TRANSCENDING TRAUMA: ASSESSMENT, STABILIZATION, AND GROWTH

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DEDICATION

To my parents,
who sacrificed much so
that I could help others.

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SERIES PREFACE

As a publisher of books, audio- and videotapes, and continuing education programs, the Professional Resource Press strives to provide mental health professionals with highly applied resources that can be used to enhance clinical skills and expand practical knowledge.

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Lawrence G. Ritt, Publisher

ABSTRACT

This book was written to assist practitioners in the assessment and treatment of adult trauma survivors in a manner that is both technically and ethically appropriate. The initial section provides the clinician with a concise overview of the more commonly employed assessment and treatment approaches for traumatic psychological injuries. The last section offers the practitioner a different look at the treatment of trauma, one that, though less scientific and more humanistic in nature, is just as worthy of consideration and practice. This second level of treatment focuses on how the therapist can help trauma survivors grow from their experience in ways that promote a more positive adjustment. Specific recommendations are made for practitioners at both levels of trauma treatment that will guide thinking and future practice.

TABLE OF CONTENTS

DEDICATION *iii*

ACKNOWLEDGMENTS *v*

SERIES PREFACE *vii*

ABSTRACT *ix*

INTRODUCTION 1

THE ASSESSMENT OF TRAUMA 2

Initial Clinical Presentation 2
Criteria for Severe Stresses 2
Symptomatic Profile 3
Traumatic Stress Conditions 5
Acute Stress Disorder (ASD) 5
Posttraumatic Stress Disorder (PTSD) 5
Differential Diagnosis 6
Adjustment Disorders 6
Mood and Anxiety Disorders 7
Psychotic Disorders 7
Malingering 7
Other Disorders 8
Assessment Procedures 9
Interview Methods 9
Brief Screening Tests 10
Psychological Assessment 12

FIRST LEVEL INTERVENTIONS FOR TRAUMA 13

The Role of the Therapist 14
Psychotherapeutic Modalities 16
Supportive Methods 16
Cognitive-Behavioral Therapy 18
Trauma Education 19
Relaxation Skill Training 19
Cognitive Restructuring 20
Exposure 21
Alternative Therapeutic Treatments 21
Pharmacological Treatment 22
Benzodiazepines 22
Antiadrenergic Agents 23
Antidepressant Medications 23
Case Example #1 24

FROM STABILIZATION TO GROWTH: TREATMENT AT THE NEXT LEVEL 27

Facilitating Traumatic Growth 27
Trauma as Therapeutic Catalyst 28
Goals for Next Level Treatment 34
Self-Affirmation 35
Relationship Enhancement 38
Life Augmentation 40
Reconstruction of Meaning 43
Case Example #2 46

CONCLUSION 51

REFERENCES 53

Cited References 53
Additional References 60

TRANSCENDING TRAUMA: ASSESSMENT, STABILIZATION, AND GROWTH

INTRODUCTION

In recent times, natural and man-made disasters have ravaged communities and psyches across the country. From the tragic events of September 11th to the Oklahoma City bombing, to Hurricanes Hugo and Andrew, to the Northridge earthquake in Los Angeles, hundreds of thousands of people have been affected. Beyond these named disasters and collective traumas, thousands of other individuals experience personal traumas such as serious accidents, illness, and violence every day.

Given this, many mental health professionals find themselves in their daily practice faced with the challenges of treating adult trauma survivors. This guidebook is designed to offer the practicing clinician a broadened perspective in this treatment of individuals suffering the effects of traumatic stress.

The first section discusses the traditional protocols for the short-term, symptomatic treatment of traumatic psychological injury. The initial goal of treatment is to alleviate suffering and return patients to their premorbid level of functioning. In this section, we will review many of the more common assessment and treatment tools to achieve this end, including testing, brief psychological interventions, and medication. In some cases, these methods are sufficient to accomplish the treatment goals.

But some trauma patients desire more from their therapists and therapy. They want to go beyond symptomatic improvement and stabilization and learn from their tragedy in ways to make their lives better. The latter section discusses a second level of intervention focused

more on helping patients who want to grow from their traumatic experiences. Whether patients have survived a heart attack, cancer, violence, an automobile accident, disaster, or lost a loved one, they want to use this event to enhance the quality of their lives.

This next level of treatment involves a different set of goals and orientation. Moving away from the focus on psychopathology that is so often necessary in the early stages of treatment, the clinician must be flexible and open to using different approaches. Second-level interventions largely require a more humanistic, growth-oriented approach and technique. Here, patients' goals are likely to involve improving their sense of self, enhancing their relationships, or finding new purpose and meaning in their lives.

To begin, the initial focus will remain on traumatic stress, what it is and what it isn't.

THE ASSESSMENT OF TRAUMA

INITIAL CLINICAL PRESENTATION

Criteria for Severe Stresses. Traumatic stress is defined as those stress- or anxiety-related conditions specifically caused by significant life trauma. But what exactly is considered a significant life trauma?

In deciding whether or not an event is traumatic, several factors need to be considered: these include the importance of the stressor, intensity and duration, and whether physical injury, loss, death, or exposure to the grotesque occurred. Several of the most salient empirically documented aspects of traumatic stress are the perception of life threat, perceived potential for physical violence, the experience of extreme fear, and the attribution of personal helplessness. The empirical literature is clear that stressor dose - determined in part by life threat, physical injury, object loss, and perhaps grotesquery - is the major risk factor for development of traumatic stress conditions (March, 1990).

These traumatic stressors can include torture; violent personal assault as seen in rape, armed robbery, muggings, and domestic disputes; combat; incarceration as in a prisoner of war or in a concentration camp; terrorist attacks; kidnapping; natural and man-made disasters; serious automobile accidents; and being diagnosed with a life-threatening illness. For children, this can include developmentally

inappropriate sexual experiences involving molestation with or without threatened or actual physical violence or harm.

These conditions can be caused by either direct experience of the trauma or vicarious or second-hand experience. It should be noted that in assessing traumatic stress, professionals also have to consider those with secondary exposure as potentially affected. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; APA, 1994) now defines the stressor event to include learning that a trauma has occurred to a loved one. For example, parents who are traumatized when they learn of their child's trauma are classified as having Posttraumatic Stress Disorder (PTSD) or Secondary Traumatic Stress Disorder (STSD) or vicarious traumatization.

Other examples involve simply witnessing someone have a serious accident or serious injury, seeing the unnatural death of another person who is violently assaulted, unexpectedly observing a dead body or body parts, learning about the traumatic experience of a close family member or friend, or discovering that one's child has a life-threatening illness.

Besides family members, this variant is often observed in first responders to disasters, such as police, fire, and medical personnel. This phenomenon is also observed in some helpers as compassion fatigue or empathic strain. In some severe cases, as seen in serious disasters, an event can affect the entire community. However, it is probably safe to say that secondary exposure seldom produces the complete post-traumatic stress syndrome.

This text will focus almost exclusively on the simpler form of traumatic disorders and not the more complex variant referred to as the Disorder of Extreme Stress Not Otherwise Specified (DESNOS; Herman, 1993) in victims of prolonged, repeated interpersonal violence and victimization which is characterized by multiple symptoms, disassociation, excessive somatization, pathological identity formation, and repeated harm-seeking behavior.

Symptomatic Profile. When we talk about traumatic stress, whether it is acute or longstanding, we are looking at many of the same clinical signs and symptoms. Which patients are least and most likely to react negatively to stressful and traumatic events? How is it that some patients seem to be immune to significant life stress? Research indicates that there are "bulletproof" or resilient individuals who are

less prone to experience stress-related symptomatology, even when exposed to the most trying of life circumstances.

These psychologically hardy individuals respond to severe stress with what researchers refer to as "self-righting behaviors," sharing three traits that provide extra protection from the ravages of stress. They (a) have solid social support networks, (b) maintain an internal belief of control over their lives, or what we commonly refer to as "optimism," and (c) have more active coping styles. These more resilient individuals are better able to bounce back than their less hardy counterparts.

Although traumatic stress disorders can occur at any age, some people are more susceptible to developing traumatic stress conditions than others. The most vulnerable are those people with a history of prior traumas, recent or subsequent major life stresses or emotional strain, and a chronic history of medical or psychological disorders.

In many cases the symptoms usually occur within 3 months after the traumatic event, although sometimes the onset can be delayed for weeks, months, and even years. As we have discussed, these symptoms follow the direct or indirect exposure to an extreme traumatic stressor that involves actual physical death or serious injury. Certain factors, such as close physical proximity and whether the trauma was of human design as in rape or torture, increase the likelihood that the disorder will be severe and long lasting.

Trauma symptoms cluster into three primary groups: disordered arousal, intrusive recollections of the event, and avoidance of stimuli associated with the trauma (Scott & Stradling, 2001). For diagnostic purposes, the person's response to the event must involve intense fear, horror, and feelings of helplessness, a persistent reexperiencing of the traumatic situation, consistent avoidance of the traumatic situation or related situations, and a persistent heightened state of arousal. Trauma survivors often manifest signs of increased arousal and anxiety with concomitant sleep problems, nightmares, exaggerated startle response, increased irritability, difficulty concentrating, and hypervigilance.

Avoidance often takes the form of emotional anesthesia, where individuals show a diminished responsiveness to outside stimuli, sometimes referred to as "psychic numbing." They report feeling detached and withdrawn, and can become estranged from those people closest to them. They have a marked decrease in their ability to experience those more tender emotions usually associated with intimacy and sexu-

ality that can cause marital conflict and problems. In more severe cases people will experience periods of disassociation lasting from a few seconds to several days.

To receive a diagnosis, these symptoms must be present for at least 1 month and cause significant distress and impairment in the person's social, occupational, or general functioning. Typically symptom duration varies; approximately half of those affected recover completely within the first 3 months after the trauma, but unfortunately, many other individuals continue to experience symptoms after 1 year posttrauma.

TRAUMATIC STRESS CONDITIONS

Let's look at the two distinct psychological conditions usually associated with traumatic stress.

Acute Stress Disorder (ASD). The essential differences between the two conditions associated with traumatic stress are onset and duration. They are both triggered by similar stressors or traumas and create essentially the same symptomatic profile. With acute stress disorder, as the name implies, the onset is either during or immediately after the traumatic event, lasts for at least 2 days, and either resolves after 4 weeks or the diagnosis is changed. As mentioned earlier, a number of people show complete remission of symptoms within 3 months, but may still be diagnosed with posttraumatic stress disorder if the full diagnostic criteria are still met after the first month.

Posttraumatic Stress Disorder (PTSD). If the full diagnostic criteria are still met after 1 month, the person is diagnosed with PTSD. The professional still specifies whether the condition is acute, lasting less than 3 months, or chronic, lasting more than 3 months. If the onset of the symptoms or condition is delayed at least 6 months after the precipitating stressor, this is noted as well.

It should be noted that many patients experience posttraumatic stress symptoms not sufficient in range, intensity, or duration to warrant a full ASD or PTSD diagnosis. I have seen a number of these patients over the years who had certainly been traumatized, but could not be "officially" diagnosed. This is a common phenomenon, and the symptoms can be quite long lasting. For example, Kulka, Schlenger, and Fairbank (1990) found in Vietnam veterans an 11% prevalence

rate for having 3 to 5 symptoms for PTSD an average of 19 years after exposure to traumatic stress.

For the purposes of this guidebook, we will also focus on clients that don't necessarily meet the stricter diagnostic criteria for traumatic stress disorders, although they have certainly gone through events that have shaken - more often shattered - the person's worldview and emotional equilibrium. This includes a broader range of clients who come to therapists coping with the more common, but still emotionally overwhelming, events such as losing one's home in a fire, being diagnosed with colon cancer, losing an infant from drowning, or the suicidal death of a loved one.

These traumatized individuals can have significant life problems, such as trouble in school or on the job, maintaining friendships, or enjoying leisure time, that do not meet full diagnostic requirements. From a purely diagnostic standpoint, these subthreshold trauma symptoms should be formally identified in diagnostic nomenclature as a V code in the *DSM-IV* (APA, 1994).

DIFFERENTIAL DIAGNOSIS

Although traumatic stress conditions in pure form are relatively simple to recognize and diagnose, this seldom occurs in clinical practice. Traumatic stress conditions usually have high levels of comorbidity, with clients often suffering from other complicating psychiatric disorders such as depression and substance abuse, to name just two common examples (Modlin, 1990). These other clinical problems should be carefully assessed and initially may become the primary target for intervention. Given the likelihood of dual diagnoses, effectively differentiating these conditions and incorporating them into a comprehensive treatment plan is a challenge for even the most astute clinician.

Adjustment Disorders. One condition often confused with traumatic stress disorders is the more common adjustment disorder. Although adjustment disorders can result from any psychosocial stressor, say a divorce, financial loss, or being fired, ASD and PTSD occur only when the stressor is more extreme and usually life threatening. Also, even though the triggering event and resultant distress may be significant, it is still considered an adjustment disorder unless all criteria are present to warrant a full-fledged diagnosis of traumatic stress.

Mood and Anxiety Disorders. Although professionals frequently see traumatized individuals experiencing depressive symptomatology such as dysphoria, crying, sleeplessness, disturbed appetite, social withdrawal, and even suicidality, this sometimes does not qualify for a formal diagnosis of mood disorder. If the symptoms are significant, there may be reason to consider a separate diagnosis of adjustment disorder with depressed features or a major depressive disorder. Suicide potential must be carefully assessed in those individuals who have been victimized and are depressed.

The clinician must also distinguish traumatic disorders from other anxiety disorders such as panic, generalized anxiety, and simple phobias.

Psychotic Disorders. Usually flashbacks with traumatic stress disorders must be distinguished from other perceptual disturbances such as the hallucinations or delusions often seen with the psychotic disorders such as schizophrenia, mood disorders with psychotic features, delirium, or medically induced or substance-abuse-associated psychosis.

Malingering. Malingering refers to the attempts by an individual to fake or exaggerate some illness and should always be considered, and ruled out, when there is the possibility of secondary gain or other external incentives. This should also be strongly suspected when the patient is being considered for any type of financial remuneration, whether for a legal settlement or government benefits, as in the case of worker's compensation or disability. Malingering can also be a factor with individuals who may be attempting to avoid criminal prosecution or work or obtain drugs or better living conditions.

We have seen an increasing number of referrals for evaluations of people claiming that they have been emotionally traumatized on the job. Some of these referrals have come from the human resource directors and labor attorneys representing the employing companies, while others have come from plaintiff's lawyers. Whatever the source, this appears to be a burgeoning field of practice. Posttraumatic Stress Disorder is one of the most malingered disorders.

Like all conditions, malingering varies in severity. Resnick (1988) described three types: pure, partial, and false imputation. Pure malingering refers to a faking of nonexistent symptoms, whereas partial

malingering involves an exaggeration of actual symptoms. The third type, false imputation, occurs when existing symptoms are falsely attributed to some unrelated causation.

If malingering is suspected, it is the responsibility of the clinician to determine to what extent it is present. According to the *DSM-IV* (APA, 1994), malingering should be "strongly suspected" if any combination of the following are observed:

1. Medicolegal context of presentation (i.e., the person is referred by an attorney to the clinician for examination)
2. Marked discrepancy between the person's claimed stress or disability and the objective findings
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen
4. The presence of Antisocial Personality Disorder

Malingering must also be distinguished from Factitious Disorder, and though both involve intentional deceit, the primary motivation for symptom production in Factitious Disorder is related to the patient's need to maintain the sick role. Malingering can be most easily differentiated from Conversion and Somatoform Disorders by the intentional, conscious production of symptoms and external incentives, rather than seeing symptoms as an unconscious expression of psychological conflict or need.

Mental health and medical professionals are reluctant to evaluate for this condition, in part because they view themselves primarily as healers rather than adversaries. Additionally, the detection of this condition is not an easy task. It requires a meticulously detailed history of symptoms, prior treatment, and work and family background, and preferably psychological testing (McDonald & Kulick, 1994; Rogers, 1997). For these and other reasons, professionals must be willing to assess for this possibility if they are to achieve an accurate differential diagnosis.

Although malingering is at times hard to determine, where the evidence is clear, clinicians should not hesitate to assign this as a diagnosis. We will discuss some of the steps for accurate assessment for this condition in the coming sections.

Other Disorders. Sometimes accurate diagnosis is made more difficult by the existence of complicating, postconcussive head injury,

substance abuse, and personality factors. For example, an adult with a diagnosis of personality disorder has a high likelihood of having experienced trauma in childhood and is therefore more susceptible to more extreme symptoms if traumatized again (Damlouji & Ferguson, 1985). It is often the case that a coexisting personality disorder is aggravated by traumatic stresses, as the effects of trauma are cumulative.

ASSESSMENT PROCEDURES

A comprehensive assessment strategy aims to collect information about the patient's life circumstances, preexisting psychopathology, symptoms, beliefs, strengths, weaknesses, and coping repertoire. For this reason, multiple measures are recommended in the assessment of traumatic stress. An excellent discussion of assessment methods is provided by Newman, Kaloupek, and Keane (1996).

Interview Methods. The basic interview format for the assessment of trauma patients would have to elicit the minimal information necessary for both diagnosis and treatment. This information would have to include the time, nature, and exact circumstances surrounding the traumatic event. When was the onset, and what are the intensity, duration, and frequency of the patient's reported symptoms? What is his or her habitual coping style? Is there history of prior trauma or psychopathology? Has any treatment already occurred, and if so, how has the patient responded? What is the relevant medical, vocational, and family history and status? Does the patient have adequate social support? Has a complete mental status exam been completed?

In most clinical cases, the assessment of trauma will be conducted solely by means of the interview, which may be sufficient. Perhaps the most widely used structured interview method is the Structured Clinical Interview for *DSM-III-R* (SCID; Spitzer & Williams, 1985). The interview is divided into several sections, each of which assesses a particular Axis I disorder. There are several features that recommend the SCID. The interview format is simple to follow. Branching built into the interview allows the interviewer to skip unrelated questions, saving considerable time. Also, suggested phrasing of the questions is provided along with the diagnostic criteria for establishing Axis I and Axis II diagnoses.

A number of studies using the more labor-intensive Diagnostic Interview Schedule (DIS; Robins, Helzer, & Croonghland, 1981) found

that this format, administered by a clinician, performed well at diagnosing PTSD. Deficiencies in the DIS and other similar standardized interview formats should be anticipated and countered by the use of multiple data measures and information. For example, in addition to interview data, I believe it is often beneficial to acquire outside records (e.g., police reports, medical assessments, agency notes) if this information would be helpful in my understanding of the case. Meichenbaum (1994) provides a more extensive reference of structured interview measures for use with trauma patients.

Whenever there is legal involvement, the assessment, including the interview, becomes much more structured and involved. This modified interview includes more detailed documentation of much of the information above as well as specific questions focused on differential diagnosis, with particular focus on malingering. Resnick (1994) offers interview guidelines for the detection of malingered PTSD.

Brief Screening Tests. There are a variety of brief trauma screening instruments that provide the clinician additional information in early assessment. In my training of primary care physicians and other "gatekeepers" (Buffone, 2002a), the use of an efficient screening device takes on greater importance, particularly given that most people experiencing emotional trauma are seen only in these medical settings. Given physicians' hectic patient schedules, the more we can involve and support their accurate detection of traumatic stress in medical settings, the greater likelihood that these survivors will receive much needed care.

Unfortunately, many people who experience even extreme traumatic events never seek professional help. Several studies have pointed out that following a terrorist event such as the Oklahoma City bombing, many of those in close proximity to the disaster do not believe they need help and will not seek out services, despite reporting significant emotional distress (Sprang, 2000). Of those individuals studied who were directly exposed to the Oklahoma City bomb blast, nearly half had an active postdisaster psychiatric disorder, with PTSD being diagnosed in one-third of respondents (North et al., 1999). Major depression was the most common associated disorder.

In these medical care situations, patients can be easily screened for traumatic stress by using simple self-report instruments completed

prior to a medical appointment. These screening questions can also be added to standard medical history forms that patients complete at first visits. Screening instruments or questions increase a physician's ability to detect PTSD and to initiate appropriate referral for specialty care.

One instrument, the Primary Care PTSD Screen (PC-PTSD), was designed specifically for use in primary care or medical settings (Prins et al., 1999). The PC-PTSD is brief, problem-focused, and easily implemented in a busy office practice (see Table 1 below).

Current research findings indicate that the results of the PC-PTSD should be considered "positive" if the patient answers "yes" to any two items or to the single Item #3, measuring hyperarousal. One study of victims of the 1993 World Trade Center bombings in New York (Difede et al., 1995) indicated that avoidance and numbing symptoms may be the best predictors of those at risk for psychiatric casualty, for both PTSD and other disorders. For those physicians who suspect traumatic stress but who do not wish to administer a written instrument, these questions can be administered verbally during a standard examination.

A positive response to the screen does not necessarily indicate that a patient has PTSD, but it does suggest that the patient may have PTSD or trauma-related problems and that further evaluation, either by the treating doctor or a mental health professional, may be warranted. Pa-

TABLE 1: PRIMARY CARE PTSD SCREEN*

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you:

1.	Have had nightmares about it or thought about it when you did not want to?	YES	NO
2.	Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	YES	NO
3.	Were constantly on guard, watchful, or easily startled?	YES	NO
4.	Felt numb or detached from others, activities, or your surroundings?	YES	NO

*From A. Prins, R. Kimerling, R. Cameron, P. C. Oumiette, J. Shaw, A. Thrailkill, J. Sheikh, & F. Gusman (1999, November), *The Primary Care PTSD Screen (PC-PTSD)*. Paper presented at the 15th annual meeting of the International Society for Traumatic Stress Studies, Miami, Florida.

tients who screen positive should be explicitly asked about suicidal ideation and substance abuse as well. This brief screening device has particular utility in medical settings where the clinician has limited time with each patient and may be something clinicians wish to share with their medical colleagues.

Despite the prevalence and marked symptomatic presentation of traumatic stress, relatively few standardized instruments have been developed to specifically assess these conditions. Some that are available include the PTSD Symptom Scale (Foa et al., 1993), the Trauma Symptom Checklist-40 (TSC-40; Elliot & Briere, 1992), the Symptom Checklist-PTSD Scale (SCL-PTSD; Saunders, Arata, & Kilpatrick, 1990), and the PTSD scales of the Minnesota Multiphasic Personality Inventory (Keane, Malloy, & Fairbank, 1984). Although these scales offer some advantages over interview alone, they have minimal standardization data and none of the validity scales so important in a trauma-focused evaluation (Litz et al., 1992).

One instrument specifically designed to measure PTSD and related psychological sequelae is the Trauma Symptom Inventory (TSI; Briere et al., 1995). This 100-item test incorporates 3 validity scales as well as 10 clinical scales measuring not only symptoms usually associated with PTSD and ASD, but also those individual and interpersonal difficulties often associated with more chronic psychological trauma. A more robust screening tool, such as the TSI, is recommended when the trauma patient's presentation is more complex or there are questions about possible malingering. A comprehensive listing of specific assessment tools and other relevant information can be found at the National Center for PTSD at http://www.ncptsd.org/index.html.

Psychological Assessment. In some cases it becomes necessary for a more extensive evaluation of the traumatic injury patient. This could involve intellectual, neuropsychological, personality, or other instruments, depending on the particular circumstances. For the purpose of this guidebook, we will focus exclusively on those psychological tests most widely employed to assess traumatic stress in clinical practice.

Of these, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Hathaway, McKinley, & Butcher, 1990) has been used most extensively. This test, in addition to offering well-developed and well-

researched validity and clinical scales measuring a range of psychopathology, provides two scales specific to trauma-related conditions.

The Posttraumatic Stress Disorder Scale (Keane, Malloy, & Fairbank, 1984) items suggest significant emotional turmoil including symptoms of anxiety, worry, sleep disturbance, guilt, depression, unwanted and disturbing thoughts, lack of emotional control, and feeling misunderstood and mistreated. The Companion Scale (Schlenger & Kulka, 1987) does not represent a formal scale, and the scores on these scales alone, though informative, do not provide sufficient evidence to assign a diagnostic label.

Other instruments that may also be considered are the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, 1983) and the Test of Memory Malingering (TOMM; Tombaugh, 1996). The MCMI-III provides a specific PTSD scale, while the TOMM can be helpful in discriminating cases of suspected malingering.

FIRST LEVEL INTERVENTIONS FOR TRAUMA

When we look at therapeutic intervention for traumatic stress, one way to conceptualize it is to first understand the stages of the disorder. One model proposed by Bard and Sangrey (1986) is useful in understanding the evolution of recovery from trauma, with the length of time and transition between the three stages varying by individual.

The first stage or *impact phase* occurs immediately after the traumatic event and usually involves the person becoming disoriented, confused, numb, and disorganized. Victims in this phase usually describe themselves as in a state of shock and disbelief and often have sleep and appetite difficulties. They feel scared, vulnerable, and isolated. Sometimes this impact phase occurs several hours or days after the traumatic event.

Fairly soon afterward individuals move into the second *recoil phase*, in which they are beginning to struggle to adapt and recover. This is usually when the survivor begins dealing with the emotional aftermath, the intense feelings of anger, self-pity, grief, fear, and guilt usually generated by such traumatic events. The intense emotions will wax and wane as individuals shift in and out of denial in order to gather the strength they need to continue their recovery.

Ideally, interventions, whether in the form of emergency triage or brief supportive therapy, will be provided during these early stages of recovery when the primary focus is establishing safety and empowering the survivor. The principle of restoring control to the traumatized person is widely recognized (Herman, 1997). Restoring safety and control involves such tasks as establishing a secure living environment, management of posttraumatic symptoms, control of self-destructive behaviors, and mobilizing available social support. Once survivors feel safe and are empowered, they begin the difficult task of remembering and mourning their losses.

In the coming section we will discuss the place of Critical Incident Stress Debriefing, supportive counseling, Cognitive-Behavioral Therapy, medications, and other treatments to help stabilize patients and restore them to functional levels. This is the first level of intervention.

The third and final recovery stage is the *reorganization phase*, in which much of the rage, fear, guilt, and other intense affect have subsided and survivors attempt to put their traumatic experience in some life perspective. They cannot forget their experience; their perception of self and the world have been permanently shattered, and individuals are thrown into an existential crisis, left to put the pieces of their life back together in some meaningful way.

This reorganization phase calls for a second level of intervention, as the outcome can be negative or positive. If positive, survivors recuperate, change, and go on to improve the quality of their life. If negative, people remain haunted by the anger, fear, and distrust, surviving yet emotionally hunkered down, unable to progress and grow. In the final section we will discuss how the therapist must be sensitive and flexible in their approach to best help patients in this critical phase of recovery.

THE ROLE OF THE THERAPIST

Clearly the overarching job of the clinician is to promote the recovery of the traumatized patient. To this end the therapist acts as ally, coach, advocate, and guide, depending on the needs and stage of treatment.

Clients who have been traumatized are initially experiencing high levels of emotional distress and decreased functioning. Given this fact,

usually I adopt a more active and directive approach in the initial phase of therapy until the goals of safety and control have been accomplished, then shift to more of a guiding presence at the later reorganization phase. As survivors stabilize and function is restored, they may then become more open to possible work on posttraumatic growth. The clinician must not rush clients but simply attend to the opportunities for growth as they present.

Regardless of the particular stage or goals of treatment, it is important to emphasize the collaborative nature of the therapeutic relationship. The therapist's role involves both intellectual and relational skills. But being well versed intellectually in the treatment methods for traumatic stress disorders is only the first step. To be truly effective, therapists treating survivors must particularly attend to the relational aspects of their work.

Most importantly, a clinician has to be present and fully engaged to provide the kind of therapy needed to help traumatized clients address these issues. They have to be able to emotionally "stand in" and not shy away from the deep exploration of traumatic events and, in the latter stages of reorganization, of life's most pressing concerns. Calhoun and Tedeschi (1999) offer a number of excellent suggestions for the clinician working to promote posttraumatic growth.

Despite what we sometimes believe, therapists are human, and regardless of their training and experience, they may hesitate to talk about things that make them uncomfortable. If you have not faced tragedy and death, for example, you may find yourself unconsciously dodging a client's need to deeply explore his or her own mortality. If therapists have trouble making their own life make sense, they may artfully maneuver around discussions of how to find meaning out of the client's pain and suffering.

So besides having some clinical knowledge and expertise in the area of traumatic stress and the related existential issues and therapy, clinicians must have some personal understanding about their own feelings when it comes to these difficult topics. Otherwise they will either avoid the client's concerns or offer a cursory attention that is less than therapeutic.

Being a fully present listener is particularly crucial in working with trauma survivors. Offering this therapeutic presence requires thera-

pists to have dealt with these issues themselves on both an intellectual and, more importantly, an emotional level. This is sometimes accomplished by the therapist's deep personal reflection, peer support and supervision, and, in some cases, personal therapy.

It is also important to realize, given that certain types of trauma, such as serious or chronic physical and sexual abuse, often damage the patient's ability to enter a trusting relationship, that therapists must expect difficulties in establishing a working partnership. Particularly in these cases, the therapeutic alliance is built slowly, and at times painstakingly, by the efforts of both the patient and the therapist.

These types of problems are most pronounced in victims of severe and longstanding childhood abuse, often resulting in the development of serious character pathology. These patients require special consideration and treatment, requiring focused attention on issues of traumatic transference and countertransference (Elliot & Briere, 1995; Herman, 1997). Careful attention to the boundaries of the therapeutic relationship offer the best protection against unhealthy, unmanageable transferal reactions.

Therapists must be especially sensitive to the dynamics of dominance and submission to keep from inadvertently reenacting aspects of the original abusive relationship. Clinicians must also guard against being vicariously traumatized by monitoring and constructively dealing with their own intense reactions. Again, therapists treating trauma victims must be responsible for the care of their patients and themselves to appropriately manage these challenges.

PSYCHOTHERAPEUTIC MODALITIES

In this section we will briefly summarize many of the more widely accepted first-level interventions for trauma survivors. The core components of early recovery are the establishment of safety, empowerment of the survivor, and the creation of new connections both interpersonally and in ordinary life. Meichenbaum (1994) offers a much more comprehensive manual for assessing and treating adults suffering from traumatic stress disorders.

Supportive Methods. As we have discussed, supportive interventions are most indicated in the earliest, most acute stages of treatment with trauma survivors. Clinicians should not lose sight of the fact that

many of the stress-induced symptoms in early stage recovery are precipitated by countless practical problems. This is particularly true in real disaster emergency mental health assistance delivered on-site. In these crisis situations, the professional helps most by helping the survivor locate needed financial and medical services, housing, employment, and transportation, and, most importantly, by establishing a safe environment.

Critical Incident Stress Debriefing (CISD) is often a large part of this early support. Largely psychoeducational in nature, it is not psychotherapy, but rather focuses on the immediate ventilation of emotions and other reactions after the critical incident. CISD also provides education, information, and stress management strategies to cope with the crisis. The four major goals of this debriefing process are to (a) reduce the impact of the traumatic event, (b) speed up the normal recovery process, (c) provide education and assessment, and, when appropriate, (d) provide referral of the victims involved. CISD workers are often serving in the "front lines" of trauma work and frequently serve this type of triage function.

In these community-based interventions, the clinician plays a more practical than clinical function, also assisting survivors to deal with what has been called the "second disaster," the anger and helplessness often resulting from seeking help from insurance companies, government, and voluntary agencies. Mental health providers can help survivors work more effectively with such bureaucratic problems (Farberow & Frederick, 1978; Smith, 1983) while also advocating with agencies on behalf of their clients. Providing information about normal grief reactions, coping strategies, mobilizing social support, and referrals for individual treatment can speed recovery and often prevent longer term problems.

In individual treatment for traumatic stress, supportive counseling also has a place, particularly in the earliest stage when the patient is not psychologically ready for a more active or intrusive procedure. Byrant and Harvey (2000) point out cautions in the use of Cognitive-Behavioral Therapy (CBT) soon after the trauma has occurred. They suggest that clinicians tread lightly and postpone the introduction of exposure treatment if they observe the following warning signs in people with ASD:

Excessive avoidance	Substance abuse
Disassociation	Depression and suicide risk
Anger	Poor motivation
Grief	Ongoing stresses
Extreme anxiety	Cultural issues
Catastrophic beliefs	Appropriate versus inappropriate avoidance
Prior trauma	
Comorbidity	Multiple survivors of the same trauma

In such acute situations, more active treatment may be delayed until supportive therapy or other targeted interventions address these obstacles to the introduction of CBT. Otherwise these factors and conditions can block the direct treatment of PTSD. As these issues are addressed, patients become more receptive and responsive to a more directive approach to alleviate their residual symptoms.

I have frequently found it advisable to involve caring and supportive family members in treatment at this juncture. Figley (1989), a pioneer in helping families with trauma, offers a number of useful interventions to assist in these situations. In cases where this may be indicated, the ultimate decision about whether family is to be involved, who will be invited, and what information will be revealed is left entirely to the patient. The family members are educated about trauma recovery, their specific roles and how they can best support the survivor, and that their involvement is solely for that purpose.

Cognitive-Behavioral Therapy. Although more supportive approaches are often necessary in the earliest stages of intervention, they may not be sufficient. Often the initial intervention may take the form, particularly in large-scale disasters, of on-site interventions or psychological triage, as seen in Critical Incident Stress Debriefing (CISD) or in the office setting, with supportive counseling. This may be followed by short-term, symptom-focused treatment, usually lasting a few weeks to a few months. In a smaller number of cases, a second level of psychotherapy may prove helpful, something we will discuss in an upcoming section.

At this level, Cognitive-Behavioral Therapy (CBT) has been well documented as an effective early intervention for traumatic stress disorders. It can be stated that there are more published well-controlled studies on CBT than any other treatment for ASD and PTSD. Further-

more, the magnitude of treatment effects appears greater with CBT than with any other treatment.

Byrant and colleagues (1998), in treating auto accident and industrial accident victims who satisfied diagnostic criteria for ASD, compared five sessions of nondirective supportive counseling, which included education, support, and problem-solving skills, with CBT. The CBT specifically involved components of trauma education, progressive muscle relaxation, imaginal exposure, cognitive restructuring, and graded in-vivo exposure to avoided situations. Posttreatment, 8% in the CBT and 83% in supportive counseling met criteria for PTSD. Six months posttrauma, 17% in CBT and 67% in supportive counseling met criteria for PTSD. There were also significant reductions in depressive symptoms in CBT as compared with the group receiving supportive counseling.

CBT, although varied in the specific approach, usually has several components in common. These are noted below.

Trauma Education. The purpose of education is not only to convey information, but also to instill hope and help "normalize" the client's reactions to the traumatic event. In this process, the therapist spends time debunking popular myths while educating the patient as to the true nature of trauma, potential triggering events and related symptoms, the stages of trauma recovery, and what is generally involved in a biopsychosocial model of treatment. One excellent source for information for both patients and families is the National Center for PTSD at http://www.ncptsd.org/index.html. I also have used Herbert and Wetmore's (1999) guide as a bibliotherapeutic assignment for my traumatic reference, as well as other books, which are noted in the References section.

Relaxation Skill Training. Anxiety management training provides patients with skills to control fear. The patient is next taught relaxation methods using various guided exercises. Different techniques are offered to clients, based on what is most effective and preferred. All skills are practiced with the therapist present and are assigned as homework between sessions, sometimes with the aid of an audiotaped recording. This training may include diaphragmatic or controlled breathing, progressive-muscle relaxation, mental imagery, and self-hypnosis.

Cognitive Restructuring. After the patient has developed a rapport with the therapist, has established adequate safety and self-care, better understands the trauma experience and recovery process, and has mastered relaxation skills, the therapist elicits a more detailed account of the traumatic event, beginning the process of remembrance and mourning.

This deeper retelling of the event is often essential for identifying specific fears, cognitions, and avoidance behavior that become targets for further intervention. Additionally, the retelling often results in some decrease in anxiety associated with the memory of the event. In cases where this does not occur or when anxiety is heightened, clients should be guided to use the skills they have learned to reduce their level of arousal. Other techniques such as thought stopping (Wolpe, 1958) and guided self-dialogue (Meichenbaum, 1974) may also prove helpful in breaking a pattern of dysfunctional thoughts and replacing them with more adaptive self-statements.

This focused processing of the traumatic event and memories potentially involves some imaginal exposure in preparation for further exposure assignments. The major goals are obtaining information about specific cues and actively providing corrective information to cognitive distortions. As this work winds down, the client should be able to discuss the event in detail without significant avoidance of memory content, and should demonstrate a reduction in many of the cognitive distortions related to the event.

It should be noted that the sequencing of these procedures is important in enhancing patient compliance and benefit. I have found that clients are much more likely to participate in and benefit from treatment if anxiety is minimized and coping skills are offered early on; thus education, relaxation, and cognitive skills are provided before a more difficult procedure such as exposure is introduced.

As mentioned previously, the systematic therapeutic processing of traumatic events using systematic desensitization, flooding in imagery, or other exposure methods requires careful planning on the part of the therapist. Exposure treatments can be rigorous and require a good deal of resources on the part of the patient and the therapist. Several conditions are necessary before exposure treatments are indicated. First, the patient must be able to tolerate the intense levels of arousal associated with revisiting the traumatic event. Second, the survivor

must have the capacity to imagine scenes presented and follow the instructions of the therapist. Third, the patient should have the tools needed to constructively manage the intense arousal created by exposure. Once these preconditions are met, the patient is prepared for direct contact with the traumatic event.

Exposure. Depending upon the reduction of anxiety achieved by the preceding methods, the client is likely to require further exposure to the traumatic event in a way that is therapeutic. The survivor tells the story of the trauma completely, in depth, and in detail, directly confronting the horrors of the traumatic experience.

This reconstruction must involve the description of the emotional feelings accompanying the facts as well. In the retelling, the patient may also experience feelings of grief, loss, and sadness, which should be addressed. The descent into mourning is at once the most necessary and the most dreaded step by the client. This work of retelling transforms the traumatic memory so that it can be further integrated into the survivor's life.

The therapist must be prepared to titrate the dose of exposure depending on the circumstances of the particular case. This process may take the form of either flooding - or intense, prolonged exposure - or more likely a graduated exposure as seen in systematic desensitization procedures. Both flooding and graduated exposure can be conducted by using mental imagery in the office or in-vivo in a real world setting. In both formats, clients are encouraged to use their learned coping skills, such as relaxation, to manage their levels of anxiety and avoidance.

Alternative Therapeutic Treatments. Eye movement desensitization and reprocessing (EMDR; Shapiro, 1995), a variant of exposure-based interventions, is a less widely accepted treatment for traumatic injuries. It combines having clients envision traumatic scenes, focus on sensations of anxiety, practice cognitive restructuring, and engage in directed saccadic eye movements. Though there is much heated debate as to the efficacy of this approach, most research cautions against the wholesale use and endorsement of this technique in the first-line treatment of trauma victims.

PHARMACOLOGICAL TREATMENT

Effective treatment for traumatic stress often includes the use of medication alone or in concert with psychotherapeutic treatments. Psychotropic medications may be particularly indicated when the patient shows signs of significant distress or has not recovered after a few months.

A few cautions about medications deserve mention. First, the patient and persons close to the patient should be cautioned against using multiple prescribed and over-the-counter medications without appropriate supervision. Secondly, they should also be warned against increasing nicotine, caffeine, and alcohol intake. It is also important to note that pharmacotherapy alone is rarely sufficient to provide complete remission of PTSD, particularly once the illness has become chronic, in which case drug therapy must be of longer duration. Kudler and Davidson (1994) present a useful decision tree to aid in tailoring medication regimens for traumatized patients.

Prior to receiving medications, the trauma patient should have a thorough medical and psychiatric examination. The rare exception would involve those survivors who are dangerous, extremely agitated, or psychotic. These individuals experiencing severe crises may require high-potency neuroleptics such as Haldol or an atypical neuroleptic such as Risperidone.

Different medications appear to affect different symptom clusters in ASD and PTSD (Davidson & van der Kolk, 1996). After trauma, some survivors experience extreme and persistent arousal in the form of anxiety, irritability, hypervigilance, panic, and insomnia. Empirical research has shown that hyperarousal during the first few weeks following trauma is a risk factor for the development of PTSD. Although alternate psychological and social techniques exist to treat this trauma-related arousal, the primary care doctor is the professional most likely to be consulted and then to rely on for pharmacotherapy. Pharmacologic agents for treatment of this form of hyperarousal include benzodiazepines such as Clonazepam, Diazepam, and Alprazolam as well as antiadrenergic agents such as Clonidine, Guanfacine, and Propranolol (Taylor & Arnow, 1988).

Benzodiazepines. Benzodiazepines (BZDs) have five clinically beneficial pharmacological effects: anxiolytic, sedative-hypnotic, anticonvulsant, muscle relaxant, and amnestic. With trauma patients they

are useful because they are fast acting, effective, and quickly reduce anxiety and improve sleep. However, prolonged use is not generally indicated. One study found that early and more prolonged use of these medications was actually associated with a higher rate of PTSD (Gelpin et al., 1996).

Studies suggest that benzodiazepines are best used to treat extreme arousal, insomnia, and anxiety acutely but that their use be time-limited because of the risk of tolerance, dependence, abuse, and withdrawal reactions, although they are less hazardous in this regard than alcohol or barbiturates. A second caution of BZDs is their most common side effect, drowsiness. At higher doses, psychomotor impairment and ataxia may occur. Other side effects to be alert for include dizziness, headache, dry mouth, depression, anterograde amnesia, fatigue, muscle weakness, nausea, fever, and skin rash. For trauma patients experiencing significant depression, the clinician must also be alert to the use of these medications, usually in combination with alcohol and central nervous system (CNS) depressants, in suicidal gestures.

For these reasons many physicians feel more comfortable prescribing another seemingly more benign antianxiety agent such as the azaspirodecanediones. These agents offer the advantage of low abuse potential and cause little psychomotor impairment. Buspirone, the most widely studied agent, does not have hypnotic, anticonvulsant, or muscle relaxant properties. Given the fact Buspirone does not appear to impair psychomotor skills, has lesser potential for abuse and dependence, and has relatively fewer side effects, it has gained some popularity with prescribing physicians.

Antiadrenergic Agents. A second alternative treatment with trauma and anxiety patients worth mentioning briefly is the beta adrenergic blocking drugs commonly referred to as beta-blockers. Beta-blockers have the effect of blocking the peripheral effects of the sympathetic nervous system and symptoms such as tachycardia, elevated blood pressure, migraine, arrhythmias, and angina. Though useful in some limited cases, these medications are not seen as a mainstay in the pharmacologic treatment of traumatic stress.

Antidepressant Medications. Recent trauma survivors may also suffer from debilitating symptoms of depression. In the past the tricy-

clic antidepressants (TCAs) such as Imipramine, Desipramine, and Doxepin were used effectively to treat the accompanying depressive symptomatology. Monoamine oxidase inhibitors (MAOIs), such as Phenelzine, were utilized less commonly due to their potential for complications. Fortunately medication advances have provided better, safer alternative antidepressants for the treatment of depression and trauma.

Because depressive symptoms originating soon after trauma may predict PTSD, it is strongly suggested that antidepressant medications, particularly the serotonin reuptake inhibitors (SSRIs), be considered as part of the treatment regimen. Sertraline is the only FDA-approved medication for treatment of PTSD. In addition, SSRIs may be useful to control the anxiety and irritability often seen in depressions and traumatic stress conditions. For patients with significant sleep problems, low-dose Trazodone, Nefazodone, and Amitriptyline are possible choices.

Finally it is essential that treaters, whether they be the prescribing doctor or attending therapist, help to educate patients about potential medication side effects and interactions with alcohol and other medications, and remain in close touch after initiating these agents. In the ideal world the clinician and doctor are closely coordinating their efforts. This allows the physician to gauge the seriousness of any side effects, encourage compliance, and respond to any negative reactions to these medications.

In addition, the added therapeutic support can help to relieve the psychological burden in persons suffering from traumatic distress. For a more comprehensive review of medication used in the treatment of PTSD, refer to the Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder (Foa, Davidson, & Frances, 1999, at http://www.psychguides.com).

CASE EXAMPLE #1

Mary* had come to me by way of her family physician after her teenage daughter's gruesome murder at their home one evening while she had been out to dinner with a friend. Mary, the first one to walk in the living room upon arriving home, had startled Kim's masked attacker, who physically assaulted her in his effort to escape. Mary was

*Names and identifying characteristics of persons in all case examples have been disguised thoroughly to protect privacy.

alone when she discovered her daughter's body, which had been severely mutilated. Tom, her husband, who had been at work, arrived only minutes later. To make matters worse, Kim was an only child.

After the police had left late the next afternoon, Mary became inconsolable, crying, shaking, agitated, and unable to stop thinking about the image of her daughter's bloodied, lifeless body. After several days of not sleeping or eating or being able to calm herself enough to return to her job as a teacher, her husband took her to see her primary care doctor.

I saw Mary for the first time several weeks after the tragic event. Her physician had started her on Xanax .25 mg and Zoloft .50 mg a few weeks earlier, and she had begun to eat again, stemming a weight slide of some 20 pounds. Although the benzodiazepines her doctor prescribed had reduced her level of anxiety, she was still having difficulties concentrating, getting out of bed in the mornings, doing chores around the house, and having any interest in her exercise or friends, things she had formerly enjoyed. Mary was also having trouble going near her home since the murder and had been staying at her sister's, often waking up in the middle of the night with vivid nightmares of what had happened. She distanced herself from her husband and friends, spending much of her time alone. Her husband, an electrician, could not understand why his wife was having such a difficult time adjusting and was becoming increasingly frustrated with her, only adding to the marital tensions already created by the earlier murder.

It was later discovered that a neighbor's 30-year-old son had committed the crime, and he was arrested the same day. The police investigation revealed that Kim had been sexually assaulted prior to her being stabbed 47 times, news that only further disturbed the surviving family. The accused perpetrator, who was defiant and was seen smirking at the television news cameras, was being held without bond until his arraignment and later trial.

Mary was a gaunt, tall, 37-year-old woman who seemed dazed at our first meeting. Quiet and reserved, she would only respond to my direct questions. I asked about her feelings about being in my office. "My doctor told me I needed to talk to someone about what happened. I've talked to the police, but I guess he means something else, something that will help me feel better," she offered. And so we began.

My initial contacts with her, and her sister at Mary's request, were primarily supportive in nature, as I also collected the information needed to formulate a diagnosis and treatment plan. Given her continuing depressive and traumatic stress symptomatology, I consulted with Mary and her physician about a modification of her medication. I met collaterally with her sister and worked to educate both as to the nature of her problems and expectations for treatment as well as to mobilize her social support system. With her reluctance to deal with her husband and some questions about their relationship, the issue of Tom would have to wait.

Fortunately, Mary's sister and parents were very supportive, there was no evidence of substance abuse problems or suicidal risk, and no prior history of significant trauma or psychological problems. In fact, prior to the murder, Mary had functioned at a reasonably high level both socially and occupationally. All these factors, plus her willingness to actively participate and comply with recommendations in treatment signaled a good prognosis for her recovery.

As treatment progressed over the next few months many of Mary's most distressing symptoms abated. She was sleeping and eating more regularly, had increased her activity levels and returned to exercising and work, had reconnected with some of her friends, and was generally less agitated, although she would become noticeably distressed when confronted with thoughts or discussion of her daughter's murder or of the attacker. She had resumed seeing her husband regularly but refused to return home other than to occasionally pick up her "things." I met with them conjointly a few times to further involve Tom and help him become more supportive of his wife's recovery. Mary, though better, still struggled.

"Every time I have to hear anything about Kim's killer or think about what happened that night, I break down. It's still overwhelming to face what's happened and to know I have to go through the upcoming hearings and a trial. I can't bear to think about that man, let alone have to be in the room with him," she said in session, unknowingly outlining what could become the next target for therapy.

Mary knew she had to face her feelings about what happened and now seemed ready. We talked about the next steps in therapy and what it would entail, and she agreed to proceed. Having already learned and practiced relaxation skills, she had gained better control over her anxiety and fear.

Over the next three sessions, Mary went through the details of exactly what had happened that evening, at times pausing to relax while other times allowing herself to express her feelings about the event. We talked about her grief and loss, her anger at the attacker for taking her daughter, and the guilt she experienced for not being there to protect her. Around the same time, she did attend a support group for parents of murdered children, but decided not to pursue it.

The more we talked, the more Mary was able to integrate the thoughts and intense emotions she had struggled with over the past months. We next worked on her following a graduated in-vivo exposure regimen to overcome the avoidance of returning to her home. Both her husband and sister served as surrogate therapists and were coached on how they would be most helpful in this process. We also worked on making her more comfortable in dealing with the ongoing court appearances involving direct exposure to her daughter's attacker. After his conviction, Mary took responsibility and later prepared a victim's statement that she presented for the family.

Our visits were thinned as she became stronger and resumed her life. At our last visit her medications had been discontinued and Mary, over time, accepted her loss and found some purpose for her tragedy through her active volunteer involvement in a victims-rights organization in the community.

FROM STABILIZATION TO GROWTH: TREATMENT AT THE NEXT LEVEL

FACILITATING TRAUMATIC GROWTH

After facing the plethora of traumatic events and related problems, it is quite easy for mental health professionals to become fixated on pathology or caught up as the "expert" whose job it is to cure the patient's problem. But by doing so, the therapist loses sight of the "silver lining" in the dark cloud of trauma, the positive changes resulting from the struggle with major loss, a phenomenon referred to as post-traumatic growth (Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 1995; Tedeschi, Park, & Calhoun, 1998).

Even as professionals help those patients whose lives have been turned upside down by traumatic events with the relief of suffering

and the restoration of functioning, the therapist's job is not complete. What happens to trauma survivors after they have physically and emotionally survived their cancer, heart attack, assault, loss of a loved one, automobile accident, or disaster?

As patients recover from their debilitating symptoms and are restored to some level of premorbid functioning, many are left still unsatisfied, yearning to make more of their experience. Many want to move beyond mere survival and use their tragedy to improve their lives. Clinicians need to be alert for those "teachable moments," the opportunities for positive growth that frequently follow from exposure to traumatic events, whether these tragedies are natural or by human design.

In this later stage of recovery, what Bard and Sangrey (1986) have referred to as the reorganization phase, many survivors seek a larger understanding of their trauma and why it happened. Having largely come to terms with their traumatic experience and the loss of their "old lives," survivors are left to create a different future, a new life based on new assumptions about themselves and their world. This next level of recovery brings on tough questions about the survivor's basic existence, and therapists soon discover that they cannot cure anyone of life's most basic and pressing issues.

Traumatic events, by their very nature, create crises, and, like the Chinese symbol that represents both danger and opportunity, the outcome of this phase can be either negative or positive. If positive, the patient not only recuperates but changes and becomes stronger. Tedeschi (1996) offers an inventory that clinicians can use to assess some of the positive effects of trauma. If negative, though functioning, individuals are never able to gain from the important lessons from their tragedy, lessons they can use to make their lives better.

How can we professionals help those patients who want more from their traumatic experience than just survival? What can we do to help guide these survivors beyond survival to higher levels of growth and development?

Trauma as Therapeutic Catalyst. Tragedy and traumas introduce clients to life's frailty while stirring important questions about their very existence. Is this all there is? Is this the way I want to spend my life? Am I happy in my relationships? Why am I here and to serve what purpose? What gives my life meaning?

These kinds of existential questions typically arise for two reasons: age and adversity. The first reason, as I have mentioned, has to do with age, particularly manifesting in the later stages of life. But here we will focus on the thorny questions triggered by adversity, particularly involving traumatic and near-death encounters.

Subtly shaken by aging at midlife and my own tribulations, I found myself listening more intently to many of my clients who survived traumatic events, all of whom survived to be left facing the same tough existential questions and concerns.

What I found most fascinating was how some survivors had not only survived these traumatic situations but had used their experiences to achieve emotional breakthroughs that had not been possible before. This phenomenon of posttraumatic growth has been observed in a significant number of people who have experienced a variety of different losses, including automobile accidents, intense combat, death of a child or spouse, breast cancer, floods, heart attacks, sexual assault, divorce, terminal illness, and job loss (Tedeschi & Calhoun, 1995).

A number of researchers have explored positive readjustment in those exposed to such traumatic events (Aldwin, Levenson, & Spiro, 1994; Burt & Katz, 1987; Fairbank, Hansen, & Fetterling, 1991) and have reported that factors such as positive reappraisal, active coping, and strong social support were often associated with enhanced well-being. Calhoun and Tedeschi (1999) report that individuals who have higher levels of optimism and hope and a more complex cognitive style, are more extraverted, are more creative thinkers, and are open to new experiences are more likely to experience posttraumatic growth. In contrast, such coping techniques as externalization, personal neglect, self-pity, wishful thinking, passivity, and avoidance were significantly associated with a lower level of symptomatic functioning.

Another central feature of those more capable survivors was that they discovered a sense of meaning or purpose in their suffering (Frankl, 1963). This took the form of reordering life priorities, rebuilding shattered assumptions, or developing better self-knowledge, all ways to reframe their experiences more positively. One example was prisoners of war (POWs) who reported benefiting from their captivity (Sledge, Boystin, & Rahe, 1980). Turnbull (1994), who had extensive experience working with survivors of traumatic events, including the Lockerbie airplane disaster and the debriefing of British hostages from

Lebanon and the Gulf War, concludes that "Individuals who experience good outcomes following treatment for their PTSD often express their belief that the experience of trauma has eventually proved to be a positive event in their lives which has increased personal insight and helped them to grow" (p. 21).

These stories of how survivors handle traumatic events are an extraordinary tale of courage and resilience. After picking themselves up and psychologically brushing themselves off in the earlier stages of recovery, their lives had somehow been changed positively by the worst of human tragedies. How did this happen? What was the therapeutic catalyst or active ingredient associated with trauma that generated such dramatic and profound life changes?

According to Criterion A1 in the *DSM-IV* (APA, 1994):

> The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. (p. 424)

People who are traumatized have faced the threat of annihilation, and their encounter has changed them forever. Their long-held assumption of invulnerability has been shattered, and they can no longer say, "It can't happen to me." Death, or even the thought of death, is transformative. But how is this so?

Irving Yalom (1980), in his seminal work *Existential Psychotherapy*, tells us that "although the physicality of death destroys man, the idea of death saves him" (p. 30). But how does the idea of death save man, and save him from what?

Existentialist Martin Heidegger (1962) explored this exact question and arrived at the important insight that the awareness of our personal death acts as a spur to shift us from one mode of existence to a higher one; from a state of forgetfulness of being to a state of mindfulness of being.

The state of forgetfulness of being involves living a leveled-down existence, immersed in everyday diversions, habits, and dull routines. In this state the person takes life for granted while losing touch with the things that are most important in life.

While in the state of mindfulness a person is continually aware of living and of being, conscious of the fragility of life and responsible for change and growth. It is at this higher level that life takes on greater meaning and purpose, where the individual is fully self-aware and embracing the freedom and nothingness that is life.

What does death, or the idea of death, have to do with all this, you may ask? Heidegger realized that people don't move from a state of forgetfulness to a more enlightened mindfulness by simple reflection or desire. This shift requires that we experience certain urgent life experiences that kick, jolt, and tug us from the first everyday existence to the higher mindfulness of being. Although there are several types of human experiences that can facilitate this urgency, such as illness, divorce, and death, death is unparalleled in its power to move us to living life in a more authentic fashion.

Death anxiety and awareness can instigate radical shifts in perspective, serving as the "urgent experience" that propels one away from the trivial everyday preoccupations and provides life with greater poignancy. Stories abound about the positive effects of near-death encounters (NDEs) in plays, novels, and popular literature. There is perhaps no better recent example of this effect than that illustrated by the best-selling book *Tuesdays With Morrie* (Albom, 1998). Just as the author began to honestly confront the death of his close friend and college professor, things changed and he began to live differently. This is the essence of existential anxiety, and the target of therapy.

A number of studies further illustrate how such near-death experiences have positively changed survivor's beliefs, attitudes, and behavior, in some cases leaving a profound and indelible impact (Ring, 1980, 1984, 1998). Earlier similar findings have been reported in studies of suicide survivors (Schmitt, 1976). Noyes (1980) conducted research on over 200 individuals who had NDEs involving mountain climbing falls, serious automobile accidents, and drownings and found that a substantial number reported a "reassessment of priorities," of becoming more compassionate and people-oriented, having a greater appreciation and zest for life, experiencing a heightening of perceptions,

and having an increased capacity to live in the moment. Many of these changes persisted even years after the traumatic event.

Frantz and his colleagues (Frantz, Farrell, & Trolley, 2001) studied nearly 400 adults who had lost loved ones, with over 84% reporting positive benefits from their loss. These individuals noted that the death had strengthened their relationships with friends and family, given them a greater appreciation for life and ability to live more fully in the moment, made them more self-reliant and independent, heightened their level of compassion and understanding of others, decreased their fear of death, and strengthened their spiritual and religious beliefs.

Another group that has been studied is terminally ill cancer patients. Although hospitalized patients in the acute stage of their illness and in great pain proved an exception, many of these individuals interviewed (Yalom, 1980) reported profound changes that can best be characterized as "personal growth." These changes included a rearrangement of life priorities, a sense of newfound freedom to make choices, an enhanced ability to live in the present moment, a vivid appreciation of the simplest of pleasures, deeper and more frequent communication with loved ones, and a greater willingness to take risks in relating to others.

Although the thought of death can positively transform lives, the clinician must at times assist the client in channeling this death anxiety constructively. Given our fear of death, it is repressed and buried under layers of defenses such as denial, sublimation, displacement, and conversion reactions. We see its contorted shape in panic attacks with the fear of dying or losing control, in hypochondriasis and the preoccupation with bodily concerns, in obsessive-compulsive behavior, in addictions and clinging dependency, and in the midlifer desperately seeking solace in his or her attachment to a younger partner, all to avoid these most primal of fears.

Therapists must be attuned to how survivors are managing their increased awareness of their mortality. I have found a number of survivors relieved to find someone willing to talk about death and what it means to them in their own life. Studies show that near-fatal experiences have a profound effect upon attitudes toward physical death. Often freed of their anxiety, these individuals better come to accept that their time is limited and live their lives more fully as a result.

Although many survivors have found their traumatic experience to have lessened their fears of dying, others need further support to overcome this anxiety. Usually, as with other fears, this is accomplished by simple exposure methods that can include discussion of the topic or the use of imaginal or in-vivo desensitization procedures. In most cases, I have found directed discussion and focused imagery, such as having them imagine deathbed scenes, very effective in eliciting the anxiety and emotional material that become grist for the therapeutic mill.

It is important to note that even though a number of survivors grow from their experiences, people who report these improvements do not make gains in all areas, and the growth achieved is not without pain and discomfort. There is no question that these people, through their hard work and suffering, have clearly earned whatever psychological benefits they have accomplished.

As I have mentioned, we see this in clinical practice most often in trauma victims, many who have survived extremely difficult and often life-threatening situations, only then to be left wondering where to go with their lives. Oftentimes clients are plunged into existential crises and then forced to face issues of mortality, loneliness, and meaning when confronted by their own end. I have treated a number of cancer and cardiac patients, auto accident and violent crime survivors, as well as grieving relatives, all shaken by their close death encounter and seeking ways to grow from their experiences.

From these crises and awakenings came much productive therapy. In this work I have found that clients gravitate toward rather specific changes, all designed to improve the quality of their life experience (Buffone, 2002b). For others who have experienced loss, they have already changed and are looking for ways to maintain what I refer to as the *invigoration effect*. These positive or invigorating changes, which I have reframed as life lessons, include the following:

- *Life Lesson One:* Determine what is most important in life.
- *Life Lesson Two:* Expand our sense of freedom and choice in life.
- *Life Lesson Three:* Recognize you are more than what you do or own.
- *Life Lesson Four:* Develop a greater acceptance of self and others.

- *Life Lesson Five:* Create a new appreciation for the elementals of life.
- *Life Lesson Six:* Focus on increasing the importance of meaning in life.
- *Life Lesson Seven:* Create a greater appreciation for religion and spirituality.

Patients at this point wish to reevaluate their lives and, in doing so, refocus their energies into increasing self-knowledge and acceptance, improving their most significant relationships, augmenting or deepening their life experience, and developing greater meaning and purpose for being. From early stabilization, the goals of treatment change at this second level, to those of growth and expansion. Although some individuals make these changes on their own, therapists are in a unique position to assist other survivors in facilitating this last, and in some ways most significant, stage of recovery.

GOALS FOR NEXT LEVEL TREATMENT

Having come to terms with the traumatic past, patients are left to create a different future. Having mourned the lost self the trauma destroyed, survivors must discover a new self. Their relationships tried and tested, patients must forge new connections. The old perceptions and meaning structures gone, now survivors must find fresh perspective and purpose for their life. In completing these tasks, people transform their very existence.

People who have gone through serious life-threatening experiences often make dramatic shifts in their values and focus. As their priorities shift, they no longer define themselves or the quality of their life solely by their work, roles, or possessions. The therapist at this stage may help in this values and life clarification process as well as more growth-oriented grief work.

In my clinical experience, I have observed trauma survivors frequently transcend the more widely embraced material and social values while shifting to deeper core values and activities - such as love, knowledge, and meaning. In their efforts to reorder their world, they focus on building a stronger self, relationships, passion for living, and purpose. To the extent that these actions foster a greater sense of personal control and safety, the effect will be positive. This shift forms the basis for a change in the therapeutic focus and goals.

I will also mention a second goal survivors bring to therapy, which is: How can they maintain or regenerate the positive changes first triggered by their traumatic experience? I have had clients tell me, "I don't ever want to go back to my old life before the accident," or "How can I keep up these feelings, the kind of invigoration, of living more fully since my father died?"

Park (1998) has raised this same question: "How long does posttraumatic growth last, and how can it be maintained?" (p. 156). I concur with Calhoun and Tedeschi (1999) that for the growth to be maintained over time, the survivor must be willing to experience some degree, although usually mild, of emotional discomfort. I have prescribed this daily dose of discomfort (Buffone, 2002b), often in the form of a thought or behavioral ritual, to help spur clients to continue the changes they want to make or sustain in their lives.

For example, clients might consciously recall a scene of their doctor giving them their diagnosis, or they may read the obituary in the morning paper, all to remind them to live the life they want to live. Survivors can never forget their traumatic or near-death experience, but the therapist can help them cognitively reframe and use this memory to create positive personal growth. I have found these selected cognitive or behavioral cues to be powerful medicine, strong motivators for change.

Self-Affirmation. Not all, but a substantial number, of individuals who have experienced adversity and major loss view themselves as stronger simply because they are able to continue to go on, to persevere in spite of the traumatic event (Aldwin et al., 1994). People who have survived rape, war, loss of a loved one, floods, or other major losses frequently increase their estimates of their strength and resilience, believing that if they can survive one traumatic nightmare, then they can survive just about anything life may throw their way.

Although some trauma survivors report an enhanced sense of self-esteem following traumatic events, others find their confidence battered and require assistance in restoring a positive self-perception. Having some understanding of the person they used to be and the changes imposed by the traumatic event, the task now is to become the person they want to be. This involves the survivor integrating those positive aspects of self they valued from before the trauma with the experience of the trauma itself, and what was gained through recovery.

Victims of trauma face the tasks of reestablishing a view of the world as coherent and meaningful, in which events make sense, and regaining a positive self-image, including perceptions of self-worth, strength, and autonomy. For this reason, one common therapeutic goal for survivors in the reconstruction phase of recovery is to increase their level of self-understanding and acceptance.

Traumatic events remind clients that no love is more important than the love for self, that how they feel about themselves affects their every waking moment, influencing their ability to be happy, relaxed, how well they work and play, the quality of their relationships, and their peace of mind. Yet some clients remain confused about how to build greater self-esteem or self-worth. Whether they suffer from an unhealthy selfishness or an unhealthy self*less*ness, as is often the case with cancer survivors, their sense of self has been neglected, ignored, and starved almost to the point of nonexistence.

In either case, one of the first therapeutic tasks is to educate the patient about the nature of healthy self-esteem. I offer a simple model of self-love using a three-factored equation. The first factor is self-respect starting with the belief that the client is worthy of respect and happiness. Factor two is assertiveness. Assertiveness is feeling entitled to express your basic needs, feelings, and wants. The third factor is self-efficacy. Self-efficacy involves people developing the confidence in their ability to cope well with whatever life may throw at them, teaching survivors to trust themselves and their capacity to effectively handle the challenges of living. This model fits well into a skill-building intervention designed to increase clients' levels of assertiveness and competency (Bandura, 1997; Lange & Jakubowski, 1977).

One option for survivors is the use of peer support groups comprising other individuals who have experienced a similar life crisis or trauma. According to Coates and Winston (1983), peer support groups are therapeutic in helping normalize the participant's experience, thereby enhancing the victim's positive self-perception. I have found, as have many clinicians and researchers, the powerful therapeutic effect of group therapy in this reconstruction process. Strong, caring, positive, available social support unquestionably helps survivors reestablish basic assumptions about their own esteem and worth and a more benevolent view of the world.

In individual psychotherapy I help clients rebuild, or in some cases develop for the first time, a healthy level of self-confidence and self-esteem. Often they have lost sight of who they really are outside of their roles, things, and responsibilities. Clinicians observe what happens when a survivor's entire identity, whether anchored in work, parenting, caretaking, physical condition, or civic duties, is suddenly shattered by tragedy.

Suddenly stripped to the core by some unexpected accident, loss, illness, or violence, survivors are left to answer the question, "If you are only what you do, and then you don't do it anymore, who are you?" I have seen such individuals shaken violently when abruptly robbed of their roles: mothers with deceased children, harried executives facing sudden retirement, healthy people suddenly ill, and active individuals unexpectedly crippled.

I will sometimes challenge patients, either directly or by assignment, to ask and answer to themselves the question "Who am I?" several times, helping them see that their answers are descriptions for what they do and not necessarily who they are. At times this process can involve using a structured exercise such as the one developed by James Bugental (cited in Yalom, 1980) that takes 40 to 45 minutes and is often used with cancer patients:

> Set aside 45 minutes and find a quiet, comfortable place to write. You will need a pad or eight 8 x 5 cards. Start by listing on each of the eight cards your response to the question, "Who Am I?" As you complete your responses, review your answers and then arrange the cards in their order of importance, putting the least important on the top and most important or core responses on the bottom. Study the first card and think carefully about what it would be like to give up that attribute. "What would that mean in your life?" After several minutes, go on to the next card, and so on until you have divested yourself of all eight attributes. When done, go back and reintegrate by going through the same process in reverse. Write your feelings from this experience in your journal and reflect on what you have learned.

I will also confront the folly of people defining themselves through externals - whether it be one more sexual conquest, one more promotion, one more raise, one more company, a nicer car, a larger home, a fatter bank account, a new relationship, or another award or title. Clients learn that such labels and attachments do nothing to describe their true inner qualities, strengths, hopes, dreams, fears, vulnerabilities, or what makes them special or unique as a person.

Once the clearing has been completed and the foundation laid, I am convinced that this rebuilding work involves several distinct steps, specific internal changes people create and practice that lead them to feel more worthwhile. These steps first involve having clients develop a greater level of self-awareness and then learning to recognize how they contribute to their own negative self-perception.

This can involve their monitoring their own internal or external dialogue for negative self-references, noticing how they deflect compliments or the way they encourage self-negating references in social situations. Next we may focus on modifying these behaviors while also helping clients identify and clear their mind of negative cognitions and judgments. As this cognitive and behavioral work continues, clients are encouraged to recognize and accept their emotions, needs, and wants or other disowned parts of themselves, with the final goal of their being willing to openly express these feelings, needs, and wants to others.

Many survivors respond well to a combination of solid social support and individual and group therapy, ultimately building a stronger core of confidence and resiliency than before the original trauma. Once this has been established, clients next focus on improving their relationships.

Relationship Enhancement. Emotional attachments provide primary protection against the ravages of even the most catastrophic stresses. Yet this protection is not absolute. Traumatic events call into question patients' basic human relationships and often breach the close attachments of family, friends, and the community. The damage to a person's relational life is real. But fortunately, by this second stage of recovery, most survivors have restored their capacity for trust and a renewed yearning for deeper connections with others. Survivors often report that their experience has led them to feel a deepened capacity

for empathy, compassion, and connectedness with those around them (Tedeschi & Calhoun, 1995) and a readiness for greater intimacy.

I have observed many people over the years who have faced death and trauma, either their own or through the loss of a loved one, intensify their connections as the individuals feel an increased sense of urgency to express their feelings and the importance of their relationships. These survivors become more willing to self-disclose and take interpersonal risks with this new expressiveness providing greater opportunities for intimacy and closeness.

They become less judgmental and prejudiced, more open and spontaneous. Feelings of tolerance, empathy, compassion, and patience flow more freely. Survivors sense the commonalities among people, focusing more on similarities and less on the differences dividing us. The usual social boundaries and categories - sex, race, age, status, and so on - are removed, and the inherent equality of all people is recognized and affirmed.

It is also seen that people who have faced death and trauma seem to overcome the most common fears of intimacy and attachment. Facades drop away. Once open, they deepen their connections by improving communication, the lifeblood of relationships. By learning to powerfully convey their immediate feelings, wants, and needs, they move closer to those around them.

I have observed this change in survivors in both individual and group counseling. I recall a group client, Carolyn, who had been diagnosed with breast cancer. Normally shy and withdrawn, she hung at the periphery socially both in and out of group, seldom speaking up or expressing herself. After her diagnosis and as she faced chemotherapy, Carolyn began openly sharing her feelings about her illness with the other patients in group therapy. By expressing her fears and vulnerability, her openness invited deeper involvement and support than she had ever known.

Some feel a need to be more intimate with a spouse or parent, others to reconcile longstanding differences dividing a relationship, still others to reconnect after years of bitter estrangement. All need to express their caring more deeply, to say goodbye, to forgive past transgressions, to heal their personal and relational wounds.

With the realization that their time is limited, trauma survivors take a hard look at what is wrong with their lives and act decisively to

change what is not working for them. As time becomes precious, only those relationships that are fruitful and nourishing are kept; the rest are ended or allowed to fall away.

Oftentimes, therapists can help in this process. Once reawakened to the importance of loving relationships, clients sometimes lack the knowledge, courage, and tools needed to strengthen their feelings of intimacy. Indeed, much of the energy of psychotherapy, and trauma treatment as well, is devoted to instituting or restoring capacities for normal intimacy and the social skills to maintain viable loving relationships.

Survivors want to feel closer, fortify their connections, and reinforce their caring, yet sometimes find themselves uncertain as to how to proceed. How do we as therapists help them carry their connections to the next level?

First clinicians can help clients inventory their relational field to sort the social wheat from the chaff. Which relationships are healthy and affirming and which are toxic and draining; which to keep and improve and which to distance or drop? This exercise alone is often useful in purifying the survivors' social mix, something they may have postponed doing all their lives.

Once the most important relationships have been identified, what changes do clients want to see occur? Do they desire a closer relationship with their spouse or child, a deeper connection with a sibling, or to address some unresolved issue with a parent? Once these specific relationships and goals are identified, the therapist can provide the support, guidance, and tools necessary to get the job done. I have found training in interpersonal skills and communication training particularly helpful to clients in this area (Gottman et al., 1976; Miller, Nunnally, & Wackman, 1975).

As these relational connections are restored and strengthened, other changes or goals emerge.

Life Augmentation. People who have encountered their end report a new zest and appreciation for life and all its simple wonders. In touch with life's essence, their feelings and senses pulse with new awareness. This reorientation may involve a deeper appreciation of the changing seasons, wind in the trees, sound of surf on the beach, laughter of children, and a hug from a loved one. Many survivors find

themselves more reverent toward animal life, nature, and the ecology of the planet.

One woman I had seen who was revived from a coma caused by a severe automobile accident spoke of these feelings: "Afterward, I enjoyed being with people more and had a fresh appreciation for the outdoors. Nature, flowers and trees budding, birds chirping, where everything just started coming alive. I used to take the spring and so many other seemingly little things for granted. But since my accident I have the feeling that I'm looking more and more and seeing life all new."

People who face down death are reborn psychologically and begin their new lives much as young children do, with amazement and wonder about the simplest experience. They reacquire the innocent eyes of youth and find they are never the same afterward. I have heard them refer to their life "before" and "after" the trauma, as if they have lived two separate, distinct existences. For them, life is no longer seen as stable, predictable, and pedestrian. Each day they see what was once mundane as remarkable, routine as pleasurable.

One effect of this realization is living life in the present moment, understanding that life cannot be postponed. Death and its awareness halts the forward and backward movement of time. Many cancer patients report that they live their lives more fully in the present moment. They learn that the only life possible is in the present. There is a new urgency for living every moment to the fullest.

As therapists we understand that many of the same walls our clients built for protection kept them from living their lives more vibrantly. Whether they used the "being tough" wall, the denial wall, the "work" wall, the "too busy" wall, the "food" wall, the "holding it all together" wall, or the "alcohol" wall to stifle their vitality, these same defenses became the same barriers separating them from their experience. The very trauma that turned their lives topsy-turvy demolished these obstacles, leaving them exposed and then more wide open to life.

Traumatic encounters often shock the mind and body, opening new ways of thinking and feeling in the world. Like knowing you are to be hanged at dawn, the prospect of death powerfully concentrates the mind. From this new perspective, even simple chores take on new pleasure; mundane tasks a different joy. I recall one cancer patient telling me, "Since surviving cancer, it feels like I've gone from seeing the world

in black and white to color. Everything's different. I see and experience everything more intensely. It's like when I was a child seeing and touching everything for the first time."

The emphasis for some survivors is to regain their zest for life. As therapists, we can assist such clients by helping them break through their stifling defenses, having them focus more on their feelings and sensations and less on their mind and intellect.

Though the intellect is invaluable for analytical tasks involving rational problem solving, it can impair our emotional functioning, dull and dampen our emotional fires, and blur the richness and color that is life. Awareness training gives clients the power to resuscitate the senses so often numbed by the mind.

How do we help our clients start practicing attention on an everyday level? To live more passionately clients must be willing to take risks, to let down their "walls," and to give of themselves without reserve, stretching beyond their previously cherished boundaries. Many people prefer to live lives of, as Thoreau suggests, "quiet desperation," to tread carefully and cautiously, just because it is easier. For this relative safety, we pay the price of a steadily decreasing sense of vitality until we slip slowly into futility and boredom.

As therapists, we sometimes become bored and frustrated by those clients who have made avoidance and safety the driving factor of their lives. Their lives are bound up in reason and control, as reason organizes and makes safe what originally was confusing and dangerous as it came to us through the senses. When patients want passion, therapists must veer away from using approaches that favor rational solutions and minimize passion, such as Cognitive-Behavioral Therapy, and lean into approaches that favor the free expression of emotion, or those that fall into the humanistic tradition. Humanistic psychology promoted clients rediscovering the full range of their emotions and experience. These "freeing up" procedures and processes are no better represented than in the area of Gestalt Therapy (Fagan & Shepherd, 1970).

For people who want sensory and emotional expansion and are open to explore their anxiety, the therapist can use many of the sensory awakening exercises offered by Lewis and Streitfeld (1972). Additionally these clients benefit from learning centering and relaxation techniques to help them slow down and begin to appreciate a fuller experience.

Much of living optimally can be learned, and next to reclaiming our senses, the ability to exist in the present moment is the most important skill in this next level of adjustment. This means that clients must be able to exist fully in this moment and experience the potency of the immediate. They must relearn the skill of being present-centered where their full attention is concentrated in the now.

As with any skill, therapists must train clients in these types of centering exercises and support their continued practice. Csikszentmihalyi (1990) offers extensive research and experience in how clients can develop a highly focused state of concentration, called flow, that amounts to an absolute absorption in the moment.

I encourage clients to use a variety of anchors to center themselves in the present, from the more traditional relaxation methods and physical exercise (Benson, 1975; Sachs & Buffone, 1997) to less traditional activities such as Yoga, meditation, tai chi, and massage. In many cases I will train the patient in these skills and assign and monitor their development and maintenance. I have had clients use external cues, like paper dots on watch faces and bathroom or car mirrors or rings from their computers or personal digital assistants, to remind them to shift their attention to the here-and-now.

In addition to sensory awareness, relaxation, and other skill training, the therapist must be willing to stand in and be present for this exploration of deeper emotions by clients and not calm these feelings down or dampen their experience by heavy interpretations and artful analysis.

To embrace life in all its contradictions is not to be afraid of its ups and downs, the good and the bad, the certainty and the chaos. The task of the therapist working with existential issues is to let all of the intensity and ambiguity of life come to the fore, to believe that engaging life's difficulties makes us stronger and avoiding reality leaves us weak, living a life that is dull and full of denial (Van Deurzen, 1998).

Beyond life augmentation, to complete their recovery, survivors must find meaning from their traumatic experience.

Reconstruction of Meaning. Survivors need to find some purpose for their suffering. In the case of serious accidents, illnesses, and crime, the problem of loss of meaning seems to focus more on the question, "Why did this happen to me?" Finding a purpose for victimization is one way of coping in a world that makes little sense. Or this

question of meaning can take other forms for the client: "Why did I survive?" "What is the reason for my still being here?" "What shall I live by?" "Why was I put on this earth?" "How do I make sense of my continued existence?" "What is the meaning of my life?"

Human beings, and in particular survivors, require meaning. To live without goals, values, purpose, or ideals generates considerable distress and in many cases is disabling. In its most severe forms, it can be terminal. Victor Frankl (1963), the Viennese psychiatrist and concentration camp survivor, reported that those concentration camp victims without a sense of meaning were unlikely to survive.

The challenge for the practitioner becomes clear. How do therapists help their clients who need meaning find meaning in a universe that has no meaning? Finding meaning from traumatic events is an essential component of posttraumatic therapy (Janoff-Bulman, 1985; McCann & Perlman, 1990) and recovery. In my clinical experience, survivors who cannot find a positive purpose for their suffering feel caught, never quite able to fully complete their recovery.

This meaning-making process usually involves clients reestablishing a sense of control and predictability in their lives, establishing a purpose for the traumatic event, and rebuilding shattered assumptions or cognitive schemas about themselves, the world, and others. Principles of cognitive therapy (Muran & DiGiuseppe, 1990) can be used to modify beliefs, attributions, and appraisals.

We have seen that most people who have faced trauma and death undergo a significant shift in their values, beliefs, and behavior. Once these people seriously evaluate what is important in their lives, they often find that many of their previous activities, pursuits, and relationships no longer provide their life with the same degree of meaning as before.

Consequently, many survivors seek new purpose in their lives. They are more determined than ever to define and fulfill their raison d'être. Finding this sense of renewed purpose manifests itself as a driving force for these clients, energizing and altering their life's direction. This can sometimes involve making major life alterations such as a career change, completing a stalled divorce, or returning to school. Sometimes the changes are smaller and involve returning to church or spiritual practice, volunteering at a homeless shelter, or joining charitable boards.

The search for meaning often takes people away from the social and material worlds. Seeking to know the reason for living, they search for a deeper understanding of the nature of life and for a higher consciousness to penetrate to the hidden significance of all things. These survivors sometimes acquire a strong inner drive for understanding and the attainment of greater knowledge. They may become more involved in personal growth experiences, religious and spiritual activities, community giving projects and organizations, and academic pursuits. Some express this newfound quest more quietly within the confines of their own family and network of friends.

Although many survivors find resolution of their traumatic experience within the confines of their personal life, some can find redemption only through what Herman (1997) refers to as a survivor mission. Survivor missions in a case of criminal victimization, as was used in an earlier case example, may take the form of engaging in social action, helping others who have been similarly victimized, speaking about the unspeakable to the public, or in making efforts to bring the offenders to justice.

Although giving to others may be at the heart of the survivor mission, those involved in it see it as an essential part of their healing.

Patients bring meaning to their lives in many ways. The path often involves work, pleasure, creativity, causes, altruism, self-actualization, and self-transcendence. Though this list is certainly not exhaustive, it captures the more common ways people have sought and discovered a sense of purpose in their lives.

One of the most common reactions I have observed in my own trauma patients is a renewed interest in an afterlife. Having conquered their fear of the annihilation of consciousness, death seems to become a mere fact of their existence. Near-death encounterers report, "I'm not afraid of death at all" or "I'm not afraid of dying and I used to be hemmed in by my fear." With this decreased fear of death comes a corresponding increased interest in religion and spirituality. Many religious worldviews not only provide answers to some of life's deepest questions, they also encourage hope in facing the terror resulting from the awareness of their mortality.

Interestingly, many survivors don't just increase their participation in more formal religious observances, but rather experience a heightened inner spiritual feeling, often expressed as a closer feeling

with God more than a church. They become more prayerful and privately religious. Therapists need to better understand the spiritual dimension and its relation to psychotherapy (Richards & Bergin, 1997; Shafranske, 1996).

One heart attack survivor I saw illustrated this shift by her comment, "My faith in there being a power higher that is somehow controlling my life has been heavily reinforced." Another client of mine has shared, "I felt closer to a God, a feeling which I had not had for years. I was an agnostic and now I find myself praying sometimes to an unknown Force."

Overall, these persons seem to experience an increased tolerance for all forms of worship. They embrace a broader spirituality which at its essence is a search for the truth of our existence. From this point of view, there is no "true" or superior religion or set of beliefs; rather, all religions are different expressions of a single truth. This is an expression of a spiritual universalism. It includes not only the traditional Western monotheistic religions but also an increased acceptance of reincarnation and Eastern religions.

This increased interest and involvement in things spiritual and religious can help or hurt. Barring any real danger to the survivor, therapists need to be open and respectful of these changes when observed in their posttrauma patients. Whenever possible, the practitioner needs to both understand and support this and other meaning-making processes.

CASE EXAMPLE #2

Theo was discovered unconscious by his cable repairman who immediately called an ambulance. After having his stomach pumped to remove over 50 Xanax in the emergency room, he was seen by a staff psychiatrist and released from the hospital on antidepressant medication. Theo was asked to see me by the consulting psychiatrist as part of his follow-up plan.

He was a tall, gaunt, soft-spoken young man who came to my office only under pressure from his family. In reviewing the hospital consultation notes, it was evident that this patient had made a serious attempt on his life.

I tried to reach Theo for some time before he revealed the reason for his despair. He was riddled with guilt over a dreadful mistake he had made in his life. He was 22, a college senior, who was close to

graduating when the accident occurred. Out drinking with his best friend, Theo never expected he would find himself in a situation he couldn't control. Speeding around a turn he had flipped his Jeep and killed Shawn, a boy he had known since childhood.

We spent the next several sessions building our therapeutic relationship while allowing his antidepressant to alleviate the worst of his depressive symptomatology and mobilizing his family's support. As our alliance solidified, Theo agreed to cut back on his drinking. We next employed cognitive-behavioral procedures to address some continuing nightmares, restlessness, and some fears and avoidance of driving.

Theo next began telling his full story. "I was drinking and we were playing around with some friends who were chasing us in their car. I must have tried to take a turn too sharply and the next thing I know the truck's flipping over. I remember flying around the car as it rolled over - we didn't have our seat belts fastened. When we stopped, I didn't feel anything. I started to look around for Shawn. . . ." He stopped suddenly in midsentence. I asked Theo what happened next.

"At first, I didn't see him. It was pitch black in the car. I started to feel around, calling his name, but he didn't answer. Then I felt Shawn's foot behind me. He must have been thrown into the back seat. I started screaming his name until I touched his chest and head. He was soaking wet. It took me a second to realize he was covered with blood." He stopped again, trying to stay composed. After a few minutes, I asked him to continue.

"By then our friends arrived and shined their headlights on my truck. They told me later I was screaming, holding Shawn's body, both of us were soaked in his blood. I knew he was dead and I just kept shaking him until they pulled us out. I wouldn't let go. The ambulance came a few minutes later and took us to the hospital. The last thing I saw was Shawn's mangled body being hauled away on a stretcher." Theo went limp.

"Were you hurt?" I asked.

"Not really. I had a few scratches and my arm and leg were broken. They said I was so drunk it must have saved me." He said this without any hint of feeling. I could tell he had shut down emotionally, needing to protect himself from the retelling of his story.

He went on. "I know I shouldn't have been drinking that night. It was stupid and I feel terrible for what I've done. I wish there was some way I could undo it." Though Theo had escaped criminal prosecution, he was devastated at the funeral by the reaction of some of their friends.

"Some of our friends blame me for Shawn's death. They won't even look at me. I've had to live with that. I can't sleep most nights and keep having nightmares about the accident. Sometimes I have flashbacks where it feels like I'm right there and it's happening all over again. I can't get it out of my head," he said anxiously. I asked about some of the other aftereffects I expected from such a trauma.

"Yeah. I can't concentrate and had to drop out of school last semester. I feel sad a lot and don't care about anything. Lately, I just sit around in my apartment all day watching TV and drinking beer. I can't get motivated to do anything."

"Are you spending much time with your family or friends?" I wondered aloud.

"My friends call me but I mostly stay to myself. Jill, my girlfriend, is mad at me for not calling her back. My Mom told me I've become withdrawn and I guess she's right."

I asked more about suicide. "I thought a lot about suicide until I tried it. At the time, it just seemed like a way out. I had never done anything like that before and I won't do it again. It scared me that I almost died."

"Tell me about your drinking." I asked, guessing his alcohol use was aggravating his depression.

"I won't lie. I drink a six-pack a day and have for the past few years. I don't do drugs though. My brother was a druggie and died last year after overdosing on cocaine. After that, I swore I wasn't going to cross that line. I've already figured out my Dad is an alcoholic, so we've got quite a family history," Theo added sarcastically. It interested me he was aware of the family's influence on his alcohol problem.

"It sounds like you recognize there may be a link between your father's alcohol problems and you and your brother's problems." I stated tentatively, wondering just how much insight he had developed into himself and his family.

"Surprised you, didn't I?" he retorted sharply. "My Mom has been in Al-Anon for some years and she used to drag me to Al-Ateen when

I was younger. I found out then about how alcoholism runs in families. My father's brother and father were both alcoholics and my grandfather died of cirrhosis of the liver. So I do know there's a problem."

"Do you see your own problem with alcohol?" I asked, wondering whether he had been able to get beyond his own denial and admit to how his drinking was affecting his own life. "Has alcohol caused problems in your own life?"

"Not until recently. I figured somehow that I was different from my family, just being a college student and all. Now, with this accident, I was drunk and I killed my best friend. I don't think it would have happened if I hadn't been drinking. So yeah, I got a problem." Theo had taken his first step to recovery from his alcohol problem and depression. An essential first step to salvage his young life.

Theo continued working in his therapy, taking his medication, and following up with his psychiatrist every few weeks. He agreed to stop drinking to "show me" he could control his alcohol. When he couldn't, he began attending AA meetings regularly as we had agreed. Free from alcohol and with his mood improving, he returned to school and completed his college degree. He found a good job at a bank and was working steadily. Theo had started spending more time with his girlfriend and family.

As his depressive and posttraumatic disorder subsided, we shifted our focus to address his larger issues. Even as his life was leveling out, Theo was still tortured by the death of his friend. His guilt festered inside him like a cancer, continuing to eat away at his soul. To heal completely, he would have to derive some meaning from his suffering.

He recognized his errors in judgment and took responsibility for his actions. Theo was genuinely remorseful and wrestled with finding some way to make amends. I reminded him of the difference between repentance and self-abuse. It was of no value to continually wallow in guilt and regret. It was time for self-forgiveness and renewal.

We worked through Theo understanding what he needed to do to make amends and set his life on a new course. This focused reflection further complemented his efforts in his recovery program.

AA was of great help in Theo's expiation, carrying him through the process with spiritual guidance, practical action, and structured steps. AA's remedy was tailor-made, systematic, and direct. He would stay sober, accept a Higher Power, take a moral inventory, admit re-

sponsibility, make amends to those he hurt, stay on the straight and narrow, and help others avoid his mistakes. As many others have discovered, AA's Twelve-Step program can be powerful medicine in helping heal emotional wounds.

He worked his recovery as we discussed the steps he had planned to redeem himself. "I have to go back and ask Shawn's family for their forgiveness. I saw them briefly at the funeral but I've been avoiding them ever since. I can't bear to face them. Just the thought of seeing his parents and sisters tears me up inside. I know how important it is to see them and ask them if they can ever forgive me for killing Shawn," he said, his words sticking in his throat. Theo took a few deep breaths to calm himself and went on.

"I've talked to my girlfriend and parents and feel they've accepted my mistakes and have forgiven me. They are very supportive since I've gotten treatment and am doing better now. It's time I faced up to what I've done and stop avoiding doing things I have to do to get my life back," he said with conviction. I was confident Theo would act on his promise.

The next week Theo bounded into the office looking brighter than he had in some weeks. "What's up? You look like you're in a particularly good mood this morning." I asked, expecting some important news.

"I did it. I called Shawn's parents and sisters and asked them if they would meet with me. I was shaking like a leaf when they answered the door. I couldn't stop myself. When Shawn's mother opened the door and looked in my eyes, I broke down in sobs. I just kept asking her and his father to forgive me for what I'd done. They hugged me and we cried together for several minutes."

Theo continued with tears in his eyes. "After a while, we went inside and talked for hours about Shawn and how much we missed him, about what happened, and where things have gone since. The sisters came in while we were talking and were glad to see me. It was emotionally wrenching. I felt exhausted afterwards, yet lighter. I feel like a thousand pounds have been lifted off my back."

As we met over the following weeks, it became apparent Theo was still unsettled about his life. "What seems to be haunting you?" I asked, sensing his restlessness.

"I think you're right. I need to do something more. I'm not sure what, but there's something else I must do to make this thing right" Theo said contemplatively. He hesitated for a moment. "I still feel some pressure in my gut that needs releasing. I've talked about it enough. I want to do something to take my experience and help others."

I spoke to him about how I had worked with others who still needed to make atonement for some misdeed in their lives. We discussed how in looking back over our lives, as in a "Life Review" or by taking a moral inventory, we discover things for which we must pay our emotional and moral debts. In many cases, this involves acts of contrition; in some instances, altruism.

He was intrigued by our discussion and we designed an experiment involving his providing community service. He contacted the local chapter of Mothers Against Drunk Drivers (MADD) and volunteered to speak to school groups about his experience. Over the next months he stood up in front of several student groups and shared his moving story.

The next time we met, Theo reported on his MADD volunteer experiences. "The first time I was super nervous and then I just decided to tell my story. I got emotional talking about the accident, but it got the kids' attention. I think some of them got the message and hopefully will think twice about driving and drinking. I'm going to keep volunteering. It's brought me a sense of peace knowing that my talks might help someone."

I knew Theo was nearing the end of our journey together. Having neared death, he had come back to save himself, make amends for his errors, and find new meaning by serving others.

CONCLUSION

Clinicians must continue to thoughtfully assess and treat traumatic stress disorders using the latest improvements in the field of traumatology. With recent advances in the biological and psychological sciences, mental health professionals have highly effective tools, many of which have been discussed here, to use in the understanding and amelioration of the suffering of trauma survivors. Historically, psy-

chology and psychiatry have focused almost exclusively on "curing" the pathology of trauma.

But in providing this relief, professionals have often lost sight of those patients who seek more from their trauma and treatment. Not all survivors are satisfied with simple survival. They want their suffering to count for something. The astute clinician must also attend to this natural human need to transcend tragedy, to turn the worst of life's misfortunes into greater growth and development. Unfortunately, this is a level of adaptation and treatment too often ignored in the past.

These exceptional survivors demand more and professionals must be better prepared to offer the presence and process necessary for this critical phase of posttraumatic growth. These survivors want to further strengthen and solidify the self, enhance their relationships, invigorate their life experience, and rediscover a purpose for their existence. As caring, competent therapists, we must be available to guide them in this noble search.

REFERENCES

CITED REFERENCES

*Albom, M. (1998). *Tuesdays With Morrie: An Old Man, a Young Man, and the Last Great Lesson.* New York: Doubleday.

Aldwin, C. M. (1993). Coping with traumatic stress. *PTSD Research Quarterly, 4,* 1-7.

Aldwin, C. M., Levenson, M. R., & Spiro, A. (1994). Vulnerability and resilience to combat exposure: Can stress have life-long effects? *Psychology and Aging, 9,* 34-44.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: Author.

Bandura, A. (1997). *Self Efficacy: The Exercise of Control.* New York: W. H. Freeman.

Bard, M., & Sangrey, D. (1986). *The Crime Victims Book.* New York: Brunner/Mazel.

Benson, H. (1975). *The Relaxation Response.* New York: William Morrow.

Briere, J., Elliot, D. M., Harris, K., & Coleman, A. (1995). Trauma Symptom Inventory: Psychometrics and association with childhood and adult trauma in clinical samples. *Journal of Interpersonal Violence, 10,* 387-401.

Buffone, G. (2002a, April/May). After September 11th: The assessment and treatment of traumatic stress in the medical setting. *Jacksonville Medicine, 53*(3), 115-118.

---

*This reference may be appropriate for patient use.

*Buffone, G. (2002b). *The Myth of Tomorrow: Seven Keys to Living the Life You Want Today.* New York: McGraw-Hill.

Burt, M. R., & Katz, B. L. (1987). Dimensions of recovery from rape: Focus on growth outcomes. *Journal of Interpersonal Violence, 2,* 57-81.

Byrant, R. A., & Harvey, A. G. (2000). *Acute Stress Disorder: A Handbook of Theory, Assessment, and Treatment.* Washington, DC: American Psychological Association.

Byrant, R. A., Sackville, T., Dang, S. T., Moulds, M., & Guthrie, R. (1998, November). Treating acute stress disorder: An evaluation of cognitive behavior therapy and supportive counseling techniques. *American Journal of Psychiatry, 156*(11), 1780-1786.

Calhoun, L. G., & Tedeschi, R. G. (1999). *Facilitating Posttraumatic Growth: A Clinician's Guide.* Mahwah, NJ: Erlbaum.

Coates, D., & Winston, T. (1983). Counteracting the deviance of depression. *Journal of Social Issues, 39,* 171-196.

Csikszentmihalyi, M. (1990). *Flow: The Psychology of Optimal Experience.* New York: Harper-Collins.

Damlouji, N., & Ferguson, J. (1985). Three cases of post-traumatic anorexia nervosa. *American Journal of Psychiatry, 142,* 362-363.

Davidson, J. R., & van der Kolk, B. A. (1996). The psychopharmacological treatment of posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress* (pp. 510-524). New York: Guilford.

Difede, J., Apfeldof, W., Cloitre, M., Spielman, L., & Perry, S. (1995). Acute psychiatric responses to the explosion at the World Trade Center: A case series. *Journal of Nervous and Mental Disease, 115*(8), 519-522.

Elliot, D. M., & Briere, J. (1992). Sexual abuse trauma among professional women: Validating the Trauma Symptom Checklist-40 (TSC-40). *Child Abuse and Neglect: The International Journal, 16,* 391-398.

Elliot, D. M., & Briere, J. (1995). Transference and countertransference. In C. Classen (Ed.), *Treating Women Molested in Childhood* (pp. 187-226). San Francisco: Jossey-Bass.

*This reference may be appropriate for patient use.

Fagan, J., & Shepherd, L. (Eds.). (1970). *Gestalt Therapy Now: Theory, Techniques, Application.* New York: Harper & Row.

Fairbank, J. A., Hansen, D. J., & Fetterling, J. M. (1991). Patterns of appraisal and coping across different stressor conditions among former prisoners of war with and without post-traumatic stress disorder. *Journal of Consulting and Clinical Psychology, 59,* 274-281.

Farberow, N. L., & Frederick, C. J. (1978). *Training Manual for Human Service Workers in Major Disasters.* Rockville, MD: National Institute of Mental Health.

Figley, C. R. (1989). *Helping Traumatized Families.* San Francisco: Jossey-Bass.

Foa, E. B., Davidson, J. R., & Frances, A. (1999). Expert consensus guidelines series: Treatment of PTSD. *Journal of Clinical Psychiatry, 60*(Suppl. 16).

Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6,* 459-474.

*Frankl, V. E. (1963). *Man's Search for Meaning.* New York: Simon & Schuster.

Frantz, T. T., Farrell, M. M., & Trolley, B. C. (2001). Positive outcomes of losing a loved one. In R. A. Neimeyer (Ed.), *Meaning Reconstruction and the Experience of Loss* (pp. 191-209). Washington, DC: American Psychological Association.

Gelpin, E., Bonne, O., Peri, T., Brandes, D., & Shalev, A. (1996). Treatment of recent trauma with benzodiazepines: A prospective study. *Journal of Clinical Psychiatry, 57*(9), 390-394.

Gottman, J., Notarius, C., Gonso, J., & Markman, H. (1976). *A Couples Guide to Communication.* Champaign, IL: Research Press.

Hathaway, S. R., McKinley, J. C., & Butcher, J. N. (1990). *Minnesota Multiphasic Personality Inventory-2.* Minneapolis: University of Minnesota Press.

Heidegger, M. (1962). *Time and Being.* New York: Harper & Row.

*Herbert, C., & Wetmore, A. (1999). *Overcoming Traumatic Stress: A Self-Help Guide Using Cognitive Behavioral Techniques.* New York: New York University Press.

---

*These references may be appropriate for patient use.

Herman, J. (1993). Sequelae of prolonged and repeated trauma: Evidence for a complex post-traumatic syndrome (DESNOS). In J. R. Davidson & E. B. Foa (Eds.), *Post-Traumatic Stress Disorder: DSM-IV and Beyond* (pp. 213-228). Washington, DC: American Psychiatric Press.

Herman, J. (1997) *Trauma and Recovery: The Aftermath of Violence.* New York: Basic Books.

Janoff-Bulman, R. (1985). The aftermath of victimization: Rebuilding shattered assumptions. In C. R. Figley (Ed.), *Trauma and Its Wake: Vol. 1: The Study and Treatment of Post-Traumatic Stress Disorder* (pp. 15-35). New York: Brunner/Mazel.

Keane, T. M., Malloy, P. F., & Fairbank, J. A. (1984). Empirical development of an MMPI subscale for the assessment of combat related post-traumatic stress disorder. *Journal of Consulting and Clinical Psychology, 52,* 888-891.

Kudler, H., & Davidson, J. R. (1994). General principles of biological intervention following trauma. In J. R Freedy & S. E. Hobfoll (Eds.), *Traumatic Stress: From Theory to Practice* (pp. 73-98). New York: Plenum.

Kulka, R. A., Schlenger, W. E., & Fairbank, J. A. (1990). *Trauma and the Vietnam War Generation.* New York: Brunner/Mazel.

Lange, A. J., & Jakubowski, P. (1977). *Responsible Assertive Behavior: Cognitive-Behavioral Procedures for Training.* Champaign, IL: Research Press.

Lewis, H. R., & Streitfeld, H. S. (1972). *Growth Games: How to Tune Into Yourself, Your Family, Your Friends.* New York: Bantam Books.

Litz, B. T., Penk, W. E., Geradi, R. J., & Keane, T. M. (1992). Behavioral assessment of post-traumatic stress disorder. In P. A. Saigh (Ed.), *Post-Traumatic Stress Disorder: A Behavioral Approach to Assessment and Treatment* (pp. 50-84). Boston: Allyn & Bacon.

March, J. (1990). The nosology of post-traumatic stress disorder. *Journal of Anxiety Disorders, 4,* 61-82.

McCann, I. L., & Perlman, L. A. (1990). *Psychological Trauma and the Adult Survivor: Theory, Therapy and Transformation.* New York: Brunner/Mazel.

McDonald, J. J., & Kulick, F. B. (Eds.). (1994). *Mental and Emotional Injuries in Employment Litigation.* Washington, DC: The Bureau of National Affairs.

Meichenbaum, D. (1974). *Cognitive Behavior Modification.* Morristown, NJ: General Learning Press.

Meichenbaum, D. (1994). *A Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults With Post-Traumatic Stress Disorder.* Waterloo, Ontario: Institute Press.

Miller, S., Nunnally, E. W., & Wackman, D. B. (1975). *Alive and Aware: Improving Communication in Relationships.* Minneapolis, MN: Interpersonal Communications Programs.

Millon, T. (1983). *Millon Clinical Multiaxial Inventory* (3rd ed.). Minneapolis, MN: National Computer Systems.

Modlin, H. C. (1990). Post-traumatic stress disorder: Differential diagnosis. In C. L. Meek (Ed.), *Post-Traumatic Stress Disorder: Assessment, Differential Diagnosis, and Forensic Evaluation* (pp. 63-72). Sarasota, FL: Professional Resource Exchange.

Muran, I. C., & DiGiuseppe, R. A. (1990). Toward a cognitive formulation of metaphor use in psychotherapy. *Clinical Psychology Review, 10,* 69-85.

Newman, E., Kaloupek, D. G., & Keane, T. M. (1996). Assessment of posttraumatic stress disorder in clinical and research settings. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress* (pp. 242-276). New York: Guilford.

North, C., Nixon, S., Sharrat, S., Mallonee, S., McMillen, J., Sptiznagel, E., & Smith, E. (1999). Psychiatric disorders among survivors of the Oklahoma City bombing. *Journal of the American Medical Association, 282*(8), 755-762.

Noyes, R. (1980). Attitude changes following near-death experiences. *Psychiatry, 43,* 234-242.

Park, C. L. (1998). Implication for post-traumatic growth for individuals. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), *Post-Traumatic Growth: Positive Change in the Aftermath of Crisis* (pp. 153-177). Mahwah, NJ: Erlbaum.

Prins, A., Kimerling, R., Cameron, R., Oumiette, P. C., Shaw, J., Thrailkill, A., Sheikh, J., & Gusman, F. (1999, November). *The Primary Care PTSD Screen (PC-PTSD).* Paper presented at the 15th annual meeting of the International Society for Traumatic Stress Studies, Miami, Florida.

Resnick, P. I. (1988). Malingering of posttraumatic disorders. In R. Rogers (Ed.), *Clinical Assessment of Malingering and Deception* (pp. 84-103). New York: Guilford.

Resnick, P. I. (1994). Malingering. In J. J. McDonald & F. B. Kulick (Eds.), *Mental and Emotional Injuries in Employment Litigation* (pp. 246-249). Washington, DC: The Bureau of National Affairs.

Richards, P. S., & Bergin, A. E. (1997). *A Spiritual Strategy for Counseling and Psychotherapy.* Washington, DC: American Psychological Association.

Ring, K. (1980). *Life at Death: A Scientific Investigation of the Near-Death Experience.* New York: Quill Publishers.

Ring, K. (1984). *Heading Toward Omega: In Search of the Meaning of the Near-Death Experience.* New York: Simon & Schuster.

Ring, K. (1998). *Lessons From the Light: What We Can Learn From the Near-Death Experience.* New York: Plenum.

Robins, L. N., Helzer, J. E., & Croonghland, J. L. (1981). *NIMH Diagnostic Interview Schedule-Version III* (PHS Publication No. ADM-T-42-3 [5/8/81]). Rockville, MD: National Institute of Mental Health.

Rogers, R. (Ed.). (1997). *Clinical Assessment of Malingering and Deception* (2nd ed.). New York: Guilford.

Sachs, M. L., & Buffone, G. W. (1997). *Running as Therapy: An Integrated Approach.* Northvale, NJ: Jason Aronson.

Saunders, B. E., Arata, C. M., & Kilpatrick, D. G. (1990). Development of a crime-related post-traumatic stress disorder scale for women within the Symptom Checklist-90-Revised. *Journal of Traumatic Stress, 3,* 267-277.

Schlenger, W. F., & Kulka, R. A. (1987, August). *Performance of the Keane-Fairbanks MMPI Scale and Other Self-Report Measures in Identifying Post-Traumatic Stress Disorder*. Paper presented at the 95th annual meeting of the American Psychological Association, New York.

Schmitt, A. (1976). *Dialogue With Death.* Harrisonburg, VA: Choice Books.

Scott, M. J., & Stradling, S. G. (2001). *Counseling for Post-Traumatic Stress Disorder.* Thousand Oaks, CA: Sage.

Shafranske, E. P. (1996). Religious beliefs, affiliations, and practices of clinical psychologists. In E. P. Shafraske (Ed.), *Religion and the Clinical Practice of Psychology* (pp. 561-586). Washington, DC: American Psychological Association.

Shapiro, F. (1995). *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures.* New York: Guilford.

Sledge, W. H., Boystin, J. A., & Rahe, A. J. (1980). Self-concept changes related to war captivity. *Archives of General Psychiatry, 37,* 430-443.

Smith, S. M. (1983). Disaster: Family disruptions in the wake of disasters. In C. R. Figley & H. I. McCubbin (Eds.), *Stress and the Family, Vol. II: Coping With Catastrophe* (pp. 120-147). New York: Brunner/Mazel.

Spitzer, R. L., & Williams, J. B. (1985). *Structured Clinical Interview for DSM-III-R.* New York: Biometric Research Department, New York State Psychiatric Institute.

Sprang, G. (2000). Coping strategies and traumatic stress symptomatology following the Oklahoma City bombing. *Social Work and Social Science Review, 8*(2), 207-218.

Taylor, C. B., & Arnow, B. (1988). *The Nature and Treatment of Anxiety Disorders.* New York: Free Press.

Tedeschi, R. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9,* 455-471.

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and Transformation: Growing in the Aftermath of Suffering.* Thousand Oaks, CA: Sage.

Tedeschi, R. G., Park, C. L., & Calhoun, L. G. (1998). *Posttraumatic Growth: Positive Change in the Aftermath of Crisis.* Mahwah, NJ: Erlbaum.

Tombaugh, T. N. (1996). *Test of Memory Malingering.* North Tonawanda, NY: Multi-Health Systems.

Turnbull, G. J. (1994). Debriefing of released British hostages from Lebanon. *Clinical Quarterly, 4,* 21-22.

Van Deurzen, E. (1998). *Paradox and Passion in Psychotherapy: An Existential Approach to Therapy and Counseling.* New York: Wiley.

Wolpe, J. (1958). *Psychotherapy by Reciprocal Inhibition.* Stanford, CA: Stanford University Press.

Yalom, I. (1980). *Existential Psychotherapy.* New York: Basic Books.

ADDITIONAL REFERENCES

The following references may prove helpful to trauma survivors.

Cole, D. (1992). *After Great Pain: A New Life Emerges*. New York: Summit.

Kushner, H. S. (1981). *When Bad Things Happen to Good People.* New York: Avon.

Lauer, R. H., & Lauer, J. C. (1988). *Watersheds: Mastering Life's Unpredictable Crises.* New York: Ivey Books.

Lieberman, M. I. (1996). *Doors Close, Doors Open: Widows, Grieving, and Growing.* New York: Putnam.

Veninga, R. I. (1985). *A Gift of Hope: How We Survive Our Tragedies.* Boston: Little Brown.

Wolin, S. J., & Wolin, S. (1993). *The Resilient Self: How Survivors of Troubled Families Rise Above Adversity.* New York: Villard.