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POST TRAUMATIC STRESS DISORDER

Interview #1: “Differential Diagnosis”

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(Edited slightly for readability)

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Welcome to On Good Authority. I’m Barbara Alexander.

You are listening to or reading Interview #1 of “Posttraumatic Stress Disorder,” a continuing education program covering diagnostic and treatment aspects of this important and controversial subject.

PTSD is one of the very few psychiatric disorders that come under attack in almost every way: every assumption and theoretical underpinning is up for grabs. Nothing about the diagnosis and its treatment has gone unchallenged. In fact, the controversy extends to a debate about our whole Western culture, a culture that tends to make every wrong a legal issue open to lawsuits, and that tends to turn “the human condition,” formerly treated by various flavors of clergy, into medical entities.

Our speakers will go into detail about this, but let me just preview.

The diagnostic category of PTSD first appeared in the 3rd edition of the Diagnostic and Statistical Manual of the American Psychiatric Association in 1980, but it had previously been far from an unobserved phenomenon. What makes this diagnosis unusual is that unlike most categories of diagnoses in the DSM, PTSD is not only symptom-dependent; it is also “situation dependent.” In other words, there must be an identifiable event that qualifies as “traumatic.”

Who, you may ask, defines “traumatic?” For a number of years, the answer was “almost everyone.” The event had to be a stressor that almost everyone would have defined as “traumatic.”

In the 4th edition of the DSM, in 1994, however, that definition was broadened (some would say it was broadened so widely that a freight train could go through it). But also, in addition to experiencing a precipitating event, the person’s symptoms must now include a re-experiencing of the event, avoidance of reminders of the event, and persistent symptoms of hyperarousal, such as sleep disturbance, concentration difficulties, etc. And, the symptoms must last for at least 3 months.

So what’s wrong with that, you may ask? Well, as far as I can gather, there are many who feel that the problems of trauma-exposed people are already covered by combinations of other existing diagnoses. Thus this diagnosis category is viewed as superfluous, with its inclusion viewed as largely political, arising out of Vietnam veterans’ advocacy groups in the late 1970s.

Plus, and this is really the most objectionable, the criteria for a PTSD-inducing stressor has become so broad that virtually any event can now qualify as long as someone perceived it as traumatic. In our finger-pointing,

litigious society where the other guy is always seen to be at blame, and which is rife with malingering, this “diagnostic creep” has brought about vast abuse in courtrooms.

As if these diagnostic issues were not contentious enough, there is little agreement on treatment. The differing opinions tend to run along professional lines—sort of like the story of the three blind men studying an elephant. They touch the elephant to learn what it is like. Each one touches a different part, but only one part, such as the side or the tusk. They then compare notes on what they felt, and learn they are in complete disagreement. The story is used to indicate that reality may be viewed differently depending upon one’s perspective, showing how absolute truths may be relative; the deceptive world of [HYPERLINK “http://en.wikipedia.org/wiki/Half-truths”](http://en.wikipedia.org/wiki/Half-truths) \o “Half-truths” half-truths.

So with PTSD, psychiatrists say that trauma and stress affect the brain and therefore medication is what works and is the treatment of choice. Evidence-based psychologists say that Cognitive Behavioral Treatment works. Some psychoanalysts say that one needs to use deep interpretations to get at the aggression underlying the disorder. Then there is eye movement desensitization, mindfulness and acceptance strategies, imagery transformation, the whole resiliency movement, and even virtual-reality simulation video games which create computerized simulations of the Iraq-like world, including soldiers, explosions, sandstorms, mosques and Muslim calls to prayer. These games slowly to let people be exposed to their fears in a safe environment. And this is certainly not an inclusive listing.

Meanwhile, our soldiers are returning from Iraq and Afghanistan not only broken in body but suffering in spirit as well, and the stigma associated with mental illness is a factor that often keeps them from the help they need.

One thing certain is that we are only beginning to understand the complexities of post-traumatic reactions.

In this program, we’ll look at some of these diagnostic and treatment issues—it is impossible to cover the whole waterfront. Just keep in mind this wonderful quotation variously attributed to a number of people, “Today’s orthodoxy is tomorrow’s heresy, and vice versa.”

We’ll begin this program by interviewing Hugh Johnston, MD, who will give us a look at the differential diagnostic issues of PTSD. Dr Johnston has also spoken with On Good Authority on the subject of Sexual Misconduct and Ethics.

Hugh F. Johnston, MD is clinical associate professor of psychiatry at the University of Wisconsin Medical School. He is a diplomate of the American Board of Psychiatry and Neurology with certification in psychiatry and in child and adolescent psychiatry. He has more than twenty years of research and clinical experience, has authored many clinical and research publications, and has been the recipient of numerous public and private research grants. Dr. Johnston’s enthusiasm, clarity, and effective use of humor have earned him many awards—including the Excellence in Teaching Award from the University of Wisconsin and the Manfred E. Swarsensky Humanitarian Service Award.

ALEXANDER: Dr. Johnston, I have really been struggling with trying to understand what posttraumatic stress disorder is and what it isn’t, because the more I read about it, the more confusing it is and the more complex and controversial it seems. So, I would like for you to tell us: what is posttraumatic stress disorder?

JOHNSTON: Well, it depends upon the lens that you view it through. Of course there is the DSM IV, latest revision TR. When you view it through that lens, it

really is a list of criteria?

There is another related lens. If you view it through the lens of a neuro- scientist, you know that when you expose humans and other creatures as well to extreme stress, you produce changes in the brain. Those brain changes, depending upon which ones you're talking about, have varying degrees of permanency and, of course, result in changes in behavior – and essentially a changed creature, so to speak. So, through that biological lens, posttraumatic stress is a collection of changes that occur when an individual is exposed to some extreme experience.

There is also kind of a humanistic lens to view it through. When we as human beings go through a terrible trauma, yes, there are biological things and yes, there is a “disorder” view of it, but there is also an experiential, humanistic view that our perception of the world and our role in it and what the universe means to us and what we mean to the universe, all of those things have a potential to change. So, I am not surprised that you're struggling a bit with the notion of posttraumatic stress disorder, because it is very complex and there are these different lenses to view it through.

ALEXANDER: So, is it a unique disorder or is it an amalgam of things that we already know about depression and anxiety?

JOHNSTON: Well, I think it is a unique disorder in the sense that, first of all, if you look at the DSM tradition that began with DSM III, the vast majority of disorders listed in the DSM are listed in a way that is agnostic as far as the cause. So, when you look at the DSM, there are descriptions of anxiety disorders and there are descriptions of mood disorders and so on and so forth, but the DSM really stands, again, agnostic as to the cause, for the most part.

Posttraumatic stress disorder and acute stress disorder are a little bit unique because in the DSM, there is a clear message that this is a disorder that has a cause that we can point to, in large measure, and that cause, is, of course, the traumatic, horrific experience. So, it is really very unique in that way. I think that is one of the big things that makes it stand apart from other disorders.

ALEXANDER: Let's say somebody has a traumatic experience like an automobile accident in their twenties or so, and they get anxious in cars over the years, or when a car comes out of a driveway there is a startle response and so it is sort of a long-term reaction, in a sense, but is that posttraumatic stress disorder?

JOHNSTON: Well, it may or may not be. One of the flaws with the DSM is that it tends, as a rule, to take things that are dimensional in nature and then tries to stuff them into categorical boxes.

ALEXANDER: Can you explain please what “dimensional in nature” means?

JOHNSTON: I can, by analogy. If you look at other problems that people have, for example, excess weight. That's really dimensional. Some people, everyone would agree, are just right. They are buff, they are muscular, they are trim. And

then there are people who have a few extra pounds, and people who have a few more extra pounds. The medical system, if you will, needs to have a line drawn and if you're above that line then you are obese and if you're below that line, then you're not obese. That is taking something dimensional and stuffing it into a categorical box.

Another example would be acne. Just about everyone, except perhaps Paris Hilton, has had a pimple or two, but not everyone gets a diagnosis of acne. There is a gray zone and then academic dermatologists figure out ways to draw lines. But really acne and excess weight and posttraumatic stress disorder -- these are all things that exist across a very broad continuum, making it a little bit illogical to try to answer the question, "Does this person have obesity or not?" You might better ask the question, "How much excess weight does the person have?" Or, in the case of acne, rather than saying, "Do they have acne or don't they?" you might ask the question, "How many pimples do they have?"

In the case of posttraumatic stress disorder, I think it would be a fair analogy to ask the question, "Does this person you mentioned who was in that car accident, how many pimples, if you will, worth of PTSD do they have?" They may have enough so that if you go down through the list of the DSM criteria, then you could say with confidence, "This person has PTSD." But, if you go through the list and they don't quite have enough, that doesn't mean that the person has nothing anymore than that the person who has 15 pimples doesn't qualify for the diagnosis of acne. They still have their problems with 15 pimples, and the person who has a car accident maybe has symptoms, but really doesn't quite rise to the threshold of a diagnosis of PTSD. They still have symptoms of PTSD and we struggle with this issue of things that are categorical and things that are dimensional and trying to put dimensional things in categorical boxes.

Some things are very clearly categorical. If you look at Downs Syndrome, trisomy 21, you either actually have an extra chromosome #21 or you don't and that is clearly categorical. Most infectious diseases are categorical. You either have leprosy or you don't and there isn't much in between. But many things in mental health are dimensional and that leads us to scratching our heads when we try to apply these DSM categorical constraints on things that truly are dimensional.

ALEXANDER: That is very helpful. I do want to go through the DSM IVR definitions, the clusters and the signs and all that, but first, what is the difference between a whole bunch of things that seem like they are the same: PTSD, acute stress disorder, anxiety disorder, traumatic neurosis, although we don't talk about traumatic neurosis anymore, and shellshock?

JOHNSTON: Well, there are a lot of things related areas and a fair amount of overlap. Another place where I think one could be critical of the DSM, although I do think it is a wonderfully helpful bit of work, is that there is significant overlap. For example, many of the symptoms that are listed as being a part of PTSD can be found elsewhere as part of the various anxiety disorders. And so because of that overlap, clinicians are often confronted with a question, particularly, I think, when you're doing the necessary paperwork and filling out some billing document or something. For example, do we put down an anxiety disorder or do we put down

PTSD? And like PTSD, the anxiety disorders themselves are dimensional.

Everyone has some measure of normal anxiety and then if that anxiety grows to the point where it causes significant interference in your life or an awful lot of distress, then we put a label on it calling it an anxiety disorder. Where things can get very muddy is if you have a person who has some measure of anxiety, but then went through a trauma and now has some measure of additional anxiety over and above their existing anxiety, people ask themselves, "Well, what is the right diagnosis here?" The DSM is pretty clear in stating that PTSD should not be diagnosed if the symptoms are the result of a trauma that somehow exacerbates a pre-existing disorder. So, you can really tie yourself in knots.

I think of it as asking how many angels can you fit on the head of a pin? The important question, in looking at the individual, is "What can you do to help?" rather than which box to put them in as far as a label, because, many people are just simply square pegs we're trying to put in round holes and they did not read the DSM before they got ill and so they didn't follow the rules and so they stand in between some of these rather strict categories.

ALEXANDER: Why did they drop "traumatic neurosis?"

JOHNSTON: Here we are going back to the DSM II tradition. There is an interesting bit of history about this. You also mentioned shellshock, and this goes back to some historical ideas. Let's go to shellshock first, because that actually predates traumatic neurosis. The prevailing theory in early World War II was that people that had this constellation of symptoms, including the hypervigilance, the emotional numbing and the re-experiencing -- the flashbacks -- those are the three main categories of symptoms in the DSM -- the prevailing view is that this was actually due to the concussion of the exploding ordinance, and so if you were too close to where a bomb was dropped, there is a significant concussion, you know, that knocks down walls and breaks windows and does damage to lungs. The view was that this actually damaged the brain physically and so this term "shellshock" was really meant in a very literal sense that the shell produced a shock wave that damaged the brain.

What was interesting about this is that shock, in our culture, has two meanings: there is the concussion of the shell, but there is also the sense of emotional shock when you are exposed to trauma and you see limbs flying and people dying before your eyes and so forth. And so over time, that term, "shellshock," became more and more confused because some people meant it in terms of the physical shock and other people meant it in terms of the emotional shock, and there is a fair amount of chaos in the literature and the understanding of what was meant.

Then that, in a sense, migrated to this notion of traumatic neurosis, which was ultimately based on Freudian theory about how trauma could induce all sorts of drive conflicts, and of course, the root of Freudian theory was that mental illness in large measure was caused by these drive conflicts. And so traumatic neurosis then emerged later out of this gradual morphing and progressing of our understanding.

Then at about the time that DSM III came into being, there was really quite a bit of tension between people who were beginning to take a very biological view of mental illness and people who were taking a very psychodynamic, in other words, “Freudian” view. What emerged out of that was DSM III, which was really the brainchild of John Feiner. John Feiner developed a very specific diagnostic criteria called “Research diagnostic criteria,” also sometimes called “The Feiner Criteria,” and this was largely adopted in the transition between DSM II and DSM

The compromise that was reached in DSM III was that, alright, we are going to list these symptoms and we are not going to get into an argument about whether this is caused by drive conflicts or neurotransmitters. We are just going to make an objective, descriptive list of symptoms. That turned out, I think, to be a very useful compromise, although a downside is that it did take an awful lot of things that are dimensional and try to stuff them into categorical boxes. That, again, has caused a certain amount of mischief, especially, I think among clinicians. It has been an advantage to researchers because if you have a categorical box, you can say someone either has it or they don’t and then you collect a bunch of people that have it and then you can do research. So, that whole progression has had some advantages and disadvantages.

ALEXANDER: Well, let’s go through the DSM IV R definition. I know that DSM V is probably going to be out in about 2010 or so. But, meanwhile, let’s go through what we have. What are the clusters? Let’s be really basic here.

JOHNSTON: A key part of the diagnostic criteria is that the person has to undergo or experience a trauma. That is critical. The trauma has to be horrific and it has to threaten a person’s physical safety, life and limb. There is language that says something to the effect of “threatening a person’s physical integrity,” and that comment, in my view, is largely jargon to include things like sexual assault, which threaten your physical integrity. You can experience a very horrific sexual assault without any danger to your life or your limb, so that little bit of verbiage about physical integrity is included largely to make sure that sexual assaults are the kind of trauma that would qualify for PTSD. So, in essence, what they are saying there is that stubbing your toe doesn’t count. According to the DSM, you cannot get PTSD from stubbing your toe or from a minor fender-bender car accident. Those kinds of things do not qualify. It has to be a real significant trauma.

Another piece of that is that the individual has to experience the trauma as horrifying. That is included because there are those people out there who go through very extreme traumas and, quite honestly, they are fearless, courageous, combat veterans or whatever, and who experience this sort of thing as exhilarating. And so, you have two parts to this: a terrible trauma and the experience of it as horrifying. That is a key part of the criteria.

The rest of the criteria really fall into three categories: there is a category of re-experiencing, in other words, you have what people often think of as flashbacks, but also recurrent dreams, intrusive thoughts. Those kinds of things are part of re-experiencing. You have to have that.

Then, you have to have this avoidance and “emotional numbing,” it’s called. When you look at these people in the military, there is the term they call, “The

Thousand Yard Stare.” These are people who will sit on a tree stump and stare off into the distance and don’t join in to the rest of the group in a card game or, you know, horsing around and playing pranks. They are emotionally numbed, and withdrawn. That is an important part of the criteria.

The third is hyperarousal. This is manifested typically by a lot of difficulty with sleep, an exaggerated startle response and a sort of subjective sense of feeling on edge. Now in the DSM IV criteria, you have to have all four of these things. You have to have the trauma, you had to have the re-experiencing and you have to have the emotional numbing and avoidance and you also have to have the hyperarousal. Furthermore, the DSM requires that you have them for at least one month. So, in a technical way, PTSD cannot be diagnosed if the incident happened a week ago or two weeks ago or three weeks ago. In that case, you use the term acute stress disorder or ASD. I do not know why they left the T out; it would make more sense to talk about PTSD and ATSD, but they left the T out so it is just ASD, acute stress disorder.

Essentially, the criteria are almost the same for acute stress disorder, although, in a sense, the trauma is the same, having to experience it as horrifying is the same, but the one thing that stands a bit apart from posttraumatic stress disorder is that in acute stress disorder, there is this notion of dissociation. This is actually what we typically see clinically: when people go through an extreme trauma, they almost feel as if it is not real, that they are outside of their bodies looking down on the incident. There is often a sense of time distortion. So, the dissociation is in some measure, not quite completely, but it is somewhat substituted for the re-experiencing in acute stress disorder. But, the reality is that if you have a trauma and you have these symptoms, for the first month you have ASD and then if symptoms persist beyond a month, then we change it and call it a PTSD, but it really is a continuum.

ALEXANDER: What is “Delayed Onset PTSD?”

JOHNSTON: Well, that is something that is pretty controversial, but the crux of the concept is that you experience a trauma, say a combat experience, and then after it is over, you are essentially asymptomatic or just have minor symptoms. Then, perhaps months or even years later, for reasons that are, again, controversial and somewhat mysterious, you develop the full constellation, including the re-experiencing, the emotional numbing and the hypervigilance. But, the development of those symptoms is delayed by months and perhaps even years from the actual trauma itself. That is essentially the concept of Delayed PTSD.

The experts, I think, are in pretty strong disagreement about whether that is truly valid or not. The data is confounded by all sorts of issues. Personally, I think that there are instances where it is valid and there are instances where certainly it is not.

One of the criticisms of the literature on delayed PTSD has been, particularly when we look at combat veterans, some critics have a sense that years later, veterans make, if you will, a discovery that there is a significant financial gain to having PTSD. Then, whether they are conscious of it or not -- that is another argument -- they develop the symptoms, because there is money to be made by

getting disability payments. That is a rather cynical view and, you know, such things do lead to tremendous controversy.

Another aspect of that that I will just mention is that in the case of childhood sexual trauma – again, the data here is pretty limited -- but one could argue that a 7-year old could have a sexual experience, be sexually assaulted or exploited and then, in a sense, recover from that and not be particularly symptomatic because when you're 8, 9, or 10 years old, overt sexuality is not a big part of your life, but then say, for example, at age 17, you develop a relationship that actually involves sexuality in the literal sense. There is intercourse and petting and so forth, and then hypothetically, and perhaps people could argue the data, but there is reason to believe that you could be asymptomatic when you are assaulted at age 7 and then at age 17 when you start becoming sexually active, that could, in a sense, reawaken some of these memories and then produce symptoms.

So, I think that there probably is face validity, at least. It makes sense. It certainly fits with my clinical experiences as well.

ALEXANDER: One of the other things that confuses me has to do with the study of trauma. So many things can be called a trauma. Can we get back into that?

JOHNSTON: Well, sure.

ALEXANDER: Because, you see, there is all this traumatology work and then there is posttraumatic stress disorder work and there is an overlap, I'm sure, but I don't know what the line is.

JOHNSTON: I think what you're talking about here is this problem of taking something like excess weight or acne, truly a dimensional thing, and then trying to pack it into a categorical box. So when the DSM says that the traumatic experience has to be horrifying and life and limb threatening etc. and has to be experienced as horrifying, what they are trying to do is draw a line that separates really serious trauma from trauma that is not so serious. If you think about it, it is illogical because there are bound to be gray areas. For example, if there is a drive-by shooting and, you know, you're standing next to your best friend and a car goes by and the shotgun goes off and your best friend's head explodes and you have, you know, brains splattered onto you and blood, everyone would agree that that meets the DSM criteria.

But then, when you start asking questions and do a thought experiment, what if it wasn't a friend? What if it was an acquaintance or what if it was not even an acquaintance, just some stranger, and how close do you have to be? If you stood right next to them, that seems to qualify, but what if you were 3 feet or 4 feet or 6 feet away? You can see that there is something not quite reasonable about trying to say "Well, if it was an acquaintance and you were more than 12 feet away, then it won't count.?" (Laughs) "But, if it was someone whom you had met twice and you were 8 feet away, then it would count?" Again, that is like trying to put angels on the head of a pin.

So, what clinicians and many people who are interested in this type of clinical work have come to realize is that the DSM, in regard to helping people, is not always a tremendously useful document, because there are lots and lots of people who, for whatever reason, do not quite fit the criteria, but have definitely had a very bad experience and are definitely symptomatic. If you are a strict constructionist, where they would fit in the DSM would be in that category of Adjustment Disorders. But, again, that is unsatisfying for lots of reasons. The

Adjustment Disorders in the DSM are very, very loosely defined and I think many clinicians look at making a diagnosis of an Adjustment Disorder and have a sense that that really does not convey the significance of the person's experience. There is a certain, I think, attitude among clinicians that that is a "lightweight" diagnostic entity. So, it is unsatisfying in a lot of ways and confusing.

ALEXANDER: Now why would one person get posttraumatic stress disorder and another person be able to not get posttraumatic stress disorder? I mean post-traumatic stress disorder is pretty rare really, isn't it?

JOHNSTON: It all depends upon how strict or how loose you are with the diagnostic criteria, and then, of course, what you mean by the word, "rare." The question that you're asking about: "How can two people undergo the same experience and one person get the disorder and another person seemingly is fine?" is really something of a mystery.

One of the things that we know, and we have had some naturalistic experiments, is that you can take a group of people -- one naturalistic experiment was the Iran hostage crisis. You might remember that there were 52 people taken hostage in Iran and held for more than one year. What is interesting about that, when you look at the aftermath, is that some of those people experienced very disabling PTSD after that experience and others did not. In fact, some of the people who were treated the most poorly actually had the least residual symptoms.

And so, it does ask the question, "Why do some people get this when they are exposed to trauma and others don't?"

We have some partial answers to that question. One thing is age. It does appear that there is an age-related vulnerability. People who are younger, and by that I mean in their late teens and early 20s, are really much more vulnerable to developing PTSD symptoms than people who are in their 40s and 50s. Nobody knows for sure why this is, but the general belief is that brain plasticity is greater when you're younger and so you are more susceptible to having the brain changes that take place in severe trauma when you're younger than when you are older. So, that is one factor that affects who gets the disorder and who doesn't.

There are also genetic factors. We are just in the middle of the process of unraveling some of those factors. I can illustrate with one example. In the brain, there is a molecule called the serotonin transporter that is coded for a particular gene. There are a number of variations of this gene. One variation that is fairly common and is of interest is what is called the "short variation." One of the things that we know is that you get one copy of the gene from your mother and one copy from your father. If you happen to be a person who gets both the short variation from your mom and the short variation from your dad, then you are probably more susceptible to having symptoms following trauma than another individual who has a long copy from mom and a long copy from dad.

Now, I do not want to overstate this, this is just one gene and one interesting piece of a very large puzzle. There are undoubtedly hundreds of genes that will affect an individual's vulnerability and this is an example of but one. So, your genetic makeup and your age are two factors that are important.

Another factor that might be important, we don't know for sure, but we have good reason to suspect that in early development, if you, in infancy, toddlerhood and childhood had a very nurturing, robust, nontraumatic development, then some measures are probably armored to some extent from getting PTSD from a traumatic experience. Of course, that is very hard to say on the basis of strong evidence, but, I think most clinicians who work in the field have a sense that that is the case.

So, there are at least three major factors: your genetic makeup, your age at the time of the trauma and your early development which are probably all playing a role in your risk of developing PTSD after being exposed to a trauma.

ALEXANDER: Let's move to more specific case examples: somebody comes to you and they present with a certain number of symptoms and clusters. How do you screen, how do you assess, and how do you unpack the whole thing?

JOHNSTON: It's a complex process. Certainly I begin with a very thorough history. That is really important. One of the things that you want to look for is not only the history of the trauma and the symptoms following the trauma, but it is also really helpful to get a sense of who the person was before the trauma. Was this a person, who, for example, even before the trauma occurred, was troubled by anxiety or troubled by mood and so, we begin with a very careful history.

Once you have that in front of you, then I think that the next step is to come back to the present and look at the person's life and ask and kind of wonder with the person out loud, "What is going wrong with your life and where are you impaired?"

What you will hear back from people with PTSD is really a wide variety of things. I have certainly worked with people in the military who complain that their major impairment is that every couple of months or so they have to go out on the range and they have to qualify with a machine gun and once they go out there and the machine gun is going off, that triggers flashbacks, and they get jittery, and they are out of sorts and they can't function. They will say that that is their impairment and what they are here in the clinic for is to get some help so that they can do their every other month drill with the machine gun and not get all unraveled by it.

Then, you will have another person who has a completely different kind of impairment: afraid to go out of the house, afraid to deviate from their well-worn path, almost a picture that looks like agoraphobia. This person might not be sleeping well at night. Every clang of the radiator startles them into wakefulness.

What you do is you get this history and then you also look at the impairments that this person is experiencing at the moment. Then your clinical intervention, I think, are targeted at the impairments that are occurring and the kinds of interventions are guided by the kind of history that you have. That is, I think, the most sensible approach. You need the full story, but you also need to pay attention to why the person is here in front of you.

You asked the question -- there are lots of ways to ask the question, but one way that I ask is, "If life were going well and you weren't here for a visit to see me for some mental health treatment, if life were going well, how would it be different?" Then you listen to what the person says and if they say, "Well, I'd be able to go more places," or "I'd be able to shoot my machine gun without trouble," or "I'd sleep at night," then you go after those symptoms that are causing them trouble in life, educated by the history that they have provided you. So, the treatment really has to be very individualized. There is not a "one size fits all" treatment for PTSD.

ALEXANDER: Back to screening, do you ever use any kind of projective tests or the MMPI or those kinds of screening tests? Are those as helpful as just the straightforward clinical interview?

JOHNSTON: We certainly do use screening. There are a number of PTSD symptom checklists and trauma checklists and so forth, and the advantage of those are that, I think, in the course of doing an assessment, it is easy to overlook things. So, those kinds of checklists are particularly useful because, maybe in the heat of the appointment and the person's relating their trauma and so forth, you might overlook asking about a startle response or perhaps you will overlook some aspect of the experiencing. Those screening instruments are really good for those of us clinicians who don't have a perfect memory and who are not hugely detail oriented. They help you fill in the full picture. But, those instruments shouldn't be viewed as anything like a diagnostic gold standard because, to tell you the truth, those instruments, especially diagnostic instruments are normed against a good clinical interview which is ultimately the gold standard. So, we certainly do use instruments, but they are not a primary focus by any stretch.

ALEXANDER: What are some other factors in the meaning of PTSD?

JOHNSTON: Again, being a little bit critical of the DSM, there is an absence, if you read through the diagnostic criteria, of any real discussion of the existential meaning of traumatic experiences. If you look at our civilian culture, for sure, and particularly when you look at children but this is also true of adults, an awful lot of the horrible traumatic experiences actually are caused at the hands of people who are important to us. So sometimes overlooked in the part of the PTSD literature is that sense of the existential meaning of the trauma.

For example, you could undergo a traumatic experience. You might be attacked by a couple of stray pit bull terriers and you're terrified, you'd fear for your life and you'd have a collection of physical injuries and you would end up in the hospital and you could have re experiencing and emotional numbing and hypervigilance and very clearly get a diagnosis of PTSD as a result of this terrifying dog attack. You could have all of the same sorts of injuries, the same magnitude of injuries, but if this happens in the context of domestic violence by the person that you have decided to share your life with, and this person whom you trust and you have children with has done this horrible thing to you, then you really have something that is a lot different than it is for the person with the same injuries who underwent the dog attack.

So, beyond all of this diagnostic criteria and symptom list, what is often very important to the patients and clients that we work with is the meaning of the trauma itself. There are some good reasons, but this is a huge issue that tends to get somewhat ignored in the literature. You know, some good reasons are, if you're going to do, for example, a study of PTSD and you want to study the treatment response to a certain drug, you round up a few hundred people who have PTSD and some of them go on the drug and some of them go on placebo and there isn't room in a study of 100 people like that to consider each individual story and the existential meaning of their PTSD.

But, in the office, we do not treat people in groups of a hundred; we treat them as individuals and their individual unique story is often very important and a big part of what they are struggling with.

ALEXANDER: That is a very important point that you've made because, so much of what I have been reading is evidence-based research -- treatment that is based on evidence of what has worked, but, it seems that just because something has been shown to work doesn't mean that other things don't work.

JOHNSTON: Well, that is exactly right. Certain treatment interventions really lend themselves structurally to our tradition of evidence-based treatment, for example, drug therapies lend themselves to that kind of work. On the other hand, helping someone come to peace with a different view of the universe and a different view of what love really means -- I mean, "Can I only love someone who cares enough about me to hit me?" -- what does that mean? Those kinds of things don't lend themselves to what we typically view as evidence-based research.

The focus on evidence-based treatment, evidence-based practice and evidence-based medicine, I think, is extremely positive. But, if there is one negative thing about it, it is that it tends to take away from the individual uniqueness of the person that you are treating. If you simply focus on group studies and group data, we are all unique and this is especially the case with PTSD, where the traumatic experience can be at the hands of this attachment figure in the case of children, a family member. The whole domain of sexualized trauma is very different and unique from individual to individual. So, to try to do the kind of randomized controlled trials to address these problems doesn't fit very well with our current research technology. There is a technology out there: individual case study design that is actually quite mathematically rigorous and can be applied, but it is not the current fashion, quite honestly. I think in some measure that is unfortunate, because, you know, that gets lost.

ALEXANDER: Well, Dr. Johnston, I think that once again you have given us a very helpful and informative interview. Is there anything that you would like to add before we close?

JOHNSTON: I could say just a few things. One of the areas that really needs further research is PTSD in children. We do not have the kind of data that we'd like to have. The DSM does make a few modifications for children. For example, when children experience a terrible trauma, they do not necessarily have to display a sense of being horrified; the DSM just allows them to become disorganized. And, similarly with children, when we look at the criteria for re-experiencing, children do not necessarily have to have bad dreams with the content of the trauma itself. They, in DSM language, can simply have "generic" bad dreams as part of the diagnostic DSM criteria. We have some inklings at this point that PTSD in children may be a somewhat different animal than PTSD in adults, so that is an

area that really needs quite a bit more research.

Also, in the case of children, PTSD is more likely, as compared to adults, to result from a trauma at the hands of an important person in the child's life. Certainly the most common cause of PTSD in children is child abuse at the hands of their parents. Again, that is probably a little bit different animal than the typical PTSD in adults. So, that is an area that I think we will look for some emerging research as time marches on.

ALEXANDER: Thank you so much Dr. Johnston. I really appreciate your interview.

JOHNSTON: Well, you're very welcome.

Listeners interviewing in contacting Dr. Hugh Johnston may email him at [HYPERLINK "mailto:hfjohnston@wisc.edu"](mailto:hfjohnston@wisc.edu) hfjohnston@wisc.edu

This concludes our interview for "Posttraumatic Stress Disorder," Interview #1. I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of ON GOOD AUTHORITY. Until next time, this is Barbara Alexander. Thank you for listening.

POSTTRAUMATIC STRESS DISORDER

Interview with GERALD ROSEN, Ph.D.

“MALINGERING”

Interviewed by Barbara Alexander, LCSW, BCD

(Edited slightly for readability)

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Welcome to On Good Authority. I’m Barbara Alexander.

You are listening to or reading interview #2 of “Post-traumatic Stress Disorder,” a continuing education program covering diagnostic and treatment aspects of this controversial and important subject.

As we have heard in the previous interview, DSM III’s definition of PTSD was “incident specific.” The implication of this was that all sorts of psychological problems could be attributed to the traumatic event.

In 1994, the newer edition of the Diagnostic and Statistical Manual issued a warning about the diagnosing of PTSD: “Malingering should be ruled out in those situations in which financial remuneration, benefit eligibility and forensic determinations play a role.”

Malingering is a medical and psychological term that refers to an individual fabricating or exaggerating the symptoms of mental or physical disorders for a variety of motives, including getting financial compensation (often tied to fraud), avoiding work, obtaining drugs, getting lighter criminal sentences, trying to get out of going to school, or simply to attract attention or sympathy.

Malingering has been recorded as early as Roman times by the physician HYPERLINK “http://en.wikipedia.org/wiki/Galen” \o “Galen” Galen, who reported two cases. One patient simulated HYPERLINK “http://en.wikipedia.org/wiki/Colic” \o “Colic” colic to avoid a public meeting, while the other feigned an injured knee to avoid accompanying his master on a long journey.

The first report to document false claims of PTSD was provided by Sparr and Pankratz in 1983. These authors identified individuals who claimed disability from combat in Vietnam when the claimants had never been to that country!

At the present time, there are no clear methodologies that allow researchers and clinicians to fulfill the guideline of the DSM IV to do that “ruling out” of malingering. The shame of this is that malingering in PTSD casts doubt on everyone who is actually suffering.

Here to tell us more about malingering is Gerald Rosen, Ph.D., whose book entitled Posttraumatic Stress Disorder: Issues and Controversies and published by John Wiley and Sons covers the problems facing the diagnosis of posttraumatic stress disorder.

Gerald Rosen, Ph.D. is a clinical psychologist in Seattle, Washington who holds an appointment as Clinical Professor at the University of Washington in the psychology Department and the University’s medical school in the psychiatry department. In addition to his book, most recently he was guest editor of a special issue of the Journal of Anxiety Disorders on these concerns, published in March, 2007.

Now to our interview.

ALEXANDER: Dr. Rosen, you've been doing so much in the field of posttraumatic stress disorder: you've written books and articles and journals. I'd like to know what your latest thinking is. What are you thinking about and working on on this subject these days?

ROSEN: Well, the issue that most interests me at this point is the question of whether posttraumatic stress disorder is actually an amalgam or a combination of other disorders that we previously knew about, specifically a combination such as phobia with depression. Take the example of a fisherman who's on a boat. The boat sinks and fellow crew are lost in the sea. When the fisherman returns, he does not have severe physical injuries, but he finds that he is anxious, afraid of going out on fishing vessels. Then, faced with his loss of career and income, he suffers many situational stressors and experiences depression.

The question comes up: should this individual be diagnosed with posttraumatic stress disorder or is it, in fact, more to the point to diagnose the fisherman as having a phobia caused by the traumatic experience, and consequently, situational depression and adjustment issues, as well as grief for the fellow crew members who are lost at sea? That diagnostic puzzle is the issue that currently is most occupying my thinking.

ALEXANDER: That must be occupying the thinking of the people who are working on the DSM V too, I would imagine.

ROSEN: Well, one would hope so. Robert Spitzer, along with Michael First and Jerome Wakefield, wrote an article in the special issue of the Journal of Anxiety Disorders that came out March, 2007. The title of his article was "Saving PTSD from Itself in DSM V." In that article, he addresses this overlap in symptoms.

There is an interesting exercise that one can do. If you create a table and you list the 17 symptoms of PTSD, and then a second column you list the overlapping symptoms of depression, and in a third column you list the overlapping symptoms of specific phobia, you can see that an individual with a specific phobia and related depression can completely meet the required criteria for PTSD. Spitzer discusses this and provides a proposal for DSM V. Whether or not the actual committee members are attending to this is an open question.

ALEXANDER: Since so much of work is based on research and you've studied the research so much, I'd like to talk about research with you. This isn't something that I usually talk about and that our speakers usually talk about in our interviews, but I think that it's very important, especially as more and more clinicians are referring to "evidence-based research," and as managed care companies and insurance companies increasingly require treatments that are evidence-based, as opposed to, let's say, psychodynamic. So I think we need to be able to understand and be critical in how we read the research that we see because one of things I most noted in your book was how many research studies were flawed in one way or another, and how you and the other writers who contributed to your book spotted all these research flaws. My question, then, is this: Is there a "gold standard" of research studies and what should we be looking for?

ROSEN: It is a very complicated issue. In the Journal of Traumatic Stress, there was specific issue on research methodologies. I don't know that I can wrap that up into a good concise paragraph. There are certain known "confounds" in

research, such as relying on retrospective reporting and so in general, prospective studies are preferred but they can be very difficult if not impossible to conduct.

Then I have raised and others have raised the concern that if the subject pool is confounded with people involved in litigation, the data collected from those individuals can be biased, flawed. There is an amazing example that I recently came across of an individual who faked depression to be in a drug study in order to get the money that the study was providing to its participants. Most people have probably heard advertisements on the radio or even on TV or on Craig's List to be in a drug trial and if they have a particular problem they can get free treatment and sometimes, actually, payment. So, this individual entered the study and faked his depression, faked his improvement and collected hundreds of dollars for participating. Similarly, there could be fake data in studies with people presenting with posttraumatic stress disorder if these individuals are involved in litigation and making claims for compensation, so that is a concern.

There are other concerns in terms of the reliability of the data that is collected and the conclusions that we can draw. As a rule, experts can pick apart almost any study and I think, in the end, someone trying to evaluate an issue wants to rely on the general weight of findings.

ALEXANDER: What does that mean?

ROSEN: The general weight of findings would mean that while one study may have this problem and another study may have another problem, if we look at all of the studies in the area, is there a general finding that seems to emerge that you can have some confidence in. So the reason that I'm saying that is that on the one hand, while it is good to be critical and to analyze the flaws in a particular study, I don't want to be dismissive of the overall findings in the field, which I think have a good foundation.

ALEXANDER: One of the things that really astounded me in one of the articles that I read was about Vietnam veterans who were claiming to have had PTSD and then it was found that they never even were in combat and that they never even were in Vietnam!

ROSEN: Yes, and one of the great concerns as we speak about this kind of issue is that it could cause skepticism to victims who truly are suffering. So, advocates and clinicians who are truly concerned about trauma victims sometimes react poorly to even a discussion of this issue. I think that is a mistake. We have to remember that there are two sides to a coin and we do need to be concerned about people who are abusing the diagnosis and taking advantage of it. That in no way diminishes the suffering of true victims. But, you are correct. There are publications about people claiming PTSD for combat in Vietnam who never were in Vietnam.

A classic study by Hickling, along with his colleague, Blanchard -- they have a clinic in Albany, New York that specializes in motor vehicle accident victims -- they hired six actors who, without the assessors in the clinic knowing it, presented as having PTSD after a motor vehicle accident. There were thorough assessments with interviews, psychophysiological measurements such as heart rate increases and such, testing, symptom checklists, and all six were diagnosed with posttraumatic stress disorder. Not a single one was identified as being simulated or malingered. That means that these individuals were not only successfully faking the symptoms, but they were successfully lying about the event having ever occurred, similar to the Vietnam vets who were never in Vietnam.

This is a real issue. People vary on how significant it is. Some people say, "Well, if it is only half of 1%, we really shouldn't focus on it because it diminishes the suffering of true victims." Other people feel that the rates

could be as high as 20% to 40% when compensation applies. So we don't know the extent of the problem. I believe that it should be addressed regardless of what the percentage is and that addressing that problem in no way diminishes our concern for real victims.

ALEXANDER: Well, how can you really assess the problem if you can't tell who's got it and who doesn't?

ROSEN: Indeed, that is very difficult. Many clinicians believe that they can tell if someone is honest and you can see in a report, the clinician will say, "The patient struck me as very sincere and very believable." But there are studies that show that clinicians, in fact, have no special skills in knowing who is telling the truth and who is not.

So, the main way that one can identify the validity of a claim is to try to look at multiple sources of data, which would mean looking at other records. So, the Vietnam vets, who never were in Vietnam, so I really shouldn't call them Vietnam vets, but the individuals claiming to be Vietnam vets who were never in Vietnam -- that is revealed simply by going to their military records. If the motor vehicle accident clinic in the Hickling study asks for records to document the car accident and medical treatment after the car accident, then, of course, it would have been discovered that that did not exist. So, I think that that is probably the main tool available.

But, this is a problem for clinicians because the clinician is working with the patient and wants to establish a rapport and if you said to every patient who came in, "Well, I want documentation, I want to speak to your family to confirm that which are telling me is true," this would not be very good for the therapeutic relationship. So it really is a problem for the typical practicing clinician. I think when it comes to doing research, it would be reasonable for researchers to have protocols that do require some confirmation and some documentation so that false data doesn't enter the database that we are relying on when coming to conclusions about post trauma reactions.

ALEXANDER: There's a requirement in DSM 4 to rule out malingering.

ROSEN: Yes, and one person joked that it should say, "It often is difficult to rule out malingering even when clinicians should." That would be a more realistic guideline. But, indeed there is this special guideline in the DSM which, interestingly, does not appear for other disorders such as depression, schizophrenia, generalized anxiety disorder. This guideline appears specifically in relationship to PTSD.

ALEXANDER: Is that because of the monetary consequences?

ROSEN: Well, another way to say it is that it is recognized that posttraumatic stress disorder has a special attraction in the area of personal injury claims and the reason for that is that PTSD specifies causality. So, if someone is diagnosed with posttraumatic stress disorder, by definition, there had to be an event that produced it, while if someone is diagnosed after say a car accident with depression, there could be ten issues associated with the depression, some of which have nothing to do with the accident. So because PTSD specifies causality, it does seem to have a special attraction that I think is one of the main reasons for the special caution in the DSM.

ALEXANDER: Is it any better to use a structured interview, in other words, a checklist of questions, rather than an unstructured interview in which you might be able to pick up inconsistencies?

ROSEN: Well, the structured interview is considered a "gold standard" in terms of covering the symptom criteria in a systematic way with the questions having known reliability and validity. A structured interview like the SKID would be an example. But, one of the problems that you're pointing out is

that it's really a checklist and a person can just say yes, yes, yes. So, Roger Pickman who has published quite a bit in the area of assessment and the psychophysiology of PTSD, had a good suggestion, which is that it is probably best to first have a general interview and ask an individual what kinds of problems are you're having, and see what the individual reports. Then, you can go later in the interview down the structured checklist and see if there is a contrast between what the individual on their own can produce in the general interview and what they end up endorsing when presented with the checklist. So, if someone in the general interview makes no mention of nightmares but then when you go through the structured interview and you ask about nightmares, they say, "Oh yes, I have those," that is more suspect than an individual who on his own speaks about nightmares in a general interview. So, I think that that was a useful suggestion that Roger Pickman made.

There is also an article by Steve Taylor and colleagues through the Journal of Anxiety Disorders that came out in 2007. I am not sure of the actual issue. In that article, the authors go over different recommendations that clinicians might consider in trying to deal with this issue of malingering.

ALEXANDER: Do you recall any of those?

ROSEN: As I recall, they also spoke about how to conduct an interview, they recommended certain types of tests. For example, the MMPI is a psychometric instrument that has what are called "validity scales" that help to assess the person's response style. Then there are a number of tests that are even more specific to the issue of malingering. In the article they go over these. In the end they also recognize how difficult the task is and how it is a sensitive issue for the clinician because it is very awkward to take a stance where it seems that you are questioning the honesty of your patient. Therapy is based on an alliance in which you are accepting the patient and not questioning what they are telling you. So, it is a delicate balance on how a clinician can assess this and still keep the therapeutic alliance.

ALEXANDER: In addition to the obvious motivation for financial gain, let's set that aside. Why would someone want to be a victim? What would be in it for somebody to view themselves that way and to feel about themselves in that way?

ROSEN: Well, there is quite a good article by an individual, LeCourseair, who speaks of the diverse motives that people might take on what we could call, "the patient's role," of a PTSD victim. One of the reasons can be that it provides an explanation for problems and failures in life. Sometimes, it is easier for an individual to take on an explanation in which they are not responsible; someone else did it to them. So, that could be a dynamic that is going on. There can also be quite a bit of attention to an individual who has been a victim and some people, as curious as it may seem, can develop quite a bit of reinforcement from the patient role and from the special attention that can come with that. So, it is difficult. I wonder myself why would someone do this but there are such cases.

To the general public, people have heard of Munchhausen's, where a person is motivated to take on illness. Munchhausen's, it turns out, is a specific form of a broader issue called "Factitious Disorder" where people are motivated to take on illness in order to actually be in the patient role. This not only applies to physical illness, it can also apply to psychological disorders.

So, to review, you can have individuals who are just motivated to be a patient and they take on a psychiatric problem, you can have individuals who are troubled in their lives and the victim role provides an explanation that frees them of their own responsibilities, and then you can have reinforcements that come with the victim role that for some people are important to them and motivate them to stay in that narrative.

ALEXANDER: What about secondary gain?

ROSEN: I think that secondary gain is covered in the types of things that I was thinking about, if by secondary gain we mean that something is reinforcing the individual to maintain their symptom presentation. So, secondary gain can be financial considerations and it can be other kinds of motivating factors including the attention or the benefit that one gets from having this explanation for their problems in life.

Again, as we talk about this, it is not suggesting that this explains the majority of individuals who are presenting with problems after trauma; it is simply recognizing that when we diagnose PTSD, there can be many considerations that we should keep in mind and there can be those minority cases where other factors are affecting the clinical presentation.

ALEXANDER: What about work with PTSD victims who don't respond to the standard protocols? Cognitive behavioral treatment is the treatment method that is most preferred and people who don't respond to that, and/or to medication, and these people become increasingly ill over time. What about work with those people?

ROSEN: In discussing the problem of the chronic patients, it is good to keep in mind the natural course of reactions after trauma. The natural course of reactions after trauma is very much like grief: the majority of people have reactions immediately after the event, meaning within the first days, and then over time, for the majority of people, their reactions get better. Most people after traumatic events do not have reactions so severe that they meet the criteria for PTSD, but a substantial minority of individuals can have severe reactions that do meet the criteria and then to contrast, upwards of 50% of those individuals' reactions subside over the first few months so they no longer meet the criteria.

Now we are left with individuals who meet criteria, are diagnosed with posttraumatic stress disorder, and they can go into treatment and the majority of those individuals will respond to treatment. But, as with any psychiatric disorder, there can be individuals who do not respond. There are individuals diagnosed with depression who do not respond to antidepressant medications, who don't respond to cognitive behavioral therapies, and similarly there are individuals diagnosed with PTSD.

When this happens, we can look for issues in the post-incident environment that could be maintaining disability. Certainly, if there are claims for compensation, that raises a concern as to the person's motivation to be getting better. If it turns out there are secondary gains or benefits in having the victim role, the clinician would want to be alert to those issues and then otherwise, I don't have a good answer. It falls into the same category as the depressed patients who just don't respond to treatment. I guess it is possible that reconceptualizing the issue more broadly could help the clinician identify what is preventing recovery.

Interestingly, some people would wonder if the diagnosis itself encourages an identification with the victim role. I probably should explain that. If we go back to the fisherman, and we tell the fisherman that he has a phobia, that would probably be a concept that he could understand, that this frightening event occurred and now he is afraid of going back to sea and we could institute a program for the phobia. If we told him that he was depressed because of everything that had happened and the loss of his career, it would be a concept that he could understand. But if we told him that he had posttraumatic stress disorder, that would possibly be a new label we had given him and he could now start seeing his reactions as a mental disorder that he has never had before. But, here I am really speculating in terms of whether there are negative consequences to that.

ALEXANDER: Well, I'm thinking about people who have suffered just overwhelming traumas: holocaust survivors, people who have gotten out of Cambodia, torture victims...

ROSEN: Right. One problem with the posttraumatic stress disorder diagnosis is that we are taking human suffering after adverse events and lumping it or categorizing it as a medical disorder and sometimes it may be best to keep the humanity of the reactions and not make it a medical disorder. Sometimes things happen that are so horrific and are so horrible that I believe that one is really left with a life that is not going to be restored. The person must live with the pain and the suffering that goes with what they have experienced. Rather than thinking of them as having a mental disorder, we can think of them as people who are truly suffering from something that one doesn't just "get over."

ALEXANDER: I'm so glad to hear you say that because I think that in the interviews that I've conducted and in the readings that I've done, there seems to be an expectation that people can get better, and of course, people can get better, but there are people who can't get better. And yes, maybe their lives as they wanted them to be, as they wished them to be, as they knew them to be are not going to be.

ROSEN: Yes, I think that it certainly is useful to take the stance that, well, first, we recognize that most people do find ways to cope with adversity. There are certainly ways that we can be helpful to people who have trouble coping with adversity. At the same time, there may be people who experienced adversity at such a horrific level that there is not a way to make their life right. It could be that the best thing is to recognize that within the humanity of what they have experienced and not think of it as a medical condition that hasn't been successfully treated. If a person loses his legs, it is great if they can have prosthetics and maybe even run on them again, but there are limitations and there are ways that the person cannot be made whole. Sometimes things happen in life and there are losses that cannot be made up and people, in fact, must go on and live with that.

ALEXANDER: Now, I think I have to ask you about your opinions about unconscious thoughts and fantasies and things that can't be quantified, and that there might be unconscious meanings or beliefs about the events that happen to a person that need to be taken into consideration.

ROSEN: Right. My first response is that the concept of the unconscious is a very complicated and difficult concept, so let me try to give it a little bit of a boundary. If, by the unconscious, you mean that there can be experiences in life that influence our emotional reactions and are responses to subsequent events and that we are not always aware of those past associations and experiences, then I could certainly see how that type of concept could influence an individual's response to an adult traumatic event. Interestingly, when we look at risk factors, I mentioned earlier that most people do not have reactions that meet the criteria for PTSD. So if we look at what puts people at risk for those individuals who do have severe reactions, one of the risk factors is childhood experiences that are traumatic including parental divorce and other significant loss experiences. So, within this term, "the unconscious," it seems possible that having experiences where one felt like a victim as a child perhaps one increases one's reactions as an adult when they are put in the role of a victim. If that is what you mean by the unconscious, I think I can relate to that and would use the example of the risk factor. Otherwise, I'm not quite certain how to use the concept of the unconscious in a way that is useful to me.

ALEXANDER: Freud talked about traumatic neurosis after World War I—I think it was in "Beyond the Pleasure Principle," and he wrote that it wasn't just the sounds of the shells exploding but "the internal noise of reawakened unconscious drives" that accounted for the shell shock. I think he was referring to aggressive drives, so if someone has terrible aggression acted upon them, maybe it reawakens primitive childhood aggressive drives.

ROSEN: Well, I'm afraid when it comes to Freud, I trained at the University of Wisconsin in the heart of dust bowl empiricism I find that all too dynamic and complicated and not useful. There is enough that goes on in combat that would shock a system, enough stimuli that could strongly condition anxiety. There is also this concept of disgust responses where you see blood and guts and it very strongly condi-

tions, the threat to life and the anxiety with that, there is enough that goes on with combat that I just don't see why it is necessary to evoke the kinds of complex concepts and sentences that Freud was evoking. So, I don't know how to respond. It is so far out of my framework that I don't know what to do with it.

If Freud was trying to explain why the majority of individuals do not have psychiatric problems after combat but some do, and so he is trying to understand the special significance, I think it is more useful to look at what we know about risk factors.

ALEXANDER: What kind of questions do you get asked most frequently?

ROSEN: Well, I get asked if I believe that PTSD is a real diagnosis. That is probably the most frequent thing that I get asked: do I believe that it is a real disorder, so to speak. It is certainly a real diagnosis in that it has been verbally decided on by committee, but I probably get asked that. I get asked about this issue of "criterion creep," which is the expansion of the PTSD model to more and more things so that it becomes an increasing narrative of how we look at human reactions to adversity.

ALEXANDER: Do you do expert testimony?

ROSEN: I do. In personal injury cases, you mean?

ALEXANDER: Yes. What kind of things do you get asked there?

ROSEN: I'm generally being asked issues about the case. I can be asked questions like, "Dr. Rosen, you don't really believe in PTSD do you?" And then my answer would be, "No, that is not the case. I think it is possible that there is a distinct disorder that results from certain types of events, but at the present time it is defined so broadly that it is being misused and being applied in such a way that it is not helping us identify whatever that unique disorder is."

ALEXANDER: That's a really good answer!

ROSEN: Yes. I think that people after trauma can present with phobias and I think they can present with depression, and I think they can present with a combination of that. I think that people can present with psychiatric problems after non-traumatic events and the research shows this.

There is a wonderful sentence by Ben Shepherd in a chapter in my edited text, where he says that "Any disorder that can be caused by rude jokes in the workplace and the Holocaust has to be a patent absurdity." He is saying that there is just no way that it makes sense that you can have the same disorder from upsetting events in the workplace and having lived through the Holocaust. And yet, PTSD is being applied as a diagnosis to that whole broad range. It really is a problem.

So, when people say to me, "Do you really believe in PTSD?" I say that I think that there could be, in fact, a distinct type of disorder and how to best define it or what the nature of it is is still open, and how we are currently defining it is getting in the way of answering the question. It could turn out that we do not need this relatively new diagnosis, and that older concepts actually do explain what is happening with people. But, even if that turns out to be the case, the diagnosis has turned out to be very useful because it has spurred thousands of research projects and has accelerated our knowledge about posttraumatic stress. Either way, the diagnosis has had its useful functions.

ALEXANDER: That could be a very good place to end our interview. Other than that, is there anything else you would like to add before we close?

ROSEN: No, it has been nice to speak with you.

ALEXANDER: Dr. Rosen, it's been very nice to speak with you and I really appreciate your talking with us today.

ROSEN: Okay.

Dr. Rosen's email address is [HYPERLINK "mailto:grosen@u.washington.edu"](mailto:grosen@u.washington.edu) grosen@u.washington.edu. His book may be ordered through any major retail or online book seller.

This concludes interview #2 in On Good Authority's program on "Posttraumatic Stress Disorder" I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of ON GOOD AUTHORITY. Until next time, this is Barbara Alexander.
Thank you for listening.

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POSTTRAUMATIC STRESS DISORDER

Interview #3: “THE CULTURE OF PTSD”

JAMES HERBERT, Ph.D.

Interviewed by Barbara Alexander, LCSW, BCD

(Edited slightly for readability)

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Welcome to On Good Authority. I'm Barbara Alexander.

You are listening to or reading interview #3 in “Posttraumatic Stress Disorder,” a continuing education program of On Good Authority covering diagnostic and treatment aspects of this controversial and important subject.

Recent research coming out of the military is showing vastly greater numbers of suicide among veterans of the Gulf War and the wars on the Iraq and Afghanistan fronts than in previous war theaters. While all wars are hell, Iraq appears to have its own unique brand of horror. According to former Iraq sniper and Veterans for America outreach coordinator Garrett Reppenhagen, the confluence of environmental, political, and cultural factors make it the Iraq war, “the perfect festering pot for psychological damage.”

According to a 2004 Department of Defense study, published in the New England Journal of Medicine, PTSD is emerging as this war's signature disability. Its prevalence ranges from 10-20%, depending on the number of firefights a soldier was involved in. Then, upon returning home, nothing is quite normal, not their marriages, not their families, not their friends. They are the same but yet not the same. Unfortunately the Veteran's Administration's care has been disgracefully wanting.

Our next speaker will cover some aspects of the culture of PTSD, on his way to looking at treatment.

James D. Herbert, Ph.D., is a clinical psychologist specializing in cognitive-behavior therapy (including newer mindfulness and acceptance-based models of behavior therapy), mood and anxiety disorders, the distinction between science and pseudoscience in psychology and related fields, and the promotion of evidence-based practice in mental health. He is Professor of Psychology and Director of the Anxiety Treatment and Research Program at Drexel University, where he also serves as Associate Dean of the College of Arts and Sciences. He also served for several years as Director of Clinical Training of Drexel's Ph.D. Program in Clinical Psychology.

Dr. Herbert has received numerous professional honors and awards, including the University's Outstanding Teacher of the Year Award in 1999. He leads an active research program on the assessment and treatment of anxiety disorders, with particular emphasis on evaluating the effectiveness and mechanisms of action underlying new acceptance-based models of behavior therapy such as Acceptance and Commitment Therapy (ACT).

He has published widely on these and other topics in professional journals, and is known internationally for his writings on quackery and pseudoscience in mental health. He is currently an Associate Editor of two professional journals (The Scientific Review of Mental Health Practice and Cognitive and Behavioral Practice), and he serves on the editorial boards of several additional journals, including the Journal of Anxiety Disorders.

Now to our interview.

ALEXANDER: Dr. Herbert, you wrote a chapter in a book entitled Posttraumatic Stress Disorder: Issues and Controversies, which was edited by Gerald Rosen, and I thought your chapter was very important, so I want to talk to you about the things you covered in your chapter. Also, before we get into that, what, if anything has changed in the field in the last few years?

HERBERT: Sure, okay. Well, we covered a lot of territory in that particular chapter, and my co-authors, co-investigators, and I have written some other things about PTSD as well. We actually have some pretty interesting new data that has just come in. What I would say has changed is that there is, I think, an increasing recognition about some of the problems with PTSD, particularly with the way the diagnosis is currently structured. On one hand, there is an increase in sensitivity to the importance of looking at posttraumatic reactions. In the aftermath of trauma, it's important to see what happens and see how we can help people. But at the same time, the PTSD model, as defined by the DSM-IV, is problematic in some ways. I think there seems to be an increased recognition of what some of those problems are. How that's going to play itself out, especially now that the DSM-V process is just beginning -- it's in its earliest stages -- is anybody's guess. We don't know that yet. But I think at least some of these issues are going to be on the table and in the forefront in ways that they probably weren't in the past.

ALEXANDER: How political do you think it's going to get?

HERBERT: Well, unfortunately, I think inevitably it's going to get political, because the diagnosis of PTSD has been political from the beginning. As you probably know, the diagnosis was originally proposed as "Post-Vietnam Veterans' Syndrome." So, it was a syndrome of Vietnam veterans that was promoted primarily by anti-Vietnam war psychiatrists. There was a concern by Bob Spitzer when the DSM-III was being organized that that was too narrow, and so these antiwar psychiatrists teamed up with people focusing on women's issues and the reaction of women to traumatic events like rape, and ended up creating this diagnosis of PTSD. So, it's had a political piece to it from the beginning.

Now, there are further political pieces to it because studying and supporting PTSD has become synonymous, in many circles, with supporting victims, whether that's veterans who are combat victims, or whether it's victims of rape, or victims of natural disaster. The idea is that if you're an advocate for victims, and you're recognizing the suffering that goes into being a victim in one of those cases, then you're an automatic supporter of PTSD. Conversely, if you raise serious questions about PTSD, then you somehow must be anti-victim, and of course that's not the case at all.

There have been people who have raised concerns about the way PTSD is treated in the VA system. Unless you call for ever more increasing funds for the VA system, if you raise questions about the way the current system may actually create and perpetuate PTSD, then you're sometimes branded: some of these folks have gotten branded as anti-veteran or anti-victim, which, of course, is a politically motivated argument, not a scientific one. So, unfortunately politics have been imbued within the whole controversy about PTSD from the beginning, and my guess is that it's going to continue that way.

ALEXANDER: Is there a fundamental truth about what PTSD is?

HERBERT: That's an interesting question. Let me see if I can try to address that question -- that's a tough question to answer. PTSD is real, in the sense that there are many people out there suffering from PTSD, suffering from the symptoms as described in the DSM. There are people who have flashbacks and nightmares and the numbing sensations and the avoidance and the exaggerated startle response, and all the symptoms of PTSD. There are people out there suffering from this, and those people need our attention. They need help. There's no question about that.

The concern is that PTSD may not be a so-called "natural kind" in nature. It may be to a large extent a social construction. What that basically means is this: a natural kind is a phenomenon that exists in nature, independent of what we think about it. A good example might be the periodic table of elements (Rich McNally used this example). The periodic table of elements is something out there in nature; nature is carved up that way, no matter how we look at it. If you're inventing chemistry on a different planet, presumably you're going to come up with the same periodic table of elements.

On the other hand, some forms of psychopathology are not that way, and PTSD may be a very good example of one that is not that way. Our story that we tell, our current cultural model or narrative about reactions to trauma appears to influence the specific symptoms, the specific manifestation of people's reactions to trauma. That doesn't make it any less real, and I hasten to add that, but what it suggests is that by talking differently about how people react to trauma, we may be able to shape people's experience in a different way and actually alleviate suffering.

So, if I can elaborate just a little bit: in the aftermath of trauma, if you tell people, "Oh my God, you're going to really have a hard time here. Here's a list of systems that you may experience. Please let us know if you have any of these symptoms," there's some evidence to suggest that maybe not everybody, but a certain number of people will, in fact, go on to develop precisely those symptoms that you've told them. Whereas if you tell them you're likely to experience a different set of symptoms, then they might experience those other symptoms.

On the other hand, if you tell them that the normative reaction is resilience -- in other words, if you tell them, "Chances are you're gonna be okay. It may be tough for a few days, and that's completely understandable, but you're going to be okay," and you create that as the expectation, it may be that that actually promotes resilience, rather than pathology.

So, I think the implication of this, and there's growing data to suggest this perspective -- I'm not going to argue that we know for sure that things work this way, but there are some good reasons to believe, I think, that this is what happens. To the extent that that's true, the implications seem pretty clear: we want to be very careful, in the aftermath of trauma, not to give pathologizing messages; rather, to give messages of resilience. Do you see what I mean?

So, if you remember, right after 9/11, every pop media psychologist around was on TV arguing that we were all going to fall apart, that PTSD was going to be rampant, and the whole country was going to suffer these horrible symptoms. That's precisely what we don't want to be doing because that suggests to people that this is how you should respond.

ALEXANDER: In your chapter, you describe the different reactions in the World Wars, in World War I and II, and I thought those were really fascinating: the difference between the British response and the French response to World War I, and then what we learned for World War II. Could review that for us?

HERBERT: Sure. Well, briefly, there is a model sometimes called PIE: proximity,

immediacy, and expectancy. This is something that the British military, in particular, recognized early on toward the latter part of World War I, and then they incorporated these lessons into World War II. The idea is this: if a soldier develops posttraumatic symptoms of some kind on the front lines, instead of pulling that individual back away from their unit, pulling him back far away from the front lines to a hospital, and treating it as a medical condition, you keep him in a forward unit, like what we think of as a M*A*S*H unit. You give him some sedatives, if need be, to help him sleep, and you give him a few days of rest and relaxation, with the emphasis on resting, and you're very, very careful not to medicalize what's going on, not to tell him that he has some sort of medical condition, or PTSD, or anything like that, that he's just tired and exhausted and just needs to rest up, to get back on his feet, and then you put him back in with his unit, actually by doing that you prevent the development of long-term morbidity, of long-term development of impairment and symptoms. This doesn't mean in every single individual; there are people for whom that doesn't work. But, what the British discovered was that this works a lot better, and you could cut your rates of psychiatric casualties way, way down by using this model.

And sure enough, this model has now been adopted by the military. That's why, in Vietnam, for example -- people tend to think of Vietnam being really bad in terms of PTSD, but actually, during Vietnam per se, the rates of psychiatric casualties were really quite low compared to other wars because the military was using this model that I'm describing. So, it wasn't until the vets came home, that there was the big increase in symptoms. The point here is that looking back over time, one of the lessons we have from the study of military psychiatry is that the way that the military system treats reactions to combat trauma seems to influence how soldiers react and how much disability they end up manifesting.

ALEXANDER: There are a couple of things I want to talk to you about in this. The first that comes to mind is this: in the movie Patton, there's a very young soldier in a hospital who's crying and quaking and Patton is reviewing the troops in the hospital. Patton sees this kid who's trembling with fear, and Patton hauls off and smacks the kid, and says, essentially "Shape up," and then Patton gets into a whole lot of trouble for doing that. So, that is not a treatment method.

(They laugh)

HERBERT: No no! No one is advocating that! I mean clearly, this is all in the context of a compassionate stance towards those people who are hurting and suffering. So, no one is suggesting that we go in just tell everyone to shape up. It's more subtle than that.

The idea is rather that we be very, very careful about giving morbid expectations. So, for example, there's a pretty popular form of psychological debriefing, post-trauma debriefing, that's become pretty popular. What happens in this is, for example, you would take first responders, say firemen, who have just witnessed horrible deaths in a disaster, a fire. You bring them together in a group and you have them recount their experiences of what they saw, what just happened. You encourage them to emote, to cry if necessary, that sort of thing. There's also some education about PTSD symptoms in that debriefing session.

The purpose of this, in theory, is to help educate them, to help them process these emotions, to help them "get it out" in a cathartic sort of way, with the idea being that that's going to help and they won't develop PTSD.

It seems like a reasonable idea on its surface. But the problem is that what the data show is just the opposite. Either these programs have no benefit at all, or they actually increase the rates of PTSD rather than decrease them. We don't know for sure why that happens, why they increase the rates but there are a couple of possibilities. One is you're forcing a round peg into a square hole in the sense that firefighters have their own way of coping. They have their own sort of cultural model. Maybe a couple of these guys will go out to a bar and have a beer, and slap each other on the back and say, "Wow, that was a rough day," "Yeah, that was," and they go

home. Maybe to a psychologist that may not sound like the ideal way of coping, but you know what? It works for a lot of these guys. So, what this debriefing model might do is interfere with that process. It may interfere with the natural, built-in social supports that are already there.

The other possibility is that by doing the education about PTSD right in the immediate aftermath of witnessing this trauma, or experiencing the trauma, it may actually encourage the development of the symptoms. As I mentioned before, we have some new data including some new cross-cultural data that seem to suggest that that may go on as well in other cultures.

The general point here is not that we shouldn't treat people with compassion-- of course not, quite the opposite. But the general point is that we need to be very careful about giving messages, whether it's at a large societal level through the media or whether it's to individuals. We need not to give messages of morbidity, of the expectation that things are going to go badly. Instead, we ought to give messages that the default assumption is Resilience – that even though it may be hard early on, most people are going to be okay.

ALEXANDER: I'm very distressed by news reports coming out lately about the greater number of suicides among veterans returning from Iraq, the family disruption, and the domestic violence. It just sounds like so many of these guys, and the young women too, come back in terrible shape

HERBERT: Well, I think that much more could be done. Let me back up and say that, first of all, I'm not in the VA system. I'm not an expert on the VA system, and so I can only speak in generalities. But, what I would say is that I do think it's clear that we're not doing enough to help reintegrate our troops as they come back from war.

It's a very difficult thing. You're away from your family, you've got, in some cases, children being born, children growing up. Also, in this war, unlike so many in the past, there are multiple tours of duty. People are away a long time. They come home, and then they're shipped right back out to the war zone.

Another thing that makes it difficult in this war is the unexpected nature of what's going on. People are on call, so to speak, a lot more because you're driving along and everything is quiet, and you never know when your vehicle is going to hit an IED. So, there are a lot of things that make this an especially difficult time, and what people need is help reintegrating back into society, whether that is job-training programs, marriage and family therapy kinds of programs -- these are the kinds of things that I think are really important

The problem is that the current VA system -- some would argue and I think with pretty good reason -- that the current VA system is too medicalized. It is too focused on PTSD as a medical condition. So if you look at the disability system, if you can get full-time disability for PTSD within the VA system, you get a monthly check. You get payments. You get payments as long as your symptoms continue. If your symptoms abate and you're doing better, the money stops.

Now, I am not for a second suggesting that people are malingering. However, you don't have to be malingering for that contingency, for that set up, to affect your behavior. So, in other words, if you started having headaches and I essentially started paying you for your disability associated with your headaches, and let's say they're really bad migraines, well now, you have no incentive for getting rid of those migraines. You have every incentive for them to continue. So even if it is not a conscious, deliberate act, it could still happen that the system perpetuates this ongoing disability, and that is what we don't want. We need somehow to find a way, and people have proposed ways, to fairly compensate soldiers who have chronic symptoms, but more importantly to try to really help them not become dependent upon that disability check but to really get better -- I think we could do a lot better than we are doing now.

ALEXANDER: I would like to talk about the medicalization of the problem and what you have referred to as “the positivistic paradigm.” Could you explain what that is, please?

HERBERT: Sure. Well the positivistic paradigm relates to what I was talking about earlier with this notion of “natural kinds.” In this context, the positivistic paradigm means viewing psychiatric disorders as things that exist out there in nature, independent of sociocultural influences -- in other words, that are independent of our way of viewing and conceptualizing them. A trend in mental health over the past 100 years is that more and more of the human experience has been medicalized and made into disorders.

Now, there are aspects of that that have been very, very positive. So, for example, schizophrenia and bipolar disorder are things that fit better within that medical model. They fit better in the sense of having a common core of symptoms that seems to be pretty consistent across time and across different populations, some commonalities in the ideological processes and then in treatment, there are medication treatments that seem to do reasonably well in helping to alleviate the symptoms of those conditions. So that positivistic paradigm of looking at something like schizophrenia as a disease state works pretty well. But, there are a lot of other areas where it is questionable how well it works and it seems that the pendulum has swung too far in terms of conceptualizing these things as diseases.

PTSD, as I have already mentioned, is a good example of that, I think. If you look across cultures, the way that people experience reactions to trauma does seem to differ across cultures, especially cultures that are not heavily influenced by the West. It is harder and harder to find those cultures because Western civilization has become so dominant throughout the world, but when you go look at them, what you find is they seem to respond to trauma somewhat differently than everybody else does -- in the West, that is.

Similarly, if you look across time, historically what you find over the past 200 or 300 years or so is that the reactions that people have had to trauma are very different. They look very different. There was a time in the 19th century, for example, especially in the late 19th century, people were having these strange paralyses. It looked what, in Freudian terms, would be called a “conversion disorder.” Your hand or your legs would go numb and you wouldn’t be able to walk. You would have this paralysis that did not make anatomical sense in terms of the way that the nervous system works. But, this was the understanding at that time. This was the narrative within the medical community at that time about how people should respond to trauma, and sure enough, that is the way that they did respond to trauma. So, people were not reporting the exact symptoms of PTSD, these numbing, and flashbacks symptoms and that kind of thing back then. They were reporting something very different.

Now, it is possible that they were still having the symptoms but they just weren’t just reporting them. But, I think that that is a little bit less likely because with other disorders, such as schizophrenia or bipolar disorder or something like that, if you look across time or if you look across cultures, there is a lot more consistency. There is a lot more consistency from one culture to another with something like schizophrenia than there is with something like PTSD. So, both the cross-cultural and the trans-historical perspectives seem to suggest that part of what is going on is not this sort of invariant, biologically based, natural kind that more typically characterizes something like bipolar disorder or schizophrenia but rather is, in part, a social construction.

Just to show that I am not being biased against PTSD, a lot of my work is in the area of social phobia, social anxiety disorder. There is evidence that over the past 10 to 15 to 20 years, there has been a gradual movement for that disorder to get bigger and bigger and bigger. I don’t mean in terms of increased prevalence, but I mean the expansion of the definition of it.

Now some people have argued -- there is a book that just came out arguing that the big pharmaceutical industry is largely to blame for this. As they get an indication for a particular disorder -- for example, Paxil was the first

drug to have an indication for social phobia -- then what happens is that the drug companies obviously have a big incentive for expanding the definition of what constitutes social phobia because that way they can sell more drugs. Now, I am not necessarily saying that that is what is happening, but you can see how that might be part of what is going on.

ALEXANDER: Back to the cultural, what are some of the places in the world where they react differently to trauma.

HERBERT: That is a very good question about the cross-cultural aspects of trauma.

The problem is that there has not been very much research done on this and most of the research that has been done is flawed, at least most of the psychiatric and psychological research. Medical anthropologists have done research in this area and it is pretty interesting. If you go to an isolated village in a non-Western culture somewhere, and you take a checklist of PTSD symptoms, and you go to the village of elders and you say, "Show me some people who have been traumatized," and then you go interview those people and you say, "Do you now have these symptoms?" and you go, boom, boom, boom and you go through the symptoms of PTSD, well sure, you're going to get a lot of hits. A lot of people who would say yes. But the thing is, that doesn't necessarily mean that they are experiencing their reaction to trauma in the same way that someone in the West does with PTSD. If you have a different list of symptoms, say of depression, and you go boom, boom, boom, well, guess what? They endorse those as well; in fact, they endorse depression at a significantly higher rate than they would endorse PTSD symptoms. So, you have to be careful how you do this.

The best research starts with more open-ended questions. So, you go and you ask them, "Tell me how you have reacted to this trauma. Tell me what your experience was," and then you code those responses so that you're careful not to suggest to them any particular answers one way or the other. After you have done that more open-ended interview, then you can give the measures. But, you have to assess not just for PTSD, but for other kinds of disorders as well, for depression, anxiety disorders, etc, etc.

Now, we recently did a study it like that in Burundi. Burundi is a country in Central Africa, just south of Rwanda and they went through a horrible, horrible civil war between the two main ethnic groups in Burundi. Many of the people experienced unspeakable trauma, things that would just make you shudder to hear about.

What we did is we went up into the hills of Burundi, in some very isolated villages that where people have had minimal contact with the West, and we assessed how much they knew about trauma. We assessed their knowledge about trauma, about post traumatic stress disorder, these Western concepts. Had they heard discussion about these types of things on the radio? Had they read about them somewhere, etc, and what we found was variability. Some people had, many people had not, and then to varying degrees.

What we found was there was a relationship between how much they had been exposed to Western discourse, Western models of trauma and PTSD symptoms: the more people had heard about PTSD, the more they displayed symptoms of PTSD. Now, it is possible that what is going on is that the people that have actually had PTSD sought out the information and that would explain the relationship. But for various reasons that I won't get into, what I think more likely is going on is that by suggesting to them, by their getting information about, "Hey, this is the way that you're supposed to react to trauma," well then, that is what happened. That is how they reacted.

We just finished another study in Burundi that is not yet published because the data has just come in where we examined a standard treatment program. It is like a group workshop, a reconciliation workshop program that some NGOs do over into Burundi where they take the two warring tribes and they put people together. It is like a healing and reconciliation experience workshop. Part of the standard workshop model that has been used includes some psychoeducation about PTSD.

We wanted to ask is if it is such a good idea to tell people about PTSD? We randomly assigned people to either get the standard workshop that I have just described, or another workshop where we took out the PTSD piece. They still got all of the reconciliation, the healing, they still got those experiences but we did not mention PTSD. Then we followed them up three months later.

What we found was that the two groups did not differ in their rates of depression, anxiety, general well-being, functioning, that kind of thing, but they did differ in PTSD. The group that got the education about PTSD actually did worse, had more symptoms of PTSD than the group that didn't. So the suggestion is that by our well-intentioned efforts to go in and teach them about PTSD, we actually may be, in some sense, creating more PTSD symptoms.

ALEXANDER: That is the "iatrogenic...?"

HERBERT: Yes, the iatrogenic effect. So if you look at converging lines of evidence -- the two studies done in Burundi -- if you look at the historical analyses that I was describing, how over time, the manifestations of post-traumatic reactions have been very, very different and if you look at the iatrogenic effects of psychological debriefing, if you put all of these things together, there seems to be some converging evidence to support this fundamental idea that in the immediate aftermath of trauma, people are very vulnerable. They are vulnerable to suggestion, either positive suggestion or morbid suggestion, so we have to be very careful what we tell them. Even if we tell them, "Look, everybody is going to be fine, everything is going to be fine, 100 percent of you are going to be fine," we know that there is still some subset-- even if we minimize that number, there is still going to be some subset that is going to suffer and is going to have negative ongoing reactions and we need treatment for those people. Fortunately, we have some; we have good treatments for many of those people. They are not perfect and they need work, but we do at least have some treatments. But, my contention is that if we are not careful, we can actually give messages that will end up creating more distress and more PTSD and that is the concern.

ALEXANDER: The whole idea of PTSD is so embedded in my mind as an expectation, I am finding it hard to imagine what it would be like if you did not have the expectation! I mean, how would a victim, somebody who survives an automobile accident or who survives a rape or who survives a battle injury or any of the number of things that could be traumatic, how would they react if they didn't expect to get PTSD?

HERBERT: Well, fortunately, we do have some information on that. The interesting thing is there are lots and lots and lots of studies showing that the modal reaction to trauma is resilience. In other words, most people who go through automobile accidents, most people who have been raped, most children who are sexually abused, when they grow up, most combat veterans turn out to be okay. Now, let me add just very quickly that this does not mean that they are unaffected by the event. I mean, how could they not be unaffected, right? I mean, if you have been through a trauma, chances are you're not going to forget it and it is not going to be a pleasant memory. But that does not mean that you are destined to a lifetime of pathology. So, most people are okay and the normative reaction is actually resilience. What we want to do is promote that as much as possible. We want to avoid things that promote pathology.

One of the problems with PTSD, and this gets us back to the political piece before, it is with the emphasis on the trauma as the cause of the disorder, the so-called "Criterion A" (if you look at the DSM, the Criterion A is the traumatic event). There is so much emphasis on the trauma that it is one of the only diagnoses, in fact I think it is the only one of two, the other being an adjustment disorder, where the primarily ideological focus is a specific event. Okay?

Now this makes it very popular among advocates. So, for example, if you are a personal injury lawyer, you like PTSD. You like that diagnosis because you can point to the automobile accident. You can say, "My patient is having all of these symptoms, and this was the cause; it was the accident," and then, you can sue successfully for that. If somebody develops depression, it is not clearly linked to a specific event and it makes it much more difficult to pin that on any particular person or any particular event.

So, PTSD gets reinforced by the lawyers and sure enough, what you find is that patients who are in the middle of litigation, their PTSD does not tend to resolve. While they're in the middle of litigation, that makes sense. I mean, if you are suing somebody and the damages are PTSD, you are going to wait until the case is over before your symptoms subside. And, again, I am not suggesting that people are malingering, although I am sure that there is some of that as well, but even unconsciously, you can have the symptoms being maintained in part by these external factors. That is obviously a problem.

ALEXANDER: You mentioned that in the period right after a trauma, people are more vulnerable to suggestion. What do you think makes us that way? Is this a neurological, a biological thing that there is something that shoots into our brain that makes us come unwired, or...?

HERBERT: Well, I am not a biological psychologist, so I won't speak directly to the biology of it. I am sure that there is a biological piece there. I think at the most general level, right after a trauma, people are very disoriented. One's normal routine, what keeps us all sane, in some sense, is that sense of continuity, that sense of routine in our lives, that expectancy, sort of knowing what is coming next, what to expect, how the rest of the day is going to unfold.

The problem is that right after a major trauma, all of that is often shattered. It's taken away. We don't know what to expect now; the world seems like a very unsafe place. Situations that we thought were safe before are no longer safe, and in terms of like natural disasters or even major man-made disasters, you have very concrete things. I mean, you may have loved ones being killed.

Just recently, this horrible record breaking hurricane hit Bangladesh, and entire villages were wiped out. I read in the paper about an elderly man who discovered his wife, his kids, and his grandkids, all had been killed, so now he has his family is gone, his home is gone. This is a very disorientating time. So, if someone comes in and tells you, "Here is how you're likely to respond in a time like that," then it seems to be understandable that that could have a big impact.

ALEXANDER: Well, because you're looking for something to hold onto that might be predictable, I think.

HERBERT: Exactly, some sense of stability and order and that sort of thing. Clearly these people need help and their primary help, of course, actually needs to be material. They need shelter, they need medicine, they need to rebuild their schools. When people have gone through a trauma, the first thing you want to focus on is rebuilding their lives. In the aftermath of Katrina, what people needed most was food and shelter and their basic necessities met more so than psychological intervention. It is not to take away that there are not some people who need psychiatric and psychological care. Of course there are. I'm just saying that we need to keep our priorities straight and we need to make sure that we are giving people messages that we are here to help but that they are going to be okay, because that will encourage resilience, which is what we want to do rather than encouraging pathology.

ALEXANDER: Is it something about the Western mind that, in a post-enlightenment sense, we have shifted away from the role of the pastors, the shamans, the spiritual guideposts that people had before that maybe they don't think about? I

think about maybe Rose Kennedy, who lost all of those children. She was a staunch Catholic holding onto her faith. I mean she did not have PTSD, that we know about. But somehow, post-enlightenment thought or Western thought – as you said, they won! In the coin toss between the priests and the scientists, the priests lost. They lost the ball toss.

HERBERT: I hear you. I would frame it a little differently. My gripe is not with science but with perhaps the medical model. I think that there is an important difference. The medical model is only one model of many to capture the human experience. I don't have a problem looking scientifically at the way people respond. But in other words, it could be that there is a place in human experience that has been neglected by the medical model for people to connect to, whether it is faith-based institutions or just community in general. It wouldn't necessarily have to be religious, but just some kind of sense of community. There is a place for that-- for everyone's understanding of their experience that has been overshadowed by the medical model. But, one could use the tools or the lens of science to examine that as well.

The problem, as I see it, is that the medical model has been so successful in so many areas, right? If you look at infectious diseases, for example, how could we argue that the model has not been effective? It has been wonderful -- the kinds of gains that we have made over the past 100 years -- it is just phenomenal. So, the medical model has been wonderful in many areas of the human experience, but it is now being applied more and more and more to areas of human experience that traditionally fell outside of the notion of disease.

No place is this more evident than in clinical psychology, psychiatry and related mental health disciplines. You have aspects of the human experience that are now being called "diseases." They are being called "disorders," being codified in the DSM and things that used to be part of the normal human experience now take on a life of their own.

I am not suggesting, for example, that there are not kids who meet criteria, by any stretch of the imagination, for ADHD. There clearly are. But, if you look at the growth, the explosion of that diagnosis to the point that there are second and third grade classrooms out there where half of the class has the diagnosis of ADHD and half of the class is being medicated with psychostimulants. So, in my view, this is an example of natural human experience that had been thought about and treated and dealt with in other contexts, and now, suddenly it has become part of medicine. I think that is the danger.

Now, I think that there is an argument that could be made that that is being driven by the marriage of organized psychiatry with the pharmaceutical industry who are promoting the use of psychotropic drugs for more and more different kinds of conditions. So, it is very, very common now to find people on a whole host of medications for things that were experiences that in the past would not have been viewed as a psychiatric condition.

I am not making some radical, extreme argument here that all of psychopathology is one big social construction, or there is some big conspiracy with drug companies or anything like that. I am not suggesting that. There is clearly real psychopathology by any definition -- real suffering. There are some people who desperately need psychiatric medications and these medications have been absolutely miraculous, nothing short of miraculous for many people, the new generation antipsychotics for example -- I mean, there are great medications. We would not want to go back to the days prior to the advent of psychotropic medications.

The problem is that whenever those tools -- you know, if you have a hammer, everything becomes a nail -- so when we have these effective tools that work well in some contexts and then we start applying them to more and more and more and more of the human experience in areas that traditionally were dealt with in other domains, that becomes a problem.

ALEXANDER: I want to ask you a question about something that falls in the middle, and that is dream work. I don't know why dreams are not considered as helpful. It seems to me that dreams are something that would fall almost into spiritual work, or helpful work in this. Do you have any thoughts about it?

HERBERT: First of all I am not an expert in dreams, but here is what I would say.

My understanding of the scientific evidence is that there is not much support for the Freudian theories about dreams. The idea is that there is a symbolic peace to dreams and that if you, say, dream about a red car going down a hill in the springtime that that somehow has some special meaning. Of course, knowing Freud, we could pretty much predict that it all goes back to repressed sexuality of some kind, that dreams have specific, symbolic meanings and that we need to uncover that. My understanding is that the evidence is pretty clear that that is not how dreams work. It is more a case of sort of random firing. Our brains are actually quite active when we sleep. People tend to think that the brain goes to sleep and doesn't move and it is really not the case. Our brains are quite active. You have all this firing going on and then the cerebral cortex is trying to make sense of it, make sense of all of these random patterns of firing that are coming from various areas of the brain, and so constructs these sorts of narratives or stories to piece it all together. But it doesn't necessarily tell us much.

Now, having said that, I do think that there may be value in helping the person understand their experience within their own context. So, if I were to see a patient who really believed that their dreams were important and had meaning to them, well, I don't necessarily have to buy into that myself, but I could still work with them and use that as a tool within their world view. In a way, it is a kind of cultural sensitivity. So, if someone comes in and they believe that their dreams reveal important truth to them, I am not necessarily going to hit them over the head with a 2 by 4 of data and tell them that they are wrong. With my clinician hat on, I am going to meet them where they are and work with them within their experience to try to move them forward. If I have my science hat, though, if I am at a conference or I'm in a classroom and I have my science hat on, well then, of course I'm going to take a very different stance. I'm going to want to know exactly what science says.

So, it is important to recognize a different role between the role of the scientist and the role of the clinician. Hopefully, as a clinician you're informed by the science, but you need to meet the person where they are at and speak the language that they speak. If that means talking about dreams, well, you know, I would not necessarily stay away from that if that is the language that they speak.

ALEXANDER: Dr. Herbert, I have really enjoyed this interview. Is there anything else that you would like to say before we close?

HERBERT: I just want to make clear that I am not misunderstood. One might listen to my comments and possibly misunderstand to think that I am saying that PTSD does not exist, that these people are just faking their symptoms or malingering and I don't mean that at all. Nor do I say that we should cut funding for people who have been traumatized. I certainly do not mean that at all. In fact, I would advocate the opposite. We need to increase funding for helping us understand reactions to traumatic events and how we can help people. So, I am not in any way advocating a position that would be insensitive or anything other than very compassionate. But, I do think that there are real scientific issues, and we have only touched on a few of them. There are many others as well -- real scientific issues with PTSD as we understand it -- and those have implications for the prevention and the treatment of reactions to trauma, and that clinicians would do well to pay attention to some of those issues.

ALEXANDER: Dr. Herbert, thank you very, very much for this interview. As I said, I have enjoyed it very much.

HERBERT: It has been a pleasure. Thank you very much.

Listeners interested in contacting Dr Herbert may email him at: [HYPERLINK “mailto:james.herbert@drexel.edu”](mailto:james.herbert@drexel.edu) james.herbert@drexel.edu.

This concludes interview #3 in On Good Authority’s program on “Posttraumatic Stress Disorder” I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of ON GOOD AUTHORITY. Until next time, this is Barbara Alexander. Thank you for listening.

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POSTTRAUMATIC STRESS DISORDER

Interview #4: “TRAUMA, the BRAIN, and MEDICATION”

ANTHONY D’AGOSTINO, MD

Interviewed by Barbara Alexander, LCSW, BCD

(Edited slightly for readability)

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Welcome to On Good Authority. I'm Barbara Alexander.

You are listening to or reading Interview # 4 of "Posttraumatic Stress Disorder," a continuing education program of On Good Authority covering diagnostic and treatment aspects of this important and controversial subject.

Posttraumatic stress disorder is characterized by symptoms that reflect some form of persistent reexperiencing of the original traumatic event. Possible symptoms of this reexperiencing include recurrent and intrusive distressing recollections of the event, recurrent distressing dreams of the event, and physiological reactivity upon exposure to internal or external cues that resemble an aspect of the traumatic event. Research has repeatedly shown that many individuals with PTSD produce significantly larger psychophysiological responses upon exposure to trauma-related cues, compared to individuals without the disorder.

Trauma has been found to make the brain's emotional processing centers — particularly the amygdalae -- the parts of the brain that judge emotional intensity and make emotional memories — more sensitive in cases of PTSD.

Cornell researchers found that three years after Sept. 11, 2001, the amygdalae were most sensitive in those who were close to the World Trade Center. These individuals tended to still experience lingering symptoms that were not severe enough to be diagnosed as a mental disorder. Those with lingering symptoms showed significantly more sensitive emotional reactions in the brain when stimulated by photographs of fearful faces. The researchers theorize that the World Trade Center experience left people who had higher activity in their fear centers with hyperactive amygdalae.

Now this is interesting: a recent study conducted at the National Institute of Neurological Disorders and Strokes found that damage to certain parts of the brain -- the amygdala and the ventromedial prefrontal cortex, areas involved in higher mental functions and planning -- appears to reduce the risk of post-traumatic stress disorder. This discovery suggests that drugs or pacemaker-like devices aimed at dampening activity in these brain regions might become effective treatments for PTSD.

Let's hear next how a practicing psychiatrist uses neurological findings and medication to treat adults and children with PTSD.

For the last 30 years, Anthony M. D'Agostino, MD, has been Chair of the Department of Psychiatry of the Alexian Brothers Hospital, now in Hoffman Estates, IL. He has been a Clinical Assistant Professor of Psychiatry at Loyola University Medical School in Illinois since 1972, and is a past President of the Illinois Psychiatric Society, where he has been active on various committees of that organization over the years, including Ethics and Insurance. He served on the Assembly of the American Psychiatric Assn from 1996 to 2002.

Dr. D'Agostino was in the military as a psychiatrist during the Viet Nam War. The Alexian Brothers Hospital is soon to be working with Dept. of Defense for issues related to returning veterans.

In addition to his administrative responsibilities, he is in the private practice of adult and child psychiatry.

Now to our interview.

ALEXANDER: Dr. D'Agostino, I'd like to talk to you today about the impact of trauma and stress on the brain. Does it really happen? What does it really change in the brain and how does it do it? That's three questions all rolled up into one.

D'AGOSTINO: Well, I don't believe that the final pathways are worked out at this point so I don't believe we can say with great authority, "These things occur." However, there is quite a bit of research and the research does indicate that there are certain areas of the brain that are particularly vulnerable.

With children, with a developing brain, it is thought that maybe the influence on the brain has more developmental consequences whereas with an adult, with the brain presumably pretty well formed, some of the effects are thought to be somewhat less. However, we certainly see lots of posttraumatic stress in adults. Just exactly what is different about their brains is still a point of scientific discussion, as far as I can see.

But, in general there are a couple of areas in the brain that seem to be extraordinarily sensitive to posttraumatic stress. The two areas that seem to be most influenced during stress or post-traumatic stress seem to be areas that are more noradrenergic in their enervation. That is, the neurotransmitter, norepinephrine, seems to be very important as opposed to some of other neurotransmitters although if you read the literature, pretty much all of them will somehow come into play in one way or another.

There are different nuclei in the brain and there are usually neurotransmitters that run the machinery of these different nuclei. Some of those nuclei have primarily norepinephrine as their major neurotransmitter. A neurotransmitter is a chemical substance that transfers information from one cell to another. Some of these cells are organized in the brain as nuclei. These nuclei are "powered," if I can use that analogy, by different neurotransmitters.

Adrenaline is something in the body that everyone is familiar with. That's what happens when you're afraid of something or you're angry or you're upset. There is no adrenaline in the brain but there's some noradrenaline. In the central nervous system, it's all noradrenaline. These chemical substances act as neurotransmitters. They transmit information from one part of the brain or from one cell to another. That's what "adrenergic" means when you're talking about particular nuclei.

In PTSD, the nucleus coeruleus contains predominantly norepinephrine as its neurotransmitter. That means that in order for those cells to operate, that particular neurotransmitter has to be present. Some of these areas may require dopamine to be powered. Dopamine is very similar to norepinephrine; it's part of the metabolism of norepinephrine. Some require acetylcholine. Some require serotonin. Some require a substance known as GABA (Gamma Amino Butyric Acid). These are just neurotransmitters that operate within the brain that transmit information from one part of the brain to another.

ALEXANDER: Then what it actually does to the brain under a stressful situation is ..?

D'AGOSTINO: There may be increased activity in those areas that are, for example, noradrenergic. Let's say in a particularly traumatic incident, there may be increased activity in, say, the nucleus coeruleus, which is powered to a great extent by norepinephrine, or noradrenaline and that area may continue to show elevated activities beyond the period of time of the stress.

ALEXANDER: So it stays there.

D'AGOSTINO: That's what they mean by "activation" of that area. That area is activated and it may stay activated for an extended period of time. So therefore, the cells that are influenced, if the nucleus coeruleus is very, very active -- the axons that go from that nucleus to other parts of the brain will be overstimulated, and consequently, people are more aware of those types of things.

Something like the nucleus coeruleus, for example, with its norepinephrine-powered cells, may influence memory. Intense experiences sometimes, whether they are positive or negative, tend to be mediated through the nucleus coeruleus, and that may influence how well they are remembered by the other cells in the brain, hence the person's consciousness. These areas become activated and they may stay activated and they develop a life of their own, apart from whether the person is still experiencing that particular trauma or memory.

ALEXANDER: Now this is going to be a totally simplistic question, but where in the brain is this all happening? Is it in the mid-brain, the frontal lobe, the back of the brain, the neck? Where is it happening?

D'AGOSTINO: Most of these areas are in the mid-brain, the subcortical areas. Most of these nuclei are considered subcortical. On the other hand, for you to become aware and conscious of them, they have to connect with your cortex somewhere. They have to influence the cortex.

Can I use an example from something else, like depression?

ALEXANDER: Please.

D'AGOSTINO: We're going to be doing what's called "deep brain stimulation" for depression here, sometime in the next month or two; we're going to be starting a project doing that. In depression, the limbic system -- areas of the mid-brain, sub-cortical areas -- are involved. That means that these areas are over active; they seem to be stimulated and they develop a life of their own. They come into consciousness by virtue of some connection with the cortex.

In the surgery for depression, one of the strategies is that you find a way to disconnect the nuclei in the mid-brain from the cortex. So in an area like Area 25—that's a "white matter" area—that means there are axons going in various directions, but some of them go to the cortex, and you disconnect by turning on the stimulator. You disconnect the impulses going from the mid-brain to the cortex and the person feels better because they aren't bombarded by stimuli from the lower brain areas. That's an example of how these "circuits," if you will—and they are circuits; there's no other way to say it—can be influenced and affect other areas of the brain. If they affect cortical areas, the person reports it as a subjective experience of joy or depression or anger or love—any of those possibilities. Those are generally mediated by circuits in the brain and those circuits can be influenced positively or negatively.

ALEXANDER: That's a very good primer for non-neurological, non-medical people like me.

D'AGOSTINO: Especially with children, it seems as though the locus cilium and the ventral tegmental nucleus -- these are areas of the midbrain and seem to be especially sensitized in children and probably in adults as well who experience posttraumatic stress symptoms. These areas appeared activated, or sensitized, if you will, when these various, fairly intense stresses do occur.

In order to meet criteria for posttraumatic stress disorder, you have to have a real event, and the real event has to be pretty intense where there's a threat to life and limb, or an experience or observation of somebody else's life

and limbs being damaged. The person has to experience it pretty much personally. Certainly the information about the death of a close person can also probably meet the criteria. But you've got to have an event. I think "speculations about events" probably weaken the over-all understanding of posttraumatic stress.

The ones that people can identify with readily, like a rape experience or being beaten and robbed, being beaten within an inch of your life, or war experiences, or experiences where a person is being exposed to extremely violent experiences that they would not normally experience in any other context, those have to be very severe.

ALEXANDER: What about the amygdala?

D'AGOSTINO: Yes, the amygdala. There's like a tension between the septum and the amygdala. The amygdala is sort of the aggressive center and the amygdala also seems to be overactive in many states of PTSD, which some people feel accounts for the violent outburst and the irritability and the anger that you see in people with PTSD, because you do get over-activation of the amygdala.

The amygdala and the septum are two parts of the brain that control -- the septum is sort of love and tenderness and good feelings, and the amygdala is the violence and the aggression. There's always a dynamic tension between those two areas of the brain. When one gets dominant over the other, let's say you damage the amygdala, you might get hyper-sexuality and abnormally warm feelings about everyone in the world. And then when you have septal damage or underactivation, you get over-activation of the amygdala and the amygdala seems to mediate a lot of the aggressive responses. The amygdala is over-activated. Neuro-imaging studies show it to be quite over-activated. That may also be one of the reasons why Clonidine may help in some of these situations too by modulating some of these nuclei that are noradrenergically mediated. But the amygdala is thought to be part of the aggressive expression in PTSD.

ALEXANDER: What happens? I know that the heart beats faster but what happens to the brain? With the heart beating faster and maybe you get adrenaline going, how does that change the brain?

D'AGOSTINO: In some way or another, these nuclei become sensitized in certain ways such that they become highly activated. Mechanisms by which they become activated are thought to be increased receptor sensitivities in these areas. These areas are particularly sensitized. What we mean by sensitized is that they become very, very active and they begin and continue to secrete these hormones that increase heart rate, make it difficult to breathe, and in one way or another, cause things like flashbacks or recurrent memories of traumatic events and things like that.

There are ways of measuring these types of things. Neuro-imaging techniques have become more sophisticated, but I think what's been used up to now are measures of things like -- one example is the Alpha 2 Adrenergic Receptor. These are often measured. These are in the brain and obviously they're affected in the brain, probably in areas like loco coeruleus and ventral tegmental nucleus but they're also measurable in blood. The alpha two adrenergic receptor is usually measured in platelets, of all places. But it has been shown that the platelet activity of this particular receptor probably parallels the same kind of receptor activity in the brain.

ALEXANDER: Well, what would come first? Let's use an example of an automobile accident. You're in an automobile accident or you anticipate you're going

to be in an automobile accident. What comes first? You notice, you observe this is going to happen, and then your brain sends signals all around? Or your heart experiences it and starts racing and that goes to the brain?

D'AGOSTINO: It's a brain phenomenon. The brain signals all the other organs in your body to react. This is called the old "fight or flight reaction." This is described early on, I think in the early part of the 20th century by Walter B. Cannon. He coined this phrase "fight or flight" to describe the body's response, appropriate response, to very stressful stimuli.

When a person is exposed to a real or perceived danger, a series of complex, interactive, gross physiologic reactions occur in the brain. These involve the nuclei that we discussed, but as far as Cannon was concerned, this involved a relationship between the hypothalamus, the pituitary and the adrenal gland, and that was called the Hypothalamic Pituitary Adrenal Access.

ALEXANDER: That's a mouthful!

D'AGOSTINO: Yes. But, it's really very important and it's been described for a long, long time. What you get is sympathetic arousal. In other words, the blood goes to the muscles, the blood goes to the brain, the blood is diverted from the gut and the liver and other places and it goes to the heart and the muscles and the brain. The person is very alert. The person is ready to fight or run – the so-called "fight or flight reaction."

When this is very, very intense, it seems like the brain picks that up and in certain vulnerable people -- and we don't understand why some are vulnerable and some are not, because different people experience the same types of things and not everybody will develop a posttraumatic stress disorder -- why do some people get it and some people don't?

Well, one can ask the same question about every other disorder that there is. There are people who will get PTSD. It is probably related to genetics. People who have family histories of various types of anxiety disorders or mental conditions appear to be more at risk. People who tend to be more vulnerable in a lot of different areas probably also tend to be a bit more vulnerable to posttraumatic stress.

I think that's probably the best we can do as far as saying why that occurs, but obviously, the secretion of steroids from the adrenal gland, the increased blood flow to muscle, brain and heart -- these are just what occur during that particular fight or flight reaction. But when that is prolonged and fairly intense, people don't seem to be able to resolve it; it doesn't go away quickly. If it goes away quickly, we don't even call that posttraumatic stress.

ALEXANDER: Is this something that would appear in the blood? Let's say somebody wanted to prove that they had posttraumatic stress disorder for insurance purposes or legal purposes, is this something would show up in blood work?

D'AGOSTINO: Yes, well, I'm not sure it would stand up in a court of law but there are measurable differences in terms of how people experience posttraumatic stress. People with posttraumatic stress disorder do have differences in the way they handle cortisol. You've heard of a dexamethasone suppression test?

ALEXANDER: No.

D'AGOSTINO: It's a situation in which you give dexamethasone and you see to what extent that is able to suppress the secretion of cortisol from the adrenal gland. People with posttraumatic stress seem to be more sensitive to the effects of cortisol, showing greater reactivity. There's even a treatment, or at least there's a research involving treatment giving cortisol for posttraumatic stress symptoms and research so far shows that 10 milligrams a day of cortisol for a month will significantly reduce the intensity of posttraumatic symptoms.

The problem there is how long is it safe to give cortisol? You can't really give it for a long period of time without maybe doing other kinds of harm. But it does show that those people are particularly sensitive to the effects of cortisol, and so-called 'normal people' don't show that degree of responsiveness.

ALEXANDER: What are some of the PTSD symptoms that medications can treat?

D'AGOSTINO: Well, PTSD is associated with, first of all, severe anxiety, sometimes with panic attacks. I think the strategy for most PTSD treatment is to treat whatever the various symptoms are—it's a symptom-oriented treatment. So if people have panic attacks, we use the same types of medications to treat panic attacks that we use to treat people who don't have PTSD. Oddly enough, that includes SSRIs and benzodiazine tranquilizers. The problem is that SSRIs are widely used for the treatment of posttraumatic stress but they don't really seem to have marvelous effects, at least for people with people with PTSD.

ALEXANDER: Now, SSRIs are anti-depressants?

D'AGOSTINO: Antidepressants like Prozac or Lexipro or Paxel or Zoloft. Those are the commonly used SSRIs: selective serotonin reuptake inhibitors. These medications are very commonly used for the treatment of depression and they're very commonly used for the treatment of anxiety disorders.

With people with PTSD, however, they're probably not as good as they are in the treatment of depression. It seems that the anxiety associated with PTSD is different from the anxiety associated with depression. But from a treating person's point of view, if a person is experiencing intense anxiety or depression, they're going to treat them with the usual medications that we use for those types of things. It's just that as a long term treatment of PTSD, they're probably not very good.

Actually, probably non-pharmacologic treatments are as good or better in the treatment of PTSD. A commonly used medication for the treatment of PTSD is a blood pressure medication called Clonidine. It's a beta agonist. Beta blockers are also used to treat some PTSD symptoms and they seem to be useful for the treatment of panic attacks in people who have PTSD. I was just reading an article, probably within the last month, about the use of beta blockers and the treatment of people with PTSD. Where you have things like tachycardia, rapid heartbeat, shortness of breath, the overall discomfort associated with intense anxiety, beta blockers do give some relief. But, probably Clonidine is the medication that has been studied a little bit more. Clonidine is not a beta blocker; it's an alpha-adrenergic agonist, meaning it acts a little like some forms of norepinephrine.

We treat whatever symptoms a person has. If they complain of depression or anxiety, we'll give medications useful for that but I don't know that they're all that effective and I don't know that they're as effective as some of the cognitive therapies for PTSD.

ALEXANDER: So when would you prescribe those? Would those be when the symptoms are more severe?

D'AGOSTINO: I think that most anybody who comes into my office usually feels that their symptoms are fairly severe, so it's from a practical point of view. Very often, those patients are referred by someone else who's treating them. So if a psychologist, a social worker in the community is treating a person with PTSD symptoms, if they send somebody in to see a psychiatrist, they want an opinion about medication, usually because the person is experiencing fairly intense symptoms. Usually they are experiencing fairly intense symptoms or they wouldn't be coming in the door.

ALEXANDER: Do people ever get hospitalized, psychiatrically, because of PTSD?

D'AGOSTINO: For PTSD, it's probably rare but one of the more co-morbidities of PTSD is depression and sometimes people experience symptoms of such intensity that they may attempt suicide or they may feel that they are about to if somebody doesn't relieve their pain pretty quickly. So under those circumstances you'll see hospitalizations. I think in a general hospital environment, like the one that I practice in, we're not going to see too many people with PTSD come in right off the street.

On the other hand, in the fall of 2005, I visited the Alexian Brothers' Hospitals in Germany. The Alexian Brothers operate probably eight or nine or more hospitals in Germany. One of those hospitals is exclusively for the treatment of PTSD. So this is a hospital that gets referrals from all over Germany for people with fairly severe symptoms of PTSD that require not so much medication intervention because if medication were effective, they probably wouldn't be there. Usually it's more of a behavioral, cognitive therapy treatment program, but apparently the symptoms are so severe that they do require a hospital environment. So they have a hospital totally dedicated just for that one condition.

So, yes, obviously, when things are so severe that the person is having constant symptoms of one kind or another that are so disturbing that they either interfere with the person's ability to function or perhaps lead to suicidal acts, hospitalization would be required. In a hospital environment where I practice now, we don't really see that too often. We see a lot of people who've had symptoms of PTSD but who probably are usually being hospitalized for one of the co-morbidities.

ALEXANDER: Can you imagine that there would be something like a morning-after pill that would prevent PTSD?

D'AGOSTINO: Well, I don't know of a morning-after pill, but yes. One could envision that if noradrenergic hyper-activation is a problem, then I think you could consider pre-treating somebody with something like that.

Now, Clonidine has been a little bit better studied with children and it looks like a good possibility because it has a modifying effect on noradrenergic stimulation in the brain, especially in the area of locus coeruleus and the ventral tegmental nucleus. So those areas seem to be sensitive to the effects of Clonidine and Clonidine seems to be able to buffer those areas,

Presumably, if you can pre-treat somebody -- the problem there is that you don't really know who's going to end up with posttraumatic stress. Sometimes the symptoms don't come on right away. I don't know if anybody has

pre-treated people just because they've been in a traumatic situation and not everybody experiences the same situation as traumatic. Like a hurricane for some people is pretty traumatic and for other people...

ALEXANDER: They get out their surfboards!

D'AGONSTINO: (laughter) Not their surf board but at least their rain gear and go and play.

You do see a lot of differential responses to otherwise traumatic things. Even in war there are people who seem to be able to manage those things somewhat better. I think in really traumatic war situations, it's probably abnormal not to experience a degree of anxiety or posttraumatic symptoms but there are other ameliorating things. That's probably why the buddy situation among combat veterans is very important. You develop really close relationships. You talk about how bad everything is. It does have a treatment-like, maybe a protective effect on a person. There are other people who are not able to benefit from that type of "group therapy," and maybe those are the people who might be more vulnerable.

It's really hard to say because in really severe stress, you're going to get a fairly high percentage of the people who experience at least acute stress symptoms. That's probably a normal thing.

ALEXANDER: But it doesn't necessarily evolve into PTSD.

D'AGOSTINO: No, it doesn't.

ALEXANDER: Now, going back to the subject of children and adolescents, under what circumstances would you prescribe medication with children and adolescents?

D'AGOSTINO: As in every area of psychology and psychiatry, you call something a disorder when it interferes with a person's ability to function. If you don't have an impairment, the question is, "Do you have a disorder?" There are a lot of people who report a lot of subjective symptoms but go about their daily business pretty well.

But I think if you're looking at medication, what I would look at is the length of time the symptoms have occurred, are the symptoms getting to be better with time or are they getting worse? I think if you see evidence that the symptoms are, in fact, getting worse with time, and you do see that fairly often, I think you can justify medication intervention if only to give the person relief from the symptoms that they are asking you to relieve.

Take the example of a child who can't sleep at night and can't concentrate on school and is constantly fearful about everything around them and screams and cries whenever they're alone. Unless you can find other ways of dealing with that -- and usually by the time they come to me, other people have tried to deal with those symptoms and don't feel that they're very successful so they'll send people asking for medication opinions, so under those circumstances where there's great distress and the person is not doing well and maybe getting worse as time goes by, I think a medication intervention is probably worth a look.

ALEXANDER: Let's say an adolescent came to you wanting medication, would you be suspicious at all of drug abuse?

D'AGOSTINO: Well, we usually don't use drugs that people abuse. It's uncommon, for example, for an adolescent to come in by themselves and ask for

medication. Usually they're brought in by a parent and usually, I find most adolescents adverse to medication. They don't want to be identified as ill. They associate medication with being sick. More often than not, they're brought in by other people who think that we ought to consider medication and usually they disagree.

I suppose I would be if they came in and said "I'm having posttraumatic symptoms and I want Atavan and lots of it." Then I would probably be suspicious. Or people have come in to me saying, "I just moved in from out of town and I'm on 150 milligrams a day of Adderall," and I usually would have a lot trouble with that. But, normally people don't come in looking for the medications that we do use, things like Clonidine, or even beta blockers.

ALEXANDER: On to the subject of beta blockers for a minute. Beta Blockers have some pretty significant side effects, don't they?

D'AGOSTINO: Obviously if you have asthma, you don't want to take a lot of beta blockers because it can precipitate an asthma attack. But apart from that, beta blockers, especially in younger people, unless you're worried about heart rate --if your heart rate falls below 45 or if their blood pressure drops to 60/20 -- yes, I would consider that a problem. But mostly beta blockers, in my experience, don't have a lot of really negative side effects. They're useful for blood pressure control. It's now common practice that for anybody who's had a heart attack who's discharged from a hospital, one of the quality indicators that hospitals will use or that insurance companies will use, is "Is the person on beta blockers when they walk out of the hospital after having had a heart attack?" So they do have a protective effect in a cardiovascular sense. Unless the blood pressure or pulse becomes perilously low, usually I don't see a lot of terrible side effects.

ALEXANDER: This brought another question to mind about heart attacks and stress. We're not talking about posttraumatic stress now because ...

D'AGOSTINO: Acute stress.

ALEXANDER: Yes, acute stress.

D'AGOSTINO: I think the mechanism there is usually pretty obvious. It's usually an intense flooding of the body with adrenaline. Obviously, for a person who is vulnerable, who has some cardiovascular disease, some coronary problems but nothing terrible, let's say they get into an automobile accident or somebody robs them at gun point on the street, obviously there's a dramatic increase in heart rate. There's a dramatic increase in blood pressure. There's also probably an increase in things like platelet stickiness.

In the fight or flight reaction of the body, if you fight, the body assumes you're going to bleed and if you do bleed, it's a little tuned up in order to control bleeding. Unfortunately, that also increases the ability of blood to clot in your arteries and the mechanism of death is usually a clot in your artery, or an arrhythmia precipitated by the dramatic increase in heart rate. Certainly beta blockers are very good. That's probably one of the reasons why people with heart attacks should be on beta blockers because they prevent some of

those things from happening.

One of the interesting things about posttraumatic stress is when you see children who come from places like Romania and some of the Eastern block countries where there is a history of chronic, somewhat low grade, but chronic stress earlier in life of one form or another. When some of these children have been adopted and come to this country, they sometimes show dramatic behavioral difficulties and dramatic mood difficulties. I don't think that anybody has explained why that is other than using a traditional, early trauma model which psychoanalysis has used for the last hundred years. I don't know that it's essentially different from that, but the reality is that there is probably some type of long term influence in the brain by early chronic stress.

One of the things that has been identified and investigated is something called hippocampal volume. Normally you can't create neurons; you can't destroy them and then re-grow them. I mean, we all know you can't do that. However, there are probably certain areas in the brain and certain parts of the hippocampus where some re-growth is possible. But it's thought, and then again, this is backed up by some degree of research, that some of these children who've experienced this prolonged trauma or neglect early in life generally end up with hippocampal volumes that are significantly smaller than in normal children experiencing normal development. That's measurable and that's documentable.

There has been some support for what is the long term effect, especially, of early stress. Well, the long term effect is poor development in certain areas of the brain. The hippocampus is simply the area that's measurable. You can measure it on CT scans and you can measure it with certain types of imaging techniques. So you do see the effects of chronic stress apparently having some dramatic influence in the brain.

On the other hand, it's also been known that people with depression will sometimes show reduced hippocampal volume. That's thought to be associated with the fact that people with depression report memory loss or difficulty in recovering memories, which is also, in some ways, not a problem in PTSD because they can't get rid of these memories. But at least in terms of chronic stress, it's thought that those are measurable developmental changes in the brain.

Oddly enough, with the treatment of things like depression, even with ECT, recent studies indicate that those areas re-grow and so a new term has come into the lexicon of psychiatry called "neurogenesis," which suggests that with treatment, you can actually grow some brain cells which is kind of interesting. I'm not sure that has been demonstrated yet in PTSD -- whether these low hippocampal volumes can be re-grown, but I hope somebody's looking at that.

ALEXANDER: This has been very interesting. Is there anything else you would like to add or are there other questions you been asked on this subject that you'd like to talk about?

D'AGOSTINO: I think the other part of PTSD is, "Do you ever really successfully treat it, especially in people who are compensated for PTSD? That's been an issue for the V.A. for years. I mean, does anyone ever really get over this? I think in the real world, we do see people that, if not "get over it," they do very well with ongoing treatment.

I think the primary therapy in PTSD is still probably Exposure and Response Prevention. Most people feel that that's where most of the action is. Using medications in these areas, as I mentioned before, is symptomatic. You can treat anxiety. To some extent, you may treat some of the flashbacks. But still, I think the primary therapy today is Exposure and Response Prevention.

There are even now Virtual programs that have been developed so the person can recreate a wartime event or situation in the virtual world in order to help people deescalate that experience in their brain. That's probably more effective than most medications right now.

ALEXANDER: When you deescalate the situation in the brain, you're taking away or you're reducing the amounts of norepinephrine in the brain?

D'AGOSTINO: It may not be just norepinephrine, but that seems to be the system that's gotten most of the interest. Norepinephrine and probably other neurotransmitters are involved, but norepinephrine is the one that's gotten the most attention. What you try to do is try to influence the areas of the brain that are being affected negatively in some way. If medication will do it, fine. If some psychosocial therapy or Exposure and Response Prevention does that, fine. These try to decrease the intensity of the stimulation in these various areas. You could do it, theoretically, by cutting or interfering with certain circuits in the brain, but we haven't gotten that far yet. If you can interfere with things like depression, or if you can interfere with OCD surgically, then if we knew exactly what tracks were involved, I suppose you could interfere with PTSD surgically, but we're not close to that.

ALEXANDER: That's kind of scary.

D'AGOSTINO: Scary --except if you have severe OCD and if you have severe depression and you can't get it treated in any other way, people are very interested in this.

ALEXANDER: I can see why. Dr. D'Agostino, I very much appreciate your time and appreciate this interview. Thank you so much.

D'AGOSTINO: You're welcome.

The Alexian Brothers Hospital is located at 1650 Moon Lake Blvd, Hoffman Estates, IL. 60169

This concludes interview #4 in On Good Authority's program on "Posttraumatic Stress Disorder." I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of ON GOOD AUTHORITY. Until next time, this is Barbara Alexander. Thank you for listening

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POSTTRAUMATIC STRESS DISORDER

Interview #5: "COGNITIVE BEHAVIORAL TREATMENT"

STEVEN TAYLOR, Ph.D.

Interviewed by Barbara Alexander, LCSW, BCD

(Edited slightly for readability)

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Welcome to On Good Authority. I'm Barbara Alexander.

You are listening to or reading interview #5 in "Posttraumatic Stress Disorder," a continuing education program of On Good Authority covering diagnostic and treatment aspects of this controversial and important subject.

Trauma outcome studies have consistently found the most effective PTSD treatments to be cognitive and exposure-based therapies that focus on emotional processing of the trauma material. Cognitive Behavior programs (CBT) are currently the most empirically supported treatments for individuals who experience persistent symptoms following a traumatic event.

CBT is a composite of several methods, all based on the principle that how we think influences how we feel and behave. The major goal is CBT is to change how the client thinks about his or her problems, whatever that may be. Then it is believed, changes in emotions and behavior will result. CBT emphasized rational thinking. As the ability to reason and think is often a casualty of trauma, both in its immediacy and in its aftermath, the cognitive therapy principles of CBT become integral to trauma therapy.

According to our next speaker, Dr. Steven Taylor, a number of cognitive and behaviors features distinguish people with PTSD. These include a complex array of cognitive abnormalities and behavioral problems. PTSD is associated with negative beliefs about oneself and the world. Behavioral factors and PTSD can mutually influence one another: PTSD symptoms can impair interpersonal functioning and aversive post trauma social environments, such as low social support can exacerbate PTSD.

In this interview, Dr Taylor discusses how and why CBT works.

Steven Taylor, Ph.D. is a Clinical Psychologist and Professor in the Department of Psychiatry at the University of British Columbia, Canada, and co-leader of the CIHR funded New Emerging Team called The Traumatic Stress Group. For ten years he was Associate Editor of Behavior Research and now is an Associate Editor of the Journal of Cognitive Psychotherapy.

Dr. Taylor has published over 200 journal articles and book chapters. He has also published over a dozen books, including *Advances in the Treatment of Posttraumatic Stress Disorders*; *Clinician's Guide to PTSD: A Cognitive Behavioral Approach*; and *It's Not All in Your Head: How Worrying About Your Health Could Be Making You Sick—and What You Can Do About It*.

Now to our interview.

ALEXANDER: Let's begin, Dr. Taylor. First, I'd like to take a few minutes and talk to you about the brain structures that involve fear and stress. I guess at a most basic level, it's sort of hard to imagine that the mind would function like a video

camera that would take in a traumatic experience as it were a movie.

TAYLOR: The mind doesn't work like a video camera.

ALEXANDER: Thank heavens!

(Laughter)

TAYLOR: Perception and memory are constructed processes. To some extent, we see what we expect to see. So really, a traumatic event is in the eye of the beholder. For one person, the event could be something that is a minor stress and for another person it could be really something traumatic.

I'll give you an example of that: one of my patients got rear-ended in a motor vehicle accident and the airbag deployed, and she suddenly thought that the cabin was full of smoke and thought, "My God, we're going to burn to death." So, this event was extremely traumatic for her. It turned out that it was just the powder from the airbag. But it was that perception at the time made that event traumatic. Objectively, it was a fairly minor accident, so it was her perception.

In terms of the brain structures involved in processing stress, there are two main pathways. One is called the low road and what is called the high road. The low road is a very rapid processing of sensory information that goes through the thalamus to the amygdala and the limbic system. The amygdala is particularly important in assigning emotional significance to events. So, that is very rapid processing.

Then, a somewhat slower processing, called the high road, is from the thalamus up through the cerebral cortex, through the frontal lobes and then down to the amygdala. That high road involves more of the processing of meaning and interpretation of events. So, that means that people can have very rapid automatic reactions to fear stimuli without really stopping to think about what they are. A good example of that is looming shapes. People can get startled if something looms up to them rapidly without them really taking time to process what it is.

So, if those two pathways are involved and, I guess, there are a whole lot number of brain structures involving the processing of threats, probably the three most important ones are the amygdala in the limbic system, which I mentioned, the orbital frontal cortex, and the hippocampus. The hippocampus is a structure that is involved in the formation of long-term memories. So, put simply, the amygdala and frontal lobes interact with one another. The frontal lobes can inhibit the amygdala, and vice versa. For fear extinction to occur, that is the overcoming of fears, it is not a process where fear memories are erased; it is a process whereby there is a strengthening of inhibition of the amygdala by the orbital frontal cortex. In studies of rats, for example, if you lesion the connections between the orbital frontal cortex and the amygdala, fear extinction doesn't occur.

That's important, clinically, because if you treat someone for a phobia or post-traumatic stress disorder and they overcome that phobia, it doesn't mean that the fear has been erased. It doesn't mean that it is gone. It means that under certain circumstances, that fear can be reinstated. In other words, under certain circumstances, the inhibition from the orbital frontal cortex can be lessened.

There are other structures involved in fear and stress -- stress related structures: one is the H.P.A. axis, which is involved in stress response. I should mention, as an aside, but a clinically important aside, a structure involved in the fear response that is interesting is the periaqueductal gray matter, and that is implicated in something called "tonic immobility." That is a fear response where the person feels frozen. You know, they are unable to move. Clinically you see it, for example, in sexual assault survivors who will say that during the rape,

they were just unable to move. They were frozen. That is a primitive fear-related reflex.

You also will see it in animals. You might have heard of the stage trick of hypnotizing chickens. That is tonic immobility. If you hold a -- well, so I've been told; I've never actually done it myself -- but if you hold a chicken, if you hold it immobile, it will freeze and if you let go of it, it is just this freeze/play dead response. It is a primitive reflex.

This is clinically important because sexual assault survivors might blame themselves for being assaulted, you know, "I didn't fight back; I was frozen." So, it would be clinically important to explain to them that this is a primitive brain reflex and it is adaptive because predators and some rapists lose interest in their prey if they don't fight back or struggle. So that is the brain structures involved in stress and fear, in a nutshell.

ALEXANDER: Well, what is H.P.A.?

TAYLOR: The hypothalamic pituitary adrenal axis. It's a series of structures: the Hypothalamus, which is a midbrain structure; the pituitary gland; and the adrenal gland, so it is part of that fight or flight response.

ALEXANDER: Well, are we going to assume then, or is it true that PTSD is caused by biological/neurological factors that were triggered by an event? Is that right?

TAYLOR: The current thinking of PTSD is that it is biopsychosocial, like just about everything, I guess. There is a biological component. In our research, for example, we have done some twin studies, which show that the symptoms had some degree of heritability. So, there is a genetic component involved, but there is also a learning component, an environmental component. For example, if person has been brought up in an aversive environment in which they had very little control and nasty events were unpredictable, they are at increased risk for developing PTSD. Conversely, people who are trained to deal with disasters, such as emergency response crews, trained to deal with burning oil rigs or shipping disasters and so forth, they are at lesser risk for developing PTSD because they are prepared to deal with these events. So, there is an important learning component involved.

Getting back to the biological component, people are born with differing degrees of vulnerability to develop the disorder. Some people are highly resilient as a result of preparation and their biological makeup, and so it would only be very severe events that would trigger PTSD. Whereas for other very highly vulnerable individuals, it could be something relatively minor.

To give you an example, when the movie "The Exorcist" came out, I think it was in about 1973 or 1974, there were some cases of people presenting to the emergency room with PTSD-like symptoms as a result of watching that movie, people with fears of being possessed by the devil. Now obviously, most people who watched that movie didn't develop symptoms or nightmares or things like that. It was only a small group of highly vulnerable individuals. So, there are all sorts of factors involved in PTSD.

ALEXANDER: Well then, how can the various talking therapies help?

TAYLOR: There are a couple of ways in which they are thought to help. I'm talking particularly about cognitive behavior therapy. One is involving exposure to the trauma. It is a part of that old saying, "If you fall off the horse, you get back on it." So, repeatedly imagining the traumatic event and going over it again and again in your memory can lead to fear extinction, fear reduction. So that is one way in which it is done. Clinically you might get the person to narrate the trauma in vivid detail, including sights, sounds, smells, what they saw, what they thought, bodily sensations, and go over that again and again and again.

That is one of the most effective treatments of PTSD. It sounds simple, but it is a little more difficult than it sounds because you have to prepare the person. Some of the events that these people have gone through are truly horrific, so you need to proceed slowly. Some of them dissociate during exposure. So, there is an art to doing exposure therapy, but this is how it is thought to work. It changes the traumatic memory; it increases inhibition by the orbital frontal cortex.

The other part of cognitive behavioral therapy that appears to be effective is what is called “cognitive restructuring.” That is identifying maladaptive beliefs or assumptions about oneself or the world that can contribute to the disorder. For example -- let’s go back to the example of sexual assault – if the person says, “I’m to blame, I’m inherently defective and bad.” Those sorts of beliefs are likely to contribute to all kinds of problems including depression and the emotional numbing symptoms associated with PTSD.

Similarly, if a person who had been through a trauma develops a strong belief that danger is everywhere: “I’m not safe anywhere,” then they are going to be very anxious. So, helping them to identify and explore beliefs about themselves, beliefs about other people, and beliefs about the world are important.

I should mention there is a third group of interventions used in cognitive behavior therapy that are useful too. These are, if you like, emotional coping skills. They could be skills like relaxation training, breathing retraining, and so forth. These are skills which help the person dampen down some of hyper-arousal, the chronically anxious symptoms.

ALEXANDER: Do these things actually change the way that the brain chemicals work?
Do they modify the adrenaline or the stress or things like that?

TAYLOR: There is some preliminary data on PTSD that this is indeed the case. There is more data on this in the other anxiety disorders, and in depression too. There are studies showing, for major depressive disorder, for example, that after a course of cognitive behavior therapy, you get a reduction in activity of the limbic system. So, these therapies are working at a biological level, not just at a psychological level. That makes sense because mind and brain are tightly interconnected and if you can manipulate one, you are likely to produce changes in the other.

ALEXANDER: This is a little off the path, but would taking something like a beta-blocker help as well?

TAYLOR: That is interesting. There has been a lot of media attention to that because the idea was that noradrenaline is involved in memory formation and during a traumatic stress, the person is typically hyper-aroused and there is lots of noradrenaline floating around in the person’s brain, so it is thought that that can lead to what is called “over consolidation of traumatic memories,” that is, these memories become very vividly fixed.

So the idea was, well, why don’t we give the person propranolol, which is a beta-blocker, shortly after the traumatic event and see if it interferes with the formation of these traumatic memories? There has been a little bit of preliminary research on this and it is encouraging, although the effect so far has not been overwhelming. It seems that it might be of some help giving beta-blocker in the short term after a traumatic event.

The media got onto this and the findings are being distorted and people have started debating, saying, “Well is it ethical to erase a person’s memory?” But, this research is not about memory erasure. These people still remembered the traumatic event after taking the beta-blocker; it was just that the medication took some of the emotional pain out of the memory.

ALEXANDER: Let's go in some detail into the cognitive behavioral work and how you make a case formulation.

TAYLOR: We start off with a diagnostic interview, of course, which is what everyone does. That is important because PTSD is very commonly comorbid with other disorders. It commonly co-occurs with mood disorders, other anxiety disorders, substance abuse disorders, so we would do a comprehensive assessment and then we try and fit things together. So, we are really trying to identify four things: the first are the predisposing factors, the things that have might increased the person's vulnerability to develop the disorder. Sometimes it is not possible to identify but sometimes you can. If the person had grown up, let's say, in an abusive environment, but did not develop PTSD until they were mugged or sexually assaulted, then you can think that perhaps growing up in that abusive environment predisposed the person to developing PTSD.

ALEXANDER: One would think that growing up in an abusive environment would sort of desensitize you. Why would it make you more vulnerable?

TAYLOR: That's a good point. It is thought this is because growing up in such an environment can sensitize the brain's stress response system. Abuse, typically, occurs sporadically, so there might be a period of time and then a short episode of abuse and it doesn't occur long enough for any sort of habituation to occur. Plus you can think of it as an unconditioned stimulus. It does produce genuine pain and suffering, so the person is unlikely to habituate to that.

The other thing we look at is precipitating factors which, in PTSD, obviously is the trauma and we look at how the person interpreted the event. So, we are looking at the possible role of interpretations or beliefs.

Then, we also look at perpetuating factors -- things that keep the disorder going. This is important because if you look at trauma survivors, most people will develop PTSD symptoms in the aftermath of a trauma. So, let's take the example of the tsunami in Thailand and Indonesia and other places. Based on previous research of disasters, most people would develop some PTSD symptoms after an event like that, such as nightmares and hyperarousal, jumpiness, but most people would naturally recover. So the important point here is that most people are naturally resilient to stress.

But, what we are looking at is why the person's symptoms persisted. In other words, what were the perpetuating factors? We try to understand those because of their implications for treatment. One of the most obvious ones in PTSD is avoidance. People's striving to avoid all reminders of the trauma can prevent them from becoming desensitized to the trauma memory.

Another often important perpetuating factor is a person's post-trauma social environment. It is known that the social support in the aftermath of a trauma helps people overcome what they have endured. But, if the person's support environment is toxic, then that can contribute to the disorder. For example, if significant others in the person's life shun them or blame them for the trauma, that can contribute to their disorder. An example is a sexual assault survivor who is blamed by her parents or her friends for being in the wrong place at the wrong time. So, post-trauma social environment is important; it can be an important protective factor or vulnerability factor.

So, we look at those things, precipitating, predisposing, and perpetuating factors in developing a case formulation and we also look at protective factors, if they are present. What things, resources, does this person have that have prevented the disorder from getting worse? The person might have some good coping skills but not good enough to completely deal with the disorder. That is clinically important because we try to build those up, strengthen them for the person. So, we use those things in trying to develop a cognitive behavioral formulation where we are looking at the person's beliefs about themselves, or the world, or the trauma, their behaviors, what

they do or don't do, and their social environment to try to formulate what sorts of things could be contributing to the disorder and we use that to develop a treatment plan.

Just to give you a quick example of that, let's say that we did an assessment of a person who survived a mugging and developed PTSD. During the assessment, we would look for behaviors that could contribute to the disorder. Some of these things we call "safety behaviors." These are things that a person does that they believe keep them safe. Let's say this person, after the mugging, started carrying around a handgun, a concealed handgun. The act of doing that, wearing a handgun every day when you go out and take the bus, can contribute to the person's sense of threat. By looking at the gun, they are always reminded of the mugging, and it can contribute to superstitious beliefs: "I'm only safe because I'm carrying this weapon." So, that can contribute to the person's PTSD.

As part of our formulation, we would look at that and see whether that behavior is helping or hindering them. We might, for example -- assuming they do not live in a truly dangerous environment -- ask them to do an experiment, to see what it feels like to go out for a week without carrying the handgun. At first, they might feel anxious, but after awhile they might find that they feel fine without it. That could reduce a person's sense of current threat. So, that is the case formulation in a nutshell.

ALEXANDER: In your book you had listed some really interesting thinking patterns that cause distress: there is the all or nothing thinking; the over-focusing on the negative; disqualifying the positives; jumping to conclusions. Would those thinking patterns have been present before the trauma?

TAYLOR: Yes, sometimes they are. These sorts of dysfunctional thinking patterns are associated with virtually every emotional disorder. In fact, all of us at some time or other, slip into them. We just seem to be biologically wired up to engage in irrational thinking -- some of the time anyway. People with PTSD will have those sorts of thoughts surrounding to do with the trauma or to do with themselves and so forth.

ALEXANDER: How would cognitive behavioral work change the emotional meaning to a person of the event?

TAYLOR: Well, let me give you an example. One of my patients had experienced some of the most horrific traumatic experiences that I have ever heard of. He was an emergency response worker in a rural area and often worked alone and had to deal with the most horrific accidents.

ALEXANDER: Do we have to warn our listeners at this point?

TAYLOR: Yes, actually if you are sensitive to these sorts of things, perhaps you could skip ahead to the next section.

ALEXANDER: Thank you.

TAYLOR: But, I want to illustrate it because it is very powerful and it shows how changing the meaning of the trauma can greatly help the person with their PTSD. Anyway, one of the events that he experienced was that he had to attend the scene of a railroad accident where a young boy had been riding his motorcycle across the railroad tracks and tried to beat the train across the crossing and he didn't. The train hit him, he got caught up in the undercarriage, he was mangled terribly and probably killed instantly, but the train took over a mile to stop. You know, these great big long freight trains. The patient went up there and

the railroad crew was not going to help him and they threw him down a blanket and said, "Here." He had to retrieve the body and actually had to get out his pocketknife and cut the boy's diaphragm to get the body from under the undercarriage.

Now, this event produced a tremendous amount of stress to him. During therapy -- I mean it took us awhile to get to the memory. We had dealt with some of the lesser severe traumas earlier on in treatment. This is part of the process of therapy; it is a gradual step-by-step process where the patient builds up trust for the therapist. We don't push them or get them to do things that they are not ready for. But, he was ready for this one.

I started assessing his beliefs about this event, and it was quite surprising. He said that he realized he believed that the boy was suffering terribly after death. This is part of what made this event so distressing for him: he thought that this young boy was continuing to be tortured and suffering terribly after he had died. So, I asked him about his metaphysical beliefs. I said, "What you think happens when you die?" He said that he has the typical Judeo-Christian beliefs. So I said, "What do you think really happened with this young boy when he was hit?" He said, "Well, he probably never knew what hit them, and died instantly." I said, "Okay, now, what's another way of thinking about this dead body? You previously had been thinking about it as this poor boy eternally suffering after death. What's another way of looking at this?" He said, "Well, the body is just an empty vessel."

This reinterpretation took a great deal of emotional pain out of that traumatic event. His reinterpreting was that the boy was killed instantly, never knew what hit him, experienced minimal pain, and although the body was mangled and looked terrible, it was just an empty vessel. So, that is one approach that we would use in treatment: to get them to consider the assumptions that they hold about events and themselves and so forth.

ALEXANDER: That is quite interesting, very interesting. I think our movies and TV shows about death and ghosts -- there is such an increase in that right now -- would tend to reinforce his thinking in that way.

TAYLOR: Yes, it could be.

ALEXANDER: Would he be able to hold on to that thought -- that the body was just a vessel? Was he really able to hold on to that or did he slide back?

TAYLOR: We used that in addition to imaginal exposure: getting him to go over that event again and again and again to reduce the amount of distress. It seemed to. I had follow-up with him for a couple years after treatment; we check in to see how he was doing and it seemed to. Yes, he seemed to be able to hold on to that because the empty vessel idea was just so compelling, whereas previously he had been going along with the unquestioned assumption that the boy was suffering after death. So yes, it seemed to stick with him. But, you know, that gets back to the point that we have to find ways that are plausible and compelling to the person and in this case, as with other patients, that work within their belief system. In this case, working within his religious and metaphysical belief system.

ALEXANDER: So, the new belief would have to, in a sense, overpower the distortion.

TAYLOR: That's right, yes. It has to be plausible for the person. This is why positive thinking never really worked -- you know, daily affirmations, standing in front of the mirror and saying Stuart Smalley's platitudes, "I'm a good enough person." That's not going to work if it's not plausible to the person. Just mouthing platitudes of positive statements is not going to help unless you really believe it, and so it has to be plausible. This is why you have to help them look at the evidence or help them examine the logic of their beliefs.

ALEXANDER: Do you think people are more realistic and logical than we think they are? I would hope so.

TAYLOR: Yes, there is some research on what is called “depressive realism.” For instance, if you give people, say, a computer task and they have to control some kind of outcome, some gambling task for example, most people have these rosy, self-serving biases. So in this task example, they will perceive themselves as having more control than they really do. The people who perform most accurately on these tasks are the people who are mildly depressed. They do not have this rosy, self-serving bias, so they perceive the world perhaps a bit more accurately than the rest of us. So, I mean although we have an obvious capacity for rational and logical thought, all of us, well, most of us are prone to all kinds of biases and distortions in their thinking. I suppose it is adaptive. If you walk around life having a rosy bias, you’re going to feel good and it is going to get you out of bed in the morning compared to if you have this depressive realism.

ALEXANDER: You have in your book a cognitive restructuring form, called the “thought recording form,” and I really like this so let’s go into the various columns.

TAYLOR: It is a standard form used in cognitive therapy for all kinds of disorders and problems. There are all kinds of ways of setting these forms up. It’s a way of helping the clinician get an idea of the sorts of interpretations and beliefs that the person has, and it is also useful for the patient’s getting insight into what sorts of assumptions they might hold that are not serving them well.

You can do this all sorts of ways: one column might have the day and date; another column might have a situation, where you ask them to write down particularly distressing situations, they might just note this down; then another column to write down any emotions that they might experience. We ask them to write the intensity of the emotion from a 0 to 100 scale with 0 as absent and 100 as extremely intense. Then we ask them to jot down their thoughts at the time.

It’s a little more challenging than it seems because none of us are raised or trained to be very good at monitoring our own thoughts. With a little bit of practice, though, patients can get good at this and can get good at spotting interpretations and then can use that as a basis for challenging their own thinking.

For example, a person might have an event where they write down, “Had a conflict with a coworker.” Then, they might report that the emotion was anxiety, and the thoughts might be, “He’s going to attack me.” Then, we can help them look at the evidence for that. This person might have been attacked before and is misinterpreting every conflict situation as a situation in which they could be physically attacked, so we help them to look at their beliefs and we might give them a handout that helps them look at common sources of thinking errors, like all-or-nothing thinking, catastrophizing, blowing things out of proportion, over-focusing on the negatives and so forth, and get them to look at those sorts of thinking errors and ask them if any of those things fit with the sorts of thoughts that they may have noted down on the thought monitoring form.

ALEXANDER: I’m trying to imagine the difference between a session of cognitive behavioral therapy and a session of psychodynamic psychotherapy. It seems to me that in some ways he would not be very different in terms of what you would want to be exploring. Is that your experience too?

TAYLOR: Sometimes, they look pretty similar. If you’re looking at the person’s basic assumptions about themselves, how they see themselves, that can look similar to dynamic therapy. If we are looking at safety behaviors, or things that they might do to protect themselves, that is sort of similar to an analysis of defense mechanisms. But, I think the biggest difference is cog-

nitive behavior therapy is more active and directive, and more educational. We would be giving the patients handouts; we would be providing them with information. We would not be interpreting dreams, if at all; we wouldn't be looking for unconscious defense mechanisms. So, it can seem similar in some ways, but can look very different too.

ALEXANDER: Another handout in your book, another chart, talks about "stimulus control for excessive worry, and ruminative thinking" -- how to control worry and ruminative thinking. You list some possible things that you can do. But, if a person is overwhelmed with ruminating about something that happened, how can they make themselves stop, other than, let's say, turn on the television or something to totally distract themselves?

TAYLOR: This is what they typically try to do: desperately distract themselves. first, we would start off with doing an assessment about the nature of the rumination. Some people deliberately initiate periods of rumination. Let's say that the person ruminates about an assault and engages in various sorts of revenge fantasies. That might make them feel good in the short term, in that they feel empowered at the thought of paying back the assailant, but it kind of gets out of control.

If they deliberately initiate these periods, then what we would do is ask them to look at the pros and cons of deliberately ruminating to see whether it is helping them or hindering them. We might introduce them to ideas like, "The best revenge is a life well lived," things like that. If it is more of an involuntary rumination, then we would do an assessment where we are looking at the situations in which this is most likely to occur. Let's say it is most likely to occur when the person gets on the bus and sees people who remind him or her of the assailant. So, trying to identify those situations as a way of helping them understand what triggers this sort of rumination.

Then we might look at beliefs associated with rumination. It might be beliefs of about being done wrong and so forth, and help them explore and understand those. The stimulus control for things like worry and rumination is used more for people who deliberately do this, so, if they are able, they might allocate a particular time of day in which they will worry and just limit it. Let's say a person is worrying about all sorts of things, and we are asking them to do the stimulus control thing. When they note a worry, they can say to themselves, "Well, I can just leave that on the shelf and not think about it at the moment. I will get to that during my worry period." So, it is trying to compress or encapsulate those periods of worry.

ALEXANDER: I want to change the subject over to the subject of EMDR. Eye Movement Desensitization Response. Is that something that you are familiar with?

TAYLOR: Yes, we have done some research on EMDR. It is controversial for a variety of reasons. I think one of the main reasons for its controversy is that the advocates of EMDR have been making miraculous claims about its effectiveness, claiming that it is better than traditional therapies, that it works faster, and so forth. So, that is one reason for its controversy -- you know, because of the old saying, "If it sounds too good to be true, then it probably isn't true."

The other reason for its controversy is, the theory makes no sense and has no empirical support -- the theory for EMDR. The main intervention used in EMDR is this: the person brings up a memory, let's say a traumatic memory, and as well, focuses on bodily sensation and emotions and thoughts associated with the memory. While doing this, the therapist waves his or her finger across the patient's field of vision initiating a series of eye movements. The patient tracks the therapist's finger with his or her eyes, and the therapist says, "What do you notice now about that memory?" and the person might say, "Well, the memory is getting a little more vague and fuzzy," and you might say "Just notice that," and you initiate another set of eye movements, and that is done for a period of time.

Now, there is no compelling reason why inducing eye movements should have any impact upon a traumatic memory. In fact, research shows that eye movements do not contribute to the efficacy of EMDR. So, given these extraordinary claims for its effectiveness and the lack of a plausible rationale why eye movements should be therapeutically useful, a number of people, including my research group, have done studies of the effectiveness of EMDR therapy. What we have found, and this is what other people have found too, is that first off, it does seem to work, but it is no more effective and no more efficient than conventional sorts of therapy.

For example, in one of our studies, we treated 60 patients with EMDR or cognitive behavioral therapy or relaxation training -- so those three treatments. EMDR was no more effective than giving the patient a relaxation tape and the cognitive behavioral therapy, in our study, was the most effective.

All of this raises though this question: research suggests that EMDR does work; it is better than nothing at all. The question is, how does it work? Many people, myself included, believe that it works because it is a form of cognitive behavior therapy. It does involve some amount of imaginal exposure to the trauma when the person is asked to remember it. It includes a form of cognitive restructuring in which dysfunctional beliefs are challenged and it does include emotion coping skills, such as calming imagery and stuff like that. So, it may be just another form of cognitive behavioral therapy.

ALEXANDER: Let's talk about some predictors of outcome of cognitive behavioral work and why some people drop out and why other people are able to continue.

TAYLOR: There are very few predictors of outcome for cognitive behavioral therapy or for other therapies for PTSD. People have been looking at this for years and very few reliable predictors have come out. Therapist skill is a likely predictor of outcome. If the therapist is unskilled in implementing therapy, doesn't seem to be credible to the patient, pushes the patient to disclose details of the trauma too early when the patient isn't ready, the person is going to drop out. That would occur for all kinds of treatment.

In terms of who does well in treatment, it looks like anger about the trauma and chronic pain associated with the trauma predict poor outcome or poorer outcome, at least with cognitive behavioral therapy. It is thought that the anger interferes with the cognitive behavior therapy and the pain in PTSD interact with one another, so, people have been looking at ways of overcoming this problem, for example, treating people with PTSD in a multidisciplinary setting where they get pain treatment as well as PTSD treatment. It is a little too early to say whether that is going to be helpful.

One of the more recent and interesting predictors of poor outcome is the person's social environment. There is a concept called "expressed emotion" that has been identified. It was identified originally in schizophrenia research. It was discovered that people with schizophrenia are more likely to relapse if they live in a high expressed emotion family, that is, a family in which the significant others are critical, hostile, over-involved with the patient's care. They are hovering around, infantilizing the person. In schizophrenia, it is thought that this raises the person's level of stress and may also influence their adherence to taking their antipsychotic medication.

There is some preliminary evidence in the case of PTSD that living in such a toxic environment interferes with the efficacy of cognitive behavior therapy. It is not known whether that applies to other therapies. But, you know, you have the patient who is in an environment where they are being criticized all the time for avoiding going out, for staying in bed all day, they are criticized for going to therapy, the significant others might give them the message that, "You're just a weak person because you developed these problems. Why don't you just snap out of it?" So, that environment is a predictor of poor outcome.

In most situations, what would be helpful would be involving the significant others in treatment. I'll give you

an example of how you might do that, a very simple example. One of my patients was a young boy in his teens with PTSD. He spent a lot of time avoiding going out. I interviewed his father, and I said, "It sounds like you're very concerned about your son's well-being. He said, "Yes." I said, "What you try to do to help him?" He said, "Well, I nag him." I said, "Okay, does that work?" "No." I said, "What do you do when it doesn't work?" "I nag him more." So, that is the sort of toxic environment that is going to raise the patient's stress level. So, I said "Well, it sounds like you're very concerned about his well-being. Let's see if we can find another way that you can help him." It involved the young boy actually telling the father what he would like him to do to help him. So, that is an example of how we would try to counter the toxic effects of interpersonal environments, if they are present, to try to get around that poor outcome predictor.

ALEXANDER: By the way, that was a very kind way of handling that.

TAYLOR: Well, it's practical too. If you start blaming the significant others, they're going to naturally dig in their heels and start trying to defend themselves. You don't want to get into that position. We are running with the presumably correct assumption that they have the person's interest at heart, or at least their own self-interest. If the patient is doing better, then the significant other's environment is going to be better for the significant other and less stressful for them.

ALEXANDER: Well, Dr. Taylor, I want to thank you, indeed, for giving us your time and for really condensing so much material for us in such an understandable way. I appreciate that very much.

TAYLOR: You're very welcome.

Dr Taylor may be contacted through his website [HYPERLINK "http://www.thetraumaticstressgroup.com"](http://www.thetraumaticstressgroup.com) www.thetraumaticstressgroup.com or by email at taylor@interchange.ubc.ca

His books may be ordered through any major retail or online bookseller.

This concludes interview #5 in our program on "Posttraumatic Stress Disorder". I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of ON GOOD AUTHORITY. Until next time, this is Barbara Alexander. Thank you for listening.

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POSTTRAUMATIC STRESS DISORDER

Interview # 6: "THE BODY REMEMBERS"

BABETTE ROTHSCHILD, LCSW

Interviewed by Barbara Alexander, LCSW, BCD

(Edited slightly for readability)

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Welcome to On Good Authority. I'm Barbara Alexander.

You are listening to or reading interview #6 in “Posttraumatic Stress Disorder,” a continuing education program of On Good Authority covering diagnostic and treatment aspects of this controversial and important subject. At this point, you as listener realize that there is no one answer, no one treatment method for all people with PTSD. The goal of our next speaker, and I quote from her book *The Body Remembers: Casebook*, is “to inspire psychotherapists working with traumatized individuals to learn as much as possible about theory, tools and treatment so that they can be well-equipped in working with the unpredictability of trauma and the diverse needs of clients.” She encourages therapists to learn to trust and use their own common sense, often in lieu of what they have been taught, stating that, “When therapy methods are applied uniformly like a recipe, their potential for harm increases, no matter how good they are.”

Babette Rothschild, MSW, LCSW, has been a practitioner since 1976 and a teacher and trainer since 1992. She is the author of three books, all published by WW Norton: *The Body Remembers--The Psychophysiology of Trauma and Trauma Treatment* (a professional book bestseller); *The Body Remembers Casebook--Unifying Methods and Models in the Treatment of Trauma and PTSD*; and *Help for the Helper--The Psychophysiology of Compassion Fatigue and Vicarious Trauma*. After living and working for 9 years in Copenhagen, Denmark she returned to her native Los Angeles. There she is working on her 4th and 5th books while continuing to lecture, train, and supervise professional psychotherapists worldwide.

Now to our interview.

ALEXANDER: Ms. Rothschild, I have been reading your book, *The Body Remembers: Casebook* which, like your other books, is about your work with posttraumatic stress disorder and I would like to ask you about your goals in general relating to the specific needs of clients and helping clients trust themselves. So, let's talk about how you have come to develop these ideas.

ROTHSCHILD: Well, I came to develop my ideas around working with trauma because I saw a lot of people getting worse from trauma therapy. They would go to work with trauma with this or that practitioner and in many different models of therapy and then a lot of people were actually getting worse rather than better. They were breaking down and decompensating. That was of a great concern to me.

So, I started looking at what might be going on when people were breaking down and what actually should be our goal in doing trauma therapy. So, over a period of time I realized that my goal in working with clients with trauma, first and foremost is to improve their quality of life. The problem I saw, and still see in general with trauma therapy as a profession -- I'm not pointing out particular models; I want you and your listeners to understand that. All of the models that we have for working with trauma therapy have something to offer to at least somebody. None of them would I throw away. The problem that I see though is that they are all very focused on processing trauma memories and not everyone who has been traumatized is going to benefit from working with trauma memories. Some people actually decompensate and get so much worse that it would have been a blessing and much better for them to have not have worked with trauma memories at all. That is where I came up with my actual goal of improving quality of life and not processing trauma memories.

ALEXANDER: So, how do you then not discuss the trauma memories? What you

focus on? What is important then?

ROTHSCHILD: What is important is helping people to be functional in their daily life.

We have a model for trauma therapy that was first put forward by Pierre Janet in the latter part of the 19th century. He is sort of the father of trauma therapy. Janet said that we should be working with trauma in a three phase model: Phase 1 is Stabilization and Safety; Phase 2 is the Processing of trauma memories; and Phase 3 is Integration and Working back into community, daily life, etc. You don't move on to the Phase 2 of Processing trauma memories until Phase 1, Stabilization and Safety is adequately achieved.

The problem that I see is that even in those therapies (I would say "most of;" this isn't 100%, nothing is 100%), that adhere to the phase-oriented model, practitioners move much too quickly and much too prematurely to the processing of trauma memories and either bypass or short change the Stabilization and Safety phase. For some people, Phase 1, Stabilization and Safety, is actually going to be the complete therapy because they won't be able to tolerate working with Phase 2.

That is where common sense becomes very, very important. It's funny: when I am giving lectures around the world, I talk about common sense and people are often very surprised. They often laugh and giggle and titter when I bring it up. I usually poll the audience and ask them, "How many of you in your university educations, your therapy educations, your continuing ed experiences have been taught to or encouraged to use your common sense?" The most hands that I have ever seen is one third of the audience -- that is the most. Sometimes, only a couple of people raise their hands but the most that I have ever seen is one third. I find that rather appalling because common sense is what would help us avoid hurting our clients with trauma therapy.

For example, with common sense, if you're a doctor and your patient has an infection and you give them an antibiotic and they have an anaphylactic reaction or they get a rash or the infection gets worse, what do you do? Well, hmm, you stop using that antibiotic. It's simple. It's common sense. It's something useful in probably every other aspect of society in the world. But in therapy, when the patient gets worse, a lot of times the therapy continues just as it has been continuing. That, to me, makes absolutely no sense and has put a lot of our clients at risk.

ALEXANDER: We also say that the client is untreatable.

ROTHSCHILD: There is a lot of client blame. When the client gets worse, sometimes they are accused of having resistance or secondary gain, not to say that clients can't have those things, but certainly not at the rates that trauma clients have been evaluated at the frustration of the therapist because the client wasn't making progress or was actually decompensating.

Joseph Volpey, who is one of the founders of behavior therapy, in one of his books on behavior therapy back in the 70s, said that if the therapy is failing, you have to look to the application of the method for the failure and not to the client. I think that that is extremely wise and common sense. When my client is not getting better, I think, "How am I not meeting them? What am I not offering them? What do they need?" rather than "Why are they being so resistant to my great methods?"

ALEXANDER: (laughs) It's pretty arrogant.

ROTHSCHILD: But, it's usual. You know, we pay a lot of money to take trainings and we invest a lot of time and our own sweat and tears. We become very fond of our methods and very identified with them and very dependent on them. One

of the foundations of safe trauma therapy, I believe, is always being able to lay aside methods and just be together with the client because sometimes that is what is needed.

ALEXANDER: I couldn't agree with you more. And also, just because some methods are not "evidence-based," that doesn't mean that we shouldn't try them and use them.

ROTHSCHILD: Well, that whole terminology of "evidence-based" and the whole concept has gotten very twisted. If you go back to the original writings on evidence-based practice -- and this goes back into medicine as well as psychotherapy -- "evidence-based" doesn't just refer to formal studies. "Evidence-based" also refers to patient and client feedback and practitioner experience. It is much richer and much broader than the current narrow interpretation.

If you read the studies, which are mostly cognitive-behavioral, EMDR, psychodynamic, and some psycho-pharmacologic, particularly with the therapy models that are cognitive-behavioral, EMDR and psychodynamic, you will see that the clients being worked with and studied are all people who have achieved Phase 1. They are all people who are relatively stable, and the traumas that they are dealing with usually are rather contained, single standing events, and/or ones that are contained within a prescribed time period. Most importantly, the clients are stable before they start being treated with those models. That is partly because when you do a study and you want to prove that your method is useful, you are going to carefully pick the people who participate in the study and make sure that they are ones who would be most likely to benefit from the method. That is, again, just common sense. But in looking at the studies, what they don't have are the kinds of very complex, multiply traumatized, chaotic kind of clients who most of us working in the trauma field have in the majority of our practice.

ALEXANDER: Let's talk about that first phase of making sure that the patient/client feels stabilized and safe. How do you achieve that?

ROTHSCHILD: In a lot of ways. You are looking at increasing their internal and external resources. External resources would be: a stable place to live; some kind of daily structure, preferably some kind of gainful employment; friends; family; their network, etc. Internal resources have to do with self soothing: being able to calm themselves down; being able to access internalized people that they have had in their lives who have had some kind of comforting influence on them; being able to utilize tools that help bring down arousal and help them mediate whether or not they are focused on their traumas, so that, for example, they can turn off the obsessive thinking about the traumatic events, or that they can manage a flashback and get it calmed down. Those are examples.

ALEXANDER: Let's talk about some of the methods you use to do that, the "containing and braking" methods and the "arousing and accelerating" methods. I have never heard these explained so well and clearly as you have explained them in your book and in the examples. So, let's talk about "braking/ containing" and arousing/accelerating.

ROTHSCHILD: Okay. I coined the term "putting on the brakes" in working with trauma. That came out of an experience that I had in college where I was the first one in my group of friends to get a car and several of my friends asked me if I would teach them to drive. When I got in the car with the first one of them, I realized that I was more nervous than I thought I would be. I had never taught anyone to drive before. What was I going to do for my safety? I realized that before I wanted them to make that car go, I wanted to make sure that they could make it stop. So, the first thing that we did was practice using the brake. I would drill them to put their foot on the accelerator pedal, on the brake pedal, find the clutch, distinguish the three pedals and always be able come back to the brake automatically, really quickly if I would say, "Brake." We drilled, I don't know, how many minutes, hours, whatever. But it wasn't until I was totally confident and they were totally confident that they could always find the brake automatically and surely that I would let them

turn on the ignition and start playing with the clutch: you know, let the car roll forward a little bit and hit the brake; let the car rule forward a little bit and hit the brake. Then when they got good at that, I would let them put on a little bit of gas, a little bit of acceleration and keep coming back to the brake. We never went any faster than we were both sure and secure knowing that they could safely slow down and stop the car. That worked for teaching my friends to drive and kept us safe and kept my insurance okay.

It is also the idea that I adapted to working with trauma therapy: I do not want my clients going any further or any faster into their trauma memories than they can stop and get out of it, that they can put on the brakes. I do not want them going into any material that is destabilizing before they can adequately put on the brakes.

So, you asked me what kinds of things we might use to put on the brakes. I can only give an overview. This is not teaching Methods; this is just talking about the possibilities. In both *The Body Remembers: Casebook* as well as my first book, *The Body Remembers: The Psychophysiology Of Trauma and Trauma Treatment*, the methods for putting on the brakes are outlined in more depth than we have time to go into now.

But to begin, Body Awareness can be a basis for that. Body Awareness is a “current time” activity. One of the problems with trauma is that people keep being drawn into the past. Having them feel their body sensations is something they can only do in the “now.” It is a very different thing to remember a body sensation than it is to actually feel a body sensation.

Now, of course, for some people, that will be a trigger into the past and you will not use body awareness with some people if it destabilizes them. You only want to use it if it helps them to become more stable. If feeling their feet on the ground, feeling the temperature of their hands, feeling how quick or slow their respiration is something that helps bring them into the present and stabilize them, then those are useful tools for Putting on the Brakes. If those things trigger them into contact with past trauma or send them out of body, or whatever, then you don’t want to use it. Any tool, whether it is a tool for Putting on the Brakes or a method for processing trauma memories, you only want to use it when it benefits. If it has a deficit, then you do not want to use it with that person, at least at that point in time. Sometimes things can be returned to.

So first, I would probably try Body Awareness because it is useful for a lot of people. That involves working with what I call, “Dual awareness:” balancing the sensory nervous system; the internal sensory nervous system; and the external sensory nervous system so that people are able to balance their internal reality and their external reality. A problem with people with posttraumatic stress disorder is that they tend to evaluate external reality based on what they feel inside. That does not work well. So, using Dual Awareness, having them both feel their internal sensations and how scared they are, but also observing, listening, smelling their current environment makes it possible to be able to evaluate whether their current environment is safe, despite the fact that they felt scared.

ALEXANDER: In the example in the casebook of Paula, on page 40, she comes in and she is really scared to be there.

ROTHSCHILD: She is an example of somebody who comes into a session with, so to speak, the accelerator already on the floor. She is so hyper-aroused -- it is like the accelerator pedal is already on the floor.

ALEXANDER: Let’s go over what you did to help her gain a feeling of control or a measure of control. In the example, it seemed she was afraid to look at you even; she was afraid of your presence.

ROTHSCHILD: Actually, that is not true. The first thing that I did with her was Body

Awareness and that did not work. It did not bring down her arousal. As I said before, with common sense, I set that aside and moved on and moved to Dual Awareness to bring her into the present situation. She was scared and her body sensations were very scared, but I had her look at me and see what she saw in me. She could see the color of my eyes and the color of my hair and my earrings etc. and as she did that, she actually calmed down. That was an indicator that she actually wasn't scared of me. What she was scared of was something that was being generated internally from another point in time, because, as she looked at me, she actually calmed down. As she calmed down, I asked her if there was anything that I was doing that was scaring her. She said, "No, but don't come any closer." I took that as an indicator that I might actually be sitting too close and then we experimented with our distance. I moved back, and her arousal continued to come down as I moved back and gave her more space. As we summed things up after the session, she said that that was one thing that was very significant. She realized that sometimes if someone is too close to her, it can jar her or make her anxious so she might pay more attention to that when she is with friends, family, other people: to take more space and that that might help her with her anxiety.

Then once her arousal had come quite down, we actually returned to working with Body Awareness and then it was actually quite useful. It further continued to bring down her arousal level. Then the last thing that we did in regards to that was that we helped her to increase her muscle tone in her legs. They were feeling rather weak and we had her strengthen them some and that helped to calm her down further.

Once she was really calmed down, then we could really start to talk about what had her so frightened when she came in to the session. It had been a situation definitely from outside of the session, a trigger from her mother. We were able to process it once she had calmed down. If we had started talking about it when she had come in in that agitated state, it was likely that her agitation would have just risen more and more and more.

ALEXANDER: Another really great example in your book about how you work with this is on page 101, the case of Jordan. He came to you still suffering three months after the September 11 attacks on New York. He had these intrusive images of the jetliners crashing into the World Trade Center and the buildings collapsing and he could not stand to look at a skyscraper. Every time he would head downtown to work, he would break out in a sweat and become nauseous. How did you help him manage those intrusive images?

ROTHSCHILD: There I drew on some techniques learned from Neuro Linguistic Programming (NLP). I should say that I am not trained in NLP, but they have some really handy techniques that are useful, particularly for that kind of situation where there are images that continue to be intrusive, which is certainly quite common with our clients with trauma and posttraumatic stress disorder. Flashbacks are comprised mostly of intrusive images. So, drawing on NLP, we worked with manipulating what NLP calls "sub-modalities," which are the different features of a sensation. Since Jordan's flashbacks were visual, we took different visual sub modalities: size, color, distance, angle, etc. and had him play around with adjusting those different features in order to feel more in control of the visual intrusions.

What we did before that, though, was quite important. I had him learn how to manipulate those sub-modalities by focusing on something that was pleasant. In this case, it was his daughter. So, he got very good at being able to manipulate images of his daughter before we went on to manipulating images that were going to be upsetting and have a negative emotional charge. Then, when we went on to those images, we actually started at the ones that were easiest first and did not go to the most difficult ones until we were at the end. It is a process of gaining facility and resource with the method every step of the way, building up like you would anything else. When you learn to swim, we now know better than to throw a kid into the deep end and let them flail until they stay on the top of the water. We don't do that anymore. We start them in the shallow end and we teach them how to breathe and to blow bubbles and float, etc. before taking them down into deeper water. It is the same principle, at least for me, when I am working with trauma: to begin with things that are easier, where they

can build skill and successful experience before taking them into things that are more difficult.

ALEXANDER: When you noticed him becoming more anxious by various visual images, then you would have him go back to Putting on the Brake, right?

ROTHSCHILD: We would have him Put on the Brakes, yes.

ALEXANDER: Putting on the Brakes by helping him to go back to the image of his daughter?

ROTHSCHILD: Right, because we had already established that as an image that brought down his arousal, and helped him to be relaxed. His breathing would get quite relaxed, his heart rate would return to normal, etc. when he would imagine his daughter's face and so we could always use that as a way to put on the brakes when his arousal would go up. By doing that, you help build in a feeling of control.

Nobody gets traumatized unless they have been out of control. If you're able to stop the car, keep the bomb from going off, fend off the attacker, etc. you don't get trauma. Trauma always has to do with being out of control. So, when you're working with somebody with PTSD, anything you can do to help them feel more and more in control again is going to be helpful for them. So, in this case, it was helping him to be able, at any time that he wanted, to go away from distressing images into the pleasant images and be able to go back and forth and back and forth.

Usually when I am working with somebody in the beginning, or who is new to me, etc., we will do that whole lot, even if they don't totally need to and are only slightly stressed. I may be Putting on the Brakes quite quickly and quite often until they really get the feel that they can have control over this. Posttraumatic stress disorder is totally a feeling of being out of control.

ALEXANDER: It seems to me that an important question would be the ability of the therapist to distinguish between the anxiety of the patient or client and their own anxiety about the material.

ROTHSCHILD: Of course!

ALEXANDER: So, in other words, if somebody is telling me something and I find it very anxiety provoking in me, but maybe that person doesn't find it that anxious. So...

ROTHSCHILD: Well, isn't that part of the art of our science, that we always, whether we're dealing with trauma or anything else, need to be able to distinguish our feelings from those our clients? That's countertransference.

ALEXANDER: It sure is, and that is the ideal, but what happens if you don't? I mean if you can't?

ROTHSCHILD: (Laughs) You got trouble!

ALEXANDER: (Laughs) Trouble in River City.

ROTHSCHILD: You have a song from The Music Man: "You've Got Trouble In River City."

But, I want to emphasize that that is not just an issue for working with trauma; that is a general issue for psychotherapy. As psychotherapists, whether you're a psychologist or a social worker or a marriage and family counselor or whatever, you need to be able to know yourself well enough and be able to stay on top of your own feelings so that you are able to distinguish your own reactions from your clients. Absolutely.

That is also much the topic of my third book that's for the helper, "The Psychophysiology of Compassion Fatigue And Vicarious Trauma." Here I talk about more than trauma, but also just general reactions that therapists can have to their clients and how our empathy with them can be sometimes confused. Sometimes when we have empathy with our clients, we get confused, just as you're saying. "Are these my feelings or theirs?" If that happens, we really need to backtrack and get that separated out. Otherwise, not only are we not going to be able to help our client, but we are going to put ourselves at risk.

ALEXANDER: And that is the common sense thing: is to be able to do that. It just makes sense that one has to.

ROTHSCHILD: Well, I think so. (they laugh)

ALEXANDER: There is something else that you do that I would love to have you explain, and that is how you include clients in the decision-making process as to what method would be most helpful for them.

ROTHSCHILD: Every step of the way with a client -- and this does get bypassed a lot with trauma therapy -- clients need to be our partner in the therapy. I think that the best trauma therapies are when the client is actually my co-therapist. So that they are in on the decision-making process, I'm explaining to them what I think is useful, why I think it is useful and we are discussing things along the way. They are having a say in it all.

That is not to say I don't have my own limitations. I mean, if I have a client who is falling apart and is on the edge of becoming psychotic and they are determined to process the memories of being raped when they were three years old and there is nothing that is going to stop them, then I still have my limitations, and I might say to such a client, if you are really determined to do that, I actually think that it is so unsafe that we have to find you a different therapist because I would not feel it ethical to participate in that. But I would explain to them every bit of theory that was appropriate to help them understand why I made that decision. I believe that therapy with trauma clients --actually I think therapy with all clients, but particularly with trauma clients -- needs to be very transparent so that the client is giving really informed consent. Then you need to set goals and find out what are we doing here and why are we doing this.

I was talking with someone yesterday, someone who comes to me for consultation -- and this is such a common situation: she has been working with this client for a long time, working with stabilization and the client still wasn't particularly stable, with still a very borderline type of acting out and features going on, a lot of difficulty maintaining any kind of daily structure, out of control hyper arousal. And now the client wants to start processing early trauma and you know, how do you put on the brakes with that? How do you help the client understand that actually, that might be to their detriment?

If they are really determined and if you want to keep working with that client, then you have to find a way to structure things, maybe take little tiny bites and see how it works. You take a little bit -- "Okay, we're going to talk for five minutes about your dad's rages, and then we are going to stop and we are going to process it and see how you feel and how you react to that and how that affects you then in your daily life. Then maybe next time, we take a little bit more"

That might be a bad example in a way, because I would not just talk with somebody for five minutes about their parent's raging. I would be more structured in it and we would talk about some process or theme around that and find a point of integration in there.

A lot of working with trauma might have to do with slowing clients down and keeping them out of the danger zone. You have to remember that when somebody has trauma or PTSD, they have used a massive amount of defense mechanisms to help them cope and continue to function in their daily lives. Even people who are not particularly functional still use defenses to cope to the extent that they have coped. When you start processing the memories of the incidents that have led to their PTSD and/or trauma, what you are actually doing as a matter of course is you're loosening those defenses that have helped them cope. So, your working with trauma memories is actually a destabilizing process.

When you start to work with trauma memories, when you start to mess around in the past there and start to loosen up those defenses, of necessity, the system becomes more destabilized. So, if you start doing that when the system is already unstable -- common sense: you're only going to destabilize them more. You really cannot risk doing that kind of work, which is always destabilizing, until they have reached a level of stability where they can tolerate that there is enough safe space in that stabilization that they can risk some destabilization and still be able to function. Then you can safely work with the trauma memories.

ALEXANDER: Between sessions, let's say you have covered something that is a memory and they've talked about it. Do you take calls between sessions?

ROTHSCHILD: Again, that is something to set up individually between each client and therapist. If a therapist is transparent about what their boundaries are before the client signs on, then there is no problem. For the therapist who says, "I never want to get calls in between sessions," just be transparent about that with your client before they sign on. If you're somebody who is fine with that or who has specific time limits for that or who charges for that, or whatever, just be transparent about that when the client signs on and then there are no surprises. So, yes, sometimes it can be very useful to be able to be available between sessions on a limited basis, or on a structured basis, or on an emergency basis. But I would not tell experienced practitioners how to do that, because everyone has different limitations about that and different comfort levels about that.

ALEXANDER: Ms. Rothschild, let's talk about your foundations for safe trauma therapy: the basic ingredients that you have found are to be required for safe trauma therapy.

ROTHSCHILD: Alright. I would just like to mention that these are, in part, thanks to a German participant in an Austrian workshop I had a lot of years ago. He challenged me on the second day of the four-day training, asking me what were the basic guiding principles of my work and at that time I really had not thought it out. I sort of floundered and said that I would get back to him by the last day of the course. These are basically what I realized at that time, slightly edited, from that time.

First and foremost, establish safety with the client within and outside of the therapy. That is part of phase one. The client has to be safe in the therapy and safe in their daily lives. That is a principle that often therapists forget about. It is not good to work with people on past trauma when they are still in trauma.

One of the easiest examples of this is domestic violence. When somebody has been a victim of domestic violence and is still at risk of domestic violence, you cannot work on the trauma of domestic violence because of that same principle that I was mentioning before. When you start working with trauma, you loosen the defenses

that a person has needed to cope with the trauma. So, if a person is still in a trauma situation, and you loosen their coping defenses, you could cause decompensation.

Second, developing a good contact between the therapist and the client: even if that takes months or years, that is part of phase one and you cannot move on to phase two until there is a good contact between the therapist and the client. The client and the therapist must be confident in applying the brakes before they use the accelerator.

More basic ingredients: Identify and build on the client internal and external resources. I mentioned that before as part of Braking techniques

Regard defenses as resources. Never get rid of coping strategies or defenses. Instead create more choices. I never ask a client to give up a defense mechanism. What I suggest for them to do is to build up more possibilities for ways to react when they are stressed. For example, if someone dissociates a lot, my goal is never to stop them from ever disassociating, because dissociation can be a real advantage. Some of my clients have been so well dissociated that they could go to the dentist without anesthesia and I have been genuinely jealous of that. But there are times, of course, in their lives when being that dissociated would not be a good idea and they need to have other options. So, that is my idea of never getting rid of defenses but creating more choices.

The trauma system is a pressure cooker. Always work to reduce the pressure, never to increase it.

Adapt the therapy to the client, rather than expecting the client to adapt to the therapy. That means that the therapist has to be familiar with several different theory and treatment models so that they can always be adapting to the client's needs. As I said at the beginning of our conversation, when a therapist only has one model that they are functioning from -- and that is no matter how great that model is because I think that all of the models have something to offer -- but no matter how great a model is, if you only have one model to offer your clients, then there is no tailoring to the client's needs and the chances of you stepping over or stepping on a client's needs are great.

ALEXANDER: I want to take a moment on this point because there are a lot of people who feel that since certain theories do not mix, that you have to stay with one theory or the other; you can't be generic in your approaches.

ROTHSCHILD: What theories would you say wouldn't mix? Give me an example?

ALEXANDER: Oh, maybe psychodynamic and the somatic trauma therapies

ROTHSCHILD: They mix fine. If you look at my casebook -- part of the point of my casebook was to show that you can mix together all sorts of different therapy models. They do mix. You just have to be well grounded enough in the therapy models you choose that you can make good decisions about, "When do I bring in this? When do I bring in that? When do I bring in a combination of the two?"

Psychodynamic therapy, for example, can go with almost anything and is very appropriate in the Integration phase. When you move from processing trauma memories into integration and you want to help people integrate what happened to them into their whole life experience and the timeline of their life, psychodynamic can be extremely important, for example.

ALEXANDER: But, I can see that in the first sessions or two of the somatic therapy, when you're trying to stabilize and help somebody be stabilized and to be able to put on the brakes, that at that time you're not going to want to delve into too much history.

ROTHSCHILD: No, but you might use other things. For example, you might bring in, tools from dialectical behavior therapy, which is brilliant for helping people stabilize. Or, you might bring in tools from cognitive behavioral therapy which can also be brilliant at helping people stabilize. You might do phobia kind of desensitization work. So, you can always be bringing in other tools.

ALEXANDER: It says a lot for training and education and consultation. Very important.

ROTHSCHILD: Absolutely. I think that people working a lot with trauma really need to have regular consultation. It is funny: in the United States, once you have achieved your license, there is no requirement for ongoing consultation. In the U.K., where I do a lot of my work, once you have become what is equivalent to our licensing -- they don't have licensing, but what would be equivalent -- you're still required to have a certain amount of consultation every year and people just automatically do it. Here, most people, once they have gotten licensed, tend to give up that kind of regular consultation. I have had a peer consultation group since the last 10 years or so, which has been great. We are all senior therapists, all at about the same level, but come with different kinds of training, supervising each other, which I think is very useful, so you don't have to pay for supervision and consultation to be able to have quality consultations.

ALEXANDER: Indeed. Back to your list.

ROTHSCHILD: So, number eight: have a broad knowledge of PTSD and trauma theory, both psychological and physiological. This reduces errors and allows the therapist to create techniques tailored to a particular client's needs. I always think that that is very important. The more theory you are grounded in, you can not only make up your own techniques, but that is where you're going to get some of your tools for knowing when to adapt the techniques and the models that you've been using.

I know that most models are taught with a rigidity that you should never vary from the model, but again, that goes against common sense. When I teach my trainings, I always suggest to people that they do adapt the things that I'm teaching them because I do not know who they're going to be sitting together with, so there is no way that I can teach them a model that is a do-all for every client that they're going to meet.

It's important to have a theory base so that you understand what arousal looks like, so that you understand what imbalance in the sensory nervous system looks like, etc. This can help guide you toward what to do when, and how to use the tools. I think that that is very, very important.

Point number nine: regard the client with his or her individual differences and do not judge him or her for non-compliance or for the failure of an intervention. Never expect one intervention to have the same result with two clients. Working with trauma is absolutely too unpredictable. You have to be able to be surprised.

Always, when I have new clients with PTSD, one of the things that I will talk with them about regularly at the beginning is diet in terms of eating things that do not provoke their nervous systems. So, reducing caffeine or eliminating it where possible, reducing sugar and increasing protein, bringing down heavy spices etc. -- these are all things that can contribute to increases in arousal. A couple of years ago, I got a new client who had severe PTSD and also happened to have very good body awareness. She told me when we were talking about diet that when she got hyper aroused, the two things that brought down her arousal the best in terms of foods were Coca-Cola and really spicy Mexican food.

ALEXANDER: How funny. That is contra...

ROTHSCHILD: Absolutely contra to anything I'd ever known or believed, and I told her

that I was going to tell people about it because it was such a good example (I got her permission.) of individual differences. She had such good body awareness that I had no problem believing that those were the things that helped her to calm down. Why they did that, I cannot tell you, but I know that they did. It is just such a good example of an individual difference.

ALEXANDER: It is like giving Ritalin or various types of speed to people who are hyperactive. Perhaps the same thing.

ROTHSCHILD: Well, perhaps it might be at least the same principle, if not the same mechanism. But, the most important thing out of that is listening to your client, paying attention to individual differences, and not expecting for them to be the same as anybody else. Certainly, not to be the same as you! Probably the biggest mistake that psychotherapists in general make is expecting that clients will have the same needs that they have. Sometimes they do, but a lot of times they don't.

Finally, as I mentioned earlier, the therapist must be prepared at times, or even for a whole course of therapy, to put aside any and all techniques in general, and just to be with the client and just talk with them.

ALEXANDER: Very important, that last point.

ROTHSCHILD: I think that it is very important. Our tools are only as good as our being able to decide when we use them and when we don't use them.

In terms of that flexibility, one last analogy: this idea that there should only be one treatment for trauma therapy has never made sense to me. In medicine, if we only had penicillin -- a wonder drug. There is no doubt that penicillin is a wonder drug and was a wonder drug when it was discovered. It cures tons of people of things that would kill them. But there is also a good portion of the population, and I am among them, for whom penicillin is dangerous and can kill. So, if penicillin were the only antibiotic we had to offer people, we would be in a tough spot.

It's the same: all of these models that we have are really great -- all of them -- for some people. For some people. They are not geared for all people, so the best that we can do for our clients is to be able to give them a choice and some variety, so that they can find the one, or we can together find the one that is actually the best for them.

ALEXANDER: Okay, excellent. Ms. Rothschild, thank you very much for your time, I really appreciate it.

ROTHSCHILD: Sure! I hope that this was useful. It was fun talking with you.

Babette Rothschild may be contacted through her website: [HYPERLINK "http://www.trauma.cc"](http://www.trauma.cc). Her " <http://www.trauma.cc>. Her books may be ordered through any major retail or online book seller.

This concludes interview #6 in our program on "Posttraumatic Stress Disorder." I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of ON GOOD AUTHORITY. Until next time, this is Barbara Alexander. Thank you for listening.

POSTTRAUMATIC STRESS DISORDER

Interview 7: “ENGAGING SURVIVORS OF EXTREME VIOLENCE”

MARTHA BRAGIN, Ph.D.

Interviewed by Barbara Alexander, LCSW, BCD

(Edited slightly for readability)

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Welcome to On Good Authority. I’m Barbara Alexander.

You are listening to or reading interview #7 in “Posttraumatic Stress Disorder,” a continuing education program of On Good Authority covering diagnostic and treatment aspects of this controversial and important subject.

Despite the myriad of treatment approaches to PTSD, many survivors do not get better. Some even get worse. Survivors of extreme violence can be difficult to engage in treatment. This may be caused by a sense of isolation arising out of the belief that no one who has not shared their experience can comprehend it. But if this were true, no one could ever help anyone, except perhaps their own clone!

But the truth is that for some sufferers of PTSD, emotional healing does not come through any treatment protocol, but through a deep, intimate acknowledgement of their suffering. Wayne Miller, former marine corporal and team leader at the Veteran’s Center in Silver Spring, Maryland has described this as, “the willingness and ability to get down and dirty with that person to the point that you can truthfully say, ‘I get it.’ It requires an understanding of what it feels like to have been to hell and not come fully back.”

Our next speaker, Dr. Martha Bragin, has spent her professional career working with survivors of extreme violence. For her, the work of Melanie Klein, a post-Freudian psychoanalyst, provides a springboard for understanding and connecting to these survivors, who feel isolated by their experiences.

Melanie Klein’s research led her to conclude that even in very early childhood, an infant has aggressive feelings toward the mother. Children fantasize murderous acts towards the parent and therefore fantasize that similar acts of violent retribution would be visited upon them. Bragin has found that survivors of extreme violence often recognize their traumatic experiences as familiar, harkening back to these early, primitive, unconscious aggressive feelings and fantasies. The more they are reassured that their responses are normal, that their torturers were to blame and that they are innocent, the more despair, isolation and beyond help they feel.

Engaging them in treatment requires the therapist’s being able to have and convey the capacity to understand and tolerate the awareness of terrible, unacceptable events in the world as well as terrible, unacceptable feelings in themselves.

Martha Bragin, Ph.D., LCSW is Associate Professor at Hunter College School of Social Work, as well as clinical and research faculty in Social Work at the International Program on Refugee Trauma (IPORT) at Columbia University, College of Physicians and Surgeons. She is a member of the working group on the psychic effects of social exclusion of the International Psychoanalytic Association, and the Committee on Psychoanalysis in the Community of the American Psychoanalytic Association.

For the past 25 years, Dr. Bragin has served as advisor to governments, international organizations and non-governmental organizations on the demobilization, demilitarization and reintegration of soldiers following war with special attention to women and children. She has developed and assessed psychosocial programs for children and families affected by conflict and disaster in the US, Europe, Latin America, Sub-Saharan Africa, Central, South and Southeast Asia and the Middle East.

Among Dr. Bragin's publications is the "Community Participatory Evaluation Tool," the CPET, an instrument designed to help members of diverse communities to participate in the evaluation of psychosocial programs designed to benefit their children. Her paper, "Knowing Terrible Things: Engaging Survivors of Extreme Situations in treatment" was awarded the 2007 Tyson Prize by the International Psychoanalytic Association.

Now to our interview.

ALEXANDER: Dr. Bragin, I'd like to begin our interview first with the conclusion of your wonderful article that was in the Clinical Social Work Journal and the conclusion says this, "By assessing our own capacity to know terrible things, through the acknowledgement of our own experience of early aggressive fantasy, we have the possibility to break the bond by which by which the oppressed and the oppressor are the only ones who share the experience. By utilizing that understanding in the beginning of treatment, we can create a connection that the client can use in the task of rejoining us in the human condition." That is a profound and powerful mouthful.

BRAGIN: Thanks.

ALEXANDER: You're welcome. You've also been quoted as saying, "In our dreams, we are all terrorists."

So, my question then is this: why is it that survivors of extreme violence are challenging or may be difficult to engage in treatment?

BRAGIN: There are probably many reasons but one reason that I'd like to focus on is what happens to us when we get engaged with them and what happens to them? First of all, survivors of extreme violence and people who are engaged emotionally in the cycle of violence raise profound challenges to us and I think that this something we all defend against. We want to see them as interesting, different, heroic, and therefore we can tend to objectify them and in objectifying them, they then don't feel heard.

For instance, we have protocols, PTSD protocols, which I think are tremendously well-intentioned and serve some good purposes, but basically they say, "Let's tell them, 'It's not your fault. You're not to blame. These things happened for external social reason, all of which are true and have nothing to do with you.'" But if somebody rapes you, shoots you, violates you emotionally, holds you in captivity, that experience is very deeply internal to you. You don't experience it as separate from yourself. A cognitive behavioral approach that says, "This is really different from you"-- you can say okay, some people are able to get help and do that, but for many, many people, certainly the kids I was seeing in family court, that kind of thing got a grunt and a turning away.

In my experience with what my patients told me, was deep in their hearts and souls, victims, survivors often experience themselves as complicit in the violence. It seems like it's in them. The difference between victim and perpetrator has gotten all mixed up, in some way. They feel not understood by something that says, cognitively, "Okay, this is something far away from you. Let's take political action, let's do this, let's think this through, let's calm down those nightmare." Instead, people feel, somehow, deeply, deeply engaged internally.

To understand that, I started going back to all kinds of early research on this issue. Freud's early seduction theory and his later review of that with the idea of *nachträglichkeit* –this is Freud's word for things that later remembered take on different meanings with different experience and knowledge. When Freud was interviewing these early girls in hysteria, you remember his thinking was that they had this terrible early experience; they were raped early on, and it turns out many of them were raped or sexually abused early on, but then he says that it's not the fact that they're abused but the meaning that they give it that makes it so noxious that they will endure any symptom rather than remember and associate to the meaning. That had a profound effect on my thinking.

Then I found this army psychiatrist who's quoted a lot in PTSD literature, A.F. Kitchener, who started looking at something he called "post traumatic decline," in the 80's, looking at Viet Nam vets and saying, "We get people, they don't get better, they're really severely affected people. They get worse. I think their getting worse has something to do with aggression. We're not dealing with violence and aggression that they've seen, that they've experienced." and then I thought "What if? There's got to be something in these PTSD symptoms; I've got to sit down and start deconstructing these symptoms because it can't just be that we have these symptoms by magic and we're going to look at them and we're going to address them by rote. It has to be that these particular symptoms are there for particular reasons, defending against particular things and if I could deconstruct them and understand them, maybe I could help my patients."

ALEXANDER: What is the therapist to do then to open themselves to these experiences? I mean, you can't just walk in and say "I'm ready to hear you." There's got to be something else then that.

BRAGIN: That's where Klein's student and analyzand Wilfred Bion came to help me. Bion was a war veteran himself, who was very blocked in his work until his second analysis with Melanie Klein. One of the things Bion talks about is that there are three links between all people. He describes them as love, hate and knowing. That "knowing," that k-link, seems to me very important. So this is not the kind of thing we can say to a patient -- I mean you can say all kinds of things to patients, and I think people sometimes do -- but what we say to patients may not be as important as what we're also able to convey in our body language and in our own emotional level of acceptance.

So if you want to create a k-link, a link of capacity to know – and that's what this paper is all about – our capacity to know terrible things, we have to do a number of things. One of them, I feel strongly as an analyst, is our own analytic work. We have to be able to get comfortable with our own aggression. Again, I'm referring to the Kleinian theory that says we've all got it, that we are all, as infants, full of early terrible fantasies and that when horrible things happen in the world, part of our fascination has to do with an eerie familiarity.

Now some of this I learned from my patient, whom I call Xiomara. Obviously she's got another name; she's a bit disguised here to protect her. Listening to her really helped me and helped me find those places in myself. I think that in today's post 9/11 world, we can see how fascinated people are with terrible real experiences out in the world, can we not?

ALEXANDER: By that fascination, you mean that we

BRAGIN: We've got this reality TV. We've got just a plethora of entertainments around us that are making good money that talk about people doing very disgusting and terrible things to each other, and they're making big hits in the box office.

ALEXANDER: Let's talk about her, as an example of how you engaged her and how you were able to make a connection with her. Can we start with that from the beginning of your meeting her? Tell us about her life as well, please.

BRAGIN: Xiomara had been a revolutionary. She had been a fighter with the revolutionary forces in El Salvador. There had been a peace accord by that time. I'd been coming back and forth from El Salvador for quite a number of years. There was now a peace accord in place. It was, I think, 1993-94. She was in a process that veterans here are going through every day of reintegration. There was a formal reintegration program in place that would get her a job and would get her some access to return from the community; that was part of the peace deal. She was working at the Women's Institute where I was doing these PTSD groups and what everybody was doing those in days, you know, to have people to talk about the trauma of the war. She was also part of the team. She was going to start working in the community. She was doing some administrative tasks there, and as I said, she was a big war hero. She had been captured, tortured and run back to the hills three times during the war.

ALEXANDER: You mean she escaped?

BRAGIN: She escaped.

ALEXANDER: And then was recaptured.

BRAGIN: She was recaptured and escaped again. She was quite a hero, a notorious person, but kind of hard to get to know, tough. So I came down visiting and she comes up to me in the kitchen. I'm making some coffee, and she's having a chat and I said that she didn't come to the groups and she said, "Those are for the good people. Those are for the innocent ones. I'm not so innocent." She changes the subject. I let her.

ALEXANDER: That statement, by the way, had to really surprise you.

BRAGIN: One of the things I have learned in this work, and that was from the kids in New York: nothing should surprise you. I'm sure that's true with all psychoanalytic work. We have to keep ourselves in that suspended state. I could have taken her literally. She had been a soldier. I didn't know what she had going on. So, I was just there, who knows, in that kind of suspended state.

In the case of Xiomara, she knew that I had in my youth, in the 60's, been briefly a political prisoner myself. Now there is no comparison; this is the United States; not the same conditions at all. I had refused to answer questions from a grand jury, at one time and she knew this about me. It made her feel like we had something in common. She wanted to ask me all about my experience. I think what might be different technically is I decided

to give her some answers and get her talking. That's when she started talking about her experience which was of the capture, the torture, and still she wanted to say that we had something in common. It was very important to her.

This is, I think, something technical: people want to say, "Oh I have suffered nothing; you have suffered." Right?

But I didn't do that. I let her say, "Oh, they kept the lights on twenty-four hours. I think that's torture, you know. I bet that's why you get those headaches you're famous for. I'm sure that's why you get your migraines."

Then she could go back to telling her own story because I wasn't one of these excluded people who didn't get it. She gave me permission to get it. She was telling me that I could get it. So I stayed with her in the torture chamber.

The next thing that happens for most clinicians, I think, is this: when we are hearing the details of torture, it is resonant. You can feel it in your body in very uncomfortable ways. I think what most of us want to do is make some barrier that says, "There's you and there's me and I am not you," because you're talking about exquisitely designed pain. I chose to sit there with that pain, with her allowing me to say, "My pain is your pain and your pain is my pain."

ALEXANDER: See, the thing that surprises me about that is that she would accept a statement like that, not a verbal statement, but that...

BRAGIN: I didn't say it. She created it. I allowed her to create this idea that we had this in common: this understanding of prison and pain. I just left it there since she created it. I don't think I could have said "I've been in prison, I know what's it like," because that would have been a lie. But instead, I allowed her to say, "You understand me." Torture is scientific. We all talk because we must get relief from the unbearable pain and she explained the details of the torture and at what point one talks and what provisions were made by her comrades-in-arms.

So she's talking about many intimate details: her body, her relationships, and I am there listening and not stopping her from telling, and asking her then if we could talk some more, and then thinking about where I'm going to talk to her, because she liked the kitchen. I wanted to continue this with more privacy but I didn't think I wanted to lock her up in an office. I thought, "Let me take her to an enclosed garden," which there was in the hotel where I was staying, with life, with shrubs, where there was an easy to see exit and we could sit and we could talk. So, then in that way, I got history, and I began doing the things that people feel you should not do in working with PTSD, which was linking her fantasies from her childhood with her reactions to the very real violence she experienced, and helping her make links between herself and herself, which I felt I could do technically because we had started with this connection.

ALEXANDER: What led you to think that there were fantasies in herself about her childhood that would be important, or that would be available for linking, or that should be linked up with her present?

BRAGIN: Originally, I didn't know, but I believe in connecting past and present by having people tell me the story of their lives, because we are all more than our experience of heroism, pain or victimization. I have had tremendous use from that all over the world. Working with child soldiers in sub-Saharan Africa, proved really important for me: helping kids to connect to the people they

love, their childhood, the things they ate, the things they did and unfortunately, the games they played that might have been mimicked by the things they were forced to do as child soldiers.

Knowing your past helps connect you to your future. That's also a Mayan idea. So, I knew it was a good South American idea and I'm in a different culture: we are not only this present moment, which is very American in some ways, that we can invent ourselves in every moment. In many other cultures, we are our past, we are our history, we are the history of our ancestors and we are going forward, we are connected to the earth.

I wanted to hear that part of her. But also, I have a Kleinian background so I have this idea from the work I did with the kids in New York, who came from all over, by the way, and from my own analysis, that perhaps early aggressive fantasies might have played a part.

Sure enough, I then heard about the bodies in the streets. I don't know how much you know about the Central American wars, but the way that the population was terrorized was that people who were felt to be supporters of the rebels, whether they were or not, would be pulled out of their houses at night, tortured and left naked, with various body parts chopped off: if they were men, their genitalia stuffed in their mouths; if they were women, other body parts stuffed in their vaginas. It was horrific to see, to experience, especially for little kids, and little kids had to walk over these bodies to go to school.

ALEXANDER: How awful.

BRAGIN: I knew that at the very least, she might have been exposed to that.

ALEXANDER: So, then what did you learn?

BRAGIN: What I learned from Xiomara was this: she then told me that all the little girls would see these disgusting bodies-- these are Catholic school girls, in their little school uniforms, walking down a dirt road, in their little village and there's a goat and a chicken and the milkman around, and they see this. And of course they're not supposed to know anything about all these things. Sin, right? You're thinking about very strong involvement with church and religious teachings and there they all are and they see the body and everybody goes, Eeeuuuh, how disgusting!" They all shut their eyes, wince.

But, she thinks she is the only little girl who, instead of feeling that this is the most foreign disgusting thing in the world, is somehow attracted and excited by that. She doesn't tell anybody that she has those feelings, so nobody can tell her how ubiquitous they are. She thinks they're so horrific that she couldn't even tell the priest in confession. He'd be horrified, right? He probably had never heard of such a disgusting fantasy.

So she's trapped in this secret bad feeling and she actually knows she's bad and wicked, so that's when I found out the stories of her and doll play as a child. Very normal kind of stuff: assisting her brother in making cannibal soup out of one of her dollies. Plus, when her mom was sick after childbirth, her grandmother was whispering things, implying sex but not talking about it, mad at her dad, mom's sick in child birth, baby is ill, kids are feeling neglected, and grandma is walking around saying, "He couldn't even get off of her. What's the matter with that terrible man?" They're all having their fantasies.

As somebody with analytic training, I do believe infantile sexuality and that kids have some fantasies and ideas about what all this and it's all mixed up, when they're little kids, with poops and pees; it's all confused for them. Nobody's explaining it. We all outgrow it if we don't have tortured, mutilated bodies lying in our wake and

soldiers coming into our communities and murdering us and our family members.

So, this is a guilty little girl, guilty little appropriate Catholic school girl and in our world, we certainly don't have the leader of our church murdered while he's saying mass in front of all us. So, this is something I learned in this experience: these little baby fantasies that we all outgrow are made literal in these kinds of situations. Blood and body parts are spewed all over the place, everywhere and you see these fantasies actually enacted.

So what happened to Xiomara was she was feeling very guilty, like, "Oh, maybe I cooked this up; I imagine it and somehow it appears?" She is trying to get rid of her bad feelings so she joins the student movement and she protests against the killings and she does many legal things before she volunteers to fight and none of them are effective. Things keep getting worse and her nightmares keep getting enacted in front of her.

She feels that she must do something to stop this. It feels very personal for her. I'm not sure that she associates one set of things to the other; she just knows that she feels personally called, that she must save her community, and off she goes. She's a great rebel fighter and takes many risks. She has a child she leaves with her mom; there's a very long and complicated story about this. She has a devoted relationship to another rebel fighter. She remains a very religious woman.

When the war is over, this is all with her. The war comes home as it does with so many of our veterans. She's not okay and she cannot go back to husband. She can't enjoy her sex life. She can't really enjoy her daughter. She's just cut off in her sense that "I haven't saved anybody; I'm a really bad person. My nightmares have been enacted so I must really be just like my torturers because I can think of every disgusting thing that they can think of."

ALEXANDER: So what was next then? How did you help her move past these things, or did you?

BRAGIN: Well, the first part of this work was to get her to be able to feel that she could engage, that she could begin to feel heard. We could interrupt this, "It's me and my torturers and I have to keep everybody else at arm's length because they don't get it and they can't get it and they keep not getting it by treating me like a hero. They really don't understand who I am." So she could feel understood as this "third" enters [ed: the third is Dr. Bragin].

Perhaps I'm making this more literal than the relational people intend, but, I think that idea of Jessica Benjamin's of "beyond doer and done to" becomes very important, that there becomes this person in our conversations, this "analytic third," which is "beyond the doer and done to." There is something else; there's another space in which we can begin to talk. The first thing is to make interpretations and begin to help her to make sense of this and to feel that sense could be made, and that she could have another way of connecting,

ALEXANDER: We've talked about some of the meanings to Xiomara of the torture, what was the personal meaning that she herself got out of it?

BRAGIN: For Xiomara, what was very important was that we understood her as a subject, not only as a victim but as somebody who had feelings that we took seriously: her own sense of being aggressive and enraged. That we didn't just say, "Oh, it's not your fault. It's not your fault," but that I could care that she was somebody who could feel very angry and who could feel to blame, but then also was able, as she spoke about these things, to normalize them for herself: one is angry when one is captured and harmed; one is angry when one sees people one

cares about harmed; when we're little kids, we find ways in our play and in our games to think about gross stuff because that's how we manage the normal experience of things in life that make use angry. So she was able to really understand that she could be a normally angry person who had an abnormal experience that brought up feelings that she had a right to continue to have. I know that sounds very cliché and boring.

ALEXANDER: But if it's true, it's true.

BRAGIN: That's what it was for her. Making her a quiet little saint and a victim didn't fit who she saw herself as and it didn't explain the rageful, violent feelings she felt, and it didn't explain that creepy feeling she had when she saw those mutilated bodies and thought, "I've fantasized this, I've dreamed this, I've seen this. This is not so strange to me," and letting her know that that's part of a normative developmental process that kids have, and that maybe everybody else was saying, "Eeuuu" for the same reason. We shut those feelings out and describe them with disgust because that's part of how we grow up. We grow up and manage our violent and aggressive feelings, and we turn them into other things, because it's not meant to be that people actually do these things. When you're a kid, and you believe that there's a difference between dreams and reality, and then people start acting out your worst nightmares; it's very hard to not feel responsible. But at the same time we didn't take away her sense that she was a person who could have agency in terms of her feelings.

Then, of course, the next step was ongoing treatment which happened, basically, at intervals because I was back and forth to El Salvador. So this was accompanied by her feeling that she did feel better when she could do good things. It was really important to allow her to find ways to do good things in the world, in the community.

ALEXANDER: Was she doing those good things as atonement, as reparation, because they honestly felt good, or all of the above, would you say?

BRAGIN: I would say all of the above. Reparation is a very wonderful thing. I think it feels good. What I'm saying with demobilized soldiers is it feels good in a lot of ways. It's an aggressive act. It makes you feel more like a subject. That's what came out. The treatments that made her feel like a passive object did not help her, but if she could say, "Okay I felt that. I did these things. I was an experiencing party with my torturers and I can be an actor on the stage of the world." That's another route for that aggression. So the reparation feels good because it atones, in part, but also because it makes space for goodness by identifications with goodness. Also, it allows you to feel like you are subject and an actor and not a passive recipient of help.

ALEXANDER: Wouldn't being a passive recipient of the torture be preferable to feeling like you're part of the torture or part of the torturer? Why would somebody want to feel active in that, as opposed to a victim of it?

BRAGIN: Because it is a way to feel connected and alive. I've had these discussions back and forth with Dori Laub, by the way. He is a survivor of the concentration camp and he writes about knowing and not knowing, and I do cite his work in *Survivors of Extreme Violence*. One of the things that Dori finds to be

so important is that to be without an object of attachment is to be so alone that it can feel unbearable. If there's only one object and that's the torturer, connection to any object is better than no connection. So that is certainly one way of understanding it.

The other way of understanding it is this -- I'm now going to take you away from Xiomara and to people I've talked from concentration camps and from Rwanda. One of the things that happen in these kinds of brutal genocidal situations is that, for instance, in Rwanda the Genocidio there called the Tutsi "cockroaches." You become not human, you have no individual past, you have no future, you have no agency. There's something about that kind of soul murder and eradication that may feel more like death than "I'm doing it to you as well." So that's, I think, a part of it. The other part of it is this: if you can picture yourself being brutally tortured by another person, what might you feel?

ALEXANDER: Other than pain, you mean?

BRAGIN: Yes

ALEXANDER: I was just wondering if you might almost feel glad to see the torturer come in.

BRAGIN: Glad to see the torturer come in because you're not alone, but at the same time, extreme rage at somebody doing all these terrible things to you, no?

ALEXANDER: Yes.

BRAGIN: All right. What happens in extreme rage? In extreme rage we start visualizing what? Horrible things being done to the person we're enraged at, yes?

ALEXANDER: So then you're the same!

BRAGIN: Especially if it's very primitive. So, the worse the pain, the worse the rage; the worse the rage, the more primitive the fantasy; the more primitive the fantasy, the more hideous one's fantasy of destruction. So, you guys are in there together!

ALEXANDER: Right.

BRAGIN: So you've got three elements propelling you toward this connection, but one of them is certainly an overwhelming rage.

I am sure that there are some people who transcendently never experience rage. I've never met the Dali Lama but I've met people who have played very saintly roles in the world and they have described feeling rage toward people, if not when those people are victimizing them, certainly when they're victimizing helpless children. There are moments when the rage takes over. And certainly, when you are helplessly being tortured and chopped up, that's a moment!

So, all of the sudden, you and the bad guys have a tremendous amount in common. You're both fantasizing

hideous things being done and lo and behold, our fantasies, across countries, across continents -- it seems like wherever you go, your torturers are coming up with the same stuff. So, where does that come from if not from the same well-spring of fantasy? Kids play very similar forms of mutilations and tortures and disgusting things.

ALEXANDER: Well, if you just look at children's cartoons -- I mean just look a Bugs Bunny cartoon and how they run and smash into the walls and break into a jillion pieces. Children's cartoons are very violent.

BRAGIN: Oh, yeah. Oh, yeah. I've looked at kids playing in all kinds of places by now and you just see this stuff.

You say, "Okay, here I am. I'm enraged. I am back to a very primitive sense of helpless rage like that of an infant." You've got to wait for the person to come and get while you're crying, right? And serve and take care of you and if you get colic, they can't take the pain away. So something is going on that Klein described: your rage and the torturer's murderousness -- now the torturer is probably not an enraged guy every day; he's going home and doing whatever they do with their lives -- Hannah Arendt talks about "the banality of evil." Each party is pulling up from somewhere the same stuff, so you really do have something in common with the torturer.

ALEXANDER: How do therapists who have no background whatsoever with violence, of any actual violence in their lives, how do they manage to connect with survivors and victims? It's sort of like if you've never been an addict, can you treat addicts? If you've never been raped, can you treat rape victims? So, if you've never experienced violence, aside from, let's say you've gone through your violent fantasies in your own treatment, but if you've had no actual experience with violence, how do you manage to connect and to get people to engage with you?

BRAGIN: My work, in its nature, is psychoanalytic and comes out of the tradition of Klein and Bion and also comes out of a relational tradition. And really we're not going to be able to understand it without acknowledging that all human beings who act violently -- torturers, people who make war -- start out in the same place the rest of us do as human beings with things that go on in our heads. So, if it is possible for human beings to imagine something and do it, we therapists have to be able to imagine it too.

I am assuming that we come equipped, hard-wired, if you will, to have some capacity to get that, as people, through accessing our fantasies, our games, our childhood experiences of helplessness and rage.

Now, that's one side, and just as if I've not been an addict, I'd presume to treat an addict with two pieces of information. One is the one I've described about our relationship to our own rage and violence and imaginings of the rage and violence on one hand and on the other, we all have to acknowledge that there are two people in the room at any time. If there are two people in the room, we know that our experience is never theirs. In other words, if I am a rape victim and I treat Xiomara, that does not mean that I know what rape was for Xiomara.

I want to move over to another case for that because that may be most helpful: the case of Anouk. Anouk and I have the same phobia. We are both frightened of snakes. But my snakes were not Anouk's snakes. I was not a survivor of the Cambodian holocaust. I barely know Southeast Asia although it was significant for her that I had

been in Vietnam and I had been on that border area, but that was not in fact the issue.

The issue was that as somebody with a phobia. I could use the fact that I know what it is to be terrified of things that are not there, and that they meant something to me that was meaningful and that I needed to know what they meant in order to tolerate the fear. But, I did not know the Cambodian genocide. I had not been the person to experience what she experienced, which were a series of unmitigated horrors and the betrayal of both her parents. So, I had to be able to call up, in myself, that capacity for terror, while at the same time, not confusing my terror and hers by listening to the meanings of hers.

One of the things that I've been accused of by people who have some disagreements with me is of being very old-fashioned. In some ways, this is very old-school Freud.

ALEXANDER: That it is. That doesn't mean it's wrong.

BRAGIN: I'm not saying it's wrong but I believe that psychoanalysis was best invented for these very serious problems. Freud was called upon to deal with World War I, Bion dealt with World War II. Freud was dealing with a tremendous plague of rape and child abuse, child sexual abuse, in turn of the century Vienna and really came to grips with these very, very difficult ideas in an atmosphere of dealing with violence.

So I use these tools to help me understand people who have experienced extreme violence because they are the ones we've traditionally used, and I think it's really at our peril and is a mistake to say that when the violence is real and out there, we can't use our tools. I think that's the very time when we most need them.

ALEXANDER: As the therapist, listening to this, how do you not become traumatized yourself?

BRAGIN: I think that that is the importance of one's own treatment and then one's own supports. Everyone has their own thing, certainly one's own treatment. It was necessary for me, in my own treatment, without going over my own life and my own story, to become comfortable with the rage and violence inside of myself with which I was very uncomfortable and to be able to accept the ways in which I am not wonderful and not good, and in which I may be very bad and violent, indeed, and to make my peace and to make my home with that. Doing that in my own analysis, I think that was step one and critical.

I think step two is that in doing this work, it is important to have supports to understand why you're doing it; to understand that in the process of doing it, it's going to turn on all the worst parts of you, and to find ways to feel good about yourself. What I like and I enjoy may not be what the next person likes and enjoys. I, by the way, find a tremendous amount of satisfaction in studying all of this, of understanding it, of making meaning. In 1997, when I gave the first description of this at a forum, a colleague stood up and said, "I believe that the way you tolerate working in such difficult circumstances is that you believe in the making of meaning and the making of meaning is what keeps trauma away from you, and therefore, you believe that you can make meaning out all of this and make useful theory." So maybe that's my form of self-regulation and self-soothing.

ALEXANDER: What is the meaning that you've been making out of this at this point?

BRAGIN: The meaning I've been making -- I don't mean the larger social

meaning, I just mean a very personal meaning -- is that there is a way of understanding the effects of extreme violence and we can understand it through the meaning of that violence to each individual person in their own life, and that through that understanding, we can help survivors transform what has happened to making social change. That's why I work with former child soldiers. That's why I work with veterans here. I believe in violence transformation.

I'm getting on in years; I may not make the world much better, but these young people, these survivors, these people who have fought and suffered are going to make the world better than the one that I found and the one that my generation was able to hand them. I continue to struggle to discover more, to do it better and to get it written.

ALEXANDER: Any follow-up with Xiomara?

BRAGIN: I haven't seen her in a few years but when last seen she was pregnant, she was about to have another child and then she did have another child, she had a girl, she was back with her husband, her *campanero*, and they and the earlier child were living together. She'd stopped working with the Women's Institute; she had another job that I don't want to talk about for confidentiality reasons, and she had gone back to school.

ALEXANDER: I didn't ask that question to pull away from what you were saying, but I did ask it because I felt that people would want to know.

BRAGIN: Of course.

ALEXANDER: "In our dreams we are all terrorists." You have really explained that to me and I hope to our listeners.

BRAGIN: I'm glad!

ALEXANDER: You made it very "experience-near."

BRAGIN: I want to say one more thing about that particular comment. The point is the difference between the depressive and paranoid-schizoid position. In the depressive position, we understand the link between ourselves and other people and the continuum between our own rage and our own pain.

In the paranoid-schizoid position, what we end up having to do is say, "I can't tolerate my own rage and my own pain so I'm going to separate myself from it and I'm going to put it in the other."

When we do that, ironically that makes us more of a terrorist because the terrorist is, in that moment, us and them, although some terrorists believe that they have to commit their acts because they have to put an end to the violence and pain that we are all experiencing, and it's unfortunate that they choose that method.

ALEXANDER: Dr. Bragin, my hat's off to you.

BRAGIN: Thank you.

ALEXANDER: You're very welcome. Is there anything you'd like to add before we close?

BRAGIN: I think I just added it.

ALEXANDER: Okay. Thank you again for this really remarkable interview.

BRAGIN: And I thank you very much, and I thank my patients, and the colleagues in the various countries where I've worked who've taken the time to teach me so much.

You may contact Dr. Bragin at 718-499-0678.

This concludes interview #7 in On Good Authority's program on "Posttraumatic Stress Disorder" I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of ON GOOD AUTHORITY. Until next time, this is Barbara Alexander. Thank you for listening.

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POSTTRAUMATIC STRESS DISORDER

Interview #8: "RESILIENCE"

FROMA WALSH, Ph.D.

Interviewed by Barbara Alexander, LCSW, BCD

(Edited slightly for readability)

FROMA WALSH, Ph.D., LCSW

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Welcome to On Good Authority. I'm Barbara Alexander.

You are listening to or reading interview #8 in "Posttraumatic Stress Disorder," a continuing education program of On Good Authority covering diagnostic and treatment aspects of this controversial and important subject.

A paradigm shift is in the wind in the PTSD world, away from the overly pathologizing intervention focus on individual symptoms and towards better understanding of posttraumatic growth and the resilience which often emerges out of trauma, and how to facilitate it.

Most people who experience major trauma worldwide do not develop PTSD and when they are experiencing difficulties, they don't go to mental health services because they don't want to be diagnosed with a mental illness. Especially of concern are the "debriefing" group sessions immediately after major traumatic events. Research has found that debriefing can make people's suffering and symptoms worse.

Dr Froma Walsh has developed core principles and values of a family and community resilience-oriented approach to recovery from traumatic loss when catastrophic events occur. In contrast to individually based, symptom-focused approaches to trauma recovery, this multi-systemic practice approach contextualizes the distress in the traumatic experience and taps strengths and resources in relational networks to foster healing and posttraumatic growth.

Froma Walsh received her MSW from Smith College School for Social Work and her doctorate in Human Development from the University of Chicago. She is the Mose and Sylvia Firestone Professor Emerita at the University of Chicago School of Social Service Administration, and co-director of the Center for Family Health at the University of Chicago.

Her books include: Strengthening Family Resilience, Normal Family Processes, Living Beyond Loss: Death in the Family, Spiritual Resources in Family Therapy, and Women and Families. She is a popular speaker and lectures internationally on topics related to helping families overcome serious life crises and adversity.

Now to our interview.

ALEXANDER: Dr. Walsh, it's been my understanding that the trauma field has changed and has shifted recently, so let's begin there.

WALSH: The trauma field has been focused from the time PTSD was first made a diagnostic category in our DSM system. It was then classified as a major mental disorder. We then focused our attention on individual symptoms and interventions on ways to reduce those individual symptoms.

It was an important milestone that PTSD entered the DSM and that was really the result of psychologists and other mental health professionals, many of whom had served in the Vietnam war, came back as veterans and began to write about the kinds of long term traumatic symptoms that persisted, not only for those who

had experienced war but also for their families, for their relationships with for loved ones.

Because my own work is family systems oriented, I've been particularly interested in the work of Charles Figley and Don Catherall and others who have tried to broaden the perspective to look not only at what are the long-term effects of war and other traumatic experiences on the victim, but to also look at the secondary traumatization of other family members, of loved ones, that occurs both through hearing about the trauma that had been experienced in the past, sometimes over and over again, but also as they continue to experience with their loved ones those symptoms of distress that continue to reemerge over time.

So, in the family therapy field, we've been very interested to take a family approach to that and to understand then that even when one person has been traumatized, it affects everyone in the family and all the relationships in the family. Secondly, from a family systems perspective, understanding how the family responds in trying to help that person recover can make all the difference in terms of that person's long term adjustment or adaptation.

In the field of psychiatry, the interventions have really been focused narrowly on the individual who is suffering from symptoms that are diagnosed as PTSD. So, let's say that there is a mass catastrophic event that affects the whole community, as we saw on September 11, as we saw with hurricane Katrina, as we see in many parts of the world. Whether it's a natural disaster or a human cause disaster, there are ripple effects throughout those communities both direct in terms of all the families that are effected through the loss of a member, loss of homes, loss of work, loss of identity, loss of livelihood, needing to rebuild community or being displaced and also their not knowing if they ever will be able to go back to the life they lived before. So, when there is a major traumatic event there are ripple effects throughout families and communities. Then there's that secondary effect that if even if only one person has been touched by that incident as, say a returning veteran, there is that ripple effect throughout the family.

So, we take a family systems approach then in intervention. We want to understand and reduce the kind of stresses that emerge in the families or in couples' relationships. There's a very high rate of conflict, violence and divorce, in couples where one is a returning from a war zone, whether soldiers or serving in some combat area. Not only then is that family affected, but if we can work to strengthen the family and tap into those family resources, it can be a lifeline to that individual or to those who are most distressed. So, the family is directly affected, it's indirectly affected and our aim, then, is to direct our interventions to call forth resources in the family and help members to link up with other resources in their community as the best means of recovery and resilience.

ALEXANDER: Well, Dr. Walsh, let's you talk about your concepts of resilience. You know, one of things that people always wonder about is, well, how come two people in the same circumstance -- one emerges fine and the other one "falls apart." This, of course, has a negative implication, "falling apart" -- so how do you view resilience and what makes one person more resilient than another?

WALSH: Just a simple definition of resilience is the ability to withstand and rebound from crisis or prolonged adversity, and to be strengthened and more resourceful through that struggle to recover. That's what distinguishes resilience from just coping or adaptation. This is what, to me, is most fascinating about the emerging research on resilience in the trauma field: when there's been a traumatic event, some people, some individuals are more vulnerable when they

are coming into the event and you really have to take a bio-psycho-social perspective on all of the influences that contribute to vulnerability, all the influences that contribute to risk and then those variables that contribute to resilience. So, some individuals are personally, through their own genetic and biological vulnerability or strengths, more or less hardy as they come into a trauma experience.

The early research on resilience in the 1980's, focused primarily then on individual traits. That's where the interventions have continued to be located. But, if we look at Michael Rudder's work with resilience (Sir Michael Rudder, in England), he was one of the most important investigators of resilience. He understood and found through his own work that it was not only what the individual child or adult brings to the experience, but it's also the interaction with resources or lack of resources in the family, in communities, in peer groups, especially for adolescents, so it is that interaction between the individual and their social context.

Now, what's really interesting to me in the trauma field is that in the last few years, there's been a shift away from that single focus on symptoms of dysfunction in PTSD once they began to find in large scale community studies, in almost every situation, over 50% and closer to 60% of those who experienced that major traumatic event may have initial, intense distress, but within several months, begin to recover and rebound from that and score high in well-being and functioning, usually by the end of the first year. So, we have to be very carefully, first of all, not to over-diagnose PTSD in terms of the immediate response of people after a traumatic event because the event is bound to effect just about everyone who is in that situation. But, we can intervene early to begin to reduce that distress and to help them rally some of their positive resources, which then lowers the risk for the long-term PTSD. That's what's most interesting in the recent studies in the trauma field.

There has, in fact, been a whole inventory developed by Calhoun and Tadashi looking at posttraumatic growth. Here again, it's more than just coping and surviving the trauma. What they found in their research is that in that struggle to recover from a traumatic event, people often tap more deeply inside themselves for latent resources, capacities, abilities that they hadn't expressed before or even know that they had. They also reach out to others and deepen relationships with others in those times of crisis. Both of those connections lead to positive growth.

If you interview individuals in qualitative studies, down the road, after they've experienced either a single traumatic event or on-going trauma, what they'll say is "I think, this may sound strange, but I think I emerged harder because of that experience. I didn't just go into it strong, in fact, I was just kind of going along with my life but somehow in struggling to recover, I feel I'm a better person, I'm a stronger person, my intimate relationships are stronger and deeper than they were before that crisis."

That's what really draws me to this work and leads me to work with individuals and their loved ones and their communities to help them tap into those positive resources.

ALEXANDER: Well, let's talk about some of the interventions that go into the "Multi-Systemic Resilience-Oriented Practice Approach."

WALSH: OK. It's a lot of words there. Multi-systemic means simply that we're intervening with the individual, with their family as they define their family. We're also bringing in community resources and we're also considering how larger systems can either help or hinder their recover. A good example is veterans, and how the system or lack of system cares for them when they come back from Iraq or Afghanistan. We're looking for resources at all levels and that's what makes it multi-systemic. In fact, some of the new evidence-based models of family therapy are these multi-systemic programs working with high risk or conduct-disordered adolescents in poor inner city communities and involving their families, peer groups, community resources, schools. Those are having really the best effects now that we're seeing. So, that's the multi-systemic piece.

The other piece, the resilience- oriented piece says yes, some individuals are suffering more than others but we don't want to neglect those who may not be showing symptoms. They've all been through this event, either directly or indirectly, and we want to offer services that help them pull together and support one another. We're not just treating the person who's showing the most symptoms.

There's another problem that we've found. I co-direct the Chicago Center for Family Health with John Rowland, and we do training and community programs with a resilience orientation. We were called to work with Bosnian and Kosovar refugees during that crisis of the ethnic cleansing campaign when many of them were flown to Chicago. The community and Steven Wein, who heads a program for response to traumatic events at University of Illinois, came to us and said many of these refugees are suffering but they won't go for mental health services because they don't want to be diagnosed with a mental illness. They don't want to be seen as crazy or disturbed so they're not going for help when they really are suffering.

There's a stigma that gets attached to the diagnosis of PTSD and also with "locating" the distress in the head or intra-individually. What we do with the resilience approach is we locate the distress in the experience -- that maybe the symptoms people are having are normal responses to extremely abnormal events, and that most of us in that situation would be extremely affected by it, at least in the early phase of recovery from it. So, we try to normalize and contextualize the distress that individuals are feeling so that it reduces the sense of pathology and stigma, and helps them to open up about their suffering in ways that are not as shaming for them.

So, we were asked with Bosnian and Kosovar groups to set up multi-family groups in the local community, in a neighborhood storefront, in a place that was accessible. It wasn't loaded with mental health meaning, and the families readily came. It wasn't a matter of who is the patient and who isn't, but "You've all been through a very traumatic experience. You've all lost loved ones. You've witnessed atrocities. Some of you are suffering more deeply than others and we want to talk about your experience with you. We want to hear and witness what you have gone through."

In listening to those stories of suffering, we're creating a support system by having all the families in the room. In addition to asking about the suffering, we're also asking and noticing the strengths, the courage, the endurance that they called forth to get through that situation. We want to rebalance and shift from only focusing on symptoms and disorder to also focusing on strengths and potential resources. That's where the approach tries to broaden the intervention.

ALEXANDER: When people are telling their stories, how does that not re-traumatize them? How does that not make them worse?

WALSH: It's the kind of inquiry that we do. There's a movement in the field of family therapy -- narrative therapy, and a lot of work around compassionate witnessing that asks for the story but also notices how strong....

Let me give you an example in the Kosovo experience because we then formed, at the request of the mental health leader in Prestina, Kosovo, a team of family systems resilience oriented trainers to go to Kosovo and do training with local professionals to help in this kind of recovery.

There have been a couple of articles written on that experience. They would sit with the family and say "Tell us your story; tell us what happened." They would expand the story to ask, for instance, "How did you find courage to get through that time?"

For instance, with one family where the mother had witnessed the shooting death of her husband and two of her sons, we had her sit with the whole family and had them all talk together, feeling each others' mutual support as they're telling the story, and as one can't express it, another can. Or one can reach out to the other and they can comfort each other in the telling and in the aftermath of a session that we have. By asking, "How did you find courage?" one family said "Seeing our mother's strength -- that she was able to get up each day and go on a prepare meals for us and put one foot in front of the other --that gave us courage, seeing her courage."

We call that "looking for models and mentors in the family." So, we will ask about that: "Who was strong? Who did you look to for strength?"

And then the next question was, "How did your mother find her strength to get up in the morning and do that?" "Well, our mother turns to our faith, to Islam, and it's very strong for us. We're very religious. We pray. We turn to God, to Allah, and ask for strength through this time."

Another family said, "Our cousins come and help us plow the fields and take over, each one taking a turn for someone who is missing. We comfort the young children who have lost their fathers. As uncles and aunts, we step in and try to fill those roles until they are grown into adulthood. We tell them stories of their fathers and grandfathers and those who are lost so they can connect with their elders."

So, it's the kind of interviewing that we do that goes beyond the symptom to their whole identity, sense of pride, sense of community, their loving care for one another and trying to reinforce those resources as they're also taking about their pain.

ALEXANDER: I'd like to go back to what you said about models and mentors.

WALSH: We do genograms in family therapy, but traditionally, we're looking for what went wrong: where was the pathology in our family of origin? Where were the conflicts and the cut-offs? Who had alcoholism, etc?

What the resilience approach does is to broaden it to also look for who did you admire in your family? Who did your family turn to in times of adversity? When you've gone through past troubles or when your family dealt with cancer in the past, who stepped forward, who was helpful, in terms of emotional support? Who was helpful in terms of more practical support? So, the kinds of questions and the way that we fill out the picture helps ground them in a broader family system and in some of the potential resources they could draw on now.

ALEXANDER: What are some of the other intervention guidelines and interventions that you use?

WALSH: One thing is we've become critical and do not use some of the widely used single session debriefing, the crisis intervention debriefing programs that are widely used. There has been research now, multi-and meta-analysis of many studies in many different countries using those debriefing, single session formats, finding that often it does only increase the suffering and trauma of individuals in the room. Those formats were originally designed for people working in crisis situations such as firefighters, police, and they've been expanded now to work with communities that have just come out of a crisis, if you just go in and focus, as those groups do, on identifying symptoms of PTSD, it focuses everybody on becoming hyper-alert to the risks. Yes, you should be aware of the risks but that needs to be re-balanced with, "What are your strengths and what are your resources and how can we build those resources to minimize the risks?"

We also think a single session isn't advisable. It's good to offer information in a single session, but to just open up the pain of the trauma and then to end the session really leaves people with that kind of ripping a band-aid off a wound without follow-up and without really mobilizing those family resources.

ALEXANDER: So in the work that you did where the Kosovo refugees would all meet together in a storefront with their families, and would that happen more than once?

WALSH: Oh, yes. It's a psycho-educational model of intervention that's been used now since Anderson and others in the 1970s developed it for working with chronic schizophrenia, working with families in modules that are usually maybe four to six sessions. They run for maybe an hour and a half.

We also try to have them co-led with a member from the community so that we're also training someone in the community; we have someone who's on the inside who can help orient us so we're not just the outside experts coming in. We're learning about them and their experience, their values, their culture from the insiders and people feel that if there are issues that come up between sessions or later on, that there's a member of their community that is now someone they can turn to help facilitate.

We might then have a follow up, maybe three months later. Often these groups will go into self-help groups after the initial period of time. We think it's extremely important though to have them led by professionals who work from this resilience oriented model initially. Then later on, they can be sustained by members themselves.

There are also two other projects that were developed by colleagues of mine in response to 911, one in lower Manhattan, where Jack Saul mobilized families and communities not only for those who had been directly affected in the building, but for all of those families that lived in that neighborhood who were displaced for several months, who had children who were in school and witnessed the falling towers and then were taken out of

their neighborhoods, taken away from their peers, really dislocated. He set up these same kinds of groups back in a community center, in a school, involved teachers along with the parents -- again, these partnerships, seeing that the teachers needed to know and wanted to know how to be helpful to the children. The parents wanted to know how to be helpful to the children. Later on they brought in shopkeepers who also had been traumatized. So, it's really a community based model.

The other example was developed by Pauline Boss, who has worked with and specializes in ambiguous loss. She set up multi-family groups for families of union workers who had been lost in the towers in 911. Many of those families, in those early weeks and months, really were uncertain about the fate of their loved one and had to deal with the anguish of ambiguous loss: is he alive or is he dead? Will we ever recover remains? Again, using that multi-family group format, building resources, not just within families but within the groups, some families could really rally and be more helpful to other families. Some individuals could speak to what it was like for a father or for a wife or for a son. We very much like this multi-family group format.

ALEXANDER: This kind of talking and sharing, do you have any thoughts about the impact of this on the neurobiology of a person? Does that have an effect of, say, in the parlance, "giving good vibes all around?"

WALSH: That would be wonderful to have research extend into this area. It is now starting. The Trauma Society Conference that I attended recently was focused on the psychobiology of trauma and resilience.

ALEXANDER: I want to ask you something else, Dr. Walsh. Has your work touched at all on work with Holocaust survivors and I'm wondering how their fate is and the fate of their families?

WALSH: I only know through colleagues of mine who have done research. I'm afraid my age is going to show here because this would go back to the early/mid-1970's, when I was fortunate to get to know an Israeli researcher who had done a good deal of research on the intergenerational, multi-generational impact for children of survivors and that wider impact in the family. What they found-- these were studies in Israel-- was that in families where survivors were able to come to a place that they could talk about and share that experience with their children and loved ones, it had a beneficial impact for the next generation, and it also had a healing impact for the survivors themselves.

I specialize in the area of bereavement and loss in family systems, and that is a way that we work. What we have found, not necessarily in the Holocaust situation, but across studies of recovery from traumatic loss, is that where people are able to communicate and share their experience with others, it has a healing effect over time. They may not be able to do that initially. It's not so much denial, but if we can think of it not in pathological terms but in terms of --and this gets into the neurobiology -- our natural healing tendencies within our bodies, within our genetic information that anesthetizes pain most initially after a traumatic event.

I like very much the work of Andrew Weil who is a health advocate and who has written about this: the body's and the mind's potential for recovery and that anesthesia, in the beginning, is very important.

What we find, in our field, is that if we can open communication in the family, it helps people deepen their relationships. It sets up barriers when people feel that "I can never tell this to anyone." Think about those who came back from Vietnam. No one really wanted to hear about the experience. If they asked, it would be, "How was it?" and then moving on. The same was true after World War II. I've been struck at this recent video series

on the war. The series was interviewing now those who are still alive from World War II, and showing them telling in great detail everything that they experienced. For some of them, now in their eighties, it's the first time they've ever really told that story.

What we've seen, particularly in the work that's been done with veterans from the Vietnam war and other situations, is that it shuts down intimacy as they shut down communication. It often walls them off, leads to more loneliness, isolation and that can then increase that distress and the sense of dislocation for those who have returned. That makes it hard for families and loved ones both to know how to be of help, and also to feel the full intimacy that can be possible when they're able to share their full experience.

Again, this has to be done with therapists who have been carefully trained to do this in a sensitive way. You don't just throw families members together and have an individual that you may have been working with in individual therapy now share everything with the family. We work toward doing that. We prepare the family for that. We work with the spouse to understand, for instance, what the spouse's experience may have been to date and understanding from her perspective or his perspective what that has been like. We may talk with children before we do that. So we're working toward, in a healing way, a constructive conversation that really can be beneficial for the person who has gone through the experience, for all the family members and for their relationships.

ALEXANDER: Dr. Walsh, is there anything else you'd like to add before we stop?

WALSH: Let's correct some misconceptions about resilience. Because there are some brief therapy approaches now that move too quickly to, "Let's just get over this." Resilience is not just about bouncing back because often you just can't go back to normal, and it also doesn't allow for people to be able to process the loss that they have suffered. So, the resilience approach is really about giving space early in our treatment or counseling to hear the fullness of that suffering along side, increasing drawing forth the strength and the potential to go on.

ALEXANDER: That's a very important point you've made.

WALSH: Because, I think it's about integrating the fullness of that trauma experience into one's identity, one's relationships and future life course.

ALEXANDER: See, I think there's a difference of opinion between those think that your survival will be better if you just put this aside, and...

WALSH: Put it behind you and move on, right. Our society tends, you know we have to think about belief systems in our larger society. A lot of my work now is around meaning making and belief systems. Our cultural belief system is, "No muss, no fuss; put it behind you and move on."

Of course, we go back to Ernest Becker and others about the denial of death and other tragic or traumatic experiences. So our society doesn't have a history of dealing very well with painful experiences. We find that we have to help families feel more comfortable and open up and begin to tolerate -- even when they don't know what to say or don't know what to do -- listening and being fully present with someone who has suffered. That's one of the early challenges that professionals work on in this kind of work. It's a very deep work. It may be a short term therapy either because that's the contract or that's all people can afford,

but it is deep work nevertheless.

ALEXANDER: I'm so glad to hear that. Dr. Walsh, thank you very much for giving your time and sharing your knowledge with us.

WALSH: You're very welcome, Barbara.

Listeners interested in contacting Dr. Walsh may do so at the Chicago Center for Family Studies; [HYPERLINK "http://www.ccfhchicago.org" www.ccfhchicago.org](http://www.ccfhchicago.org)

This concludes interview #8 in On Good Authority's program on "Posttraumatic Stress Disorder" I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of ON GOOD AUTHORITY. Until next time, this is Barbara Alexander. Thank you for listening.

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POSTTRAUMATIC STRESS DISORDER
Interview with BILL O'HANLON, M.S., LMFT
"POSTTRAUMATIC GROWTH"
Interviewed by Barbara Alexander, LCSW, BCD
(Edited slightly for readability)

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Welcome to On Good Authority. I'm Barbara Alexander.

You are listening to or reading interview #9 of "Posttraumatic Stress Disorder," a continuing education program of On Good Authority covering diagnostic and treatment aspects of this controversial and important subject.

Continuing on the theme of posttraumatic growth and resilience, our next speaker presents alternative perspectives on the development of trauma-related disorders as well as powerful new methods for their successful resolution. His approach incorporates a treatment philosophy and methodology hope for the future. Clients are left with a feeling of freedom and a sense of renewed possibilities sometimes missing from more traditional approaches.

Bill O'Hanlon, MS, LMFT, has authored or co-authored 28 books, the latest being *Write is a Verb* (July 2007); *Pathways to Spirituality* (W.W. Norton), *Change 101: A Practical Guide to Creating Change* (W.W. Norton), and *Thriving Through Crisis* (Penguin/Perigee; winner of the Books for a Better Life Award). He has published 54 articles or book chapters. His books have been translated into 16 languages. He has appeared on Oprah (with his book *Do One Thing Different*), *The Today Show*, and a variety of other television and radio programs. Since 1977, Bill has given over 2000 talks around the world. He has been a top-rated presenter at many national conferences and was awarded the "Outstanding Mental Health Educator of the Year" in 2001 by the New England Educational Institute. Bill is a Licensed Mental Health Professional, Certified Professional Counselor, and a Licensed Marriage and Family Therapist. Bill is clinical member of AAMFT (and winner of the 2003 New Mexico AMFT Distinguished Service Award), certified by the National Board of Certified Clinical Hypnotherapists and a Fellow, Diplomate and a Board Member of the American Psychotherapy Association.

Now to our interview.

ALEXANDER: Mr. O'Hanlon, you have been working for a long time with PTSD and I'd like to get some thoughts from you on how it is that you get interested in it, and how your work has developed and evolved.

O'HANLON: Well, yes, I have been a psychotherapist for over 30 years and so I have, naturally, worked with many people who come with posttraumatic problems. Many of the people I see in therapy have been traumatized in one way or another.

I was influenced by a fellow named Milton Erickson, a psychiatrist who had, I guess the best way to say it is a "resource-oriented" way of thinking about people. Even their symptoms, he thought, were resources for the possibilities for change. So, he had what these days is called a "positive psychology view." He wanted to find out in addition to what was wrong with people and the traumas that they had experienced and the symptoms they were having, what was right with people, what their resources were, what their competences were, where they thrived instead of where they were thwarted.

So, that had me thinking in a slightly different direction. I was sexually abused when I was a child, so when I

started hearing all the stuff about sexual abuse, it did not really fit entirely with my experience and the aftereffects of my trauma. As with many of my clients, the aftereffects were mixed. It wasn't just post-traumatic stress, although there was certainly enough of that. It was also, what I would call "posttraumatic success." Because of their traumas, they developed some coping abilities or they developed some aspects of their lives that had become assets and strengths and abilities.

One of them was mine, and I will just go into it very quickly and then we will move off into personal and get some more professional. When I was sexually abused, the person who sexually abused me used confusion to manipulate me into the situation. So, I had a very low tolerance for confusion in the future and developed sort of a compulsion to clarity, which, to a certain extent, when I began to teach psychotherapy, which I have done for a number of years, and I began to write books about psychotherapy, became a great asset because people would read my books or come to my presentations and say, "This was really, really clear," and I thought, "Well, it's not surprising." I don't like to go to presentations that I find muddled and confusing and I think it is in part because I had a personal intolerance of confusion because of my traumatic experience. So, I was thinking, "Well, yes, of course being traumatized like that and being sexually abused affected me in negative ways, but let's not denigrate and dismiss the aspects of trauma that can lead to positive benefits."

For me, one of the catalysts for beginning to speak about this, and teach about it and write about it -- I have written a couple books about it-- was seeing the after-effects of 9/11. Many people, of course, directly affected or indirectly affected by the 9/11 attacks were quite traumatized. The predictions were that all of New York was going to suffer from posttraumatic stress. Well, it turned out not to be the case and the research shows that people are generally resilience and bounce back from traumas.

So, all of the media pundits got on there and all of the mental health experts got on there. I remember one person, two years after 9/11, had come on the television and made a statement that just really upset me and got me to write a book, actually, which was, "These people will never recover from this."

I thought, "Well, first of all, that's a pretty discouraging message and why are we doing psychotherapy with people if we do not think that they can recover from it. The second thing is that the research actually shows that that mental health expert is wrong. The vast majority of people, when exposed to overwhelming trauma and crises do not develop posttraumatic stress disorder. I think that because we have come to recognize post-traumatic stress disorder in recent years and begun to treat it, which we didn't for many years. That is the good news, that we are recognizing it.

The bad news is that we begin to generalize, like most things. Multiple Personality Disorder became popular in the 1980s and all of a sudden, it was like there were trillions of multiple personalities, when really it is a fairly rare illness and it is a fairly rare disorder. But it seemed like it was everywhere.

Same thing with posttraumatic stress disorder, I think. It is obviously more common than multiple personality disorder, but it is not universal when people go through traumas. So, that kind of got me exercised and led to you and me talking, actually, to talk about some of the myths of posttraumatic stress disorder and some of the benefits, actually, of trauma, and then some ways when people do develop posttraumatic stress, that they can overcome or move on from that kind of PTSD symptomatology.

ALEXANDER: I like that positive view of things and your desire to have things be clear. So, let's go through some of the myths and "de-mythify" them. Is that a word?

O'HANLON: Yes, that is probably a word. The first myth is that everyone who goes through overwhelming trauma and stress and crises develops posttraumatic stress. Again, the research very

clearly indicates that the vast majority of people are more resilient. They do not develop posttraumatic stress. That's the first part. The second part is that some people do actually develop an immediate case, a fairly quick case of posttraumatic stress, but they get over it without treatment. They have some natural resources in their environments, within themselves and beyond themselves in their social and other environments, that help them recover without treatment. So that is the most surprising thing to me, because being a psychotherapist of course, I'm a little biased towards, "You'd better come to therapy if you have a problem."

What the research indicates is that most people do suffer some sort of post-traumatic symptoms, not necessarily full-blown cases, of posttraumatic stress, but even if they do develop posttraumatic stress, they get over it on their own. They somehow have some ways of coping and bouncing back and being resilient. So, most people are resilient, I guess, is the bottom line for those first two points to challenge the myth of posttraumatic stress.

The third thing is that people do develop posttraumatic stress. Obviously, we are recognizing that more and more. It started to come to the foreground in World War I, where soldiers came back from the war and they developed this syndrome that was called "shell shock." Some of them never recovered. Some of them did recover with the right kind of care and rehabilitation. But, we did not really know how to approach this stuff and so when World War II happened, we saw the same kind of thing.

Then in the 1960s, there started to be more of a theory, if you will, or a set of systematic understandings of this shell shock, postwar trauma, post-combat trauma and it was linked to the after-effects of car accidents and the after-effects of rape and sexual abuse. Some of the psychiatric and psychotherapist researchers and clinicians started to notice that there was this syndrome where people would be haunted by or reliving in some ways -- I guess what characterizes this as posttraumatic stress is that you go through the original experience, but somehow, some parts of it continue to revisit you in some way: sometimes, the actual memories of it. Sometimes two kinds of major symptoms appear: one is of a numbing or diminished sense of some aspect of your life-- you can't remember certain things, so there is a diminished memory, or you can't feel certain things. I had a client who was sexually abused who said that when she would have a sexual interaction with her partner and she would get sexually excited, then she would just start to go numb. So there is an actual numbing of sensations, sensory elements, memory, perceptions.

That is one of the sides of posttraumatic stress. The other side is sort of a more active and disturbing and intrusive symptom or problem, and that is flashbacks to the memories: flashbacks sensorially or memory wise, or a repetition of certain behaviors. This often is implicated in addictive behaviors and the after effects of trauma, where people will repeat certain behaviors to either cope with the overwhelming emotions or memories or perceptions or sensations, or they just repeat -- like they loop through some part of the posttraumatic experience that never seems to go away. It just seems to keep repeating and never gets resolved.

So, these two symptoms are very common, but back to the myths. One of the myths is that it is going to take years to get over this and you have to have memory therapies, where you have to go back and remember everything and re-feel everything. This is called the "unexperienced experience" approach to it. You never really metabolized the experience in the first place because it was so shocking you detached and disassociated from it, so now in a caring context of psychotherapy, you are going to go back to the past, relive it. Sometimes that leads to people writhing on the floor of the therapist's office reliving being raped or beaten or going through their war memories and smelling the charred flesh or hearing the gunfire or whatever it may be. That is pretty traumatic not only for the clients or the patients, but for the therapists. There has been some research on that secondary or tertiary trauma of therapists doing a lot of trauma treatment, and how they get traumatized by witnessing the terrible stuff that people go through. But, for many years that was thought to be the only possible approach.

In the recent years, there have been, I think, four really new developments that are very exciting, that more

brief, less torturous, and that seem to also work for resolving posttraumatic stress.

So just to summarize: the myth is that treatment for trauma must take years and must involve reliving the trauma, which is pretty torturous for all concerned. That is the third myth I that I would challenge.

The fourth myth is what we talked about a few minutes ago, and that is that trauma always results in negative impacts on people's lives. The fourth myth is disputed by the fact that in studies of patients with heart attacks, terminal cancer diagnoses, as well as other psychological and emotional traumas in addition to physical traumas, there are often positive benefits: social positive benefits; relational positive benefits; personal positive benefits; spiritual positive benefits; physical positive benefits to going through a major life trauma like that.

ALEXANDER: So, your basic orientation, then, to this work is positive, promoting resilience....

O'HANLON: Recognizing resilience. I don't even say, "promoting,"—it's recognizing, and then furthering, obviously yes.

ALEXANDER: So, how does one further resilience? How do you work?

O'HANLON: Well, the first thing is I will talk about these four innovative approaches that have come about in the last really 15 or 20 years that are alternate approaches to having to go back and relive it. Then we will talk about what I will call, "From posttraumatic stress to posttraumatic success," the three elements that I think make the difference between post-trauma symptoms or problems and post-trauma growth and positive benefits.

So, we will take the four alternative approaches to treating trauma really quickly. The first one turns trauma treatment on its head. One of the things that can help people get through posttraumatic stress is to orient it to a future where things work out and they are through the trauma, a future with possibilities, a future with meaning, a future where things are resolved.

Probably the most poignant story that I heard of this was one that I heard in a talk by Victor Frankel. He was a Viennese psychologist who died in the 1990s. He had been imprisoned by the Nazis during World War II and had been transferred to four different concentration camps. He talks about an experience near the end of his imprisonment in which he was being marched out by the Nazi guards into a cold, snowy field to do a work detail. He was so ill that he collapsed, basically, in a coughing fit and the guard threatened to kill him unless he could get up and keep moving. Frankel said that he just thought, "I haven't got the strength. I haven't had food, I've been ill treated, I have some sort of pneumonia or bronchitis, and I just can't get up," and he thought, "Well this is the day that I die because the guard is going to kill me unless I can get up but I just don't have the strength."

All of a sudden, without his conscious intention, he found himself kind of in his imagination, in the future, giving a talk in postwar Vienna on the psychology of meaning and the psychology of death camps, giving a really poignant talk in his imagination and time just slowed down and stretched out. During this imaginary talk, he talked about the day that he almost died in the death camp back in 1944, and how somehow, he found the strength to get up and keep walking. While he is giving that imaginary talk in his mind's eye, his body gets up and starts walking.

He did something different from what most trauma victims do. He did not stay frozen in that moment, which is part of that posttraumatic stress that we were talking about -- this frozen moment that keeps repeating. He did not get paralyzed with fright. He went to a future in which things worked out and then worked backwards to the present and let the future pull him through.

With many of my clients, one of the first things that I ask them is, “How have you kept going with all of this?” Often they tell me, “I’d like to help other people someday. I’d like to write a book about my experiences. I’d like my children not to have the same kind of experience that I had.” They have an orientation towards something in the future that will be beneficial to themselves or the world or other people and a future that they are going to live into that helps them move past this terrible trauma in some ways.

That is the first approach to kind of turning this old trauma treatment on its head--that you have to go back and relive the thing. You have to find a way to get through the thing and the future is often the thing that keeps my clients going.

So, one of my first questions is, “What’s your idea about the future?” If they haven’t got one, then the question that you asked earlier is, “How do you promote resilience?”

One of the things that characterize resilient people, in most of the studies on resilience is that they are “present to future” oriented. They do not spend a lot of time dwelling on the past. It’s not that you have to deny the past; it’s just that they really are oriented towards, “What can I do now toward some sort of direction or goal that will bring me to a better place?” Sometimes abused kids will seek out other people outside of their families to help them get socialized in a new way. They have this future orientation, this very active orientation, rather than the passive and victim orientation. So, that is the first alternate approach to treating posttraumatic stress.

ALEXANDER: That is a very powerful story from Victor Frankel and that you were able to take that and run with it yourself and in your work.

O’HANLON: Yes, and sometimes, of course, my clients don’t have such powerful futures and so I work with them in more minute ways, saying, “What would you do when you left here if you knew in the future things were going to work out? What would you do tomorrow?” So I bring it back to a much more small future, because Victor Frankel obviously had a very powerful dream for the future and he went on to achieve that future. He wrote books and he gave lectures and he made it out of the death camp. But, most of my clients are a little less future-oriented and so if they are not future-oriented, I will try to inculcate that. That is what you asked earlier: “How do you enhance or evoke or help people to develop that resilience? and one of the ways is to help them to be more future minded?”

ALEXANDER: What if they say, “Well, I just don’t see anything good in my future?”

O’HANLON: Well, then at that point, that is probably not the way to start because we have three other ways to approach people. But, what I typically will do is start to plant some seeds. So I will say, “OK, you can’t really imagine what is going to happen after you get over this problem.”

Now, it is a funny thing to say that because now, I have implied that they will get over this problem. So I just start to plant the seeds that there will be a time when they get over this future problem, without pushing the point too much so that it gets too much pushback from them because they are just so discouraged or stuck in the moment. I will just say, “So when you get over this, you really don’t know what will be happening in the future,” or, “After you get over this, you just really don’t, right now, have an idea what is going to happen.” So I plant that seed with a little bit of positive expectancy language that I start to use with them quite regularly but quite subtly, so they don’t even really notice that they are in being invited to a time beyond the trauma, beyond the posttraumatic stress. I plant those little seeds even if they can’t consciously or deliberately imagine anything beyond the trauma, which, a lot of my clients can’t, so I think you make a good point. They are just so stuck in the past or in this nightmare of the present, that imagining the future is a little too hard for them. But luckily, we have these other approaches that we are talking about, so that’s not a problem.

ALEXANDER: Okay.

O'HANLON: All right. The second alternative approach has come to the foreground with a bunch of controversial and new methods that have been designed in the last 15 or 16 years to treat trauma. I'm sure you've heard about them and many therapists have heard about them: EMDR, which stands for eye movement desensitization reprocessing; emotional freedom techniques; thought-field therapy -- these are called the energy therapies, sometimes. They are still controversial and there is still a lot of research that needs to be done. But they have all these ideas that you're changing the energy fields through the therapy or EMDR has this idea that you're helping to integrate the right and left brain.

I actually don't have that idea. I have a different idea, and it leads to the second approach to changing posttraumatic problems or posttraumatic stress disorder. One of the things, as I said earlier, that characterizes posttraumatic stress disorder is a repetition of something. Patterns just keep repeating -- some experience. It could be a smell, it could be a taste, it could be an action, it could be a thought, it could be an image, it could be an interaction that you have with people. You just keep repeating this pattern posttraumatically, compulsively, obsessively, whatever you want to say.

One of the ways to get people out of that is to change the pattern. So, I have had people eat with their left hand rather than their right-hand if one of the post-traumatic symptoms is over eating or compulsive eating. If they are usually right-handed eaters, I will have them change to their left hand. Now EMDR has them focus on their traumatic symptoms or their traumatic memories and change their eye movements. So, for some reason this disrupts the pattern in some way, or that is what it seems to me that it does. Instead of them collapsing into the old trauma experience, you are having them stay present and change the pattern a little. You're having them remember new things about it, you're having them think new things about it and you're having them change their eye movements because they typically get locked physiologically and neurologically. So, I think that these tapping things and these so-called energy therapies may work because they disrupt the posttraumatic pattern. They have the person remember the trauma, but they have the person do a new neurological pattern or physiological pattern along with it: tapping on the person; having them move their eyes; having them roll their eyes; having them hum (in one of the FT or TFT approaches).

Whether you believe in these approaches, and whether they ultimately get validated by all of the experimental work that is being done to test them, I am suggesting that they sort of point to a larger thing, that is, get the person to teach you what their posttraumatic pattern is and do any small thing to disrupt the pattern. It can be a small action, it can be a small change in thinking, it can be a small change in imagery. Sometimes you have people, if they have the same image haunt them again and again, or the same voice haunt them again and again, or sound haunt them again and again, you have them make a slight change. I have even done absurd things, like have people imagine that the person who was saying abusive things to them had taken a hit of helium before they spoke and they had a Mickey Mouse voice. Now that seems a little silly, and to some people that will seem dismissive, or diminishing, or invalidating of their experience, so you have to be careful not to make light of it, but to help them regain their power to change their posttraumatic experience by participating in the pattern and changing it slightly because it is so repetitive, that any slight change can sometimes break the pattern in anyway you can.

Obviously, behaviorally you can change the pattern. I had a colleague who was working with a woman who cut herself -- that was part of her posttraumatic experience. She was an artist and her therapist had her make a painting of the slashes on her arm and that was one way to change the pattern. She had another client of hers paint red nail polish on her arm, because the woman said that seeing the blood helped her to dissociate and diminish the pain. She said, "Okay, instead of cutting herself, the next time that you feel like cutting yourself, paint red nail polish on your arm," and that was able to change the pattern in some slight way.

You can be creative in this, you can enlist your clients or patients in their ideas about how they could make some slight changes: where do they have a moment of choice in that posttraumatic pattern and introduce some small changes to lead out of it or something that disrupts the pattern in some even major way, if they are willing and able to do it.

It is a very interesting and different way to think about posttraumatic stress. But, if you think about it, that is what it is! It is just a repetition of part of the trauma that repeats in the same sort of way over and over again. So, if you can introduce some small change in that element, it can lead people out of it. It is like a train is going around on a track, and your efforts or their efforts can pull the lever to get the train moving down the track rather than going around and around in a circle.

ALEXANDER: Well, they don't really know why that works neurologically or anything, do they?

O'HANLON: They don't. There are a bunch of theories. Again, EMDR believes that it is integrating the right and left brain; the energy therapies, so-called thought field therapy or emotional freedom techniques and some other variations on that believe that it is working with the energy fields in the body. Who knows? This stuff is very speculative. But, some of us who have learned EMDR, or thought field therapy, or emotional freedom techniques, or some of the other power therapies, or energy therapies, as we call them, have had pretty amazing effects with some of our clients. Now, we don't know for sure whether it is going to work for the vast majority of posttraumatic stress but the early indications are pretty good. EMDR has been studied a lot more than those other ones and it seems to be turning out pretty well. So, again, whether you take those therapies or whether you are skeptical about them, I want to make the more generic point that, what I believe they are doing is changing the posttraumatic pattern. I think that that is a powerful thing to do however you can do it. So, I think that you can make up other posttraumatic treatments that wouldn't have anything to do with eye movements or tapping. As long as they change the posttraumatic pattern, that would be powerful.

Let's move on to the third approach. The third approach is more of a present-oriented approach to metabolizing the after-effects of trauma. Remember again that one of the things that characterizes trauma is dissociation. People dissociate parts of their experience because they are overwhelmed by the feeling or the sensations or the shame, or the pain, or whatever. Sometimes they disassociate smells, sometimes they disassociate sounds, and those sounds almost become frozen in time. And the sound, the smell, or the feeling or the memory then come back to haunt them because somehow they have not developed a relationship with it.

The next two methods that we are going to talk about are present-oriented methods for re-metabolizing or bringing back that missing or disassociated aspect that seems to keep haunting them because they are sort of disassociated from it. It is almost like there is an iceberg in their life that is floating out there that could hit their ship and cause trouble on their ship, on their Titanic. It could sink their Titanic because that iceberg has been disassociated from the land. It is floating free, and therefore it can cause a lot of damage. So, that could be anger that is disassociated, it could be sadness that is disassociated. I had a client who, many years after his trauma, would just break down crying and couldn't stop crying for hours and had no idea what he was crying about. It was this sort of disassociated sadness. I have had people who would go into rages, posttraumatically. Something will trigger them and they will just start to throw things and scream. Later, they will calm down, and think, "What did I do? I wasn't myself." So there is that sense of dissociation.

One of the ways to bring this missing piece back in is just very gently and softly give people permission to allow that experience. It's okay to be angry. It's not okay to scream and yell and smash things, but it's okay to be angry. It's okay to be sad. To just give them permission, very, very simply, for whatever the missing piece is. It's okay to not remember. It's okay to remember. Very simply. There is a second kind of permission that

I sometimes give and you don't have to, so there are two separate kinds of permissions: it's okay to, and you don't have to.

This is sort of Carl Rogers on steroids because you are very much targeting a particular posttraumatic symptom and giving them permission for bringing in or allowing that posttraumatic symptom. It's not just a generalized positive regard and acknowledgment or validation of a person's experience; it is very much going after a particular part of their experience and saying, "This piece? You can bring it in. It's okay." Or, "You don't have to be dominated by this piece; it's okay. The smells, they can go away. It's okay to smell them; it's okay not to smell them." You give them two kinds of permissions: it's okay to, and you don't have to.

Sometimes, what I find with my posttraumatic clients is that because that permission is coming from a therapist or from an external source, somehow they finally get the permission or the allowance to experience that thing in the present. They don't have to go back to the past and remember everything. They can remember, if that's what is important, but they don't have to. That is the third approach.

The fourth approach is very related to this: to help people connect in places where they have disconnected. Sometimes they are disconnected socially or relationally. Sometimes they are disconnected from their bodies. I had a client who had been sexually abused and she mentioned, just in passing in therapy that she had bruises all over her body because she kept running into things. She had no idea where her body was most of the time because she was not living in her body. She was disassociated and detached from it and that was her strategy for dealing with the physical abuse and sexual abuse that she had experienced when she was a youngster.

So, she came up with a plan, when we talked about it, about reconnecting to her body. One of the things was just to stand naked in front of a mirror and realize that she lived in a body, that she was a body. The other thing was that she hated to be touched. She said that it felt like hot coals on her body any time someone touched her partly because, again, of this posttraumatic stuff. She had a friend who was a massage therapist, so she asked her friend if she would work with her very slowly and very gently to get her desensitized to being touched. Her friend, first, could only touch her through clothing and it would still feel uncomfortable. But, after seven months, she was able to get a full body, sort of naked massage from her friend and she was okay with it. It took her a while to reconnect with her body and she did other things to reconnect with her body, like really noticing when she was eating food what that food tasted like, because most of the time she was just disassociated and overate and ate compulsively, so all of these measures helped her to reconnect.

We probably don't have time to get into all of the details of the many ways that people can reconnect, but I think that there are seven places where people disconnect and there are seven places where people can reconnect. I will just go through the list really quickly. First, they disconnect to their deeper self, their intuitions, their deep feelings, how they know who they are, what their values are, and what is going on with them. The second place that they disconnect or reconnect is their bodies, as I just mentioned with that client. The third place is they disconnect from another person. The fourth place is that they disconnect from groups of people or communities. They disconnect from their social venues and social relationships, their neighborhoods, their communities, their extended families and their group of friends. The fifth place that they disconnect from is nature, and sometimes I send people out to nature to reconnect with nature as a posttraumatic thing. There is some good research that connecting with nature can be healing for people in the after effects of trauma. The next place is through art. Many of my clients and I'm sure many of yours, and I'm sure many of the people listening, when they have had traumatic experiences, they write songs, they write poetry, they draw pictures, they do paintings, they do sewing or knitting or some creative thing, or they sing. They do some creative thing that helps them to connect or express what is going on with them. Sometimes people have disconnected from art and I help them reconnect, or they do naturally.

The last one is just connecting to a sense of higher meaning or purpose or God or spirituality. I know you have

a whole program on spirituality and I think it is an important subject that a lot of my clients that have been through trauma use as a resource to get through the trauma. But some people, when they go through a trauma, decide that God hates them, God doesn't care for them, God was punishing them, or they have stopped believing in a bigger purpose or mission or value in life. They just think that their whole life is meaningless, it just doesn't matter, that people are just cruel to one another, there is no purpose for us being here. So, whether it is a religious sense, or spiritual sense or just a sense of an existential meaning, I think that that is the last place that you help people either connect or you discover whether they are disconnected and you help them reconnect.

So, through those pathways, I think treating posttraumatic stress can be quicker and much more rapid than years -- it can be weeks and months -- and the second thing is that it can be less torturous for both client or patient and therapist. The third thing is that it uses, again, some natural resources that people have and help them to make pretty rapid changes in everything.

ALEXANDER: A person's identity. How important is it that they are able to say, "I'm a person who was raped. I'm a person who was seriously injured in a car accident." There is a commercial right now on television where you see maybe 25 different women, referring to having been raped, say the words, "I was," "I was," "I was." They are all ages and races. I'm just wondering how important is it that people integrate this experience as to who they are. So, for instance, if you were raped and you say, "Okay I'm somebody who was raped. This is part of who I am," versus somebody saying, "I'm the same person that I always was, but this thing happened to me."

O'HANLON: Well, luckily, we don't have to decide that; that that is for our clients to decide. Now, let me give you an example. There are some people who use the kind of AA approach to dealing with alcoholism. Part of what helps them to deal with alcoholism is to take on the identity of an alcoholic: "I'm Bill, and I'm an alcoholic." That really helps liberate them to face their problems and to get help and to move on. With other people, that is the exact wrong approach. They don't want to develop the identity of an addict and so that is why AA doesn't work for everybody. It only works for a certain percentage of people. Other people have to find other pathways out of it.

I think that it is the exact same thing with posttraumatic stress. Some people are going to have to say it out loud. But the distinction I want to make, from what you said about that commercial, is that sometimes people are saying that this is an experience that I went through and I just need to acknowledge it publicly. That is an admitting of the experience and a validation of the experience. But, there is a slightly different approach and that is to say, "I'm a rape victim," or "I'm a survivor of sexual abuse." That is an identity statement and for some people, to be able to acknowledge that and say that and incorporate that as part of their identity story is going to be really important

I would say I'm sort of agnostic on which is best, that is, I would have to ask my clients or my patients, "Which one works for you? Is it better for you to make this part of your identity story-- the idea that you have about who you are. Or, is it better for you to say, 'This is something that I went through and it's not me. It's not who I am.'" That is the variability of human beings. Some people need that identity story of a rape victim; some people need the identity story of not being a rape victim, of being a human being who survived a rape and the rape does not define them. So, I think you just have to find out. That is an individualized thing for me, so individualized.

ALEXANDER: That is very interesting because you can't just take one way of doing this. You can't just say, "You've got to incorporate this; you've got to integrate this into your identity," or "You need to keep this away from who you are." It just depends, doesn't it?

O'HANLON: People are different. As I said, some people really find that identity

approach better and some people don't.

Now, there is one more element that I mentioned before that I want to be sure that I get to before we run out of time and that is this: I think that there are clear pathways for transforming posttraumatic stress into posttraumatic growth or posttraumatic success. There are three elements. I've already covered one of them but we will go over them, we will just say the three things. To me, these are the three C's. You and I have actually previously talked about these in your previous program on spirituality. If you look at the research, you find people who have been through traumas, who do well after the trauma, who actually grow and have positive benefits. Those positive benefits include a bigger sense of what they are here on earth for, or a kind of transformed sense of purpose or meaning. It can be better relationships. In studying people who have been through heart attacks or get a cancer diagnosis, they often report that they have closer relationships to their families or to their spouses or partners as a result of the heart attack or the cancer diagnosis. Again, this isn't universal, but there are some people who really thrive through these traumatic experiences. They develop better relationships with their health, they improve their health, their eating habits, their exercise habits. They improve their relationships with other people. They improve their sense of purpose and value in the world.

So, how do they do that? Three keys I think. I call these "The three C's." First is "Connection," which we have already talked about. If as a result of the trauma, you connect in a better way or more deeply to those around you and yourself and some meaning and purpose beyond yourself, then it is probably going to lead to posttraumatic growth and posttraumatic success. If you don't, it is probably going to lead to posttraumatic stress, and again we know that dissociation is one of the things that characterize posttraumatic stress. Dissociation is a great coping mechanism in the short run of dealing with the overwhelming trauma, but if you stay disassociated, that is probably going to be associated with PTSD.

The second C is "Compassion." Do you, as a result of being traumatized or hurt or going through this terrible life crisis, become more compassionate towards yourself, softer, less critical of yourself, less harsh on yourself, or do you become more critical of yourself? If you become more compassionate towards yourself, less posttraumatic stress. If you become more critical of yourself, more down on yourself, more rejecting of yourself, more posttraumatic stress. Also, do you become more compassionate towards other people? If you do, more post-traumatic growth, and if you become more critical or more judgmental or harsh towards other people or punitive towards other people, typically more post-traumatic stress.

The last one is "Contribution." Take your trauma and move it out into the world and help other people, which is why many people have the desire to write their stories and their books, or tell their stories on television, to help other people going through this. That's why, Oprah, when she admitted that she was sexually abused, helped millions of people because then they thought, "She's gone through it and somehow she's come out the other side and she's successful and she can admit it on television. She's not ashamed of it." That helps a lot of people-- that sense of taking your traumatic experience and making it into something that contributes.

Candy Lightner, whose teenaged daughter was killed by a repeat drunk driver, was devastated by this terrible trauma. Then after a few months, she began to get angry and thought, "No other parent should have to go through what I am going through now." She got up out of her bed and created an organization called "Mothers Against Drunk Driving," which changed drunk driving laws and the enforcement of drunk driving laws and prevented thousands and thousands of unnecessary deaths. So, she took her trauma and moved it out into the world and made a contribution. If you can do that, you're much less likely to have posttraumatic stress or be overwhelmed by posttraumatic stress, much more likely to transform that posttraumatic stress into posttraumatic success. So, those three Cs: connection, compassion and contribution.

Research indicates this. There are a bunch of researchers who have done research on posttraumatic growth. Richard Tedeschi is a psychologist who has done most of it, started it, I think. He has this scale, "The Posttrau-

matic Growth Scale,” where they have people take a 21 question survey and find out whether they had positive growth or positive benefits from going through a medical or life crisis or trauma, and they are finding out that a good percentage of the people they are studying have posttraumatic growth instead of just posttraumatic stress.

ALEXANDER: Alright, here is one of the last questions that I would like to ask you. Let’s hypothetically say that you had a trauma, let’s say you were raped. You are now a mother or father. You’re a parent. You have personally no posttraumatic stress over this. I mean, you’ve adjusted.

O’HANLON: It seems like you’ve come through just fine.

ALEXANDER: Seems like you’ve come through it fine. But all of a sudden, you don’t want your child to go out to the mall without you there. You become very over watchful, over vigilant. Or, you’ve been in a terrible accident and you don’t want your child to drive, Or you don’t want your child to become a soldier. Well, that’s not odd but..

O’HANLON: I think that that is one of the symptoms of posttraumatic stress, that hypervigilance. It’s not for you necessarily; it’s for someone else, and that is one of those symptoms. So I would go back through the list of the things that we’ve talked about, those four ways. I would probably recommend that that person gets some treatment for that. It’s not that those things cannot happen. As a parent, you wouldn’t always be worried about it, even if you hadn’t been raped, you’re probably a bit worried about that. But, because this person has been hypersensitized to that possibility -- it’s like people who have flying phobias. It’s not that it isn’t possible for you to die in a plane crash. It certainly is. It is just fairly unlikely. It’s the same thing with these situations. They are hypersensitized to the possibility of rape or the possibility of a car accident. So, I would probably recommend some treatment. I think that that is posttraumatic stress. I think that that is one of the symptoms of posttraumatic stress.

ALEXANDER: And it could happen 10, 15 or 25 years after?

O’HANLON: Absolutely. In fact, I think that that is not uncommon. The person seems to come through it okay, just fine. Then, many years later, something triggers it. Interestingly, I thought that your example was a really good one because it is often triggered when you have a child and that child gets to a certain age, sometimes it’s the same age as you were, or they are exposed to the same kind of possibility that you were, like they start driving, it could be a car accident or something like that. Absolutely, that is when that posttraumatic stress might get triggered. It might be years later. You seemed fine, everything seemed fine, but if something triggers it, then it’s time to go back through that list of possibilities of moving on through that trauma.

The other thing that I would say, this is a more generic thing -- one of my teachers, as I mentioned earlier, Milton Erickson, the psychiatrist, used to have this saying. He said, “In my family, in the Erickson family, we consider troubles to be the roughage of life. That just comes with life.” And Dabroski, a psychiatrist in the 1960s, wrote about what he called “positive disintegration.” It seems to be part of life that people hit traumas and crises that break them down and really challenge them, and that seems to be part of our development in life. It’s just part of the roughage of life. It helps you to move on and you cannot protect your children from all of the roughage of life. You do your best to protect them, and it’s scary sometimes as a parent, and that is just one of the things that happens. You just have to accept that that is part of life. As much as you would like to, you cannot protect them 24 hours a day, all the time, from any possible problem.

ALEXANDER: Of course, if you do, it can really damage their forward motion, their growth.

O'HANLON: Well, exactly. Then it becomes a trauma for them in that they were restricted in some ways, invalidated and frightened in some ways, and they can sometimes carry that fear into their future or they rebel against it and they become daredevils. That's not good either.

ALEXANDER: Mr. O'Hanlon, you're so articulate. You've got this stuff so well integrated, shall I say. I mean, you really know your material and it's just a pleasure to talk with you. Is there anything that you would like to add before we close?

O'HANLON: Well, I just have a great passion for this, and before this ends, I want to say that I am so happy that finally, after all of these years, we're really paying attention to posttraumatic stress. I recognize that as the human tendency goes and as the therapy tendency goes, these things go in fads. Sometimes we over-emphasize things, like a posttraumatic person would over-emphasize the possibility of getting raped or getting sexually abused or getting in a car accident or whatever it may be. I think it is probably best to find some balance. There is natural resilience that people have. There is encouraged resilience -- we can encourage people to use their resilience mechanisms. Plus we know that all of the things that happen from trauma aren't necessarily posttraumatic stress. They may be posttraumatic success! And, we can draw upon some of these new methods of more rapid and less traumatizing treatments.

I have this great passion to tell the world that at least there are all these alternatives. There is nothing wrong with the original approach to treating trauma, but everybody should know that there are alternatives because, as we talked about earlier, there isn't a "one size fits all." Everybody probably has a different pathway for healing when they are dealing with posttraumatic stress. So let's let them know that there are a bunch of alternatives and help them to find the one or the ones that are right for them.

I really appreciate your talking to me today. I have written a couple of books about this. One is called *Thriving Through Crisis*, and another is called *Weaving Through a Broken Web*. I teach seminars on this all around the world and I go all around the world because I am so passionate about telling people about this stuff.

ALEXANDER: Thank you very much, Mr. O'Hanlon.

O'HANLON: Thank you.

Bill O'Hanlon's books may be ordered from any major retail or online bookseller.

This concludes interview #9 in *On Good Authority's* program on "Posttraumatic Stress Disorder" We hope that you have learned from these interviews and that you enjoyed them.

I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of ON GOOD AUTHORITY. Until next time, this is Barbara Alexander. Thank you for listening.