

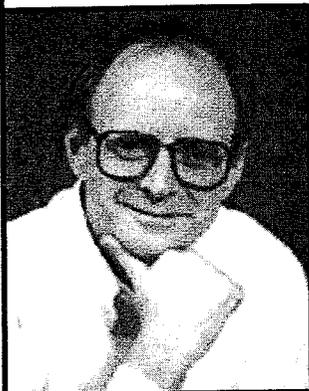
Clinical Quarterly



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THE EFFECTS OF WRITING ABOUT TRAUMATIC EXPERIENCE

JAMES W. PENNEBAKER, PH.D. AND R. SHERLOCK CAMPBELL



James W. Pennebaker, Ph.D.

In the early 1980s, a number of intriguing results started turning up in labs around the world. Although we had known for many years that traumatic experiences were associated with health problems, a closer look suggested that how people interpreted and coped with the trauma was equally important. In our own work, we were discovering that individuals who did not talk about traumas were far more likely to suffer from health problems than people who had comparable experiences but who had talked about them – even when controlling for social support, age, sex, etc. We eventually discovered that having people disclose traumatic experiences in the laboratory could profoundly affect markers of physical and mental health. By the mid-1980s, we were finding that having people write about traumas was a particularly efficient way to improve health (1). Since the first studies, dozens of similar experiments using the writing technique have been conducted.



R. Sherlock Campbell

By way of background, the standard laboratory writing technique involves randomly assigning participants to one of two or more groups. All writing groups are asked to write about assigned topics for 3-5 consecutive days, 15-30 minutes each day. Writing is generally done in the laboratory with no feedback given. Those assigned to the control conditions are typically asked to write about superficial topics, such as how they use their time. The standard instructions for those assigned to the experimental group are a variation on the following:

For the next (three) days, I would like for you to write about your very deepest thoughts and feeling about the most upsetting or traumatic experience of your entire life. In your writing, I'd like you to really let go and explore your very deepest emotions and thoughts. You might tie your topic to your relationships with others, including parents, lovers, friends, or relatives, to your past, your present, or your future, or to who you have been, who you would like to be, or who you are now. You may write about the same general issues or experiences on all days of writing or on different topics each day. All of your writing will be completely confidential. Don't worry about spelling, sentence structure, or grammar. The only rule is that once you begin writing, continue to do so until your time is up.

These simple instructions have proven to be exceptionally powerful. Participants — from children to the elderly, from honor students to maximum security prisoners — disclose a remarkable range and depth of traumatic experiences. Lost loves, deaths, sexual and physical abuse incidents, and tragic failures are common themes in all of our studies. If nothing else, the paradigm demonstrates that when individuals are given the opportunity to disclose deeply personal aspects of their lives, they readily do so. Even though a large number of participants report crying or being deeply upset by the experience, the overwhelming majority report that the writing experience was valuable and meaningful in their lives.

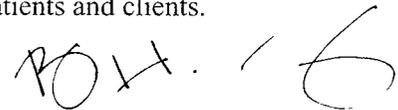
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One might say that in the field of psychotherapy, a hallmark of the 20th century was the advent of new therapies extending far beyond 19th century formulations of White-European psychoanalysts. At the beginning of the 21st century, matching appropriate treatment to the patient has become a primary challenge. Empirically-validated treatments are few, but even so, clinical experience makes it clear that no form of treatment is suitable or appropriate for all individuals diagnosed with PTSD. A person's age, developmental capacity, global functioning, capacity to manage physiological arousal, degree of social support, degree of self-cohesion, cultural values, emotional intelligence, degree of trauma, degree of reactions, etc., are just a few of many factors we now consider important when exploring treatment options. Moreover, some survivors arguably do better with didactic presentations than with process oriented techniques, some benefit more from here-and-now problem solving attention than with historical review and cognitive re-appraisal, some respond well to confrontation, others only to supportive approaches. Each new patient challenges our clinical abilities to help harness the patient's resources and regenerative powers, to help him or her build on diverse strengths, accomplishments, and skills brought to treatment.

In this issue of the Clinical Quarterly, we are pleased to feature two articles describing distinct forms of psychotherapy that can be used to broaden the clinical repertoire. The use of writing as a means of clarification, self-dosed exposure, and positive reinforcement is described by James Pennebaker and Sherlock Campbell. A description of emotion focused therapy, designed to help resolve trauma-related emotional problems, is presented by Sandra Paivio and Leslie Greenberg. For some survivors, writing a trauma narrative, either exclusively or before giving an oral narrative, may be more helpful than giving an oral narrative alone. Survivors who are particularly fearful of being overwhelmed by emotion may benefit from a structured approach that helps tolerate intense affect and arousal, especially when there is a need to change maladaptive emotional meaning. These brief introductory articles to the work of Pennebaker, Campbell, Paivio and Greenberg reiterate the need to carefully consider the best treatment options for our richly diverse patients and clients.



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EFFECTS OF WRITING

Researchers have relied on a variety of physical and mental health measures to evaluate the effect of writing. As discussed in recent reviews (1, 2), writing about emotional experiences relative to writing about superficial control topics has been found to be associated with significant drops in physician visits from before to after writing among relatively healthy samples. Writing about emotional topics has also been found to influence immune function in beneficial ways, including t-helper cell growth (using a blastogenesis procedure with the mitogen PHA), antibody response to Epstein-Barr virus, and antibody response to hepatitis B vaccinations. Self reports also suggest that writing about upsetting experiences, although painful in the days of writing, produce long-term improvements in mood and indicators of well-being compared to controls.

Behavioral changes have also been found. Students writing about emotional topics evidence improvements in grades in the months following the study. Senior professionals who have been laid off from their jobs get new jobs more quickly after writing. Consistent with the direct health measures, university staff members who write about emotional topics are subsequently absent from their work at lower rates than controls. Interestingly, relatively few reliable changes emerge using self-reports of health-related behaviors. That is, after writing, experimental participants do not report exercising more or smoking less. The one exception is that older samples of men and women in their 40s and older report that writing reduces alcohol intake.

....several studies have persuasively demonstrated that writing about a trauma does more than allow for the reduction of inhibitory processes -- it appears to bring about changes in the way people think.

The writing effect is remarkably robust. Studies comparing writing alone versus talking either into a tape recorder or to a therapist find comparable biological, mood, and cognitive effects. Indeed, the effect sizes of the writing paradigm compare favorably with those of psychotherapy (2). In fact, in a recent study of individuals with arthritis and asthma, Smyth and his colleagues (3) found that those individuals who were asked to write about traumatic experiences compared to control writing showed objective health improvements at rates superior to what has been found in any psychotherapies with comparable samples (d 's > 1.00 for most behavioral measures). The effects hold up in studies conducted throughout Europe, Japan, North America, and across social classes.

Very few consistent personality or individual difference measures have distinguished who does versus does not benefit from writing. Most commonly-examined variables unrelated to outcomes include anxiety (or Negative Affectivity), and inhibition or constraint. The one study that preselected participants on hostility found that those high in hostility benefited more from writing than those low in hostility (4). In a recent study by Paez and Velasco (5), individuals high in the trait of alexithymia benefited more from writing than those low in the trait. Alexithymia is characterized by the inability to label and understand one's own emotional state. Finally, in the Smyth meta-analysis (2), males were found to benefit more than females. The interesting pattern that is emerging from this work is that people who naturally don't talk about their emotional state to a great degree (men, alexithymics, and those high in hostility) benefit more from writing about traumatic experiences than more open individuals.

Why Does Writing about Traumatic Experiences Work?

Most of the research on disclosure has been devoted to demonstrating its effectiveness rather than on identifying the underlying mechanisms. Two very broad models that have attempted to explain the value of disclosure are those that invoke inhibitory processes and cognitive processes.

Inhibition and disclosure. The original theory that motivated the first studies on writing was based on the assumption that not talking about important psychological phenomena was a form of inhibition. Drawing on the animal and psychophysiological literatures, it was posited that active inhibition was a form of physiological work. This inhibitory work, which is reflected in autonomic and central nervous system activity, could be viewed as a long-term low-level stressor. Such stress, then, could cause or exacerbate psychosomatic processes thereby increasing the risk of illness and other stress-related disturbances. Just as constraining thoughts, feelings, or behaviors linked to an emotional upheaval was stressful, letting go and talking about these experiences should, in theory, reduce the stress of inhibition.

Findings to support the inhibition model of psychosomatics are growing. Individuals who conceal their gay status, traumatic experiences in their past, or who are considered inhibited or shy by others exhibit more health problems than those less inhibited (6). Whereas inhibition appears to contribute to long term health problems, the evidence that disclosure reduces inhibition and thereby improves health has not materialized. For example, Greenberg and Stone (7) found that individuals benefited equally from writing about traumas about which they had told others as about traumas that they had kept secret. Self-reports of inhibition before and after writing have not consistently related to health changes. At this point, then, the precise role of inhibition in promoting health within the writing paradigm is not proven.

Cognitive changes associated with writing. In the last decade, several studies have persuasively demonstrated that writing about a trauma does more than allow for the reduction of inhibitory processes – it appears to bring about changes in the ways people think. Follow-up interviews in the months after writing indicate that

people extoll the virtues of the writing paradigm by noting that it changed the ways they understood what had happened. Their explanations almost always included words like "I now realize..." or "It helped me to understand..."

In recent years, we have begun analyzing the language that individuals use in writing about emotional topics. Our first strategy was to have independent raters evaluate the essays, however, the relatively poor inter-judge reliability led us to develop a computerized text analysis system. In 1991, we created a computer program called LIWC (Linguistic Inquiry and Word Count) that analyzed essays in text format. LIWC had been developed by having groups of judges evaluate the degree to which about 2,000 words or word stems were related to each of several dozen categories (8). The categories included negative emotion words (sad, angry), positive emotion words (happy, laugh), causal words (because, reason), and insight words (understand, realize). For each essay that a person wrote, we were able to quickly compute the percentage of total words that represented these and other linguistic categories.

The interesting pattern that is emerging from this work is that people who naturally don't talk about their emotional state to a great degree (men, alexithymics, and those high in hostility) benefit more from writing about traumatic experiences than more open individuals.

Analyzing the experimental subjects data from 6 writing studies, three linguistic factors reliably predict improved physical health. First, the more that individuals use positive emotion words, the better their subsequent health. Second, a moderate number of negative emotion words predicts health. Both very high and very low levels of negative emotion word use correlate with poorer health. Third, and most important, an increase in both causal and insight words over the course of writing is strongly associated with improved health (9). Indeed, this increase in cognitive words covaries with judges' evaluations of the construction of a story or narrative. That is, people who benefit from writing begin with a poorly organized description and progress to a coherent story by the last day of writing.

The language analyses are particularly promising in that they suggest that certain features of essays predict long term physical health. Further, these features are congruent with current views on narratives in psychology. The next issue that is currently being addressed is the degree to which cohesive stories or narratives predict changes in real world cognitive processes. That is, does a coherent story about a trauma produce improvements in health by reducing ruminations or flashbacks? Does a story ultimately result in the assimilation of an unexplained experience that allows the person to get on with life? To what degree does the use and integration of emotion language affect the narrative and, ultimately, health?

Implications for the Use of Writing in PTSD

Despite the clear relevance of the writing technique for the treatment of PTSD, relatively few studies have actually been conducted. Indeed, two lines of research have yielded contradictory findings. In two studies in the Netherlands, Schoutrop and her colleagues (10) enlisted community samples through newspaper ads who met criteria for PTSD using the Impact of Events Scale (IES). Most participants were suffering from accidents, robbery, violent crime or some combination of such events. In both of her studies, there were significant reductions in IES scores for those who wrote about the emotional topics compared with controls who wrote about superficial topics.

On the contrary, Gidron and his colleagues in Israel (11) employed 14 outpatients with significant PTSD symptoms and had them write about either the trauma or about superficial topics for 3 consecutive days. Unlike other writing studies, however, the authors also required the participants to orally expand on what they had written. Unlike any other writing study, the authors found that the writing/talking intervention for the emotion condition resulted in elevated symptoms and more health problems than for the controls. Ironically, the Gidron paper bears an intriguing similarity to some of the Critical Incident Stress Debriefing (CISD) interventions. That is, individuals were required to orally express their feelings as part of the "therapy."

Our sense is that the Gidron project points to a critical feature of the original writing technique: in writing, people are able to dose themselves. That is, individuals are encouraged to write in as much detail with as much emotional involvement as they desire. There is no social feedback nor "pushing" on the part of the experimenter. It is very possible, then, that excessive prodding to express emotions in a social setting may be counterproductive.

people who benefit from writing begin with a poorly organized description and progress to a coherent story...

EFFECTS OF WRITING

We encourage researchers to explore the viability of the writing paradigm with individuals who have experienced trauma. Based on our research so far, we suggest the following strategies:

- We do not recommend writing immediately after a massive trauma. It would probably be more effective at least 2-3 weeks after the event. After that time, we have generally found it to be effective for most individuals who continue to think, dream, or worry about the event—even if it is 40 years later.
- Set aside a fixed number of days (e.g., 5 days, 30 minutes per day) for the initial intervention. Repeated interventions in subsequent weeks or months may serve to integrate new experiences.
- It is possible that in extreme cases of PTSD – where possible hippocampal damage has occurred – writing may not be helpful.
- For individuals who are unable or unwilling to write, have them talk alone into a tape recorder. Recent studies indicate talking in this manner is as effective as writing.
- From a clinical perspective, encourage the client to experiment with different writing strategies, at different times, using their own novel procedures.

Writing about significant emotional experiences has been shown to be a powerful intervention associated with long term benefits. Moreover, writing is most beneficial for those that find it most difficult to discuss their feelings and experiences. Evidence suggests that this intervention works by reducing inhibition through disclosure and encouraging cognitive changes about the chosen topic. This writing intervention is easy to incorporate into existing treatment programs, easy to adapt to special circumstances, and allows individuals to dose themselves.

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James W. Pennebaker received his Ph.D. in psychology at the University of Texas at Austin where he is now Professor of Psychology. His research, which is funded by the National Institutes of Health, focuses on how individuals cope with traumatic experience. Most recently, he has been exploring the nature of language and its links to social behavior and physical health.

R. Sherlock Campbell is pursuing graduate studies in Social Psychology at The University of Texas at Austin. His interests include Health Psychology, especially the impact of traumatic events on the self concept.

EMOTION FOCUSED THERAPY FOR INTERPERSONAL TRAUMA

SANDRA C. PAIVIO, PH.D. & LESLIE S. GREENBERG, PH.D.



Sandra C. Paivio, Ph.D.

The fundamental assumption of current emotion focused (1) and process-experiential psychotherapies (2) is that the emotion system plays an organizing role in human functioning. Subjective emotional experience is a complex phenomenon associated with a network of information that includes thoughts, feelings, desires, sensations, and physiological reactions. This is a multimodal meaning system that, when activated, provides each individual with an integrated experience of reality, sense of him or herself, and orientation toward the world. Negative learning experiences, such as exposure to traumatic events, may result in the development of maladaptive emotion structures or meaning systems that negatively influence affective experience, perceptions, physiological reactions, and behavior in current situations. The second fundamental assumption of emotion focused therapy (EFT) is that it is only through accessing emotion and emotional meaning that emotional problems, such as those stemming from traumatic experiences, can be cured.

Trauma as a Source of Emotional Disorder

The therapy approach outlined in the present manuscript primarily has been implemented in individual therapy for noncombat-related interpersonal trauma. The perpetrator can be a stranger, friend, lover, or caregiver, and the person can be exposed to a single traumatic event or repeated victimization over several years by one or several perpetrators. Traumatic events involve a profound assault on the self that include, not only feelings of fear and helplessness, but hurt, shame, betrayal, loss, rage, and associated negative beliefs and physiological reactions. This network of information can continue to be activated long after the event, and generates a complex of affective disturbances.

From our perspective, there are three main sources of emotional disorder connected with exposure to trauma—the physiological effects of extreme emotional arousal, avoidance as a maladaptive coping strategy, and maladaptive emotional meaning. First, violence and the chronic threat of violence (e.g., through child abuse, family violence, or war) result in extreme emotional arousal that is embedded in memory (3). The arousal symptoms of posttraumatic stress disorder (PTSD), such as chronic hypervigilance, uneasiness, and alarm reactions (4), represent the enduring physiological impact of terror experiences. Automatic alarm reactions continue to be inappropriately triggered by situations that resemble past events and activate the fear memory. As well, experiences of fear and shame during the original trauma continue to resurface and intrude on current awareness in the form of reexperiencing symptoms.

Another primary source of emotional disorder that is characteristic of exposure to trauma is avoidance of emotional experience. Avoidance of painful emotion is an adaptive coping strategy that fosters control and protects the person from being overwhelmed. However, there is considerable agreement among scholars that chronic inhibition of important emotional experience has several negative consequences. First avoidance of trauma-related emotion is thought to result in accumulated stress and tension that can contribute to health problems (5) and to maladaptive anxiety and rage (6). As well, chronic avoidance of important internal experience results in individuals being cut off from core feelings and needs that define the self, and this has disruptive effects on functioning (7-9). Avoidance of trauma feelings and memories also filters out information that could lead to productive action and is thought to maintain the symptoms of PTSD by preventing integration of the traumatic event into one's view of self and the world (10). Thus core internal experiences that are suppressed remain "unfinished business," pressing for integration and intruding on current awareness (11).

Another source of emotional disorder that is central to traumatic experiences is the development of maladaptive affective meaning. Trauma involves the disruption of fundamental assumptions about self, others, and reality (12). These include beliefs about personal worth and invulnerability; a world that is meaningful, fair, and predictable; and other people as benign, trustworthy, and worth relating to. Following traumatic victimization people experience themselves as stigmatized and fragile, the world as unsafe, and others as dangerous or unhelpful. Alternately, chronic and repeated exposure to traumatic events, particularly in childhood (e.g., child abuse), forms the basis of a core sense of self as worthless and insecure while viewing others as dangerous and untrustworthy. Survivors of all types of interpersonal trauma commonly report problems, not only with symptom distress, but with self esteem and interpersonal relatedness (10).

EFT for Interpersonal Trauma

EFT is a comprehensive and integrative approach, grounded in the experiential tradition, that addresses the complex of affective disturbances stemming from interpersonal trauma. These include problems with affect dysregulation, emotional overcontrol, and maladaptive emotional meaning. The first step in therapy with many trauma survivors is to help them gain mastery over reexperiencing and arousal symptoms (13-14). When appropriate, commonly accepted methods for affect management are integrated into EFT.



Leslie S. Greenberg, Ph.D.

These methods have been discussed extensively by clinicians in the behavioral and cognitive-behavior traditions (15) and will not be presented here.

In the present paper we will focus on distinctive features of experiential and emotion focused therapies (1, 2, 16-18). The first is the quality of the therapeutic relationship with its emphasis on establishing a strong attachment bond. The second is specification of the processes and techniques for overcoming emotional constriction or overcontrol. In trauma therapy, avoidance of important emotional experience must be explored and minimized because it interferes with integration of traumatic events into current views of self and reality. EFT also contributes a distinct conceptualization of the processes and techniques for reexperiencing and reprocessing trauma material. These techniques generally are intended to activate trauma memories so that maladaptive aspects of the memories are available for emotional reprocessing, that is, modification through the admission of new information.

Through telling and retelling the story of their victimization, clients gradually learn to tolerate the associated feelings and memories. EFT uniquely integrates the principles of exposure with construction of new meaning and emphasizes the role of adaptive emotion and the therapeutic relationship in psychotherapeutic change. Information from accessing inhibited adaptive emotion, such as anger at violation and sadness at loss, rather than skills training or directly challenging distorted beliefs is what usually modifies meaning. The orienting information thought to be associated with specific emotions (19) then can be integrated into and contribute to modifying maladaptive emotional meaning. For example, assertive anger expression facilitates the externalization of blame, thus modifying maladaptive guilt and shame. Primary anger at violation also fosters a sense of empowerment to counter powerlessness and insecurity. Likewise, sadness expression permits grieving and accesses self-soothing resources that help the individual cope with distress. As well, the therapeutic relationship plays a dual role in promoting change. First, a supportive relationship helps to contain potentially overwhelming affect and provides the necessary safety and support so people can explore trauma material. The relationship also is viewed as directly curative in repairing negative relational experiences and disconfirming negative expectations of others.

In sum, both adaptive emotional experience and the therapeutic relationship are viewed as sources of new information that modify meaning. The three posited mechanisms of change in EFT for trauma are (a) accessing and modifying maladaptive emotion structures, formed through traumatic events, that generate experiences such as fear/anxiety and shame; (b) accessing adaptive emotional reactions, such as anger and sadness, so that the associated adaptive information can be integrated into current meaning systems; and (c) providing a corrective interpersonal experience with the therapist (18).

There are three interrelated affective tasks in EFT for interpersonal trauma—establishing the therapeutic relationship, overcoming avoidance or over control, and reprocessing trauma memories.

Establishing the therapeutic relationship The fundamental therapeutic task in EFT is establishment of a safe and collaborative

therapeutic relationship. This usually is the exclusive focus of the first three sessions and is the fabric of therapy throughout. EFT particularly attends to establishing a secure attachment bond. The therapist stance is one of empathic attunement and responsiveness to client feelings and needs. The therapist's calm and soothing presence provides the safety and support necessary for clients to tell the story of their victimization and allow painful emotional experience. The narration of traumatic experience, in turn, creates distance from potentially overwhelming affect. Description and accurate labelling provides a "handle" for emotional experience and increases self-control. The person no longer is his or her feelings but has feelings which he or she can observe and describe. As well, the client learns to tolerate and regulate intense affect by internalizing the soothing interactions with the therapist (2).

...techniques generally are intended to activate trauma memories so that maladaptive aspects of the memories are available for emotional reprocessing, that is, modification through the admission of new information.

The primary intervention is empathic responding to client presently-felt subjective experience, including fear of trauma feelings and memories and the need for control. Empathic responding serves three main purposes: It helps clients feel understood, accepted, and less isolated; it directs clients' attention to their internal experience; and it helps clients articulate the meaning of their experience. Responses that communicate acceptance and understanding help to strengthen the person's sense of self as fragile or stigmatized, and foster interpersonal trust and acceptance of one's own experience. Empathic responding also is thought to foster self-development by enabling clients to clarify their own feelings, wants, and needs, and empowering them to express and value these core aspects of self (7, 20, 21).

Another feature of the therapeutic relationship in EFT is to allow the client maximum control over the process of therapy (18). Safety and control are corrective interpersonal experiences for individuals whose problems stem from experiences of profound powerlessness and loss of control (13). Client control is accomplished through a therapeutic relationship that is minimally hierarchical and through collaboration in establishing the goals of therapy and how these will be accomplished. Collaboration allows clients to pace themselves and to make decisions about when they feel able to explore painful

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In this New Directions column, I'd like to call attention to the reactivation of an old direction that hit a dead end several years ago. The Veterans Health Care Bill of Fiscal Year 2000, the Millennium Bill, has created the Under Secretary for Health's (USH) Committee on PTSD. This is a reincarnation of the old Chief Medical Director's (CMD's) Special Committee on PTSD, which played a quiet but decisive role in helping to transform VA from relative institutional indifference to international leadership in treatment, research, and education on the psychological consequences of traumatic stress.

Since institutional memory spans are short, it is the responsibility of oral historians, such as myself, to pass on important past events that have a significant bearing on the present and future. Therefore, I shall tell you about the CMD's Special Committee for PTSD in order to help set the stage for the recently mandated USH Committee that has yet to be selected.

In 1984, because of its concern about VA's commitment to address the problems of Vietnam veterans with PTSD, Congress mandated that VA establish a Special Committee to provide oversight on all PTSD programs. What made this committee "special" was that its Annual Report was submitted to the House and Senate Veterans Affairs Committees rather than to VA leadership. Although the Annual Report was first reviewed by the CMD, and other top VA officials, it could not be altered or withheld from Congress. Since, at first, many recommendations were not viewed favorably by these top officials, VA usually submitted a lengthy rebuttal whenever the Special Committee's Annual Report was delivered to Congress.

It must be understood that PTSD did not appear to be an important VA priority in 1984, when the Special Committee began to operate. Furthermore, VA leadership was concerned that any recommendation to upgrade VA PTSD programs would have significant budgetary implications. This actually was a realistic concern (from their point of view) since the Special Committee recommended: a) that a PTSD Clinical Team (PCT) be established at every one of VA's 172 medical centers; b) that Readjustment Counseling Service be supported through expansion of the Vet Center program; c) that there be an appropriate increase in funding of research proposals on PTSD; d) that there be an expansion of VA educational programs devoted to PTSD; and e) that the quality of compensation and pension examinations be improved so that disability claims by veterans with PTSD would be adjudicated properly. Other Special Committee recommendations that were equally important concerned the establishment and enforcement of minimal standards of care for all veterans seeking treatment for PTSD.

The Special Committee was extremely effective in making its case to Congress and, eventually, to VA's top leadership. Its Annual Reports had far reaching effects, most notably in helping to provide justification for a series of Congressional appropriations earmarked specifically to expand and create a variety of PTSD clinical programs such as PCTs, Vet Centers, Specialized Inpatient PTSD Units, Dual Diagnosis Units, Specialized Programs for Women Veterans and other clinical initiatives.

Eschewing rhetoric, the Special Committee enunciated two operational principles at the outset that guided all subsequent activities. First, it stated axiomatically, that military-related PTSD should rank at the top of VA's priorities since the primary mission of VA is to provide care for men and women whose health has suffered as a result of their service to their country. Second, it stated its policy that all recommendations would be based on empirical data.

As a result of this second principle, the Special Committee initiated comprehensive surveys of all mental health outpatient visits and inpatient visits at all VA medical centers for an entire month. It also surveyed all visits to Vet Centers for readjustment counseling during the same period. It monitored the national veterans benefits process on an annual basis. It reviewed funding for PTSD research in comparison with funding for research in other areas. And it reviewed VA educational programs to determine whether PTSD was receiving its fair share of attention and resources.

With respect to hospital-based PTSD treatment and veterans benefits, data generated by the Special Committee revealed major inconsistencies from one Medical Center to the next and from one Regional Office to the next. As stated in its Annual Reports, unless one wished to argue that there was much more PTSD in one part of the country than in another, these findings could only be explained as indicating vast differences in professional competence and institutional priorities with respect to the diagnosis and treatment of PTSD. These data appeared at about the same time as findings from the National Vietnam Veterans Readjustment Study (NVVRS) that found that the current and lifetime prevalence of PTSD among Vietnam theater veterans was 15% and 30%, respectively. Taken together, Special Committee and NVVRS Reports convinced Congress to allocate more money for PTSD programs and convinced VA officials that PTSD treatment was a major responsibility of the VA system. Special Committee oversight also helped to correct deficiencies in the peer-review process for research funding and to promote an appropriate allocation of resources for educational programs on PTSD.

Except for two eminent senior psychiatrists (who were both World War II veterans), Lawrence Kolb MD and Arthur Arnold MD, most members of the Special Committee were young professionals in early stages of their careers. They represented different professional perspectives (e.g., psychiatry, psychology, social work, nursing, and administration). They worked in hospital-based as well as Vet Center programs. Six were Vietnam veterans while one was the spouse of a theater veteran. And although all had exercised

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Women's Health Sciences, NC-PTSD

Understanding Problems of Self-Care in Trauma Survivors: A Clinical Model

Self-care behaviors, such as eating, sleeping, bathing, and wearing clean clothes, are basic to healthy adult functioning. Deficits in self-care agency and self-care behaviors are central to the problems of many trauma survivors. Problems with diet, sleep, medications, and adequate health care are only some of the self-care issues that may compromise the health and mental health of survivors. Critical to helping survivors in engaging in these important activities is a model for understanding why an individual does not do so. The concept of *self-care agency* (Orem, 1995) may be a helpful model for trauma clinicians to use in addressing the pervasive problems in self-care that are evident during treatment of trauma survivors. Why does an individual not engage in adequate self-care? Orem's model suggests that a variety of factors may be implicated, including motivation, decision-making, energy, and knowledge necessary to perform self-care actions.

This concept of self-care agency may be more understandable when talking about medical populations, which is where its nursing roots began. For example, an individual who has recently suffered a heart attack may not engage in adequate self-care upon discharge from the hospital for a variety of reasons. This individual may have low motivation because she does not believe she is in control of her health or because she is getting attention for being ill. Alternatively, she may have low energy because of her medical problems or due to the depression that often accompanies a heart attack, making self-care more difficult. Or she may not have had adequate instruction, e.g., regarding diet or medications, making adequate self-care impossible.

Research has only recently examined the concept of self-care agency deficits in traumatized women. Campbell & Soeken (1999) presented longitudinal data showing that women who remained in a battering relationship over the course of the 3rd years of the study had poorer self-care agency than those who ended the battering relationship earlier. Renker (1999) found, in a sample of adolescent mothers, that self-care agency was one of the social factors that interacted with physical abuse during pregnancy to predict infant birth weight.

When self-care becomes a salient clinical target, clinicians need to find ways to conceptualize these problems to help facilitate change. For example, a knowledge deficit, such as not understanding how to take medication correctly, may require teaching the client and coaching her in how to do it correctly, while lack of sufficient energy to engage in self-care may suggest an evaluation of current medications and medical conditions. Within traumatized populations, additional factors may play a part, such as feelings of hopelessness and powerlessness. For example, Lee (1999) examined women living in squatter settlements in Pakistan exposed to extraordinary stress and severe poverty. This study specifically examined the perception of power as an underlying factor that enables self-care agency. Lee found that women's perception of power did predict self-care agency and that both of these factors predicted actual self-care behaviors.

Orem's model may provide a starting place for trauma clinicians and researchers to develop assessment and treatment models that target self-care behaviors. Over time, we may develop a more trauma-specific models for assesses the deficits in self-care agency. These new models can lead to improvements in self-care that are critical to the success of any interventions with trauma survivors.

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material. While fostering client control, collaboration in the early stages of trauma therapy paradoxically also means agreement on the preliminary goals of relinquishing overcontrol. Clients need to accept that avoidance of trauma feelings and memories is contributing to both intrusive symptoms and social isolation. The corresponding goal of therapy is to explore client fears of emotional experience, and eventually to enable clients to accept their feelings. Therapist empathic responses validate and convey understanding of fear, normalize avoidance as a coping strategy, and make the avoidance processes available for exploration. Therapist responses also encourage clients to relax control by providing a rationale that is tailored to their own goals for change. For example, in therapy with a client who was extremely distressed by intrusive nightmares of childhood physical abuse (18), the therapist responded, *"But it has not worked to keep all these feelings inside; they are still eating away at you, demanding attention, escaping in your dreams."* At the same time, it is important to reassure clients that one of the goals of therapy is to *"find ways to help you gradually get used to your feelings, so you don't feel overwhelmed."* Another important aspect of collaboration is to heighten client experiential awareness of the negative impact of such emotional overcontrol. This can be accomplished in the early phase of therapy, through empathic conjectures, such as, *"It must be so difficult to be afraid of your own feelings, like you have to hide from yourself."* Such responses help access and support a healthy desire to be more spontaneous.

Overcoming avoidance and emotional overcontrol Within the above relational context, the second affective task in EFT for trauma is overcoming avoidance processes. This usually is the focus of the middle phase of therapy. Avoidance includes suppression of feelings for fear of being overwhelmed or losing control, and guilt and shame that interfere with acknowledging feelings and needs. Fear of overwhelming affective experience is a common theme among trauma survivors (22). Clients are afraid they will "go crazy" or become violent if they allow themselves to get in touch with their anger, or they will "never stop crying" if they allow themselves to feel their sadness and pain. However, chronic suppression of threatening feelings such as anger can play a role in generating anxiety and depression, and disavowal of vulnerable experiences such as fear, hurt, and shame can contribute to secondary rage. Healing from the effects of traumatic events is not possible unless all the feelings and beliefs associated with the trauma are accessed and available for reprocessing (10). However, appropriate intervention depends on accurate assessment of different emotional states and processes as they emerge in the session. This is accomplished, first, through therapist empathic attunement to client presently-felt subjective experience. As well, this is accomplished through knowledge of the characteristics of specific emotions, and knowledge of the client's personality history and of specific disorders (2). Depression, anxiety, and rage are secondary feelings and defensive reactions that need to be explored, understood, and changed, and the more core experience needs to be accessed. Even shame from being humiliated by another or from violating internal standards, that contributes to depression or rage, needs to be disclosed, accepted by another, and lived through in order to be

transformed. Intense anger can be a particularly difficult emotion for traumatized clients to handle. In all cases, anger at violation needs to be validated and its expression supported as a healthy resource that can promote adaptive behavior (23). However, appropriate intervention with rage involves exploring the underlying cognitive-affective processes and management, rather than accessing rage for its adaptive information. Intervention with generalized and chronic anger involves focussing expression at specific individuals for specific offenses; "putting it where it belongs." Intervention with constricted anger involves intensification and expression to promote self-empowerment and self-protective behavior. As a general rule, EFT focuses on accessing experiences that are disavowed and less available to the client.

Exploring emotional overcontrol is, in part, a process of gradual exposure to trauma material. Throughout therapy, the therapist is attuned to the various avoidance processes that emerge as the client repeatedly tells the story of their victimization. Processes such as catastrophizing or guilt about experience, shutting down, going numb, and dissociation, interfere with reprocessing and integrating trauma material. These processes can be explored through empathic responses, by directing attention to bodily experience, and the judicious use of Gestalt-type dialogues. The above processes are conceptualized in terms of a split between two parts of the self—a critical, catastrophizing, or controlling self and an experiencing self that feels guilty or afraid of feelings, or emotionally constricted. In Gestalt dialogues the client enacts both parts of the self (2, 11, 18). The goal of this therapeutic work, regardless of the intervention, is, first, to heighten awareness of maladaptive controlling processes, and, second, to access disavowed internal experience and allow uninhibited emotional expression once they feel safe enough to do so. In this way, the person learns to live through painful emotion and adaptive aspects unique to each emotion can be integrated into current meaning.

The second fundamental assumption of emotion focused therapy (EFT) is that it is only through accessing emotion and emotional meaning that emotional problems can be cured.

For example, when a client states, nervously or flatly, that he or she feels angry, the therapist can invite exploration by responding, *"There's something really difficult about getting in touch with that feeling?"* Alternately the therapist can ask where in their body they can feel that anger, to describe the sensations, and to articulate what they think their body is telling them; *"what would your gut say if it could speak?"* (18). This helps people attend to their internal experience as a

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source of information that can guide them. Directing attention to bodily experience, along with Gestalt-type techniques for heightening arousal (e.g., "say that again" or "say it louder") are particularly helpful for counteracting emotional numbness (2).

For clients who feel afraid of their anger, for example, two-chair dialogues can be used to differentiate the two sides of this conflict, the experiencing side of self that feels angry, and the controlling/catastrophizing side of self that makes them feel afraid of feeling angry. At in-session "markers" of suppression, clients can be directed to enact how they control or suppress their feelings (e.g., "What do you tell yourself will happen?" or "Make this other part of yourself afraid."). Exaggeration and intensification of catastrophic expectations or injunctions against emotional expression are used to heighten awareness of the experiential impact these have on them, that is, how anxious and blocked these make them feel. Intense experiential awareness of the tension, isolation, and powerlessness of anger suppression seems to access a desire to relieve the discomfort through expression, and motivates adaptive action to stand up for the self. These dialogues also promote awareness of one's own specific anxiety and guilt-producing cognitions. Clients recognize that what they have learned to say to themselves leave them feeling confused, conflicted, and insecure. These interventions thus facilitate a greater sense of agency and control over one's own experience. Clients can choose to allow their feelings once they feel safe. This will help them eventually tolerate and explore painful trauma material. Similar interventions can be used to explore and transformed catastrophizing about personal safety, negative expectations about others, and self-blame (1, 2).

Reprocessing and integration of trauma material The third affective task in EFT for interpersonal trauma is reprocessing and integrating trauma memories. Reprocessing necessitates accessing maladaptive aspects of the memory or meaning system that generate experiences of fear/anxiety, guilt, or shame, and accessing previously inhibited adaptive emotional responses, such as anger and sadness. Thus the adaptive information associated with each emotion can be used to modify meaning. A variety of reexperiencing techniques can be integrated into an emotionally-focused approach. However, these techniques are contraindicated for affect dysregulation problems with accompanying risk of retraumatization, self-mutilation, suicidal ideation, or aggressive behavior. In other cases, that include extreme distress from intrusive symptoms, anxiety management strategies, such as provision of structure, breathing regulation, and present-centeredness, are used to help regulate emotional intensity while accessing trauma material. For clients unwilling to or unable to engage in reexperiencing techniques, alternate techniques, such as empathic exploration of traumatic events are employed. The goals and principles of therapy remain the same regardless of the techniques used to achieve them. EFT helps the individual tell and retell the story of his or her victimization with accompanying affect in order to relieve tension, alleviate intrusive symptoms, and integrate trauma experience into current meaning systems.

Gestalt-derived imaginal confrontation techniques can be particularly effective when the trauma involved someone known to the victim, such as an abusive parent or an assailant who was a lover or friend. Imaginal confrontation is used to evoke the trauma material and help clients express previously constricted feelings and needs directly to imagined other(s). These types of enactments involve the exploration of thoughts, feelings, needs, nonverbal behavior, interpersonal reactions, and bodily experience, in an experientially alive context. This can provide a more holistic, powerful, and embodied experience than traditional imaginal exposure techniques or telling the story to the therapist. This experience is integrated into a new multi-modal meaning system. In helping clients to reexperience traumatic material, the soothing presence of the therapist and directives to regulate breathing and attend to the present reality of the session are important in regulating arousal.

In the early stages of EFT, it is typically less threatening for clients to imaginably confront nonprotective, neglectful, or unhelpful others (e.g., the police), than it is to confront or even imagine the perpetrator or assailant. Dialogues with minimally threatening others gradually expose clients to trauma material which allows for later confrontation and resolution of issues with the imagined perpetrator. Safety is provided partly by clarifying that dialogues are not rehearsals for real life. Rather they are tools for accessing and clarifying internal experience so that clients can be more aware of and guided by their own experience. It is an opportunity to reprocess the experience, for themselves, with no pressure to act in the real world. Clients are encouraged to tell imagined others exactly what happened during the victimization, and the impact it had on them (e.g., "tell your truth," "make him understand"). This evocation of memory helps to facilitate arousal and expression of emotion and unmet needs for protection, help, support, acknowledgement, or justice, and to clarify the meaning of these experiences. Therapist validation and support helps clients feel entitled to these needs even if, in real life, others can not be responsive or admit to negligence or wrong-doing. Anger expression in therapy can help to empower clients and, later, enable them to acknowledge the pain of losses and betrayal and grieve for what they have missed. In other situations, the client first must acknowledge hurt, sadness and loss before they can move on to anger expression. Vulnerable experience is appropriately expressed, not to the imagined perpetrator, but either to an imagined other who the client believes will be responsive to their feelings and needs or to the therapist. Again, EFT focuses on the experience that is disavowed and needs support.

Confronting the imagined perpetrator usually takes place in the final integration phase of therapy once the client has worked through secondary issues and is strong enough to tolerate the experience. For example, a client who had been sexually molested over a period of years as child was encouraged to imagine the scene of waiting for the perpetrator to arrive (2). He reexperienced his dread, not wanting sexual contact, and having no control over the situation. He also reexperienced his shame at participating in sexual acts, fear of being found out by family and friends, and feelings of alienation and isolation. He felt tainted and dirty and feared being stigmatized and rejected. There are various theoretical perspectives on the tendency to "blame the victim," whether self or another person. For example, psychodynamic and object-relations models suggest that anger directed at the self (guilt) may be less threatening than anger directed at a needed and/or dangerous other (24).

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Alternately assuming responsibility may increase a sense of predictability and control thus reducing the sense of vulnerability to random acts of victimization. In any case, there is agreement that internalizing responsibility for victimization often is inappropriate and maladaptive. In the safety of the therapy environment this client was able to disclose and receive the therapist's acceptance and support and thus tolerate the memories. He also was able to access his healthy adult anger at the perpetrator for imposing this on him, to verbally express his anger directly to the imagined perpetrator and, thus, externalize blame and responsibility. This helped transform maladaptive guilt and shame.

Imaginal confrontation of the assailant or perpetrator usually is used to access and promote anger expression. Importantly, the intervention is appropriate for accessing constricted anger experience; it is not appropriate for uncontrolled rage or a vehicle for acting out aggressive fantasies. Emotion intensification techniques can be used to heighten arousal and promote expression in order to relieve tension and access the associated adaptive information. Physical expression of anger, such as pounding a pillow with a soft battaca, always is accompanied by verbalization of the meaning of emotional experience. Revenge fantasies call for special attention in this type of anger work. Many clients are disturbed by their revenge fantasies. They are either afraid, embarrassed, or feel guilty about them. Revenge fantasies need to be expressed and validated as normal expressions of unresolved anger at violation, victimization, or betrayal. Clients can be encouraged to express them in terms of "I am so angry, I feel like..." and reassured that expressing intense anger in the safety of the therapy session is not the same as acting on it.

In emotionally evocative interventions, it is important to follow client moment-to-moment experience because emotion quickly shifts. Anger expression can heighten arousal thus activating associated feelings of hurt and humiliation at having been so victimized and powerless, or sadness at loss and betrayal. After intense anger expression, clients often collapse into tears and, thereby, are able to receive the therapist's comfort and support which provides an additional corrective interpersonal experience. These experiences help clients to feel less afraid of their own feelings. In general, the goals are to access adaptive information and modify maladaptive meaning, help the client feel more empowered and distant from traumatic events, hold the perpetrator rather than themselves accountable for harm, achieve a more differentiated and balanced view of others, and perceive the traumatic event as part of their life rather than defining their life.

Summary

The fundamental assumption underlying the present therapy model is that the emotion system is associated with a network of multimodal information and plays an organizing role in human functioning. Furthermore, it is only through accessing emotion and emotional meaning that emotional problems, such as traumatic stress, can be cured. Emotionally focused therapy for interpersonal trauma integrates principles of exposure with construction of new meaning, and emphasizes the role of adaptive emotion and the therapeutic relationship in psychotherapeutic change. The first affective task in this type of therapy is establishing a safe and supportive therapeutic relationship. This is accomplished through empathic responsiveness and providing the client with maximum control over the process of

therapy. The second task involves exploring and reducing experiential avoidance. The goal is to access previously avoided trauma material and allow uninhibited emotional expression. In this way the person learns to tolerate emotional pain and the information associated with specific emotions is accessed. The third task is reprocessing trauma memories through the use of reexperiencing techniques. These interventions access maladaptive affective experience so that it can be modified and adaptive emotional experience so that the associated orienting information can be integrated into new meaning. New meaning consists of a more positive view of self and more differentiated view of others and reality. This contributes to reduced symptom distress and improved functioning.

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NEW DIRECTIONS (continued from page 8)

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leadership in local clinical, research and educational PTSD programs, few had any national experience. For some of them the Special Committee served as an important training ground that facilitated their maturation as future leaders in VA and in the PTSD field. They were (in alphabetical order) Bob Baker, Al Batres, Pat Boudewyns, Spencer Falcon, Joan Furey, Joe Gelsomino, Fred Gusman, Jack Harrington, Terry Keane, Steve Petty, Ted Podkul, Jack Smith, Bud Wittlin, and myself.

As I understand it, the USH Committee will submit a progress report to Congress every year. It will have major oversight responsibilities for all of VA's PTSD programs. The quality of clinical services, research activity, educational initiatives and allocation of veterans benefits will all be evaluated by this committee. This includes the performance of the National Center for PTSD. The Committee's report should serve as an important management tool for VA's top leadership and enable congress to monitor such programs in order to sustain VA excellence in this area. So I look forward to the activities and oversight of the USH Committee on PTSD. Hopefully, it will reactivate the dynamism and vision of the old Special Committee and will promote excellence in all VA PTSD programs.

The National Center for PTSD and Readjustment Counseling Service co-host a teleconference call to facilitate networking and information sharing for VA practitioners interested in disaster mental health. Calls are scheduled the first Thursday of each month, 11:00am (EST). Phone **800-230-2250** and request to be connected to the "Mental Health Crisis Counseling call."

For further information, please call Bruce H. Young, LCSW, Disaster Services Coordinator, NC-PTSD, 650-493-5000 ext. 22494.

To be put on the email list, send request to: **bhb@icon.palo-alto.med.va.gov** and list subject as "MHCC Participant."

The Education and Clinical Laboratory Division for the National Center for Post Traumatic Stress Disorder at the Palo Alto CAVAMC, in collaboration with the VA Employee Education System, offers a Clinical Training Program (CTP). The training program is approved for 35 Category 1 CEUs for physicians, psychologists, social workers, and nurses.

Each year we welcome many mental health professionals from across the United States and from around the world. Most clinicians who enroll in the program have a working knowledge about treating the effects of trauma and PTSD and are looking to upgrade their clinical skills. The CTP offers a broad range of educational activities, including:

- * **Lectures**
- * **Clinical consultation**
- * **Clinical observation of group treatment**
- * **Group discussions facilitated by staff**

Specific training topics include warzone trauma group treatment, treatment of women veterans, treatment of sexual assault related PTSD, relapse prevention, cross cultural treatment issues, assessment and treatment of families, disaster mental health services, cognition and PTSD, assessment of PTSD, and psychiatric assessment.

Training programs are scheduled for a minimum of one week, though longer programs are available if the applicant can justify an extended stay. Programs are scheduled nine times per year, on the second or third week of the month.

At present time, funding for attendance is not available from the National Center. There is no fee for the training program itself, but participants are responsible for providing their own transportation, lodging, and meals. Interested applicants are encouraged to explore funding options through their local medical centers or VA Employee Education System.

For more information, or to request an application, please email:

jir@icon.palo-alto.med.va.gov

or telephone FTS 700-463-2673; commercial number 650-493-5000, ext. 22673

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 a description of activities of the National Center for PTSD and other trauma related information. The world wide web address is: <http://www.ncptsd.org>

PILOTS Database

PILOTS, the only electronic index focused exclusively on 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. <http://www.ncptsd.org/PILOTS.html>

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: bhb@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.