2*, 195-205.
13. Zlotnick, C., Shea, M. T., Rosen, K.H., Simpson, E., Mulrenin, K., Begin, A., & Pearlstein, T. (1997). An affect-management group for women with posttraumatic stress disorder and histories of childhood sexual abuse. *Journal of Traumatic Stress*, *10*, 425-436.
14. van der Kolk, B.A., Dreyfuss, D., Berkowitz, R., Saxe, G., Shera, S., & Michaels, M. (1994). Fluoxetine in Post Traumatic Stress. *Journal of Clinical Psychiatry*, *55*, 517-522.
15. Zlotnick, C., Shea, M.T., Pearlstein, T., Simpson, E., Costello, E., Begin, A. (1996). The relationship between dissociative symptoms, alexithymia, impulsivity, sexual abuse, and self-mutilation. *Comprehensive Psychiatry*, *37*, 12-16.
16. McFarlane, A.C., Weber, D.L., & Clark, C.R. (In press). Abnormal stimulus processing in PTSD. *Biological Psychology*.
17. Linehan, M.N. (1993). *Cognitive-behavioral treatment of border-line personality disorder*. New York: Guilford Press.

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A copy of the SIDES is available by e-mailing to [bvanderk@traumacenter.org](mailto:bvanderk@traumacenter.org), or by writing to HRI Trauma Center Research Department (c/o Dr. James Hopper), 227 Babcock Street, Brookline, MA 02116. The cost is \$25 for a copy of the written, self-administered SIDES instrument, as well as the Traumatic Antecedents Questionnaire (TAQ), and a self-administered PTSD scale. A computerized, self-administered version of these three instruments is available for \$250.

# THE MANAGEMENT OF DISSOCIATIVE SYMPTOMS IN PTSD PATIENTS

CONSTANCE J. DALENBERG, PH.D.



Constance Dalenberg, Ph.D.

Of the many symptoms that form the diagnostic cluster that we label PTSD, dissociative experiences are often the most emotionally disturbing to the patient. Dissociation typically is described as disruption in the integration of consciousness, identity, memory or perception. As Judith Armstrong, James High and I argued in a recent workshop for the International Society for the Study of Traumatic Stress (1), such symptoms deserve focused clinical attention for a number of reasons.

1. First, the phenomenological experience of dissociation (such as the depersonalization or derealization experience) is distressing for virtually anyone who must live through it. The feeling of estrangement from the self or one's environment is terrifying for the dissociative patient, as is the knowledge that one is not in command of the self experience.
2. Dissociation can result in practical problems for the patient, interfering with the performance of social and occupational activities. The multiple problems in memory also interfere with any long-term relationship.
3. Dissociative clients are poor predictors of danger (2). They are over-represented among those who tend to see danger and ill-intent everywhere, alienating their well-meaning friends and colleagues. Ironically, they also are over-represented among those who do not recognize evil even when it brandishes its claws and fangs. The therapist of such a client often feels as if he or she was watching a bad horror film, shouting internally at the young victim-to-be as she invites the killer into the house. ("No, no, you fool. Lock the door. Can't you see you're in danger?") Both the underprediction and the overprediction of danger can precipitate crises for the patient.
4. Dissociation is an impediment to self-understanding for the client (3-4). For those of us with cognitive or psychodynamic orientations, who believe that predicting and understanding the self is a key to developing strategies to change attitude and behavior, this obstacle is an important one to target in therapy.
5. Since dissociative symptoms may render the patient a less reliable reporter of his or her own emotional or cognitive life (4), they can undermine (or make more difficult) the accurate diagnosis of the patient. The diagnosis of PTSD

requires someone, typically the patient, to connect symptoms and memories (5), e.g., to know that a situation is being avoided because it is a reminder of a trauma. If the client is unaware of a symptom-trauma connection, and cannot provide an accurate history of the onset and course of symptoms, the diagnosis of PTSD is much more difficult to support.

6. Finally, dissociation may be an impediment to treatment in general (4-5). Dissociating clients will find it difficult to describe current triggers to distress, and may report confusing transference reactions (or emotional reactions to the therapist) that cannot easily be described (3, 6).

For these reasons and others, it is important to recognize dissociative symptoms and specifically target them in PTSD treatment.

## Targeting Dissociation within the Session

The most important initial goal to be undertaken by treating professionals is to teach the client to recognize the presence of dissociation, which naturally involves improving our own ability to recognize it. One common form of dissociation is the disruption in the ownership and recognition of emotion, experienced by the patient as a disconnection between emotional life and present experience. Less commonly noted forms of dissociation that can occur within sessions include shifts in topic combined with loss of memory ("What was I saying?"), a distant or minimizing verbal style ("I was somewhat upset when it happened...") or a sense of distance and disconnection between therapist and client (1,4, 7-8).

*The feeling of estrangement from the self is terrifying for the dissociative patient, as is the knowledge that one is not in command of the self experience.*

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When such events occur, it is helpful to draw attention to them immediately, but with the understanding that repeated labeling will be necessary before the client typically accepts that the pattern actually exists. It is difficult for a client or therapist to be argue with conviction that a single example of topic-veering was dissociative, that is, that it was an effort to avoid the self-awareness of painful thoughts or emotions. Once a pattern of avoidance is identified, however, the therapist might comment "I've been noticing that every time I raise the issue of x, you seem to think of another topic to raise. Is that something you have noticed?" If the client replies that it is not, the therapist is wise to initially accept the client's view. If the therapist is correct, the avoidance pattern will reoccur. When and if it does, the therapist might gently remark, "There's that pattern again. It looks like when we begin to talk about x, it might make you uncomfortable and you divert. Do you think that's possible?"

It is critical in these initial recognition stages to empathize with the patient's resistance or unwillingness to let another person label his or her internal state, even a therapist. This resistance is normal, and has both defensive and healthy functions. If we assume that a given content is dissociated because it is disconcerting to accept (or even re-traumatizing), we should hardly expect that the same content will be greeted warmly by the patient when the therapist reintroduces it. Additionally, it is healthy for the client to protect some sense of ownership of the self and to resent therapist intrusion in the form of interpretations of what might be unconsciously felt. Therefore, the process of labeling dissociative diversions typically must include a normalization of this tendency, often through therapist disclosure. "Haven't you ever had the experience of not knowing you were angry or sad until someone else noticed that you were acting a certain way? I know I have. It may be that you do feel badly about x, but it passes too quickly for you to feel it because you push it out of your mind so fast." A therapist stance of compassionate and non-judgmental curiosity can facilitate a similar or parallel state in the patient. Bringing the client's resistance to consciousness also is useful, again often accomplished most effectively through disclosure. "I know I don't like it when someone else tries to tell me what I probably feel, and I am not trying to do that. I think that's what is making you a little angry. I'm just inviting you to join me in noticing how it is that you keep moving away with so much energy when I raise the issue of 'x'. What do you think that might be about? I thought you might be feeling 'y', but maybe it's something else."

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***The client often believes that to be angry is to risk flying out of control, to be sad is to risk devastation and suicide, and to be nervous is to risk freezing in terror or running from the scene.***

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While there are methods of treating dissociation that are useful to the patient outside of therapy, which will be briefly discussed below, the in-session focus is typically the key to successful treatment. Prior to therapy, the triggers that lead to the onset of dissociation are often unconscious. The patient thus typically must be taught to recognize the specific precursors that trigger this state and the signs that dissociation has occurred or is occurring. Since one effect of dissociation is to distort or interfere with long-term memory, the patient may not recall these specifics. This is likely to require the therapist's vigilant attention within the therapeutic hour, so that these internal or external events may be brought to the patient's conscious awareness. Some excellent examples of such therapist interventions are given in Vaillant's (9) text on short-term anxiety-regulating psychotherapy.

Once the patient accepts that a thought or emotion is being cut off or dissociated, the therapist can begin a titration of guided brief experiences that allow the client to contemplate the typically avoided material (5). The client should be encouraged to consider what it would mean to believe x or to feel y. In so doing, the therapist may underline the value of the emotions to a client who has a negative

view of them. The client often believes that to be angry is to risk flying out of control, to be sad is to risk devastation and suicide, and to be nervous is to risk freezing in terror or running from the scene. But the ability to feel sadness, for instance, is also a sign of the capacity for compassion, intimacy and connection. If one values something or someone, one is sorry for the damage or loss of that entity. Sadness can lead to a wish to fill the void or to mend the tear in the client's relational world. In such cases, the therapist is trying to reduce the need for dissociation by reducing the intensity of the negative emotions. This occurs both through reframing the emotions in a more positive light and through teaching emotional risk management techniques (e.g., anger management or relaxation to mitigate anxiety). It may initially seem awkward to teach anger management to a client who claims to feel little anger, but when fear of anger is present, this technique may be necessary (5). Guided experiences of allowing the client to feel the rejected emotions in a safe environment (in which they can be contained through emotion management, if necessary) are effective routes to this end (8).

It is also worthwhile to teach the client methods to break out of an acute dissociative state. Treatment research of clinical interventions with acute states of dissociation has indicated that asking the patient to engage in a brief task (of any sort) that involves visual-spatial description, e.g., touching something while they describe the feel and look of the object is effective (1). This intervention in part rests on the theory that dissociation during the acute stage is a disorder of attention, during which time the patient is unable to be fully "mindful" (10-11). The patient also may be taught to more consciously control the dissociative state (much as we teach the stutterer to stutter on purpose to control verbalization by bringing on dissociation through the use of imagery (drifting away from the body, relaxation exercises). The patient then is taught to return to clear consciousness through verbal spatial narrative (such as the verbal description of spatial objects described earlier). Body consciousness exercises, such as observed breathing also serve to disrupt dissociation in the moment. These skills are described along with other useful techniques with dissociative and non-dissociative borderline clients in Linehan's workbook (12). Skill development requires regular practice during and between sessions.

#### **Recommendations for the Client for Use Between Sessions**

In a prospective study of 8 women with persistent dissociative symptoms, Dalenberg et al. (1997) found that most women made significant gains (defined as reduced self-reported dissociation and increased productivity) before the cognitive interventions described above were instituted (1). These gains appeared to be due to the practical self-care interventions made in Phase 1 of the study, which included exercise, more attention to maintaining a regular sleep pattern, and a small change in diet (toward increased reliance on fruits and vegetables and lowered intake of sugars). These forms of attention and care for the body not only combat depression but also enhance bodily awareness and increase energy. A decrease in dissociation as measured by our State Dissociation Measure appears to naturally accompany these bodily changes (although this change in the self-reported clarity of cognition may be due to reasons other than decreased dissociation).

Outside the session, the client also may be given specific help to organize experience in a more coherent and linear way. The techniques described below serve not only to provide more usable data for the

therapeutic hour, but also to directly counteract the habitual dissociation of the highly traumatized patient.

Briefly, the severely dissociative patient will dissociate in an event-specific and an emotion-specific way. As the connections between event, emotion, and symptom are clarified and stripped of their capacity to cause terror, this type of dissociation (which I call Type I dissociation) decreases. However, dissociation may lose its connections to its causal roots and become habitual, resulting in more generalized dissociative states (Type II) wherein the person becomes less aware of environmental triggers in general. Type II dissociation is a partial protector against the more acutely painful Type I experiences (since the triggers that occur during these periods may not be processed at all). Thus, as stated earlier, it is important to conceptualize Type II dissociation in part, as an attentional disorder, the result of which is a disruption in the coherency, flow, and story-like quality of daily life. Utilizing self-monitoring techniques aids the patient in becoming more habitually conscious of daily life (decreasing Type II dissociation) and more aware of the triggers of acute episodes (allowing therapy to more effectively combat Type I dissociation).

The self-monitoring technique I most frequently use to help the client recognize and track dissociation-laden emotional reactions. For example, when the client is exhibiting an intense emotional reaction, I ask him or her to reflect on the following questions:

1. Do you know what triggered the reaction?  
("No" is the dissociation answer.)
  - (a) If not, write out a brief account of what you were thinking, feeling, or doing directly before the reaction.
  - (b) If you believe you know the reason, write out the experience in concrete terms (that is, so that an actor could reproduce the scene exactly).
2. Think about the trigger, if you know what it might be. Does your reaction seem as if it is strong in comparison to the event that triggered it? ("Yes" is the dissociative answer).
3. How would you wish to respond to this situation? Write out a response as if it were stage directions to an actor.

It is not surprising that the act of self-monitoring tends to decrease self-reported symptoms even with no other therapeutic interventions. Within sessions, the results of the self-monitoring exercise may be examined with an eye to identification of triggers to dissociation.

It may be heartening to add that we have found that the multimodal intervention of self-monitoring, encouragement of self-care, and in-session cognitive interventions outlined above is effective in most cases even among treatment failures from other modalities. Furthermore, successful treatment of the dissociative symptom can be a turning point in the management of the chronic PTSD patient.

## References

1. Dalenberg, C., Armstrong, J., & High, J. (1997). Evaluating, managing and treating the dissociative symptom in post-traumatic stress disorder. Pre meeting Institute: Annual meeting of the International Society for the Study of Traumatic Stress Studies, Montreal.
2. Hedges, L. (1994). Remembering, repeating, and working through childhood trauma. New York: Jason Aronson.
3. Davies, J., & Frawley, M. (1994). Treating the adult survivor of childhood sexual abuse. New York: Basic Books.
4. Briere, J. (1996). Therapy for adults molested as children: Beyond survival. New York: Springer.
5. Jacobs, W.J., & Dalenberg, C. (1998). Subtle presentations of posttraumatic stress disorder: Diagnostic issues. Psychiatric Clinics of North America, *21*, 835-846.
6. Liotti, G. (1992). Disorganized/disoriented attachment in the etiology of dissociative disorders. Dissociation, *5*, 196-204.
7. Bernstein, E., & Putnam, F. (1986). Development, reliability and validity of a dissociation scale. Journal of Nervous and Mental Diseases, *174*, 727-735.
8. Bremner, J., & Brett, E. (1997). Trauma-related dissociative states and long-term psychopathology in posttraumatic stress disorder. Journal of Traumatic Stress, *10*, 37-49.
9. Vaillant, L. (1997). Changing character: Short-term anxiety-regulating psychotherapy for restructuring defenses, affects, and attachment. New York: Basic Books.
10. Langer, E. (1989). Mindfulness. New York: Addison-Wesley.
11. Teasdale, J., Segal, Z., & Williams, J. (1995). How does cognitive therapy prevent depressive relapse and why should attentional control (mindfulness) training help? Behavioral Research and Therapy, *33*, 25-39.
12. Linehan, M. (1993). Skills training manual for treating borderline personality disorder. New York: Guilford Press.

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## NEW DIRECTIONS

*Matthew J. Friedman, M.D., Ph.D.*  
*Executive Director, NC-PTSD*

There were many exciting research and educational presentations by National Center for PTSD professionals at the Annual Meeting of the International Society for Traumatic Stress Studies (ISTSS) recently held in Washington, DC from November 19-23, 1998. The relevance and diversity of National Center initiatives can be ascertained by a brief glance at the ISTSS program. Broad topics covered included: treatment research, practice guidelines, clinical training, diagnostic assessment, and gender and cross-cultural issues in PTSD. Specific presentations focused on Persian Gulf veterans, psychobiological findings, primary care/health issues, and disaster mental health. In all, professionals from the National Center made 43 formal presentations and displayed 14 posters at the XIV Annual Meeting of ISTSS.

Reflecting the National Center's high priority on treatment research, many presentations focused on treatment research or clinical training. Special half- or full-day training sessions were devoted to the cooperative study on group treatment for PTSD (Paula Schnurr, Ph.D.); cost-effectiveness/quality-of-life measurement in outcomes research (Lynda King, Ph.D.); screening for traumatic experiences and PTSD symptoms (Eve Carlson, Ph.D.); and treatment in a cross-cultural context (Beth Stamm, Ph.D.).

Research papers, presentations and posters on treatment and assessment focused on advances in cognitive-behavioral treatment (Terry Keane, Ph.D.), new data analytic strategies for outcomes research (Dan King, Ph.D. and Eve Carlson, Ph.D.), treatment of veterans who report atrocities (Ray Scurfield, D.S.W.), stages of change in assessment and treatment of PTSD (Ron Murphy, Ph.D.), and cross-cultural issues in treatment (Beth Stamm, Ph.D.). In addition, a number of new assessment instruments are in various stages of validity and reliability testing to measure: warzone traumatic experiences of women (Annabel Prins, Ph.D.), lifetime trauma in veterans (Karen Krinsley, Ph.D.), global functioning among PTSD patients (Rose Zimering, Ph.D.), preliminary findings on the Brief Trauma Interview (Melanie Vielhauer, Ph.D.), and an analysis of PTSD and alcohol use (Jeff Knight, Ph.D.).

Notable psychophysiological/psychobiological presentations reported on brain imaging studies showing hippocampal dysfunction among female child abuse survivors with PTSD (Doug Bremner, M.D.); sleep abnormalities in PTSD (Steve Woodward, Ph.D.); and heightened autonomic responses to novel trauma-irrelevant stimuli in PTSD (Steve Woodward, Ph.D.). There were also a number of presentations on PTSD as a risk factor for medical problems and the implications of these findings for primary care practitioners and for comprehensive health screening protocols (Paula Schnurr, Ph.D., Danny Kaloupek, Ph.D., and Greg Leskin, Ph.D.).

Anger, aggression, and cycles of violence, especially as they affect children and often as they are expressed cross-culturally, were the subjects of a number of presentations. Claude Chemtob, Ph.D., Beth Stamm, Ph.D., Eve Carlson, Ph.D., Deborah Dowdall, Ph.D., Glen Saxe, M.D., and Greg Leskin, Ph.D. were especially prominent with respect to this important area of concern.

Other presentations worth noting include coping strategies and combat stress among Persian Gulf veterans (Erica Sharkansky, Ph.D.); ASD and PTSD among recently traumatized children (Glen Saxe, M.D.); religious participation among combat veterans with/without PTSD (Kent Drescher, Ph.D.); and the beneficial effects of participating in a research protocol by patients recently hospitalized for a trauma-related injury (Joe Ruzek, Ph.D.).

Several presentations should be singled out because of their important impact on the PTSD field in general and on the VA's mission in particular. Edna Foa, Ph.D., Terry Keane, Ph.D., and Matt Friedman, M.D., Ph.D. (co-editors) presented the final draft of the ISTSS-sponsored comprehensive Practice Guideline on PTSD that includes guidelines for all treatment approaches currently available. This ISTSS initiative is coordinated with VA's Mental Health Practice Guidelines Project that is directed by Larry Lehmann, M.D.

Julian Ford, Ph.D. chaired an all-day specialty training course on disaster mental health: research, practice, and policy developments. This presentation was the culmination of National Center efforts to develop a coordinated and coherent approach to disaster mental health. Other participants were Jane Morgan, R.N. (American Red Cross), Ann Norwood, M.D., Col. James Stokes (Department of Defense), Robert DeMartino, M.D., Brian Flynn, Ed.D. (Health and Human Services), Larry Lehmann, M.D., John Tasse, Ph.D., Paul Ofman, Ph.D. (VA), Joseph Gelsimino, Ph.D., and Rod Haug, Ph.D. (RCS), Connie Boatwright, R.N. (VAEMSHG), Robert Ursano, M.D. (Uniformed University of the Health Sciences), Joseph Barbera, M.D. (George Washington University), Betty Pfefferbaum, M.D. (University of Oklahoma Health Sciences Center), Gerald Jacobs, Ph.D. (Disaster Mental Health Institute), Patricia Tritt, R.N. (EMS, Colorado), Ann Carr (Family Support Network), and Fred Gusman, M.S.W., Bruce Young, L.C.S.W., and Claude Chemtob, Ph.D. (National Center for PTSD).

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# WOMEN AND TRAUMA: A CLINICAL FORUM

*Marie B. Caulfield, Ph.D., & Annabel Prins, Ph.D.*

*This column is devoted to increasing understanding of the role of trauma in women's lives and improving approaches to the professional care of women who have experienced trauma. Clinicians and researchers are invited to exchange information through brief articles, literature reviews, and commentaries. If you wish to have material included in this column or would like to suggest topics to be covered here, please contact Marie Caulfield, Ph.D., Women's Health Sciences Division 116B-3, National Center for PTSD, Boston VA Medical Center, 150 S. Huntington Ave., Boston, MA 02130 or at e-mail address [caulfield.marie@boston.va.gov](mailto:caulfield.marie@boston.va.gov).*

## **The Role of the Mental Health Professional in Addressing the Physical Complaints of Trauma Survivors**

*Marie B. Caulfield, Ph.D.*

Clinicians and researchers alike have found that trauma survivors are likely to experience not only emotional symptoms and difficulties but also may report a wide range of physical complaints and medical conditions. This appears to be particularly true of female survivors of sexual assault (1, 2). Because the physical complaints of trauma survivors may be out of the range of the expertise of the non-medical mental health professionals, these issues may present a challenge in working with trauma survivors. This column discusses some ways that non-medical mental health professionals can aid the trauma survivor around physical and medical complaints, including the role of the mental health provider as adjunct to primary health care.

Mental health professionals generally do not have training in medical problems or treatments. However, they are trained uniquely well in the science and art of assessment. An initial contribution that mental health professionals can make to the medical care of their clients is instruction and coaching on self-observation and tracking of symptoms. This is particularly relevant for trauma survivors who often present with chronic global physical complaints.

For example, a rape survivor may report a range of vague somatic complaints to both her medical and mental health care providers. By working with her to systematically record symptoms (e.g., pain, fatigue, sleeplessness, gynecological difficulties), mental health providers can help the client recognize patterns in the symptoms and improve her understanding of these symptoms. In addition, clear well-recorded information will aid the client's primary care provider in working with the client to address medical causes and prescribe treatment. Because the mental health professional is likely to have longer-term and more regular contact with the client than does the primary care provider, the mental health provider can be an important source of information for the medical provider on the course and severity of physical and psychological symptoms.

Mental health professionals can also aid primary and specialty medical care providers when invasive diagnostic or treatment procedures are necessary. For example, rape survivors and survivors of child sexual abuse often have substantial gynecological problems and may experience intense emotional distress around necessary gynecological procedures. Trauma survivors more generally may experience fear or anger during any procedure that leaves them in a vulnerable state, for example, under anesthesia or any kind of restraints, with tubes down their throat, or with an oxygen mask on their face. Pressuring clients to submit to such procedures is likely to damage rapport with the patient or discourage the patient from seeking further care.

When such procedures are necessary, however, mental health providers can provide instruction in behavioral medicine techniques, such as relaxation, imagery, and distraction (3). They can also help the client determine other aspects of the situation that would make the procedure easier, e.g., having a family member present, listening to music during the procedure, or obtaining more information about the procedure. Although long-term psychological work may be necessary for trauma survivors to address the wide range of emotional sequelae of trauma, this type of educational and behavioral intervention may be sufficient for these clients to tolerate a necessary health care procedure. Working with the client on such preparation can often be done in 1-3 sessions and these interventions have been cited as major ways in which mental health professionals such as psychologists can decrease the costs of medical health care (4).

1. Koss, M.P., & Heslet, L. (1992). Somatic consequences of violence against women. *Archives of Family Medicine*, *1*, 53-59.
2. Kimerling, R., & Calhoun, K. (1994). Somatic symptoms, social support, and treatment seeking among sexual assault victims. *Journal of Consulting and Clinical Psychology*, *62*, 333-340.
3. Horne, D.J., Vatmanidis, P., & Careri, A. (1994). Preparing patients for invasive medical and surgical procedures: II. Using psychological interventions with adults and children. *Behavioral Medicine*, *20*, 15-21.
4. Groth-Marnat, G., & Edkins, G. (1996). Professional psychologists in general health care settings: A review of the financial efficacy of direct treatment interventions. *Professional Psychology: Research and Practice*, *27*, 161-174.

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# MOTIVATING VETERANS TO CHANGE PTSD SYMPTOMS AND RELATED BEHAVIORS

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Combat veterans receiving treatment for PTSD typically report chronic, long-term difficulties due to PTSD symptoms and co-morbid problems such as substance abuse. Treatment programs usually focus on teaching veterans new coping behaviors and self-talk with the aim of suppressing or replacing maladaptive behavior, cognitions, and emotions. Also, veterans often participate in exposure treatments or desensitization tasks, in which they are expected to approach feared or unpleasant cues and memories without resorting to avoidance-based coping strategies.

These approaches are based on the assumption that combat veterans in treatment are ready to give up long-held styles of thinking and acting. Unfortunately, clinical experience and our own data have indicated that combat veterans in treatment are often ambivalent about changing not only common problems associated with PTSD such as substance abuse, but also the symptoms of PTSD themselves. One reason for this may be that trauma-based perceptions of the world often feel “right”, i.e., adaptive and protective with regard to safety and interacting with others. For example, combat veterans with PTSD often react strongly to challenges to their beliefs about the appropriateness of their mistrust of others, hypervigilance, and need for weapons. Viewing trauma-based behaviors and cognitions as problematic is often a difficult leap to make for trauma survivors. In addition, problems commonly co-occurring with PTSD such as substance use and poor relationship skills (e.g., aggressiveness, problems in expressing feelings, conflict resolution, and lack of warmth) frequently are not seen as problematic because individuals often learned these behaviors in environments (e.g., military, families, and neighborhoods) where they were the norm. This may also be true for PTSD symptoms, that is, many Vietnam veterans grew up with fathers who experienced combat trauma (i.e., World War II veterans).

Patients will not learn new coping behaviors or ways of thinking if they are ambivalent about the need to change these old ways of being. As we discuss later, this may be a factor in poor outcome in studies of standard VA treatments: patients are not

likely to learn or practice new coping skills if not sure of the need to do so.

To help patients engage in treatment, we have developed and evaluated a group treatment protocol, called the Motivation Enhancement (ME) Group, which aims to raise motivation to change PTSD symptoms and related problem behaviors. The ME group targets problem behaviors which patients report ambivalence about changing or feel no need to change. The goal of the group is to help patients make decisions about the need to change any behaviors, coping styles, or beliefs not previously recognized as problematic, in order to increase engagement in treatment and promote good post-treatment functioning.

The group is conceptually based on the Stages of Change model of readiness to change (Prochaska & DiClemente, 1983), and draws specific interventions from the literature on motivational interviewing techniques (Miller & Rollnick, 1991). The Stages of Change model posits that individuals are at different levels of readiness to change any particular problematic behavior and that different psycho-educational or therapeutic techniques are needed at each stage to help individuals resolve questions about the need or ability to change that behavior. For any particular problem behavior, individuals in the first stage, called “PreContemplation” do not believe that they have a problem (“What problem?”). Here, for example, education about what constitutes a problem (e.g., hypervigilance, substance abuse, or PTSD in general) helps individuals move to the next stage, labeled “Contemplation.” In this stage, individuals may begin to consider the need for change (“Do I need to change?”). In this stage, decisional balance techniques and comparison of one’s behavior to population norms are used to help resolve ambivalence about the need to change. Once convinced of the need to change, individuals still may be doubtful or ambivalent about their ability to make the necessary changes (“Can I change?”). Other stages are Action, in which individuals are actively making behavior changes, and Maintenance, in which they are doing what is necessary to maintain the behavioral change.

### The ME Group: Implementation

The ME group has been developed and implemented on the men's treatment unit of the National Center for PTSD in Menlo Park, a 60-day inpatient program primarily serving Vietnam War combat veterans. The seven-session group is designed for managed-care environments, and addresses the need in such environments for manualized treatment, measurable outcomes, brief interventions, built-in program evaluation, and assessment of patient satisfaction.

**Rationale.** As explained to the patients, the purpose of the group is to help participants make decisions about problems they might have, i.e., whether behavioral change is necessary for a particular behavior. More specifically, the goal is to help patients decide whether these behaviors defined as "Might Be A Problem" are either Definitely A Problem or Definitely Not A Problem. A clear distinction is drawn between problems listed as "Might Be A Problem" and behaviors and cognitions that they definitely are convinced they need to change, i.e., Definitely A Problem. The reasons why it might be useful to make decisions about problems they might or might not have are elicited from the group or suggested by the group leaders. Patients are encouraged to consider that post-treatment "relapse" to PTSD symptoms or related difficulties is often not due to inadequate treatment or "unfixable" patients, but rather to unacknowledged problems that lead to gradual or sudden return to old coping styles. We draw from case examples to illustrate that social isolation and excessive alcohol use often lead to disconnection from support, poor judgement, and rumination, resulting further in depression, increased hypervigilance, intrusive thoughts, anger, and loss of control. Thus, the ultimate goal for patients is to avoid getting "blindsided" by problems following discharge.

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*...combat veterans in treatment are often ambivalent about changing not only common problems associated with PTSD, such as substance abuse, but also the symptoms of PTSD themselves.*

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**General Structure.** The group protocol consists of 7 group sessions: 6 sessions with 4 separate group modules (2 modules are repeated) and a seventh session which is a repetition of the first group they attended. This seventh session was added because veterans enter the group on a rolling admission basis and are typically disoriented during their first few days in the program. Thus they may enter the group at any module. To accommodate the effects of rolling admissions and the extent of memory and attention deficit in this population, and to use behavioral learning principles of repetition and rehearsal, the first half of each group consists of reviewing the purpose and format of the group. In this review period, time is given to individualized identification of problems patients "Might Have". This review is accomplished by group leaders asking questions of the group, usually with more experienced members answering, thereby educating and acculturating the newcomers. The second half of each session consists

of discussion of the use of specific tools that will assist in patients deciding whether problems that they "*Might Have*" are behaviors they need to change.

Group leaders follow a manualized protocol, but the format is interactive and makes extensive use of a whiteboard and patient worksheets. Psychoeducation, group structure and process, and patient workbook forms are used to increase awareness, enhance motivation, and decrease ambivalence about behavioral change in an objective, non-confrontational atmosphere.

**Group Content.** A key part of the group is having patients generate a list of problem areas which they identify as "Might Be A Problem" for them. This process occurs in the first half of every session, following the general review of rationale and purpose. At that time, patients fill out a worksheet (Form #1), which is divided into three columns: "Definitely A Problem", "Might Be A Problem", or "Definitely Not A Problem." The goal of the group is for patients to sort items listed under "Might Be A Problem" into "Definitely A Problem" or "Definitely Not A Problem." Under "Might Be A Problem" patients are asked to list any problem which they have wondered if they have, or any problem someone told them they have (but the patient disagreed). We have defined "Might Be a Problem" in these two ways to elicit not only problem areas that they have considered as possibly needing change, i.e., on which they are in "Contemplation Stage", but also problems that they might be unaware of or unwilling to change, i.e., "Precontemplation Stage".

In Group 1, "Rationale and Review", the purpose and potential value of the group is reviewed in detail. Time is also used for reviewing the worksheet (Form #1) on which patients identify areas that "Might Be A Problem". Groups 2 & 3, called "Comparison to the Average Guy," are aimed at helping patients compare their behavior to estimated age-appropriate but non-veteran "norms" in order to help them judge how problematic their behavior might be. Behaviors are categorized along a range including "Average", "Moderate Problem", "Extreme Problem." Three dimensions are used to assess behavior at each of these levels: frequency, severity of consequences, and purpose. Group leaders guide members in analyzing what a particular behavior would look like at each of the three levels on each of the three dimensions. For example, if hypervigilance was the behavior selected, group leaders would elicit a description of normative levels of safety awareness (e.g., checking to make sure doors are locked before retiring for the night, installing motion-sensitive lights outside the house; negative consequences being mild other than the cost of the lights; purpose being to be reasonably safe), moderately heightened security-consciousness (e.g., checking doors twice, installing a burglar alarm, getting a big dog; consequences being more time and money invested, maybe intimidating people with the dog; purpose beginning to take on more of an anxiety-reduction role), and extreme levels of hypervigilance (e.g., checking the perimeter of the house several times a night, keeping a gun under the bed; consequences of increased time and energy spent, risk to children from the gun; purpose being survival and anxiety management).

In Groups 4 & 5, "Pro's & Con's", decision balance techniques are reviewed and practiced to help patients decide about the need to change "Might Be A Problem" behaviors which they agree they do, but are not sure are actually problematic. In this simple but effective technique, patients weight the pro and con of various PTSD symptoms and related behaviors, such as gun ownership, continued alcohol use, hypervigilance (e.g., "setting perimeters"), and social isolation.

Group 6, "Roadblocks," focuses on how difficult it can be to consider changing one's own behaviors. Leaders explain the concept of roadblocks as being those things that make it difficult to even consider

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whether behavior is problematic and in need of change. Common roadblocks include fears, cognitive distortions, and belief in stereotypes. Fears might include being overwhelmed by problems, or being rejected if problems are acknowledged. Cognitive distortions include errors, such as "black-and-white thinking" (e.g., "If I admit to having one more problem, I will have to acknowledge being a complete failure") or blaming of others. Stereotypes can cause problems such as reluctance to admit to an alcohol problem because of ideas of what it means to be an alcoholic (e.g., the town drunk, homeless) or wanting to avoid being perceived as a "crazy Vietnam veteran." The group generates a variety of possible roadblocks and veterans are instructed to fill out their worksheet using only those that apply to them. Psychological issues related to shame frequently arise in the context of this group. The collaborative process additionally provides a supportive context in which veterans can normalize the difficulty of acknowledging problems.

*Post-treatment "relapse" to PTSD symptoms or related difficulties is often not due to inadequate treatment or "unfixable" patients, but rather to unacknowledged problems that lead to a gradual or sudden return to old coping styles.*

#### The ME Group: Preliminary Program Evaluation

**Procedure.** As part of the group structure, data from every group participant are regularly collected at two points: at the end of each group and when a patient has completed seven sessions. At the end of each group, each veteran is asked to list any behaviors which he identified as "Might Be A Problem" during the course of that particular session. Also, patients are asked to report if they had reclassified any behaviors previously identified from "Might Be A Problem" to "Definitely A Problem" or "Definitely Not A Problem" at any time during that group session. It is hoped that patients will identify previously unacknowledged problems, and more importantly, use the group to identify problems requiring change. Such changes would suggest that participation in the group resulted in increased awareness of and decreased ambivalence about changing PTSD symptoms and related behaviors.

In addition to these session by session data, patients who complete all seven sessions of the group are asked to fill out a questionnaire to assess their understanding of group goals and process, ratings of helpfulness of various group modules, and self-reported changes in acknowledgment of problem behaviors.

At this time we have collected data on all patients (n=243) who attended the ME group for any number of sessions (maximum 7 sessions) over an 18 month period. These findings have been previously reported (Cameron & Murphy, 1998) and are briefly summarized here.

**Results.** Over the course of the study period, participants listed approximately 4,000 behaviors which they defined as "Might Be A Problem". Again, it must be kept in mind that these are distinguished from behaviors defined as "Definitely a Problem", and thus reflect unwillingness to acknowledge or ambivalence about changing the

The investigators coded these behaviors into 65 categories including DSM-IV PTSD criteria B, C, and D, Associated Symptoms, co-morbid conditions, as well as various behavioral, cognitive, and emotional problem categories. Of the 65 categories, only those endorsed by more than 15% of subjects (18 categories) are reported here.

*Behaviors Endorsed as "Might Be A Problem".* Relatively high percentages of the patients were ambivalent about or unwilling to modify PTSD symptoms or closely related behaviors. Almost 50% of participants classified Anger as "Might Be A Problem", followed by Isolation (35%), Depressive Symptoms (35%), Trust (34%), Health (34%), Conflict Resolution (29%), Alcohol (28%), Communication (26%), Relationship/Intimacy (23%), Numbing and other Restricted Range of Affect (22%), Drugs (22%), Need for Control & Perfectionism (17%), Hypervigilance (16%), and Authority (15%).

*"Might Be A Problem" Behaviors Changed to "Definitely A Problem".* Over the course of the group, the problems that most participants changed their minds about included: Guilt (49%), Anxiety (46%), Anger (45%), Isolation (40%), Smoking (40%), Depressive Symptoms (34%), Authority (31%), Trust (31%), Communication (31%), and Health (29%). Participants were *least* likely to change Conflict Resolution (13%), Need for Control (19%), and Drugs (21%) to "Definitely A Problem".

*Patient Rating of Satisfaction.* Data from the patient satisfaction questions indicate consistently high levels of satisfaction with all aspects of group content and process, suggesting that the patients find it a non-threatening environment in which to evaluate whether they need to change PTSD-related behaviors. Their ability to clearly verbalize the core concepts of the purpose and rationale of the group was less than expected, though upon review the questions assessing this area were vague and allowed for alternate interpretation.

This work has potentially important implications for relapse prevention, in that veterans who use the group successfully to identify previously unacknowledged problem areas for change may be more likely to anticipate difficulties and utilize newly-acquired coping strategies following treatment. PTSD treatment is generally oriented towards helping patients acquire skills and change behaviors with an implicit assumption that staff and patients share a common understanding of problem definition and goals. Treatment programs may benefit from a motivational component such as the ME group to help veterans further engage in treatment and decide to change behaviors which treatment providers see as critical to adaptive long-term functioning.

We believe that our preliminary clinical and evaluation work with the development of this group may help clarify why some outcome studies of standard VA treatment show poor results, while controlled studies of behavioral treatment of PTSD symptoms generally show clear improvement. It may be that motivated or high functioning patients with less ambivalence about the need to change volunteer or are recruited for controlled trials, while the majority of patients in the studies of standard treatment are more likely to have chronic PTSD with more ambivalence about the need to change (which may be a factor in why they are chronic), as is reflected in the results from our inpatient sample. In any case, we plan on further modifying and researching the effectiveness of the ME group in the hopes that it may prove to be a valuable means of motivating combat veterans to learn new coping styles with less ambivalence about the need to change.

**MOTIVATING VETERANS TO CHANGE**

Use this form as tool to help you decide where your behavior lies on the range of average, moderate, and extreme.

Example: Hypervigilance

	<b>AVERAGE GUY</b>	<b>MODERATE PROBLEM</b>	<b>EXTREME PROBLEM</b>
<p><b>FREQUENCY OF BEHAVIOR</b> (e.g., how much, how often, and how many)</p>	<p><i>Making sure the door is locked before going to bed</i></p> <p><i>Installing motion detector lights outside the house</i></p> <p><i>May own a dog</i></p> <p><i>May think about buying a gun but decides it is too risky</i></p>	<p><i>Likely to install motion detector lights and a burglar alarm system</i></p> <p><i>Checks the locks at least twice a night</i></p> <p><i>Gets a big dog for protections</i></p> <p><i>May own at least one gu</i></p>	<p><i>Checking perimeter of the house several times a night</i></p> <p><i>Multiple locks on doors that are checked often</i></p> <p><i>Owns mean dogs-Pit bulls</i></p> <p><i>Gun under pillow</i></p> <p><i>May own high caliber weapons</i></p> <p><i>Has multiple weapons</i></p>
<p><b>SEVERITY OF CONSEQUENCES</b> (e.g., relationships, employment, financial, and taking care of self)</p>	<p><i>If he owns a gun, it makes his family nervous</i></p> <p><i>He's out the cost of the lights</i></p>	<p><i>Limits his relationships with neighbors and others</i></p> <p><i>Intimidates others with dog</i></p> <p><i>May interfere with work</i></p> <p><i>More time and \$ spend on security</i></p> <p><i>Interfering with sleep</i></p> <p><i>Not caring for self</i></p>	<p><i>Has no relationships with neighbors-sees threats everywhere</i></p> <p><i>Keeps spending \$</i></p> <p><i>His kids are at risk with gun in home</i></p> <p><i>Difficulty supporting himself</i></p> <p><i>Can not sleep</i></p> <p><i>Health problems</i></p>
<p><b>PURPOSE</b> (The "why" of the behavior, i.e., what function does the behavior serve?)</p>	<p><i>Allows him to feel secure</i></p>	<p><i>Tells himself it's better to be safe than sorry</i></p> <p><i>Trying to feel safe</i></p>	<p><i>Survival</i></p> <p><i>Feels "life or death"</i></p>

## NEW DIRECTIONS

*con't from page 30*

## References

- Prochaska, J.O., & DiClemente, C.C. (1983). Stages and processes of self-change in smoking: Toward an integrative model of change. *Journal of Consulting & Clinical Psychology*, 40, 432-440.
- Miller, W.R., & Rollnick, S. (1992). *Motivational interviewing*. New York: Guilford.
- Murphy, R.T., & Cameron, R.P. *Evaluation of a group targeting motivation to change PTSD-related behaviors*. Paper presented at the Annual Meeting of the American Psychological Association, San Francisco, CA, August, 1998.

*Ronald Murphy, Ph.D. is a staff psychologist at the National Center for PTSD in Menlo Park, where he is involved in clinical work and research. Dr. Murphy recently completed a NLAIA grant examining the relationship of alcohol use to childhood trauma and combat exposure severity. He is currently examining how motivation enhancement interventions for PTSD symptoms affects post-treatment outcome.*

*Rebecca P. Cameron, Ph.D. is an NIMH postdoctoral fellow at Stanford University Department of Psychiatry. Dr. Cameron's research background is in stress, coping, and social resources. Currently, she is conducting psychotherapy outcome research focused on providing brief, cost-effective interventions for anxiety and depression.*

*Lois Sharp is doctoral candidate at the Pacific Graduate School of Psychology, in Palo Alto. She is interested in working with victims of trauma and her research interest is in the areas of program and outcome evaluations.*

*Gilbert Ramirez is a doctoral student in Counseling Psychology at Stanford University. Mr. Ramirez is completing a clinical practicum at the NC-PTSD where he is a co-facilitator in a motivational enhancement group. His research interests include cultural trauma, American Indian mental health, and spirituality/forgiveness.*

Matt Friedman, M.D., Ph.D. chaired a symposium on stress and health: its relevance to the problems of Gulf War veterans. He was joined by Frances Murphy, M.D. (VA) who presented the latest data from VA and DoD Persian Gulf registers; Jessica Wolfe, Ph.D. and Darin Erickson (National Center) who presented five-year longitudinal data on medical and psychological symptoms among 3,000 veterans; and Bruce McEwen Ph.D. (Rockefeller University) who reviewed the latest medical knowledge about the impact of stress on physical health.

Susan Roth, Ph.D. and Matt Friedman, M.D., Ph.D. (co-editors) presented the recently published ISTSS pamphlet: "Childhood Trauma Remembered: A Report on the Current Scientific Knowledge Base and its Applications." This publication is a multidisciplinary collaboration between memory and trauma experts on the "recovered memory" controversy that provides the first balanced report on our scientific understanding of the human memory process and what that implies for clinical and forensic issues.

Last, but definitely not least, Greg Leskin, Ph.D. and Terry Keane, Ph.D. chaired an extraordinary all day symposium on the Vietnam legacy, thirty years after the Tet Offensive. The symposium provided a broad overview (i.e., political, mental health, media, historical) about what occurred in Washington and South-East Asia during and after the Tet Offensive and how that event has affected our society, our government, VA programs, and Vietnam veterans. Participants were: Jonathan Shay, Ph.D., M.D., Ron Spector, Ph.D., Kevin Bowen, Ph.D., Skip Isaacs, Myra MacPherson, Joan Furey, R.N., M.A., John Wilson, Ph.D., Shad Meshad, M.A., Bill Brew, John Sommer, Charles Figley, Ph.D., Richard Kulka, Ph.D., Fred Gusman, M.S.W., Matt Friedman, M.D., Ph.D., Al Batres, Ph.D., and Spencer Falcon, M.D.

All in all, it is clear that National Center investigators have been prolific in generating pertinent research on a wide variety of topics related to the assessment and treatment of individuals with PTSD.

## Note to Librarians

Volume 8 (2), Spring, 1999 follows Volume 8 (1), Winter, 1998.



# NC-PTSD EDUCATION & SUPPORT SERVICES

## **PTSD Assessment Library**

Available upon request are selected instruments from our library of assessment and program evaluation tools (with accompanying articles), together with templates describing over 100 trauma-related measures courtesy of Beth Stamm, Ph.D., and Sidran Press. Telephone (650) 493-5000 ext. 22477.

## **PTSD Article Library**

A helpful set of key articles on aspects of PTSD is available to VA or Vet Center clinicians free of charge. Telephone (650) 493-5000 ext. 22673.

## **PTSD Video Library**

The Menlo Park Education Team maintains a small videotape lending library exploring topics related to PTSD diagnosis, evaluation, and treatment. Videotapes may be borrowed free of charge. Telephone (650) 493-5000 ext. 22673.

## **PTSD Program Liaison and Consultation**

The Menlo Park Education Team can help VA health care professionals locate needed resources. Services may include assistance in locating relevant articles, locating resource persons, or problem-solving. Staff are available to consult in the areas of PTSD Diagnosis and Treatment, Program Development and Design, Women and Trauma, Relapse Prevention, and with other PTSD-related concerns. Telephone (650) 493-5000 ext. 22977.

## **National Center for PTSD Web Page**

The NC-PTSD Home Page provides up-to-the-minute description of activities of the National Center for PTSD and other trauma related information. The world wide web address is: <http://www.dartmouth.edu/dms/ptsd/>

## **PILOTS Database**

PILOTS, the leading electronic index to the world's literature on PTSD and other mental health consequences of exposure to traumatic events, provides clinicians and researchers with the ability to conduct literature searches on all topics relevant to PTSD. Telephone (802) 296-5132.

## **NC-PTSD Research Quarterly**

The *Research Quarterly* reviews recent scientific PTSD literature. Telephone (802) 296-5132 for subscription information.

## **Disaster Mental Health Training and Consultation**

Education staff provide training in disaster mental health services, including team development, interfacing with other agencies, on-site and off-site interventions, debriefing, and psychoeducational and treatment interventions with disaster survivors and workers. Telephone (650) 493-5000 ext. 22494 or email: [bhh@icon.palo-alto.med.va.gov](mailto:bhh@icon.palo-alto.med.va.gov)

## **Conferences and Training Events**

The Menlo Park Education Team provides consultative support for the development of training in PTSD. Services include assistance in finding faculty and designing program content. Telephone (650) 493-5000 ext. 22673.

# NC-PTSD CLINICAL TRAINING PROGRAM

The National Center for PTSD Clinical Training Program provides a one-week, 35-hour series of lectures, group discussions, clinical observations, and tutorials to educate clinicians about post-traumatic stress disorder. The primary goal of the Clinical Training Program is to educate clinicians about care for patients with PTSD. Our curriculum covers a broad range of topics, including diagnosis and assessment, etiology and theory, group and individual psychotherapeutic treatment, and pharmacology. During the training program, participants have the opportunity to view ongoing clinical activities at the National Center for PTSD residential rehabilitation program in Menlo Park, the oldest and largest VA-based PTSD program in the United States.

Every year, we welcome many psychiatrists, psychologists, social workers, nurses, readjustment counselors, and occupational/recreational therapists from the United States and from around the world. Most clinicians who visit the center have a working knowledge about treating the effects of trauma and PTSD. While the focus of training is on treatment of male and female veterans, we also encourage visitors who serve other traumatized populations (e.g., survivors of sexual assault or community violence).

## Some of the goals of the Clinical Training Program include:

- Assist individual clinicians to upgrade their clinical skills in the treatment of PTSD
- Increase knowledge about current PTSD assessment methods and materials
- Offer consultation and discussion with experienced clinicians and administrators
- Increase knowledge of therapeutic milieu management in the treatment of PTSD
- Introduce the National Center for PTSD as an ongoing resource for consultation and information

The National Center for PTSD Clinical Training Program is delivered by a multi-disciplinary staff which includes psychologists, psychiatrists, social workers, nurses, and counselors. The staff offers multiple clinical perspectives about these different topic areas.

## A sample of our core curriculum and presentation topics:

- \*Group Treatment for Combat Veterans
- \* Cognitive-Behavioral Treatment of PTSD
- \*Assessment of PTSD
- \*Theories of PTSD and Dissociation
- \*Psychiatric Evaluation of PTSD
- \*Treatment of Traumatic Memories

The Clinical Training Program has been approved for 35 Category One Continuing Education Credits for physicians, psychologists, social workers, and nurses. A Certificate of Attendance will be granted by the Department of Veterans Affairs Employee Education Service at Long Beach. The NC-PTSD Clinical Training Program runs from October to June each year. The program tries to accommodate as many interested parties as possible; however, each incoming class is limited to 12 people. If you are interested in receiving an application or to request more information, please call the Clinical Training Program at (650) 493-5000, Extension 22673.

The Clinical Training Program is open to all Department of Veteran Affairs employees whose clinical work involves the treatment of PTSD. In addition, non-VA clinicians are welcome based on availability. There is no fee for the training program, but participants are responsible for providing their own transportation, lodging, and meals.

## For more information or to request an application:

**National Center for PTSD**  
**Education and Clinical Laboratory Division Phone: 650-493-5000, Ext. 22673**  
**VA Palo Alto Health Care System Fax: 650-617-2684**  
**795 Willow Road (352/117) Email: [jir@icon.palo-alto.med.va.gov](mailto:jir@icon.palo-alto.med.va.gov)**  
**Menlo Park, CA 94025**

