



ASSESSING PTSD IN COUPLES AND PARTNERS: THE DYADIC DANCE OF TRAUMA

JOHN P. WILSON, PH.D. & ROBERT R. KURTZ, PH.D.



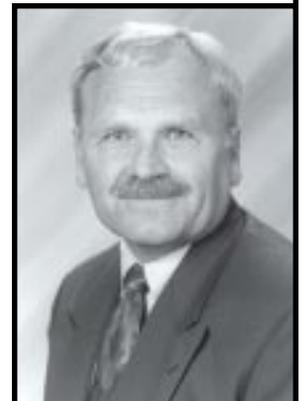
John P. Wilson, Ph.D.

He had difficulty sleeping even though he felt extremely tired after working one of his twelve-hour shifts as an emergency medical technician. His dramatic mood shifts created conflicts in his marriage and he was feeling emotionally distant from his wife. Russ's alcohol use increased to the point that it alarmed his wife. His sexual drive diminished and his wife complained that he seemed detached and unavailable. He felt responsible for their marital problems and felt guilty over his anxious and irrational behavior. His wife thought that he needed counseling for his emotional problems. However, she did not believe that she should attend the sessions since it was her husband that was troubled. She was distressed by the changes in his behavior and felt confused as to what was wrong in their relationship.

Since he was an emergency room medical technician (EMT) working at a large metropolitan hospital in the inner city of Cleveland, Ohio, he had witnessed the deaths of many people and had seen trauma of the worst kind. He began work as an EMT in 1970 after two tours of duty in Vietnam. Occasionally, he would have nightmares about what he had seen at work, especially mutilated and burned victims. Moreover, Russ personally witnessed a gruesome car accident while off-duty where four teenagers were killed. He felt guilty for not being able to save

Russ Smith, a former combat medic in the Vietnam war, needed an operation after he had seriously damaged his knee at work. After orthoscopic surgery on his torn cartilage, he took some time off from work to recover. Shortly afterward, he began to suffer from other symptoms that seemed to have little to do with his knee injury. His skin broke out in a rash and he began having frequent headaches. He felt "on edge" and "jumpy" at work and, more recently at home.

them, especially since a bad knee had slowed him down while attempting to respond. He had flashbacks of the accident. For reasons unknown to him, he found himself thinking about the dead and injured he attended to in Vietnam as a medic. He began to lose interest in the things that he normally did to relax, especially playing golf. He wanted to quit his job, and he began to doubt his ability at work, even though most of his colleagues held him in esteem. He felt that his wife did not understand what he was going through and expressed the idea that she might never understand him. Their relationship became strained and they stopped communicating about day to day decision making. He began to feel more and more hopeless as his concentration waned and his mind drifted to the past.



Robert R. Kurtz, Ph.D.

Post-traumatic stress reactions have been conceptualized and studied as individual attempts at adaptation to severely disturbing events such as disasters or other traumas. As such, individual reactions have been characterized as normal attempts to respond to extremely abnormal circumstances (1). The symptoms of Post-Traumatic Stress Disorder (PTSD) have been well documented in the research literature (e.g., 2). The symptoms described in our case illustration match some of those listed in the DSM-IV (3) for PTSD. Events that are experienced as so stressful that they produce dramatic changes in the individual have also been shown to produce significant changes in intimate relationships as well.

Understanding how PTSD impacts dyadic relationships has been studied under the rubric of family stress therapy (4-10). Family stress theory rests on several assumptions: (a) stressful events and even crises are common in the history of many couples and

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FROM THE EDITOR...

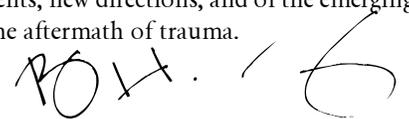
The Clinical Quarterly and Research Quarterly are just two of many educational products the National Center for PTSD (NC-PTSD) makes available to mental health professionals across the United States and throughout the world. Currently, the NC-PTSD disseminates information about PTSD through electronic delivery, workshops, training, videotapes, and of course, printed materials.

Recently, the NC-PTSD website (www.ncptsd.org) was reconstructed to expand and make available more in-depth information for veterans and other survivors of traumatic experiences, as well as clinicians, researchers, journalists, family members, students, policymakers, lawyers, and librarians. The new website has an easier navigational structure, greater access to Clinical and Research Quarterly articles, increased number of fact sheets and links, and, over the course of the next year, down-loadable access to research articles and chapters written by NC-PTSD Staff. We are also working to offer audio and video materials and distance learning courses via the webpage. Links on the new website include: *Facts about PTSD*; *What is PTSD?*; *What causes PTSD?*; *Who is affected by PTSD?*; and *How can PTSD be treated?*. New fact sheets on the website include: *Anger and Trauma*; *PTSD in Children and Adolescents*; *Child Sexual Abuse*; *PTSD and Community Violence*; *Complex PTSD*; *PTSD and Criminal Behavior*; *Discussing Trauma and PTSD With Your Doctor*; *PTSD and the Family*; *Traumatic Response to Motor Vehicle Accidents*; *PTSD and Physical Health*; *Trauma, PTSD, and the Primary Care Provider*; *Sexual Assault Among Females*; *Sexual Assault Among Males*; and *Information on PTSD for Women's Medical Providers*. In addition, the website offers access to research articles related to PTSD and trauma and access to our PILOTS Database, the largest interdisciplinary index to the worldwide literature on traumatic stress. You can also find information about the NC-PTSD including its mission statement and history, how the Center is organized, its annual report, as well as employment and training opportunities.

Other recent NC-PTSD educational products include the publications Incarcerated Veterans Forensic Outreach Training Manual, Peacekeepers: A Military Mental Health Practitioner's Guidebook, and Disaster Mental Health Services: A Guidebook for Clinicians and Administrators; and the recent videos, Wounded Spirits, Ailing Hearts: PTSD, and the Legacy of War Among American Indian and Alaska Native Veterans (four tape series with manuals for professionals and laypeople), and Responding to Disaster an overview of the VA's role in disaster mental health (available in each VA Medical Center library).

All Center divisions continue to offer a variety of training opportunities. The Education division in Menlo Park continues to offer a week-long clinical training program with CEUs for PTSD professionals (see page 47 for more information). In addition to workshops and training, the Center utilizes teleconferencing and multi-site conference calls as a means to facilitate educational events. These include hosting several monthly nationwide calls on a range of topics.

Hopefully, the National Center's educational efforts to keep you informed of recent developments, new directions, and of the emerging PTSD scientific literature will aid your own efforts to help men, women, and children cope with the aftermath of trauma.



Bruce H. Young, Editor

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ASSESSING PTSD IN COUPLES AND PARTNERS

families, (b) stress places extreme demands on intimate relationships, (c) most couples adapt reasonably well to stress; but (d) if the initial attempts at adaptation fail, the couple will experience additional stressors which will stimulate other crises in their relationship.

Stated simply, post-traumatic stress reactions create instability in relationships and may lead to additional crises in them. Bowen (11) characterized the dyadic relationship as the most unstable of all forms of family relationships. Therefore, we would expect that a dyadic relationship would experience even greater instability than families when one of the members is suffering from the symptoms of PTSD. Clinical observation confirms Bowen's hypothesis that when one member of an intimate relationship suffers from the symptoms of PTSD, there is a high probability that the relationship will be negatively affected and become unstable.

The research studies of Vietnam veterans describe how the symptoms of PTSD affected their marriages (12-15). The most often reported marital problems included: (a) constricted intimacy and expressiveness, marked by limited affective expression and a lack of self-disclosure (12); (b) overt hostility in the form of unpredictable outbursts of verbal and physical aggression (15); and (c) global maladjustment characterized by general dissatisfaction with the relationship and recurrent crises (16-19). These studies suggest that the existence of PTSD symptoms had negative consequences to the intimacy and bonding within marital relationships of war veterans.

The most often reported marital problems included: constricted intimacy and expressiveness, overt hostility in the form of unpredictable outbursts of verbal and physical aggression, and global maladjustment characterized by general dissatisfaction with the relationship and recurrent crises.

Studies conducted on non-military populations have reported similar findings (20). For example, the growing literature on rape trauma also illustrates the potential negative consequences within the dyadic relationship (21, 22). In the wake of rape trauma, couples generally report difficulties in affective expression, commitment, emotional support, sexual relations and communication. In addition, other research suggests that rape trauma appears to have an impact upon many of the areas that are typically considered important for successful relationships (21). These include: (a) expression of affect, (b) decision making, (c) personal commitment, (d) perceptions of personal distance and closeness, (e) world view, (f) self-esteem, and (g) personal meaning. Most theories of psychotherapy rely on at least some of these variables to create the leverage for therapeutic change. Therefore,

when one of the members is suffering from trauma, these relationships present a difficult challenge for psychotherapists. Table 1 summarizes the common PTSD symptoms found in studies of couples or partners (20).

TABLE 1. Common Symptoms and Behavioral Problems in Couples with Post Traumatic Stress Disorder

- Loss of intimacy
- Breakdown in communications
- Decreased sexual activity
- Diminished, impaired, or ineffective decision making
- Detachment from significant others
- Increased anger and irritability
- Displaced, overt, or passive hostility
- Decreased levels of normal social activities
- Marital or partner dissatisfaction
- Generalized anxiety and fears (e.g., fear of abandonment)
- Instability in core areas of relationship (i.e., responsibilities, decision making, role expectations, etc.)
- Low self-disclosure of personal concerns
- Confusion, shame, doubt, and guilt
- Changes in hygiene, self-care, and sleep patterns
- Isolation, withdrawal, social, and self-alienation
- Discernible changes in normal coping patterns
- Loss of interests in shared activities, hobbies, holidays, and vacations
- Depression, dysphoria, and anhedonia

The presence of PTSD in a dyadic relationship appears to affect the core tasks of establishing good communication, expressing support and caring, commitment to others, role clarity, and the resolution of conflict in intimate relationships. Since a major symptom of PTSD is affective dysregulation, therapy with a traumatized couple that focuses on affect initially will prove difficult because the focus is likely to stimulate more painful affects.

When PTSD originates in acts of interpersonal trauma (e.g., childhood abuse, assault, rape) affective dysregulation appears to generalize to other relationships, often resulting in problems of trust. Moreover, it is likely that the fear and anger will be more intense in intimate relationships because there is more at stake for the victim. Thus, the cyclical patterns of affect instability, role ambiguity, detachment, and dissatisfaction become issues in most relationships impacted by PTSD. Along with its associated features such as depression, hyperarousal, and alcohol abuse, PTSD can stimulate even more stress for the couple. The reciprocal effects of PTSD in a relationship result in a dyadic dance with trauma's wake.

The major goal for treating relationships with PTSD in one or more of the partners is to change the dysfunctional patterns that have developed since the trauma. We prefer to begin by listening to the narrative of the trauma as it is described by the victim in whatever way they choose to tell it. We try initially not to interpret symptoms because comments by the therapist are easily misinterpreted as negative judgments to already vulnerable persons.

We typically begin treatment by using the “debriefing” technique of helping the victim understand that his or her symptoms are a common reaction to what they had experienced in the trauma. When the partner is present during the debriefing, it helps to educate them about the nature of PTSD. Once the partners understand the symptoms of PTSD, they are usually more supportive of the victim. We try to remain as “non-interpretive” as possible because the victim’s expectations of treatment may be unrealistically high whereas their ability to “hear” interpretations may be low. We encourage the partners to support each other because their mutual support is more important than the therapist’s empathic nature. We have found it beneficial to use some of the assessment instruments that are described by Wilson and Kurtz (20) on assessing post-traumatic stress disorder in couples and families to establish achievable goals for treatment.

We begin treatment by asking both parties three basic questions. First, “*What meaning do these events have to you both?*” Second, “*Are there any other possible meanings that this might have?*” Third, “*What does this mean to your relationship?*” We start with questions about personal meaning because of the need to understand the context in which they have framed the traumatic experience. It is important to identify the way they have been impacted by the traumatic experience and their cognitive formulation of its impact to self-esteem, personal identity, and to behavioral dispositions, especially in terms of communication in the intimate relationship.

The issue of trust and safety in the therapy process is crucial to achieving a sanctuary in which the couple will feel secure to explore how the trauma has changed their lives (23). Further, the therapeutic situation is one of variability depending on whether only one or both partners experienced the traumatic event(s). If only one partner has a history of trauma, it may be necessary to facilitate an understanding of PTSD for the non-affected partner. Thus, the therapeutic process may require joint sessions on a periodic basis to maintain and promote open communication of feelings so as to counteract affective dysregulation, resistance to self-disclosure, and attempts at emotional intimacy.

It is interesting to note that, when treating trauma victims, therapists often report feelings of frustration and hopelessness similar to those reported by the partner or spouse. If these feelings are left out of the therapist’s awareness, he or she may form a collusive relationship with the partner (23). This collusion will distance the traumatized person even more, possibly causing a rupture in treatment. At the same time, the victim may find that the interpersonal distance represents safety to them. When this happens, however, relationship therapy will be less effective. As noted by Wilson and Lindy (23), countertransference is ubiquitous in PTSD treatment and the therapist working with couples needs to monitor trauma-specific transference reactions as well as their own empathic distress.

The assessment and treatment of PTSD is even more complicated when both partners have shared a traumatic event together or have individual histories of trauma and abuse that antedate their union as a couple. For example, couples who survive such traumas as airline crashes, automobile accidents, war-related oppression, or unexpected loss of a child due to illness or injury,

may both suffer from symptoms of PTSD and associated features. If the trauma involves bereavement, care must be taken to assess traumatic bereavement and PTSD (24). While PTSD symptoms

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and those of traumatic bereavement may overlap, they are distinct but interrelated phenomena. Traumatic bereavement involves sudden and unpredictable loss. The bereavement process directly concerns the three core areas of yearning, mourning, and loss of attachment to a significant other. However, bereavement reactions may trigger intrusive recollections of the trauma and set in motion PTSD processes such as hyperarousal, numbing, or feelings of being overwhelmed by what has happened. When a couple has shared the traumatic experience and each partner develops PTSD, their symptoms may increase their risk to have ineffective coping and intense complications in the relationship since supportive efforts to assist one another may not be possible without clinical intervention. Thus, in such cases, both the assessment procedures and therapeutic goals for treatment need to be “mapped” to determine what will be the most efficacious approach to treatment (21).

The clinician working with couples or partners who suffer the adverse effects of trauma need to consider both clinical and psychometric assessment procedures. Clinical assessment addresses the issues of how the trauma has led to PTSD and other symptoms and how they, in turn, impact aspects of psychosocial functioning (e.g., work, leisure time, social activities, personal relationships, and capacity for intimacy). Clinical interviews are useful to obtain information as to where maladaptive changes have occurred from the pre-trauma level of coping and adaptation. Given the natural reticence and avoidance tendencies in persons suffering from PTSD, several sessions may be required to uncover the specific ways that PTSD adversely impacts psychological functioning, especially in terms of the dyadic interactions between the partners. As noted by many clinicians (e.g., 1, 23, 26), the trauma client needs a safe sanctuary in the treatment situation in order to disclose the distressing aspects of their trauma.

ASSESSING PTSD IN COUPLES AND PARTNERS

In addition to clinical assessments, it is suggested that psychometric assessments be utilized as well. Today, practitioners have a broad selection of instruments to consider in assessing PTSD, marriage satisfaction, and other aspects of stress response reactions and their effects on behavior. We recommend books by Briere (27), Carlson (28), and Wilson and Keane (29) which contain reviews and descriptions of the available resources to assist therapists in assessing psychological trauma and PTSD.

Finally, it should be noted that when a therapist begins treatment with one or both partners who have endured trauma, he or she becomes psycho-dynamically part of the transference-countertransference matrix which has its own dynamics in terms of unconscious, trauma-specific transference reactions by the client(s) (23, 30). In this regard, the therapist may be placed in various "role enactments" by the client(s) (e.g., moral judge, parental figure, the partner, perpetrator, etc.) Analysis of the trauma-specific transference (TST) behavior is also an important assessment process since it will reveal the critical areas of ego-defensiveness, resistance, and injury to the self-structure and well-being of the individual(s) engaged in the dyadic dance with trauma.

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COUNTERTRANSFERENCE AND THE MANAGEMENT OF ANGER IN TRAUMA THERAPY

CONSTANCE J. DALENBERG, PH.D.



Constance J. Dalenberg, Ph.D.

Anger is a basic emotion, tied by cultural, social, and biological strings to certain provocative events. Thus, individuals around the world recognize an angry face, largely agree on the common causes for anger, and agree on the remedies an angry person would most likely wish to take (1, 2). The basic nature of the emotion of anger alone should guarantee that anger would have an important place in the psychotherapy of trauma, as indeed it does. In fact,

Mayne and Ambrose (3) report that anger and rage are “the most salient and prevalent emotional responses in men with post-traumatic stress disorder” (p. 360). Further, the dysregulatory consequences of PTSD, together with the likelihood of enhanced distrust and hostile outlook, may mean that there are fewer impediments to violent action in those with PTSD (4). The relationship of PTSD severity and anger expression may be cyclical, with anger expression predictive of later PTSD severity (5) and PTSD severity predictive of the expression of anger in violence (6).

The anger of the trauma victim can be understood theoretically through use of existing biosocial frameworks. Anger serves a role in attachment (“Pay attention to me!”), goal-attainment (“Get out of my way!”), defense against physical and psychic attack (“Stop that!”), restoration of pride (“How dare you treat me that way!”) and restoration of justice (“Serves you right!”). Trauma survivors thus may have their anger aroused along many dimensions simultaneously, as they are physically endangered, shamed, rendered powerless, and subjected to injustice.

Unfortunately, the most common response of the therapist to hostility, anger, and aggression in trauma therapy is counterhostility and counteraggression (7, 8). Hostility in the therapist in response to verbal aggression from the patient was a major predictor of poor outcome (early termination or lack of a success in therapy) in the well-known Vanderbilt Psychotherapy Project (8, 9). In fact, Strupp noted that...

We failed to encounter a single instance in which a difficult [client's] hostility and negativism were successfully confronted or resolved. Admittedly, this may be due to peculiarities of our therapist sample and the brevity of therapy; however, a more likely possibility is that therapists' negative responses to common and far more intractable than had been generally recognized.

It seems, then, that clients' ability to express or resolve anger in psychotherapy may be hampered by therapists' angry countertransference reactions.

Even if we come to less depressing conclusions than did Strupp regarding the possibility of resolution, it is certainly clear that anger in the therapist is common in trauma therapy. In addition to the overt provocations of the angry client, sources for anger can be found in the slow pace of trauma therapy (leading to therapist frustration and hopelessness), vicarious anger at the perpetrators of crimes against the patient (producing a shared sense of injustice), and responses to perceived patient manipulation. To the extent that the therapist is part of the “system” to whom the patient must turn to for monetary and social support, the patient's resentment and the therapist's sense of being used may be multiplied. For example, veterans who seek treatment in VA settings may feel considerable resentment toward their therapists because they perceive them as part of the VA system that controls their compensation and as part of the military system that was responsible for their traumatization. Similarly, therapists working in VA settings may feel manipulated by clients who seek PTSD-related compensation, believing that the link of money and symptoms undermines the therapeutic goal of honest patient disclosures. Finally, the patient's intractability can shame the therapist. Psychotherapy, as Wachtel (10) wrote, “is no profession for the individual who likes certainty, predictability, or a fairly constant sense that one knows what one is doing. There are few professions in which feeling stupid or stymied is as likely to be a part of one's ordinary professional day, even for those at the pinnacle of the field.”

Research on the Therapist's “Countertransference”

Most of the research and theory on the therapist's reactions to patient anger uses the analytic term “countertransference.” Cut away from its earlier Freudian meaning of conflict-driven responses to the transference, countertransference has come to mean “the entirety of the [therapist's] reactions to the patient within the treatment situation” (11). Clinicians and researchers have begun to study the phenomenon, typically through surveys of therapists, self-analysis of cases, and vignette studies. In survey studies, therapists are asked how often they feel or express anger or sexual interest or how often they engage in “boundary violations” (12, 13). In vignette studies (14, 15), therapists are given videotaped or written sample scenarios, such as the following, and asked how they would respond.

John is a Vietnam veteran who has been having problems with anger, often verging on spousal abuse. Today he reacts strongly when you are 5 minutes late for an appointment, and lashes out at you in an abusive manner. What would you do?

NEW DIRECTIONS

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

Practice Guidelines for PTSD

Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies (ISTSS) will be released by Guilford Publications in a few months. Produced under the aegis of ISTSS and edited by Edna Foa, with Terry Keane and myself serving as co-editors, this book is the most current, comprehensive, and authoritative review of evidence-based treatments for PTSD.

Although I must confess to a definite lack of neutrality, there is abundant objective evidence to support my enthusiasm for this book. It is historically important because it is the first time all the empirical treatment literature on PTSD has been assembled and critically evaluated. It is scientifically accurate because of the rigorous process through which 42 leading experts evaluated the data in favor or against the effectiveness of every major treatment currently offered to PTSD patients. And its obvious clinical relevance should guide clinicians who wish to select the most efficacious treatments for their patients. The 12 treatments reviewed (in order of appearance) are: psychological debriefing, cognitive-behavioral therapy (CBT), pharmacotherapy, treatment of children and adolescents, eye movement desensitization and reprocessing (EMDR), group therapy, psychodynamic therapy, inpatient treatment, psychosocial rehabilitation, hypnosis, marital and family therapy, and creative therapies.

The organization of Effective Treatments is unique, with two major complementary sections. The first section consists of traditional literature reviews of the 12 treatment approaches, in which research findings are carefully evaluated, effect sizes calculated for each treatment are discussed, and the quality of this research data is rated according to a 6-point scale adopted from the Agency of Health Care Policy and Research (AHCPR) classifications.

According to this scheme, Level A evidence is based on randomized clinical trials, while Level B evidence is based on well-designed clinical studies without randomization or placebo comparison groups. Level C is based on naturalistic clinical studies combined with compelling clinical observations. Level D evidence is based on long-standing and widespread clinical practice that has not been subjected to empirical tests in PTSD. Level E is based on long-standing practice by circumscribed groups of clinicians that has not been subjected to empirical tests in PTSD, and Level F applies to new treatments that have neither been subjected to clinical or empirical tests in PTSD. For example, much of the research on CBT, EMDR, pharmacotherapy, or group treatment is Level A or B. Psychodynamic psychotherapy is mostly Level C with a few studies at the A or B level. Marital and family therapy, psychosocial rehabilitation, and creative therapies are at Levels D and E, since they have not been subjected to any empirical trials with PTSD subjects. Finally, anecdotal observations on a unique drug or new treatment, as reported in a Letter to the Editor, would be ranked at Level F.

The second major section consists of Treatment Guidelines on each of the twelve treatments reviewed previously. Each guideline is a concise summary of the empirical evidence along with a set of recommendations (including indications and contraindications for each treatment). Although the full book has not yet been published, the Treatment Guidelines have been accessible for months on the ISTSS website <www.istss.org>.

Effective Treatments also has useful introductory chapters and a final "Integration and Summary." The Introduction presents the general format of the book, a review of the process through which it was produced, and describes our six-point revision of the AHCPR guidelines described previously. In addition, important general overarching clinical issues are addressed concerning: type of trauma, single versus multiple traumas, chronicity of PTSD, gender, age, children, and elder adults. Also addressed are factors affecting treatment decisions such as: treatment goals, treatment modality, comorbidity, suicidality, chemical abuse/dependence, concurrent general medical conditions, disability, and functional impairment and indications for hospitalization.

A second introductory chapter reviews the current state-of-the-art on diagnosis and assessment of PTSD.

The final "Integration and Summary" chapter attempts to synthesize common themes and remaining questions about PTSD treatment that could not possibly have been addressed in single chapters on specific treatments. The discussion in this chapter is organized around seven key questions that cut across the various treatment approaches. Many of these questions have yet to be addressed in empirical research on PTSD. They are:

- How should one choose among treatment modalities?
- What to expect from treatment and how to define realistic goals?
- How can one combine various treatment techniques?
- How to approach complex clinical pictures and co-morbid conditions?
- How long should a treatment be followed? Booster sessions? Follow-up?
- Are there features of PTSD that require a special approach that cuts across treatment modalities?
- How to make sense of clinical difficulties and how to assess failure?

As stated in the final paragraph, "Practice Guidelines is a work in progress." We must increase our efforts to investigate single and combined treatments for PTSD. We do believe, however, that the analysis of treatment research and recommendations by acknowledged experts will be useful and will promote better treatment for PTSD.

WOMEN AND TRAUMA: A CLINICAL FORUM

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"... danger had a way of driving people together, and no human enterprise is more dangerous than combat. In combat people need one another, need to know who can think clearly, and who can be counted on when things start to go wrong."

E. M. Norman, *We Band of Angels*, p. 41

Research has documented that social support both during and after a trauma aids in the adjustment of survivors (see examples of references below). Clinicians who treat trauma survivors know that the reaction of persons close to the survivor, such as family and friends, following the trauma are critical to their adjustment. A supportive reaction from significant others following a rape may buffer negative reactions. The adjustment of children who disclose sexual abuse is directly related to their perception of social support in the time following the disclosure. Similarly, social support at homecoming has been shown to be critical to the post-war adjustment of military veterans.

Clinicians who work with trauma survivors often encounter the detrimental aftereffects of an absence of social support following trauma: the long-standing pain due to the unsupportive spouse or the punitive judicial system following a rape; the non-believing parent following disclosure of sexual abuse; the strident protestors on return from Vietnam. Part of the clinical response to this is often providing a more supportive response than the patient found at the time of the trauma or disclosure. For those clinicians who work with survivors of recent trauma, it also may be possible to encourage more supportive responses from their world by providing psychoeducation and support for the survivor's significant others. Although this work is often not done, facilitating support in the survivor's world may be the most powerful thing we can do in the immediate aftermath of a trauma.

Because the traumas that women experience are likely to be interpersonal and women more generally experience the world in interpersonal terms, the role of social support in the face of a trauma may be particularly critical. We cannot underestimate the power of facilitating support and validation in the real world of the female trauma survivor.

As I said above, much of the issues of social support have to do with the support that the individual did or did not receive at the time of the trauma. For clinicians who treat war-zone veterans, understanding the personal relationships forged by combat, the trust and closeness shared by comrades, can help in our understanding how veterans lived through their experiences. There is a growing research literature on the role of unit cohesion in adjustment and military performance.

However, we now have an opportunity to learn more intimately about the power of social support in the war-zone. Dr. Elizabeth M. Norman, director of doctoral training at New York University Division of Nursing in the School of Education, published a book in 1999 that provides a powerful and vivid description of what women are capable in combat conditions and of the power of cohesion in their survival. This volume, *We Band of Angels*, chronicles the three-year internment by the Japanese of 99 female nurses in Bataan and Corregidor during World War II. Dr. Norman spoke with 20 of these women and used excerpts from diaries to bring the reader into the difficult world that these women endured. This book powerfully adds to our understanding of what people can mean to each other in the face of a trauma.

I asked Dr. Norman what she felt the role of social support was for these women. Dr. Norman replied, "When these women were POWs, everyone and everything familiar to them was taken away. All they had was each other. The concept of social support took on an ever important, almost life-saving meaning. The women helped one another cope with the hunger, isolation, and uncertainty in their daily lives. They got each other through everyday and kept their hope alive for their rescue, which arrived after almost three years in internment camps. Without group support, some women may not have survived."

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No doubt it would not surprise the reader to learn that few therapists claim that they would be abusive in response to a patient's verbal stimulus or that they are lax in maintaining therapeutic boundaries. In part, this is an understandable self-protection mechanism – we would rather keep our professional mistakes to ourselves. However, it is also possible that therapists are unaware of the degree to which their retaliatory anger or frustration seeps into the clinical waters, at times through hostile interpretation, a retreat to jargon, or a false apology. (The false apology is the professional version of “I’m sorry you feel that way,” which conveys less the speaker’s contrition than his or her judgment of the listener’s inappropriate affect.)

My own learning has been immensely aided by a series of experimental studies and clinical interviews recently completed in our laboratory (7). In the experimental studies, clinicians are placed “on the spot” with actors providing them with powerful angry, sexualized, or shaming stimuli. Responses are recorded and then rated by clients who have completed therapy for trauma disorders (How would this response make you feel?). In the clinical interviews, rather than ask the therapist to self-examine, questions about the behavior of therapists were put to “successful” clients (who believe that they resolved their trauma-related problems through therapy) and “unsuccessful clients” (who left therapy prematurely). The goal was to learn from clients how therapist countertransference reactions were perceived and how they might be more safely and effectively expressed. The subjects in the interview sample included those who had experienced childhood trauma ($n = 41$), and victims of adult trauma ($n = 43$).

Recommendations On Use of the Countertransference

Many of the conclusions drawn from the Trauma Countertransference Study described above are generally applicable to the management or disclosure of clinician affect. Four conclusions based on my own clinical experience and from the research interviews seem particularly important to the specific instance of the escalation of hostilities between patient and therapist.

The goal for the therapist during periods of greatest arousal is to model anger management, not anger prevention.

The cognitive distortions that both precipitate and maintain cognitive arousal are well-understood, at least in theory (16). It is common knowledge that humans become less competent in reasoning ability during arousal. Yet, clients in the Trauma Countertransference Study reported that their therapist’s most common response to the client episodes of (self-labeled) irrational anger was to attack (or more gently confront) the reasoning leading to the explosive reaction. Thus therapists were trying to reform reasoning during the times that the client was least open and least capable of reasoning well.

If the anger was directed at the therapist, the clinician typically slipped quickly to self-defense. (I should add here that in talking to the therapists, this was seen as showing the client the “true situation,” i.e., illustrating to the client that the therapist’s

behavior did not deserve angry response.) But if the therapist’s primary concern seems to be the legitimacy of patient anger, the client may subtly receive the message that anger management is appropriate only when anger is illegitimate. This is a dangerous message, given that it means that every offer of anger management strategy also conveys the message that the client’s angry feelings are inappropriate.

Trauma survivors thus may have their anger aroused along many dimensions simultaneously, as they are physically endangered, shamed, rendered powerless, and subjected to injustice.

A more effective strategy is to separate for the client the issue of managing and soothing one’s anger from the issue of the legitimacy of the cause for arousal. By addressing the arousal first, the clinician can signal to the client that, independent of the provocation, consuming anger can be detrimental to problem-solving, relationship management, and physical and psychic health. The clinician can admit to his or her own arousal, and model that this arousal can and should be addressed before problem resolution is attempted. Thus, the question is not whether I (the therapist) would also be angry in this situation, but instead whether the client is comfortable with the level of anger (whatever the cause) that is being experienced. If not, relaxation, self-talk, and breathing retraining may be appropriate. The therapist might say something like the following:

“OK. Let’s agree that X (the target of the patient’s anger) probably should have behaved differently. Right now, though, you are too angry to think through what you’d like to do about it. Let’s try using some of those self-calming exercises first and then we’ll talk more about X.”

Both therapist and client may find it difficult to tear themselves away (temporarily) from the issue of who is right, who is at fault, and who “should” be angry at whom. Learning how to be effective in the expression of anger, however, can facilitate for both parties the later discussion of any situation calling forth that anger. Given the complicated anger regulation difficulties of many PTSD victims, particularly combat-related PTSD victims (17), the therapist often must help the patient to find some acceptable method of anger display before moving to the differentiation of appropriate reasons for anger. If the reverse order is attempted, patients tend to confuse negative outcomes due to problematic display (that could and should be resolved through appropriate assertive behavior) with negative outcomes due to hostile misinterpretations (confrontation that could and should be avoided entirely). Patients may then attempt to suppress rather than transform anger, a solution leading to other significant health risks.

Do not pretend to be unaffected by patient anger.

In the Trauma Countertransference Study, eighty-six percent of the trauma survivors interviewed stated that they had experienced at least one episode wherein their therapists expressed “inappropriate” anger. Slightly more than a third stated that their therapists “lost control” at least once, engaging in a behavioral act of cruelty. Almost half stated that their therapists at least once made an angry or frustrated comment that the therapists later regretted. This supportive evidence for the frequency of therapist angry outbursts fits with the dozens of recent articles on hate, anger or rage in the countertransference (7). Yet, when one watches the examples of master therapists responding to patient anger, such as the American Psychological Association’s Psychotherapy Videotape Series (18), one is first struck by the remarkable lack of emotional response shown by most therapists to the angry material. The Trauma Countertransference Study interviews suggested that these two phenomena – rageful response and complete nonresponse – may be connected.

When patients first express anger at their therapists for a perceived injustice, the therapists (by patient report) often label the anger, normalize it, and profess not to be moved by it. This was the most frequent stance of the master therapists in the APA training tape. The therapists in the tape (and by report, in the trauma therapies of participants in the Trauma Countertransference Study) did not disclose their own discomfort and did not apologize for their part in the anger provocation, although they occasionally explained what they believed to be patient misperception. When I discussed successful trauma therapy in depth with the involved patients, however, the most commonly mentioned helpful tool was the therapist’s use of judicious self-disclosure of the countertransference (disclosure of the therapist’s own feelings). Patients reported that the more traditional therapeutic practice of therapists trying to present an implacable face to anger led these patients to feel even more disempowered, lessened, or humiliated. One veteran complained bitterly (choking back tears at one point) of his therapist’s tendency to nod calmly and murmur encouraging phrases during the patient’s emotional disclosures. *“If this stuff doesn’t even rate a change in expression,”* he told me, *“what kind of man am I when I crack up over it. It made me escalate, you know, keep edging up the feeling when I talked to [my therapist]. I had to make him recognize me.”*

The patient above is also touching upon the importance of shame in eliciting and maintaining anger (19, 20). Trauma patients often report that they believe that the magnitude of their anger or pain is greater than the therapist knows; the therapist’s frequent references that anger will not affect the relationship is taken as a minimization of the patient’s feelings, and a covert statement that overwhelming and irrational anger is not to be expected as part of a trauma reaction. One Trauma Countertransference participant was quite contemptuous of his therapist’s assurances that he could “take it” if the client

exploded, pointedly stating that the therapist was unaware of the homicidal nature of the client’s anger (similar to Shay’s (21) “berserk state”). It is quite reasonable for both patient and therapist to be more respectful of the power of the victim’s rage.

Of course, it is not necessary and not recommended to shout angrily at patients who are providing provocations. However, I am arguing here that this outcome is less likely if the moderate confrontations are treated as real human interactions, leading to emotional arousal in both participants. Successful patients reported that their therapists discussed their reaction to the patients’ provocations while making clear that the basic connection between them was not in jeopardy.

Model the awareness of alternative perspectives.

An angry episode between patient and therapist might also be an opportunity to model an important self-evaluation skill. Look, for instance, at this exchange, taken from an angry episode between a psychiatrist and his patient (for whom I consulted):

Patient: *“you’re such a jerk. That was condescending”* [referring to the psychiatrist’s explication of his view of the patient’s pathology].

Therapist: *“Perhaps this is an example of the problem we have been talking about. You are putting this problem into me.”*

Yes, indeed, the patient is putting the problem into the therapist. The therapist, in response, is trying to shove the problem back into the patient. But what message does the therapist’s action send? By not stopping to evaluate his own actions, the therapist above sends the message (a) that he knows when he is and is not condescending, and therefore (b) the client’s perception is wrong. This position will interfere with later analysis of angry episodes, when the therapist will be trying to convince the patient to consider the possibility that stimuli may operate outside awareness, that other people’s perceptions contain valuable information, and that social situations (such as psychotherapy) can be sources of ideas for

...the most commonly mentioned helpful tool was the therapist’s use of judicious self-disclosure of the counter-transference (disclosure of the therapist’s own feelings).

change. A more fruitful approach to a patient accusation is to engage in visible self-evaluation (“*First, I apologize. I really don’t want to come across as condescending. Do you think you could help us both with this by telling me specifically what you saw me do that was offensive?*”) By acknowledging that there might be a reality basis to the patient’s perception, the therapist models one of the tools for self-growth. As a side benefit, the patient learns what stimuli might be eliciting his or her anger or upset, setting the stage for his or her own self-evaluative process. This process helps to avoid the conflicts that led to early termination among the trauma patients in the Trauma Countertransference Study (e.g., perceived struggles over control and perceived devaluing of the patient’s perspective).

Model anger in connection.

Perhaps most important in the successful management of anger in psychotherapy is the gradual introduction of the understanding that anger can be experienced in the context of a relationship. For many who have been traumatized by violent actions, an angry individual is by definition a dangerous one. Similarly, anger and attachment in the self cannot be experienced simultaneously in some traumatized patients. When the patient either sees or feels anger, the threat of abandonment or injury produces a protective distancing response. Thus a minor frustration is presented with the behavioral and affective power of a relationship-ending betrayal. (“*I don’t know if I can continue to see a therapist who respects me so little that he can be late for my appointment.*”) Here again, the response of the therapist (and significant other) is to be frightened, upset, or angered by the seeming over-reaction, knocking the entire discussion off-track.

Therapist disclosure of low levels of countertransference anger in the context of a continuously existing and respectful relationship is a model for the patient, moving the individual toward acceptance of anger in the other and in the self. The goals of countertransference management and disclosure of anger, I have argued elsewhere (7), is to model “anger in connection” – the ability to feel and disclose anger without indirectly implying that the relationship has suffered irreparable injury. For example, the therapist might say:

I know that I hurt you and I hope we can try to work it out. That matters to me. But right now you are sending me a message that our whole relationship is in jeopardy instead of just letting us be angry at each other for a short time. I end up being so worried about your threat of destroying our relationship that I stop thinking about the thing I originally did wrong. Don’t you think that might defeat the purpose of your statements, preventing me from changing rather than helping me change?

Conclusions

Both the empirical investigation described above and the theoretical and clinical literature underline the importance of anger in trauma therapy, as well as the difficulty in managing it well. The discomfort of therapists in these situations – even the master therapists in the APA training tape mentioned earlier – is clear,

suggesting the need for further discussion and training on this key topic. This brief review is meant to provoke such discussion among trauma therapists.

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MONTHLY MENTAL HEALTH CRISIS COUNSELING CONFERENCE CALLS

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."

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For further information, please call:
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Disaster Services Coordinator,
National Center for PTSD,
650-493-5000 ext. 22494.

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The Education and Clinical Laboratory Division for the National Center for Post Traumatic Stress Disorder at the Palo Alto CA VAMC, in collaboration with the VA Employee Education System, offers a Clinical Training Program (CTP). The training program is approved for 30 Category 1 CEUs for physicians, psychologists, social workers, and nurses.

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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:

Josef.Ruzek@med.va.gov

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

NATIONAL CENTER FOR PTSD EDUCATION, TRAINING , & SUPPORT SERVICES

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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

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Conferences and Training Events

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