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EXPOSURE THERAPY FOR THE TREATMENT OF POSTTRAUMATIC STRESS DISORDER

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Millie C. Astin, Ph.D.

Early conceptualizations of the development and maintenance of Posttraumatic Stress Disorder (PTSD) were based on Mowrer's Two-Factor Theory of classical and operant conditioning (1-2). This conceptualization was further developed with the introduction of emotional processing theory. Foa and colleagues proposed that a fear-based memory network develops following a traumatic event which contains information about trauma-related stimuli, responses to the trauma, the meaning of trauma-related stimuli, and subsequent responses (3-4). In order to modify the fear network, it must be activated so that adaptive and accurate information can be incorporated into the network that is inconsistent with an extreme fear reaction. Avoidance of trauma-related memories and cues, however, prevents this from happening.

The core component of exposure therapy is helping the client confront realistically safe, feared stimuli until fear decreases. While there are a number of different adaptations of exposure with trauma survivors, in Foa and Rothbaum's approach, the trauma patient is asked to "relive" her trauma experience by describing it aloud repeatedly in present tense for 45-60 minutes (4). The patient is encouraged to use as much detail as possible, especially sensory memories such as smells, sounds, etc. as well as thoughts and feelings experienced during the event.

An example of imaginal exposure follows:

Barbara O. Rothbaum, Ph.D.

It's dark. I'm driving home from work and decide to stop by an ATM machine to make a withdrawal because I won't have a chance before work the next day. I drive into the bank parking lot. It's deserted. I think, "Good, no one else to worry about." My heart is beating a little faster anyway, but I tell myself that I'm safe." I get out of my car and walk up to the ATM. I have my card ready and I begin the transaction. I get the money and put it into my purse. Suddenly I hear something rustle and I feel like someone is behind me. I turn around quickly and see a man with a ski mask over his head. He's got a gun and he's pointing it at me. I'm terrified. All I can think is that he's going to kill me. He's going to kill me. Somehow he grabs me by my neck. He puts the gun right up to my temple. It feels cold and hard. I can hardly breathe because I'm so frightened. My chest feels tight and my legs feel weak. He smells of tobacco and sweat. I feel a wave of nausea come over me. He stands behind me with the gun to my head and tells me to withdraw as much money as I can. I do it, but my hands are shaking. Then he tells me to hand over the money I had withdrawn. When I do, he starts dragging me over to my car. I say to myself, "No, you can't go with him. He'll rape you and then he'll kill you. I've got to figure out how to get away." My heart is pounding so loud that it's hard to think. He opens the door to the driver's side and tries to push me in. I try to resist. I say, "no!" This makes him mad and he takes the gun and hits me on my right cheek and the side of my head. He says, "don't make me kill you, bitch." My cheek stings and I'm afraid he'll shoot me right there, so I get into the car and move over to passenger side. He gets in and tells me again, "don't do anything stupid or I'll pop you." I know what he

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FROM THE EDITOR...

This issue revisits the use of exposure treatment for PTSD. Since Keane wrote about the role of exposure therapy five years ago in the Clinical Quarterly (2), exposure therapy has gained more empirical evidence for its effectiveness than any other trauma-related treatment. Proponents of emotional processing theory hypothesize that a maladaptive fear-based memory network can develop in response to traumatization and that this maladaptation can be modified through the survivor's repeated detailed re-telling of what was experienced during the course of the traumatic event. This implies that in order for a survivor to "successfully" adapt, he or she must remember thoughts, feelings, and images (imaginal re-exposure) which have been consciously or unconsciously avoided. Naturally this raises questions for clinicians and survivors. For example, does imaginal exposure result in adverse reactions similar to actual exposure? Does exposure therapy cause patients to become depressed, or can it induce a psychotic reaction? These and other questions about exposure therapy are addressed in this issue of the Clinical Quarterly. Mille Astin, and Barbara Rothbaum provide a brief review of the efficacy of exposure therapy, list 8 common myths associated with its use, and provide an overview of clinical guidelines for exposure treatment.

In a second article, Donald Meichenbaum, discusses the mediative role of survivor's stories, delineates common narrative themes that interfere with effective coping, and describes how a constructive narrative approach to psychotherapy can help individuals create new stories wherein they view themselves as survivors instead of victims. In addition, Dr. Meichenbaum highlights core tasks of psychotherapy with patients with PTSD.

This issue of the Clinical Quarterly also marks the introduction of *Early Intervention: A Clinical Forum*. Joe Ruzek, Associate Director of Education, National Center for PTSD, and co-chair of the "ISTSS Early Intervention Area Interest Group" will review current issues and findings related to emergency response and early intervention. *Women and Trauma: A Clinical Forum* will appear alternately with this column. We wish to thank Marie Caulfield for her contribution as co-editor of the women's column this last year. Dr. Caulfield moves into the private sector and Annabel Prins, psychologist, National Center for PTSD, becomes sole editor.

Bruce H. Young, Editor

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means. He means he'll kill me. I think about my family, how my kids aren't going to have a mother. I feel tears welling up, but then I feel angry. He starts driving around town. Soon, I realize that I have no idea where I am. Then..."

The patient finishes her description of her trauma including the sexual assault and repeats it two more times while the therapist audiotapes it. Following imaginal exposure, therapist and patient discuss the exposure and insights into the trauma made during exposure to facilitate cognitive integration. For homework, the patient listens to her exposure tape multiple times to facilitate further habituation.

Research Findings and Clinical Conclusions about the Efficacy of Exposure Therapy

Exposure therapy has been used with great success for many years to treat a variety of disorders including phobias, panic, and obsessive-compulsive disorder. In the last 15-20 years, exposure has been applied and adapted for treatment of PTSD. Exposure therapy has more empirical evidence for its efficacy than any other treatment for trauma-related symptoms. Twelve studies were included in the review of exposure for PTSD in the ISTSS Treatment Guidelines, eight of which were well-controlled methodologically (5). Eleven out of the twelve studies found exposure to be an effective treatment for PTSD for combat veterans, rape survivors, and mixed trauma survivors. The one study with equivocal results used guilt and shame-producing stimuli during exposure with combat veterans rather than anxiety-producing stimuli (6). Given these data, it was concluded that exposure is a highly effective treatment for trauma, has the strongest empirical data to support its efficacy, and has been evaluated with a greater number of trauma populations than any other treatment.

The Expert Consensus Guidelines for the treatment of PTSD also rated exposure treatment as one of the most effective treatments for PTSD (7). These guidelines identified exposure therapy as the quickest acting treatment for PTSD and one of the treatments preferred across trauma populations. Despite extensive and consistent empirical evidence supporting the efficacy of exposure treatment for PTSD, many clinicians are reluctant to use exposure. In fact, in the Expert Consensus Guidelines, exposure was rated as less safe than other treatment options such as cognitive therapy, psychoeducation, and anxiety management and as less acceptable than these other treatments. They were also reluctant to recommend the use of exposure when other comorbid conditions were present (e.g., depression, substance abuse, etc.).

Exposure therapy has more empirical evidence for its efficacy than any other treatment for trauma-related symptoms.

Myths about Exposure Therapy

As we have presented our work with trauma survivors, we have been confronted with a number of beliefs of clinicians and researchers that have led them to be less than enthusiastic about exposure therapy. We list and discuss several of these below.

1. ***Encouraging trauma survivors to relive their trauma in imagination (the key component in exposure) is cruel and revictimizing.*** Exposure elicits traumatic memories and trauma-related affect particular to the trauma survivor. These memories are not dangerous in and of themselves. However, because they have been linked with trauma-related affect, they often *feel* dangerous. Allowing oneself to think about the trauma memories actually allows the survivor to process them so that they can be integrated into memory in an adaptive manner. Moreover, it is important to remember that these memories and feelings are already experienced, in a nonadaptive fashion, by the trauma survivor. In reality, successful exposure treatment reduces the survivor's intrusive memories and diminishes painful affect associated with those memories.

2. ***Exposure takes away the autonomy of trauma survivors because they are confronted with what they do not wish to remember.*** Avoidance is key to understanding PTSD. The trauma memories intrude into consciousness because they have not been adequately processed, and because they are painful, the survivor avoids the memories, which prevents them from being processed. This vicious cycle has to be broken in order for the trauma survivor to gain control over the traumatic experience. Exposure actually empowers

trauma survivors to be able to be in charge of their trauma memories. Because it is key to therapeutic change, all good therapists at times confront their clients with painful information that clients would rather avoid. Such "confrontation" is crucial to trauma therapy. While this may be done in a variety of ways, exposure therapy is a very efficient and effective way to help the survivor confront traumatic memories. Like any therapy, it is important to describe the components of exposure and explain the rationale for them so that the client can make informed choices about treatment. Also, patients have chosen to participate in this type of therapy, so therapists are helping them to do what they have not been able to do alone. Exposure therapy respects that some clients may choose alternative treatment options.

3. ***Exposure can only be used with survivors of discrete traumas such as rape, natural disaster, and motor vehicle accidents.*** Exposure-based treatments were first applied to combat veterans, then to rape survivors, and ultimately expanded to a variety of trauma populations. Even within the context of "discrete" traumas, there can be multiple events and/or multiple perpetrators. In our current studies with rape survivors and mixed trauma survivors, many have a history of childhood sexual abuse and other chronic trauma that we also address in treatment. Naturally, with multiple events to cover, additional sessions are sometimes necessary. However, in our experience, using the worst memories and/or typical incidences representative of the trauma as a whole usually allows generalization to the complete trauma experience.

4. ***Exposure can only be used with individuals who are healthy and stable; it cannot be used with the typical trauma survivor who is complex and fragile.*** As with most outpatient treatments of trauma, care must be taken with clients who are imminently suicidal, psychotic, or who have a history of psychotic decompensation. There are no data to support the use of any trauma-focused therapy with these populations. All therapists must switch from trauma therapy to crisis management and containment when a client becomes actively suicidal. At the same time, however, we have successfully treated or have colleagues who have treated trauma patients with a history of multiple psychiatric hospitalizations, multiple suicide attempts, high levels of dissociation, treatment resistance to other therapeutic interventions, borderline intelligence, mild brain injuries, and comorbid disorders such as depression, panic disorder, and substance abuse.

5. ***Exposure may induce psychosis or severe depression.*** There is no evidence at all to support this. Clients typically feel worse (more intrusive memories, decreased sleep, increased depression, etc.) for the first half of treatment, but these problems usually resolve as the trauma is processed. For clients who do not improve or who drop out prematurely, symptoms are not likely to stay at the same level. Such clients typically resort to avoidance and acute symptoms diminish to pre-treatment levels.

6. ***Exposure cannot address broader trauma-related symptoms other than anxiety and PTSD.*** Even though the rationale for exposure focuses on modification of fear structures, most strong affect will habituate in the absence of adverse consequences. In our clinical experience, many clients note that their feelings of depression, rage, sadness, and guilt diminish with exposure. Generally, in addition to reducing PTSD, studies have shown prolonged exposure (PE) also reduces depression and self-blame (5). Pitman et al. did find equivocal results when they used exposure to guilt and shame-producing stimuli in a few combat veterans whose guilt and shame were often related to their behavior in combat(6). Additionally, Foa et al. report that patients whose primary response is anger rather than anxiety may not benefit as much from exposure (8). Preliminary research by Novaco and Chemtob (9) suggests that some trauma populations may benefit from anger management in conjunction with trauma treatment. Also, exposure is frequently combined with cognitive restructuring to address other issues crucial to trauma resolution such as self-blame or distorted relationships or worldview.

7. ***Exposure does not allow trauma survivors to recover at their own pace.*** The fact is that patients haven't recovered at their own pace if they are presenting for treatment of PTSD and they need assistance. Therapist sensitivity to individual differences in their speed of habituation and response to anxiety-provoking situations is an essential component of good exposure therapy. At the same time, making sure that the client's exposures are long enough and are repeated frequently enough is vital as well. In this regard, exposure can be likened to a medical procedure.

The procedure is deemed necessary for recovery, although not pleasant for the patient. Furthermore, the procedure must be conducted in the optimal manner to receive optimal recovery.

8. ***Controlled studies of exposure therapy only use "clean" PTSD patients.*** Subjects are not usually excluded for multiple trauma history, other comorbid conditions or for Axis II pathology. Generally, the primary exclusionary factors are limited to substance dependence, imminent suicidal risk, history of psychosis or mania, illiteracy, and mental retardation (5).

Clinical Guidelines for Exposure

We sometimes hear from clinicians who say they have tried exposure, but have not found it to be effective. Frequently, important guidelines for exposure have been overlooked making successful use of exposure less likely. Some of the more important guidelines are discussed below. See Foa & Rothbaum (4) and Jaycox & Foa (10) for more detailed guidelines.

1. ***Patients should remain in the exposure situation long enough for their anxiety and distress to decrease.*** The tendency for most clinicians is to back off or discontinue exposure at the first sign of distress in the patient. While this is a generally well-intentioned effort to protect the patient, it actually reinforces avoidance of the trauma and impedes necessary emotional processing. Initially, a certain amount of distress *should be expected and normalized* for the patient. Again, because the trauma memory itself is not dangerous, trauma-related affect will diminish if given the chance. We want clients to learn that they do not need to fear their trauma memories. The therapist's job is to help the patient "ride out" the anxiety in a safe environment until it is significantly diminished and/or eliminated.

2. ***The therapist should encourage the patient to use as much detail as possible, especially for the worst parts of the trauma.*** Again, the tendency here is to let the patient summarize the worst parts or to skip over them entirely. For example, a rape survivor might give good details of being abducted, but when she reaches the description of the actual penetration, she may say something vague like, "then he did it." This essentially allows the patient to go through the motions of doing exposure, but still avoid critical elements of the trauma. In addition to wanting to avoid the memory, patients may also be embarrassed or ashamed of some elements. As described above, such avoidance impedes emotional processing of the trauma and short-circuits the treatment.

3. ***Patients should be allowed to progress at their own pace.*** Despite the need to do exposures long enough, repeatedly enough, and detailed enough, it is essential to go at the patient's pace. This is especially true in the first exposure when the patient is likely to be experiencing high levels of trauma-related affect. Pushing the patient for details should be avoided in the first exposure. Additionally, individuals differ in their speed of habituation and response to anxiety provoking situations. The therapist must take these differences into account. Never proceed to a new trauma memory or to the next level of the hierarchy (for *in vivo* exposure) unless there is sufficient time to allow for habituation. If the client's anxiety and distress do not significantly decrease before the end of the session, be sure to spend time helping the client to relax and debrief. If a patient is highly anxious after exposure, it is crucial to help him calm down before ending the session so that he learns that he can think about the trauma and experience strong feelings, but still be OK.

4. ***Therapists should gauge their responses according to patients' reactions to exposure.*** Problematic responses tend to fall at two extremes: either the patient has trouble engaging in the memory or feeling trauma-related emotions; or the patient is so engaged in the trauma that she is overwhelmed by trauma-related affect. Frequently, when a patient becomes engrossed in the exposure, she is having trouble remembering that she is not actually in the trauma at that moment. In such situations, it is appropriate for the therapist to remind the patient that she is in a safe place, that the therapist is right beside her, and what they are dealing with is just a memory. This helps the patient to detach slightly from the exposure so that trauma-related affect is more manageable. The more typical and troublesome scenario is the patient who has trouble engaging in the exposure. Exposure, of course, requires that the patient trust the therapist enough to engage in the very memories that he has been actively avoiding. Avoidance can be quite direct, but it frequently can be amazingly

subtle. Some patients go through the motions of exposure, but distance themselves emotionally. Their descriptions of the trauma often sound flat and matter-of-fact. Many trauma survivors have learned to dissociate as a form of avoidance and may not even realize that they are detaching from the trauma memory. In this situation, it falls to the therapist to try to engage the patient in the memory in a gentle manner. This can sometimes be accomplished by prompting for more details ("where are you standing as he attacks?"), asking about emotions and thoughts during the trauma ("what do you feel as he says that?"), and probing for sensory memories ("can you smell him?"). Anything that makes the memory more vivid may help patients to engage emotionally. During the preparation stages before exposure begins, it is crucial to encourage patients to allow themselves to feel those emotions and answer any fears about what will happen if they do so. After the exposure is over, it is also important to reinforce this message, and praise their efforts to engage in trauma-related emotions.

Although we are clearly advocating the use of exposure therapy for PTSD, we end on a word of caution. Only therapists trained in exposure therapy should attempt it with patients. Bad exposure therapy is simply bad therapy. However, both research and our own clinical experience suggest that when done properly, exposure therapy is a highly effective treatment for PTSD.

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Barbara Rothbaum is Associate Professor of Psychiatry and Behavioral Sciences at the Emory University School of Medicine and Director of the Trauma and Anxiety Recovery Program. She is principal investigator for three NIMH treatment outcome studies including one grant which is exploring the efficacy of Virtual Reality Exposure with combat veterans with PTSD. She has been instrumental in the development, application, and empirical validation of exposure treatment for PTSD.

TREATING PATIENTS WITH PTSD: A CONSTRUCTIVE NARRATIVE APPROACH

DONALD MEICHENBAUM, PH.D.

Donald Meichenbaum, Ph.D.

People are story-tellers. They offer accounts that are designed to make sense out of the world and their place in it. They construct narratives that include descriptions of behavioral events and of their and others' reactions. As Mair (1) observed, "We live through stories."

The observation that people tell stories, or actually construct their personal realities, is not new From the philosophical musings of Immanuel Kant to those of Jean-Paul Satre, from the psychological writings of Wilhelm Wundt to those of George Kelley, there is a long tradition of the importance of story-telling or the creation of personal meaning. Common to this tradition is the view that individuals do not merely respond to events, but that they respond to their interpretations of events. This constructivist view has both an historical and a current tradition. The simplest rendering of the constructive narrative perspective is the Buddhist observation:

> *"We are what we think. All that we are arises with our thoughts. With our thoughts ("stories") we make the world."*
> Dhammapada

In modern form, Howard (2) observed:

> *"We are lived by the stories we tell. Beware of the stories you tell yourself, for you will surely be lived by them."*

Now, consider what happens to people's stories when really bad things (traumatic events) are experienced. What happens to child's story when she is sexually abused; or what happens to the account of the individual who is raped; or to community that is devastated by a natural disaster that they believe was avoidable?

In considering the answer to this question, it is important to keep in mind that not all individuals who have been sexually abused, raped, or victimized by traumatic events that were due to intentional human design, will develop PTSD or other forms of psychopathology. In fact, epidemiological research indicates that while three-quarters of individuals will experience traumatic events during the course of their lives (i.e., stressors that meet Criterion A of the DSM-IV diagnosis of PTSD), only approximately 10% to 25% (depending on the specific population sampled) will evidence a lifetime instance of PTSD (3). While a number of stimulus, response, vulnerability and recovery factors can be highlighted as influencing the coping process, the focus of the present discussion is whether these variables are mediated through the narratives that individuals offer themselves and others. Meichenbaum and Fitzpatrick (4) compared the nature of the narrative of those individuals who continued to have difficulties following exposure to traumatic events versus those who were able to continue functioning, in spite of the trauma exposure. Once we appreciate these differences, then we can examine how psychotherapists and others can help individuals cope more effectively with the aftermath of trauma exposure.

An examination of the literature indicates that individuals who continue to evidence ongoing distress and maladaptive behaviors following trauma exposure, tend to:

(1) evidence intrusive ideation and are unable to resolve their stories and integrate their traumas;

(2) continue to search for an explanation and fail to find satisfactory resolution (i.e., try to answer "why" questions for which there are not acceptable answers);

(3) engage in "undoing" activities or what has been called contrafactual thinking ("What – if" or "only – if" thinking);

(4) continually make comparisons between life as it is, as compared to what it might have been or what it was;

(5) see themselves as blameworthy;

(6) see themselves a "victims" and "at risk" with little expectation or hope that things will improve or change.

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NEW DIRECTIONS

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

During the eleven years in which this New Directions column has appeared, I have generally focused on new directions of National Center programs or on new directions for the trauma/PTSD field itself. Today, with a mixture of emotions, I need to tell you about new directions in the National Center's leadership. This is because a number of colleagues have decided to move on to new opportunities. I want to recognize them for helping us move forward, honor them for their important achievements, describe some of their unique contributions, and wish them all well for the future. They are: Dennis Charney, Jessica Wolfe, Ray Scurfield, Doug Bremner, Frank Weathers, Sarah Miyahira, David Riggs, Marie Caulfield, and Julian Ford.

Before I begin to thank each one of them, in turn, I'd like to remind you about the remarkable stability in leadership we have enjoyed since we were established on August 29, 1989. As you know, we live in an era of great mobility in which nomadic academicians tarry at oases of learning for relatively brief periods of time before they seek new challenges beyond the distant horizon. Indeed, the people mentioned above, as well as other National Center colleagues, have all had a succession of tempting offers from elsewhere throughout this period. Fortunately, until recently, emigration has been negligible and most have remained. And while they remained, they helped to generate the research and educational momentum that has propelled the National Center to its present position.

In a future column, I will tell you about our new leaders and about some of the new directions towards which they will lead us. But for now, let's focus on our distinguished colleagues and thank them for their unique achievements.

Dennis Charney, a psychiatrist, was one of our founding fathers who in 1988 helped to create the vision that later became the present National Center for PTSD. One of the most creative and productive biological psychiatrists in the world, Dennis established and led our Clinical Neurosciences Division at the West Haven VA Medical Center and Yale Medical School. His lasting contribution is the demonstration that PTSD produces abnormalities in brain structure and function and that many key psychobiological systems that promote coping and adaptation are altered in PTSD patients. He has moved on to the National Institute of Mental Health where he will direct its intramural research program on affective and anxiety disorders.

Jessica Wolfe, a psychologist, began as a researcher on women with PTSD in the Behavioral Science Division at the Boston VA Medical Center. Results of her well-designed survey of female Vietnam veterans led to a belated appreciation of special aspects of PTSD among these women. The importance of her work prompted us to establish the Women's Health Sciences Division as the sixth component of the National Center consortium in 1994 with Jessica as its Director. Her interests were wide ranging and included assessment of PTSD in women, integrating PTSD and primary medical care, neuropsychological assessment of Persian Gulf veterans, and utilization of VA clinical facilities by female veterans. She has moved on to become a health consultant in the private sector.

Ray Scurfield, a Vietnam veteran, social worker, and passionate advocate for veterans, was an early Vet Center Team Leader and Deputy Director of Readjustment Counseling Service. Next he established a Specialized Inpatient Unit at the American Lake VA Medical Center before heading further west to become the first Director of the Pacific Center for PTSD in Honolulu. When the research and education component of the Pacific Center was reconstituted as a separate entity, Ray joined the National Center as Director of the Pacific Islands Division, the seventh and final member of our consortium. Ray's major interest was in group therapy and the delivery of effective and accessible care to veterans. He also fostered research on anger management and the unique and complicated challenge of treating minority veterans with PTSD. He has moved to academia where he is in the Department of Social Work at the University of Southern Mississippi.

Doug Bremner, a psychiatrist at the Clinical Neurosciences Division, has been an extremely prolific investigator who has made some very important discoveries. Utilizing brain-imaging techniques, Doug was the first to demonstrate reduced hippocampal volume among male Vietnam veterans and female childhood sexual abuse survivors with PTSD. He also showed elevated corticotropin-releasing factor (CRF) in the spinal fluid of veterans with PTSD. Doug's other important research activities included the development of a scale to study dissociation in people with PTSD before the importance of dissociation in this disorder became apparent to most of us. He is moving to the Department of Psychiatry at Emory University Medical School.

Frank Weathers, a psychologist, formerly at the Behavioral Science Division, was a major force in developing two major instruments for assessing PTSD symptom severity. Along with Dudley Blake (who left the National Center for Montana many years ago), Frank developed the Clinician-Administered PTSD Scale (CAPS) which many consider the gold standard for PTSD assessment, and studied its psychometric properties. He also developed the PTSD Symptom Checklist (PCL), a self-rating scale that has also performed extremely well. He has joined the Department of Psychology at Auburn University.

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EARLY INTERVENTION: A CLINICAL FORUM

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In this issue, we begin an occasional column focusing on developments and new thinking related to early intervention to prevent development of chronic PTSD and other post-trauma problems. It has long been believed that mental health intervention is more likely to be successful if services are delivered shortly after traumatization. This idea, along with the obvious human desire to respond quickly to help trauma survivors, has led to the development and widespread implementation of a variety of early intervention approaches. Well-known are methods of critical incident stress debriefing, now commonly delivered to many trauma survivor audiences (e.g., Red Cross workers, emergency services personnel, disaster victims) following local incidents and large-scale community disasters alike. In major disasters, many of the other services that are offered are also intended in part to improve the mental health of affected individuals. In the arena of sexual assault, various forms of support and counseling (e.g., in the ER or via rape crisis center services) are available in many communities to assist women shortly after their attack. Services designed to reduce mental health casualties associated with combat, long a feature of U.S. military psychiatry, have continued to evolve; combat stress control teams often now accompany combatants into the warzone and work to prevent problems due to extreme stress.

What is striking about these various approaches is that they have evolved largely independent of one another. The professionals and paraprofessional workers who have designed and delivered these services have traveled in different circles, with the result that ideas developed in one sphere have not always fully been brought to bear in the others. This may offer a useful opportunity for a "cross-fertilizing" dialogue between practitioners and researchers operating in these different fields. What is also striking is that systematic evaluation of the range of early preventive interventions to assess their impact has been slow to develop. Partly this is due to the very real logistical and ethical difficulties of evaluating services offered in times of crisis. Perhaps it is also due to the relative newness of the field of traumatic stress research. Things do appear to be changing rapidly now, however. Randomized controlled trials comparing some alternate early intervention methods have now appeared in the literature (4). Also, a number of systematic literature reviews related to early intervention have been published (e.g., 5). Therefore, it also seems a good time to make practitioners aware of evaluation efforts as they unfold.

Across the next decade we can expect to see significant developments in the field of early intervention, as more prospective studies are conducted to trace the trajectory of traumatic stress symptoms and as a variety of interventions are developed and tested. Cognitive-behavioral preventive treatments are rapidly being developed and evaluated, with promising results to date. On the other hand, early evidence bearing on the effectiveness of debriefing in preventing PTSD is not so positive (6). It is to be hoped that advocates of a range of theoretical approaches to traumatic stress will apply their ideas to early intervention, and that delivery settings with significant opportunity to provide preventive services to trauma victims (e.g., hospital trauma centers) will experiment with new methods of doing so.

In future editions of this column, we'll highlight innovative early intervention approaches, interview those who have developed them, and describe efforts to evaluate the effects of these approaches in preventing development of chronic PTSD.

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Individuals who have been exposed to traumatic events often get "stuck" in engaging in such a narrative account. Moreover this negative stress-engendering process is further exacerbated by the style and manner with which they offer their accounts. For example, when traumatic events occur and individuals feel victimized, mere words often seem inadequate to describe what they have experienced.

In order to describe the traumatic events that have transpired and their lingering impact, individuals often use metaphorical descriptions:

"I am a prisoner of the past."

"I am soiled goods."

"I am on sentry-duty all the time."

"I stuff my feelings."

Meichenbaum (3) has collated the variety of metaphors that patients with PTSD offer describe their hypersensitivity, their psychic numbing, their intrusive ideation, their sense of personal loss, and the implications for their life.

Consider the impact of individuals telling others and themselves that they are "prisoners of the past," or that they are "soiled goods." Consider also the impact on the view of oneself and the world if an individual is a member of a family or a community that offers a similar story-line and employs similar metaphorical descriptors. It is proposed that the language individuals use, the metaphors they employ, have important implications for how they appraise events and how they construct narratives. Moreover, when traumatic events occur, they effect individuals' core beliefs about issues of safety, trust and fairness that provide the scaffold or building blocks of the stories individuals tell (5-6).

Implications for Treatment

If one adopts a narrative perspective, then psychotherapy can be viewed as a collaborative co-constructive approach, where with the help of the therapist, the patient comes to "re-author" his/her account or construct a new narrative. The PTSD psychotherapy literature is filled with descriptions of how therapists try to help their patients to:

Assimilate the traumatic experiences (Janet)

Fabricate a new meaning (McCann & Pearlman)

Develop a healing theory (Figley)

Re-story their lives (Epston & White)

Restructure and conclude the trauma story (Herman)

Come to terms with or resolve their hurt (Thompson)

Rebuild shattered assumptions (Janoff-Bulman)

Develop new mental schema and seek completion (Horowitz)

Acknowledge and work through memories (Courtois)

Reconstruct the self and provide new perspectives about the past (Harvey)

Develop their own voice and not repeat the voice of the perpetrator (Meichenbaum)

What do all of these psychotherapeutic tasks have in common? They each imply that patients needs to tell their stories differently. Patients enter treatment with an account that reflects a sense of victimization, demoralization, helplessness, and hopelessness. They feel "victimized" by circumstances, by their feelings and thoughts, and by the absence of support from others. This is especially true if they have a history of victimization (Note, that 38% of female victims in North America have a history of repeated victimization, Meichenbaum (3)).

How can therapists help patients change their accounts from being "victims," to becoming "survivors," or to people who can "thrive"? Moreover, how can the therapist help patients with PTSD develop the intra- and interpersonal coping skills to manage PTSD and comorbid symtomatology, and to handle any occasions of relapse (as trauma), as well as to develop skills to reduce the likelihood of revictimization?

Meichenbaum (3) has provided a detailed account of how these treatment steps can be implemented. The main treatment features can be highlighted in point form as a set of core psychotherapeutic tasks.

CORE TASKS OF PSYCHOTHERAPY WITH PATIENTS WITH PTSD

1. Develop a therapeutic alliance that is non-judgmental, empathic and supportive. The therapist should validate their patient's experience and even commend the patient for his or her ability to be in touch with his/her feelings. It is also important to ensure the patient's safety.

2. Educate the patient about the nature of PTSD and its various features (e.g., features of traumatic memories, relapse symptoms, and so forth). This is not a lecture, but arises from a Socratic-dialogue and discovery process (e.g., as a by-product of the patient self-monitoring).

3. Help the patient stabilize PTSD and comorbid symptoms. Increase the patient's coping skills and enhance self-care activities.

4. Nurture hope. Focus on what the patient has been able to accomplish "in spite of" the trauma experience. Obtain the "rest of the story" of the signs of resilience and build on protective factors.

5. Help the patient to do "memory" work of trauma resolution and reintegration. It is important for patients to share the trauma account and also consider the implications and conclusions they draw about themselves and the world as a result of having experienced the trauma.

6. Help the patient find meaning (salvage something from the trauma) that gives a new sense of purpose, mastery, control, competence and self-acceptance.

7. Ensure that the patient reconnects with others (not delimit social contact to only other victims).

8. Ensure that the patient takes credit for any change (self-attributes improvement to his/her own efforts).

9. Ensure that the patient has the skills to avoid revictimization.

10. Address issues of relapse prevention (i.e., warning signs, high-risk situations, coping with lapses, and anniversary effects of the trauma).

In short, the construction of a new narrative emerges out of the actions that patients take to refashion their lives. Patients need to perform "personal experiments" in their everyday experience and take the data from these efforts as evidence to unfreeze their beliefs about themselves and the world. They need to begin to tell themselves new stories that move them from viewing themselves as "victims" to becoming "survivors." For example, in one clinical case the patient initially viewed herself as being a "stubborn victim: and over the course of treatment she came to view herself as a "tenacious survivor." In therapy, the patient was asked what she had done that justifies her observations that she was a "tenacious survivor." In answering, not only was she conveying information to the therapist, she was also able to convince herself of her "tenacity." This is an evidential model of change that follows from the constructive narrative perspective.

Therapy provides the safe supportive environment where patients can begin to experiment ("try on") their new story. In turn, the patients can extend their new story-line to their every day living experiences.

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New Directions, continued from page 56

Sarah Miyahira, a psychologist, was enticed away from the East-West Center at the University of Hawaii to become Ray Scurfield's second-in-command. When Ray departed for the Gulf Coast two years ago, Sarah became Acting Director of the Pacific Islands Division. She carried out these responsibilities for two years before her recent resignation. In addition to training young psychologists, Sarah's major interest has been the application of telehealth technology to the assessment and treatment of psychiatric disorders in rural and remote areas such as the Hawaiian and other Pacific Islands. She also played a key role in initiating our ongoing research collaboration with active duty personnel at Tripler Army Medical Center. Sarah has remained at the Honolulu VA facility but has recently left the National Center to pursue her other interests.

David Riggs, a psychologist at the Behavioral Science Division, had a keen interest in family dynamics, interfamilial aggression, and how both are uniquely affected by PTSD. He carved out a unique role for himself as an expert on domestic violence, especially within the families of veterans with and without PTSD. His conceptual and experimental approaches were always original and clinically relevant. He has entered the private sector as a consultant.

Marie Caulfield, a psychologist at the Women's Health Sciences Division, was especially interested in the impact of acute and severe stress within the military setting. She investigated predictors of successful adaptation to the severe stress of basic training at Parris Island among female recruits in the Marine Corps. Marie also graciously served as Acting Director of the Women's Health Sciences Division for the six months between Jessica Wolfe's resignation and her own recent departure. She has also entered the private sector to work with her husband, David Riggs, as a consultant.

Finally, Julian Ford, a psychologist, served at the Executive Division for four years as my Deputy for Education and Clinical Networking. Julian worked closely and energetically with the Education Division to develop our, now flourishing, programs on disaster mental health and integration of PTSD with primary medical care. He also joined our research effort on the psychological impact of experimental exposure to mustard gas among World War II army and navy personnel. Julian often served as my personal representative in networking assignments with officials in VA, DoD, American Red Cross, and the Nation's Emergency Medical Disaster System. He has joined the Department of Psychiatry at the University of Connecticut.

In some cases, these words of thanks are long overdue. In others, the departures are very recent or just about to occur. In all cases, however, these individuals have enriched our National Center community and spurred us onward through their creativity, initiative and determination. Each in his or her own way, has made a unique and lasting contribution to expanding our understanding of the psychological consequences of traumatic exposure. Each has helped open up new vistas for prevention and treatment.

Please join me in thanking each of these individuals for all they have accomplished.

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** and **American Red Cross** volunteers 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."

Past speakers have been affiliated with VA Central Office, VA Medical Centers, Readjustment Counseling Service, American Red Cross, Department of Defense, the private sector and have included:

Laurent Lehmann, M.D.
Teri Elliot, Ph.D.
Judith Lyons, Ph.D.
Dusty Bowencamp, R.N.
Mark Dembert, M.D.
Paul Ofman, Ph.D.
John Whitten, M.S.W.
Bruce Crow, Ed.D.
Jerry Jacobs, Ph.D.
Joe Gelsimino, Ph.D.
Patricia Tritt, R.N.
John Tassey, Ph.D.
Joe Sivak, M.D.,
James Munroe, Ph.D.
Karen Sitterle, Ph.D.
John Weaver, M.S.W.
Francis Abueg, Ph.D.

For futher information, please call:
Bruce H. Young, L.C.S.W.
Disaster Services & Training Coordinator
National Center for PTSD

650-493-5000 ext. 22494.

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NATIONAL CENTER FOR PTSD CLINICAL TRAINING PROGRAM

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.

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.

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

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: *bruce_young_ncptsd@hotmail.com*

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.

POSTDOCTORAL PSYCHOLOGY FELLOWSHIPS IN PTSD

Two one-year fellowships are available through the multidisciplinary PTSD Training Program at the National Center for PTSD, Pacific Islands Division of Honolulu Veterans Affairs Medical and Regional Office Center. Training includes working with veterans in outpatient and inpatient settings, weekly didactics in PTSD, and involvement in research in PTSD and/or cultural psychology.

Qualifications include: U.S. citizenship, earned doctorate in psychology from an APA-approved program by start date, and completed APA-approved internship. Appointment begins September 1, 2001. Stipend for the current year (40 hours per week for the full year) is $37,000 before taxes, including ten paid Federal holidays, 13 days of annual leave, and 13 days of sick leave if needed.

Request application packet from: Dr. Julia Whealin, Education Program Leader, Department of Veterans Affairs, NC-PTSD Pacific Islands Division, 1132 Bishop Street, Suite 307, Honolulu, HI, 96813. Phone: (808) 566-1546. Fax: (808) 566-1885. Completed applications must be received by February 19, 2001.

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