

CHAPTER 5: Understanding Posttraumatic Stress Disorder

CHAPTER OUTLINE

INTRODUCTION

HISTORY OF POSTTRAUMATIC STRESS DISORDER

POSTTRAUMATIC STRESS DISORDER POPULATION STATISTICS

SYMPTOMS OF POSTTRAUMATIC STRESS DISORDER

COMPLEX POSTTRAUMATIC STRESS DISORDER

POSTTRAUMATIC STRESS DISORDER ASSESSMENT METHODS

POSTTRAUMATIC STRESS DISORDER AND GENDER

Comorbidity

Physiological Diseases and Disorders

Depressive Disorders

Substance Abuse

POSTTRAUMATIC STRESS DISORDER AND CHILDHOOD TRAUMA

POSTTRAUMATIC STRESS DISORDER AND THE FEMALE JUDICIAL CLIENT

ALLOSTASIS AND THE ALLOSTATIC LOAD FACTOR

RECOVERY FROM TRAUMA

Safety

Remembrance and Mourning

Reconnection

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CORE AREAS AND TREATMENT GOALS FOR POSTTRAUMATIC STRESS DISORDER

TREATMENT MODALITIES

Cognitive-Behavioral Treatment for Co-Occurring Posttraumatic Stress Disorder and Substance Use Disorder: An Exemplary Model: *Seeking Safety*
Key principles

Psychopharmacology

Exposure

Hypnosis

Eye Movement Desensitization and Reprocessing

THERAPIST CHARACTERISTICS

CHAPTER REVIEW

LEARNING OBJECTIVES

- ▶ To provide historical and etiological perspectives on Posttraumatic Stress Disorder
- ▶ To describe criteria for the diagnosis of Posttraumatic Stress Disorder and complex Posttraumatic Stress Disorder
- ▶ To discuss gender-sensitive assessment tools for diagnosing Posttraumatic Stress Disorder
- ▶ To distinguish between Type I and Type II traumatic events
- ▶ To explore the connection between criminal behavior and traumatic life experiences

- ▶ To discuss the co-occurrence of Posttraumatic Stress Disorder and other mental disorders
- ▶ To present a three-stage model for recovery from trauma: safety, remembrance, reconnection
- ▶ To describe the basic tenets of *Seeking Safety*, the most studied model for Posttraumatic Stress Disorder treatment
- ▶ To discuss additional intervention strategies including psychopharmacology, exposure, hypnosis, and eye movement desensitization and reprocessing
- ▶ To discuss relationships among therapist personal experiences, job satisfaction, and treatment outcomes
- ▶ To explore whether effective trauma therapy is feasible for community providers

INTRODUCTION

This chapter is intended to provide a summary of the research related to the causes, symptoms, and treatment approaches associated with traumatic life events, specifically as they relate to women in corrections. Treatment of posttraumatic stress disorder (PTSD) requires specialized training and professional supervision. The information in this chapter is intended to sensitize providers to the prevalence of PTSD in the judicial population, promote awareness of issues involved in assessment and diagnosis of PTSD, and provide an inventory of resources available for client care. The information in this chapter should not in any way be construed as a primer for developing the necessary skills to effectively treat PTSD.

HISTORY OF POSTTRAUMATIC STRESS DISORDER

Earnest research concerning PTSD began after the Vietnam War as a result of the profound psychological problems experienced by the war's veterans, both men and women. PTSD-like symptoms have, however, been observed in all veteran populations, including both World Wars, the Korean conflict, in United Nations peacekeeping forces deployed to other war zones, as well as the Gulf War and the War in Iraq. Similar symptoms also occur in veterans from other countries, including Australia and Israel (Beall, 1997). Written accounts of PTSD symptoms are documented from the Civil War, when it was known as "Da Costa's Syndrome," based on his paper written in 1871, where it was described as "soldier's heart" or "irritable heart." Holocaust survivors are also discussed in medical literature as having similar symptoms, as are survivors of railway disasters and atom bombs on Hiroshima and Nagasaki. Most recently, PTSD has come to the forefront of psychological interest as the survivors of the September 11, 2001, terrorist attacks in New York City and Washington, D.C., exhibit PTSD symptoms; survivors of the 2004 tsunami in southeastern Asia and eastern India, and 2005 survivors of the earthquake in Pakistan and hurricanes in the southeastern United States will undoubtedly suffer PTSD as well.

What we now know as PTSD was, in the 1800s, grounded in hysteria. Freud, Janet, Charcot, and

Breuer suggested that hysteria was precipitated by environmental events (Beall, 1997). Detractors of this theory looked for organic causes, including:

- Damage to the spinal cord, such as from railway injuries
- Microsections of exploded bombs entering the brain, particularly in World War I
- Brain damage resulting from starvation, such as in Holocaust survivors

Other theories included those with a psychological attribution, such as malingering or preexisting unstable personalities that were prone to develop neurosis.

Before the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*; (American Psychiatric Association [APA], 1980) defined this as a disorder, the syndrome had numerous monikers, including "shell shock," "war neurosis," "traumatic neurosis," "operational breakdown," "combat trauma," "fright neurosis," "nuclearism," and "battle fatigue." Due to the persistence of forensic psychiatrists and psychologists, PTSD gained credibility in the *DSM-III* as a subcategory of anxiety disorders rather than its previous categorization of dissociative disorder.

Also evolving has been the definition of *trauma*. In the *DSM-III* (American Psychiatric Association, 1980), *trauma* was defined as a "recognizable stressor that would evoke significant symptoms of distress in almost everyone" and as a "psychologically traumatic event that is generally outside the range of usual human experience," and, as the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-Revised)* (American Psychiatric Association, 1987) adds, "Outside the range of such common experiences as simple bereavement, chronic illness, business losses, and marital conflict."

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (American Psychiatric Association, 1994), reclassified PTSD as a stress response, giving it respect as a clear disorder and pointing to the importance of specific research and appropriate treatment options. The current definition of a traumatic event requires that both of the following are present: "(1) The person experienced, witnessed, or

was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (criterion A1), and (2) the person's response involved intense fear, helplessness, or horror (APA, 1994, pp. 427–428).

PTSD is no longer considered a disorder only of war veterans; it occurs in men and women, adults and children, Western and non-Western groups, and at all socioeconomic levels. Only a small minority of people appear to be invulnerable to extreme trauma. These stress-resistant individuals appear to be those with high sociability, a thoughtful coping style, and a strong perception of their ability to control their own destiny, or possessing an “internal locus of control” (Herman, 1992).

At the core of PTSD diagnosis is a traumatic event that is outside the individual, as opposed to a weakness or flaw within the individual (Bayse, 1998). The traumatic event was described in the *DSM-III* (APA, 1980) as a catastrophic stressor that was outside the range of usual human experience. At that time, reactions to such events as divorce, failure, rejection, and so on would have been diagnosed as adjustment disorders rather than PTSD. As Herman (1997) points out, however, rape, battery, and sexual and domestic abuse are so common they can hardly be described as outside the range of ordinary experience. Military trauma, too, affects millions; thus, Herman asserts that traumatic events are extraordinary not because they are rare but because of the way in which they affect human life.

Included in the *DSM-IV* and its text revision (APA, 1994, 2000) as categories of traumatic events are those *within* the range of usual human experience, such as automobile accidents and deaths. The *DSM-IV* specifies that the individual must have an intense emotional reaction to the traumatic event, such as panic, terror, grief, or disgust (Bayse, 1998). Herman (1997) uses the *Comprehensive Textbook of Psychiatry's* description of trauma: “intense fear, helplessness, loss of control, and threat of annihilation” (p. 33).

POSTTRAUMATIC STRESS DISORDER POPULATION STATISTICS

The National Center for Posttraumatic Stress Disorder (NCPTSD, 2007) reported that about

8 percent of the population will have PTSD symptoms at some time in their lives. Approximately 5.2 million adults have PTSD during a given year; however, this is only a small portion of those who have experienced a traumatic event. About 60 percent of men and 50 percent of women experience a traumatic event at some time in their lives.

Women are more likely to experience sexual assault and child sexual abuse. Men are more likely to experience accidents, physical assault, combat, or disaster or to witness death or injury. About 8 percent of men and 20 percent of women who experience a traumatic event will develop PTSD (National Center for Posttraumatic Stress Disorder, 2007). Sexual assault is more likely than other events to cause PTSD (Vogt, 2007).

Approximately 30 percent of men and women who served in war zones experience PTSD symptoms. An additional 20 percent to 25 percent have had some symptoms. More than 30 percent of male and 26 percent of female veterans of the Vietnam War experienced PTSD symptoms at some time during their lives (Beall, 1997). As many as 10 percent of the first Gulf War veterans, 6 percent to 11 percent of Afghanistan veterans, and 12 percent to 20 percent of the Iraq War veterans are expected to have experienced PTSD (National Center for Posttraumatic Stress Disorders [NCPTSD], 2007).

According to the National Center for Posttraumatic Stress Disorders (2007), individuals most likely to develop PTSD are:

- Those directly exposed to a traumatic event as the victim or as a witness
- Those who were seriously injured during the event
- Those who experienced a trauma that was long lasting or very severe
- Those who believed their lives were in danger
- Those who believed that a family member was in danger
- Those who had a severe reaction during the event such as crying, shaking, vomiting, or feeling separated from the surroundings

- ▶ Those who felt helpless during the trauma, not being able to help themselves or family member(s)
- ▶ Those who had an earlier life-threatening event, such as being abused as a child
- ▶ Those with another mental health problem
- ▶ Those with family members with mental health problems
- ▶ Those with minimal support from family and friends
- ▶ Those who recently lost a loved one, particularly if it was unexpected
- ▶ Those who have had recent, stressful life changes
- ▶ Those who drink alcohol in excess
- ▶ Those who are women, poorly educated, or are younger

The National Center for Posttraumatic Stress Disorders (2007) also reported that African Americans and Hispanics may be at higher risk than whites to develop PTSD and that one's culture or ethnic group may affect how one reacts to PTSD symptoms; people from groups that are open and willing to talk about problems may be more willing to seek help.

While one person may have few problems adjusting and returning to a normal state after a traumatic event, others may be debilitated for years; two people exposed to the same event will have different levels of reaction. It is impossible to predict or measure the potential effect of a traumatic event on different people, but certain variables seem to have the most impact, including:

- ▶ The extent to which the event was unexpected, uncontrollable, and inescapable
- ▶ The level of perceived extent of threat or danger, suffering, upset, terror, or fear
- ▶ The source of the trauma: human-caused trauma is generally more difficult than an event of nature
- ▶ Sexual victimization, especially when betrayal is involved
- ▶ An actual or perceived responsibility for the event
- ▶ Prior vulnerability factors, including genetics or early onset as in childhood trauma

Herman (1992) agrees that no two people will have identical reactions to the same trauma, despite PTSD's constant features. She reported a study of veterans with PTSD whose symptoms were related to their individual childhood history, emotional conflicts, and adaptive style. Those who had displayed antisocial behavior before going to war showed symptoms of irritability and anger. Those who had high moral expectations of themselves and compassion for others were more likely to have predominant symptoms of depression.

SYMPTOMS OF POSTTRAUMATIC STRESS DISORDER

Chronic PTSD typically involves periods of increase in symptoms followed by a remission. Some individuals experience symptoms that are unremitting and severe, while others report a lifetime of mild symptoms, with significant increases in symptoms following major life events such as retirement, medical illness, or reminders of military service such as reunions or media attention to anniversaries of events.

Generally described, the symptoms of PTSD include (Dryden-Edwards & Stoppler, 2007; Kinchin, 2005; Smith, Jaffe, & Segal, 2008):

- ▶ Reexperiencing the trauma
 - Flashbacks
 - Nightmares
 - Intrusive memories and exaggerated emotional and physical reactions to triggers that remind the person of the trauma
- ▶ Emotional numbing
 - Feeling detached
 - Lack of emotions, especially positive ones
 - Loss of interest in activities
- ▶ Avoidance
 - Avoiding activities, people, or places that are reminders of the trauma
- ▶ Increased arousal
 - Difficulty sleeping and concentrating
 - Irritability
 - Hypervigilance
 - Exaggerated startle response

PTSD also creates physiological changes in the body, including:

- Neurobiological changes
 - Alterations in brainwave activity
 - Changes in the size of brain structures, including decreased size of the hippocampus and abnormal activation of the amygdala
 - Changes in functioning, such as memory and fear responses
- Psychophysiological changes
 - Hyperarousal of the sympathetic nervous system
 - Increased startle reaction
 - Sleep disturbances
 - Increased neurohormonal changes resulting in heightened stress and increased depression
- Physical manifestations
 - Headaches
 - Stomach or digestive problems
 - Immune system problems
 - Asthma or breathing problems
 - Dizziness
 - Chest pain
 - Chronic pain or fibromyalgia

Psychological outcomes can include the following:

- Depression, major or pervasive
- Anxiety disorders such as phobias, panic, and social anxiety
- Conduct disorders
- Dissociation
- Eating disorders

Social manifestations include:

- Interpersonal problems
- Low self-esteem
- Alcohol and substance use
- Employment problems
- Homelessness

- Trouble with the law
- Self-destructive behaviors
 - Substance abuse
 - Suicide attempts
 - Risky sexual behaviors
 - Reckless driving
 - Self-injury

To be diagnosed with PTSD, according to the *DMS-IV* (American Psychological Association, 1994, 2000) the stressor must be of an extreme nature and considered life threatening; however, in adjustment disorder, the stressor can be of any severity and includes divorce or job loss. Symptoms of avoidance, numbing, and increased arousal that are present before exposure to the stressor do not meet the criteria for PTSD diagnosis and should be considered as a mood disorder or another anxiety disorder.

Other diagnoses to rule out include brief psychotic disorder, conversion disorder, major depressive disorder, acute stress disorder, obsessive-compulsive disorder, and malingering. As emphasized by Armstrong and High (1999), "It is important to carefully assess causality, intentionality, and motivation as well as traumatic events and symptoms" (p. 46) when considering an appropriate diagnosis. Simple recounting of a traumatic event or listing of symptoms by a client and accepting a client's presentation of the problem is not a strong enough basis for PTSD diagnosis. Armstrong and High further stress that the client's state of mind at the time of the critical event should be thoroughly considered. PTSD sufferers are able to describe the horror, helplessness, and/ or dissociation they experienced. To ensure proper diagnosis, these authors suggest careful observation of the client's physical responses when discussing the traumatic event.

COMPLEX POSTTRAUMATIC STRESS DISORDER

Complex PTSD is considered to be a form of PTSD that includes impaired affect regulation, dissociation, and severe difficulties in interpersonal relationships, along with the main features of reexperiencing the trauma, avoidance, and hyperarousal (Kimerling, Prins, Westrup, & Lee, 2004). Kimerling and associates

note that *affect regulation* has been defined as the “ongoing process of an individual’s emotional patterns in response to moment-by-moment contextual demands” (Kimerling et al., p. 573). These individuals show low-threshold and highly intense emotional reactions with a slow return to baseline. They are easily upset, have trouble calming down, and feel overwhelmed by negative emotions.

Affect dysregulation, a symptom of complex PTSD, is a more common occurrence in women with PTSD, probably because of the differences in how men and women experience emotion. Women are more likely than men to utilize emotional coping strategies and are more likely to report negative emotions such as shame, sadness, and guilt (Kimerling et al., 2004). In addition, affect regulation is developed when young; when trauma occurs in childhood, the ability to experience, identify, and talk about emotions can be disrupted.

Another component of complex PTSD, dissociation, ranges from simple daydreaming to depersonalization or derealization. Trauma during childhood, particularly that perpetrated by family members or those in authority, is indicative of the more severe forms of depersonalization (Kimerling et al., 2004). As with affect dysregulation, dissociation is most often found after exposure to events that are more common among women.

The interpersonal relationships of those with complex PTSD are problematic. Individuals with complex PTSD have difficulty assessing and receiving social support and have issues relating to social stigma associated with the event (Kimerling et al., 2004). The symptoms of PTSD themselves can cause problems in existing relationships. Male veterans with PTSD exhibit more problems with marriage and intimacy and are more likely to separate or divorce than veterans without PTSD. Interpersonal violence is also linked to PTSD in men. Kimerling et al. reported that research with women, which has not been as extensive as with males, has focused mainly on exposure to child sexual abuse and adult sexual assault. It has been shown, however, that sexually abused or assaulted women are less likely to be married and more likely to be single mothers. Less satisfaction with relationships, specifically with trust and

communication, are frequently reported, as is violence with intimate partners.

POSTTRAUMATIC STRESS DISORDER ASSESSMENT METHODS

While the questioning of clients who have experienced recent acute trauma allows for a fairly straightforward diagnosis, those who have suffered prolonged, repeated trauma are not as easily diagnosed (Herman, 1997). Presentations are often disguised, particularly in complex PTSD. Physical symptoms, insomnia, depression, or anxiety may be initially reported, but without explicit questioning it can be difficult to determine that an individual has actually lived in fear of very real violence. Prolonged childhood abuse is more complicated to detect, as the client may not have full recall of the history. In addition, the client most likely will not connect the childhood trauma with current symptoms and particularly not with criminal behavior (Herman).

Herman (1997) encourages clinicians who suspect a diagnosis of PTSD to share this with the client. By giving the client words to describe and attach to her feelings and experiences, the client can feel not alone, not crazy, and can even expect to recover as others have.

Caution, however is strongly recommended. Sharing such assessment and diagnostic impressions must be carefully thought out and should be given as a reflection of the client’s story that directly indicates such a diagnosis. It is best that reflective feedback be couched in the client’s own words, and it should be given within the context of how data from the client match formal diagnostic criteria, such as from the *DSM-IV* (American Psychiatric Association, 1994). These criteria and the clinical evidence should be reviewed with and confirmed by the client. It should also be made clear that diagnosis only provides a guideline, but does not offer a complete understanding; that understanding only evolves in the course of continued assessment and treatment (Wanberg, K., personal communication, March 5, 2008).

Assessment tools for PTSD fall into two categories: those that measure trauma history and those that

measure symptom history. Norris and Hamblen (2004) suggest the use of one tool from each category in order to properly understand the full impact of each individual's circumstance.

Kimerling et al. (2004) discuss the importance of using assessment methods that sustain reliability and validity measures in the context of gender. They list three general concepts that will affect the use of trauma exposure measures when considering gender issues:

1. The behaviorally specific language that is used and its ease of being understood,
2. The extent to which specific characteristics of traumatic events are measured, and
3. The inclusiveness of the events being examined.

Studies have shown that some women, although they had experienced the legal definition of rape, may answer "No" to the question, "Have you ever been raped?" Kimerling et al. (2004) encourage the use of gender-sensitive measures such as the Life Stressor Checklist, Revised (LSC-R) by Wolfe and Kimerling (1997b). This 30-item questionnaire includes unique assessments for abortion, death of a child, domestic violence, sexual assault, and rape. As Kimerling et al. point out, this checklist includes a measurement for stressors that usually do not meet the *DSM-IV* (American Psychiatric Association, 1994, 2004) criterion A for PTSD but are very relevant to women. These include unwanted separation from their children, care giving for a disabled or ill family member, and severe financial strain.

Kimerling et al. (2004) also support the use of the Potential Stressful Events Interview (PSEI) by Kilpatrick, Resnick, and Freedy (1991). Using sensitive, plain language, the PSEI is appropriate for use with both men and women. Exposure characteristics such as age at time of event and severity are also considered.

The reason for the importance of collecting information, such as age at the time of trauma, the severity, and chronicity, is that these factors define the parameters of exposure that may explain gender differences in PTSD prevalence and comorbid symptoms. One tool that meets these criteria is the Trauma History

Questionnaire (THQ) by Green. This tool is able to differentiate multiple incidents of physical assault from repeated and chronic partner violence or physical abuse (Kimerling et al., 2004).

The Traumatic Life Events Questionnaire—(TLEQ) by Kubany et al. (2000) also utilizes specific terms to describe 21 potentially traumatic events, including gender-specific ones such as miscarriages and abortions. It also includes an open-ended question to assess other highly disturbing events.

POSTTRAUMATIC STRESS DISORDER AND GENDER

According to Herman, in her 1992 book *Trauma and Recovery: The Aftermath of Violence—From Domestic Abuse to Political Terror*, the study of psychological trauma is dependent upon the political movement of the time. She demonstrates how Sigmund Freud found the source of hysteria in female patients to be childhood sexual abuse. At that time, however, because the "patriarchal world" was not ready to accept this reality, he retracted his theory and instead asserted that women with hysteria fabricated stories of childhood sexual abuse (Beall, 1998). With the feminist movement of the 1960s, the study of rape and other sexual-based trauma was given credibility.

As Beall (1998) reports, Lenore Walker's *Abused Women and Survivor Therapy: A Practical Guide for the Psychotherapist* (1994) shows how the effects of interpersonal violence in women's lives, including experiences such as physical, sexual, and psychological abuse, cause profound changes in abused women, including PTSD symptoms. According to Kimerling et al. (2004), gender itself plays a part in the type of trauma to which an individual is exposed; hence the original studies of two specific populations: male combat veterans (shell shock) and female sexual assault survivors (rape trauma).

Women, have, however served at war. As Beall (1998) reports, this small group of women is unacknowledged as victims of war and is often misdiagnosed with borderline personality disorder. They often receive inadequate treatment by male therapists who are not equipped to deal with the psychological difficulties

of women. In the early 1970s, a pattern of psychological reactions following rape was identified and called “rape trauma syndrome.” As reported by Herman (1997), researchers Burgess and Holmstrom found that women viewed rape as a life-threatening event, fearing mutilation or death during the attack. Insomnia, nausea, startle response, nightmares, and numbing symptoms followed. A link was then drawn between rape victims and combat veterans.

Stemming from the feminist movement, this research on rape was followed by studies on domestic violence and sexual abuse of children. Lenore Walker (Beall, 1998) defined “battered women syndrome” as having the same symptoms as rape trauma and shell shock.

Kimerling et al. (2004) point out that research shows that men are more likely to experience traumatic events in their lifetimes, yet women are more than twice as likely to develop PTSD. Studies conducted in the United States have indicated that approximately 61 percent of men and 51 percent of women report at least one lifetime traumatic event, with the majority experiencing multiple events. Men, on average, reported 5.3 events and women reported 4.3 events. Women were more likely to report sexual assault in childhood or adulthood; men were more likely to report having been shot or physically assaulted or having experienced motor vehicle crashes or combat.

Kimerling et al. (2004) also suggest that there may be an underreporting of traumatic events by women. They cite evidence that assessment tools may not possess content validity or gender sensitivity; for example, trauma lists do not include “sudden miscarriage” or “stillbirth.” Further, references to “rape” or “sexual assault” often will miss early childhood experiences of sexual abuse, which is more common for women. In addition, these authors point out that the broad categorization of traumatic events can encompass a single, brief event with a stranger as well as prolonged physical abuse by an intimate partner, making the category of “physical assault” not an accurate descriptor.

Kimerling et al. (2004) also report that, in addition to being twice as likely to suffer from PTSD

as men, women experience more chronic forms of the disorder. This may be explained by the fact that women typically experience trauma at an earlier age, and the trauma is typically in the form of sexual assault. Kimerling et al. hypothesize that factors beyond the specific exposure, such as differences in cognitive processes, social roles, and relationships, also help define the differences in response between men and women.

Comorbidity

Kimerling et al. (2004) reported on a 1995 study that showed differences between men and women and their patterns of comorbidity: Fifty-nine percent of men and 43.6 percent of women were shown to have three or more additional diagnoses. Most common in men were alcohol abuse or dependence (52 percent), major depressive disorder (MDD) (48 percent), and conduct disorder (43.3 percent). Women experienced major depressive disorder (48.5 percent), simple or social phobia (28–29 percent), and alcohol abuse or dependence (28 percent). Kimerling et al. emphasize that comorbidity has a major effect on the severity of PTSD and is therefore an important aspect of assessment and treatment.

Physiological Diseases and Disorders

Bender (2004) reported that women with PTSD experience more adverse medical conditions such as arthritis, lower back pain, obesity, emphysema, and hypertension than women in general or those with depression only. Depression has long been known to be associated with poor physical health, but women with PTSD exhibited even worse health, based on a 1999 survey of 30,000 female veterans. Nearly 90 percent of women with a diagnosis of PTSD experienced at least one medical condition, which, in addition to the conditions mentioned previously, included low energy, chronic pain, and poor physical functioning. According to this study, women with PTSD also experienced more physical pain than women with depression or with neither diagnosis. Bender states that the study suggests that trauma may be linked to “chronic neuroendocrine dysregulation” as well as to poor personal habits such as smoking, drinking, or drug use and cautions those

in the mental health care field to be aware of the need for additional treatment for comorbid medical conditions.

Kimerling et al. (2004) concur that both men and women with PTSD have a greater incidence of functional impairment as well as a poorer course of disease. These include cardiovascular disorders (a significant finding since heart disease remains the leading cause of death among women in the United States), gastrointestinal disorders including liver disease, viral hepatitis, irritable bowel syndrome, and gastroesophageal reflux disease (commonly known as heartburn).

Women with PTSD who experienced childhood sexual trauma are also commonly found to have sexually transmitted diseases, suggesting that trauma exposure serves as a risk factor for infection, particularly HIV. Sexual trauma exposure is a direct risk factor for sexually transmitted diseases. Kimerling et al. (2004) reported that a 1996 study of HIV-infected women showed that 43 percent of them had been sexually assaulted at some time in their lives. It was also reported that the disease progresses more rapidly among women with PTSD than among those without.

Studies also show that, in victims of trauma, there are physical changes, specifically volume reduction in the hippocampus, the learning and memory center of the brain. The hippocampus works in tandem with the medial prefrontal cortex, the area that regulates emotional response to fear and stress, thus indicating a physiological relationship to PTSD symptoms (Bremner, 2002). Combat veterans were found to have an 8 percent reduction in hippocampal volume, yet no differences were found in other parts of the brain. Interestingly, Bremner also reports that the hippocampal volume reduction is specific to those with PTSD but not associated with closely related disorders such as anxiety or panic disorder. Further, the hippocampus has the ability to regenerate neurons; however, stress has been found to stop or slow neuron regeneration. Bremner suggests that this change in size of the learning and memory center of the brain among PTSD sufferers may explain the delayed recall or “recovered memories” that many victims of childhood abuse experience. He

explains that the abuse caused damage to the hippocampus, leading to a distortion or fragmentation of memories.

The changes in the function of the prefrontal regions of the brain may explain the pathological emotional responses in those with PTSD (Bremner, 2002). Bremner reports that studies of veterans with PTSD showed a decreased blood flow to this area when viewing combat-related scenes and sounds. This did not occur in veterans without PTSD. Similar results were found when comparing women who experienced childhood sexual abuse and suffer PTSD as opposed to those with childhood sexual abuse and no PTSD symptoms.

Depressive Disorders

As noted previously, major depressive disorder (MDD) is a frequent partner of PTSD, with studies showing similar rates of occurrence in both genders. As Kimerling et al. (2004) pointed out, this is an interesting phenomenon, since women’s risk for MDD in the absence of PTSD is greater than men’s. Their explanation is that PTSD “may create a vulnerability toward depression in men that suppresses the protective effect of male gender” (p. 579).

Due to the overlap of MDD and PTSD symptoms (diminished interest in activities, sleep and concentration disturbances), assessment and diagnosis can be difficult. In an attempt to distinguish the two disorders, Kimerling et al. (2004) report that clinicians have outlined several methods of determining the difference between the two diagnoses. The symptom of diminished interest in activities in PTSD is specific to cues of past trauma exposure; in MDD, it is generalized and characterized by loss of energy and hopelessness. PTSD sleep difficulties are characterized by nightmares and hypervigilance that occur only after the traumatic event. Difficulties in concentration with MDD are more global, whereas with PTSD they are dissociative and result from trauma-related memories. Kimerling et al. also assert that because prolonged childhood trauma is more common in women than in men, and because there is a closer relationship between childhood maltreatment and adult psychopathology in women than men,

gender tends to be a confounding factor in the process of diagnosing PTSD and MDD.

Substance Abuse

A 1990 study found that approximately 74 percent of men and 29 percent of women with PTSD had a lifetime diagnosis of alcohol abuse (Ouimette, Wolfe, & Chrestman, 1996). Kimerling et al. (2004) report that approximately 30–50 percent of men and 25–30 percent of women with lifetime PTSD also are substance abusers. It has been shown that a comorbid diagnosis of PTSD and substance use disorder (SUD) is associated with poorer substance use outcomes: those with PTSD relapse more quickly, drink more on days when they do drink, have a greater percentage of heavy drinking days, and suffer greater negative consequences due to their substance abuse than do non-PTSD abusers (Brown, 2000).

Interestingly, women are more likely than men to develop substance use disorders after exposure to a traumatic event and symptoms of PTSD, with approximately 65–84 percent of women experiencing PTSD before developing substance use disorders. This supports the “self-medication” hypothesis as an important component of PTSD/SUD comorbidity among women, in which women use alcohol or drugs to cope with trauma-related symptoms. In contrast, men are more likely to experience trauma due to their behaviors linked to substance use, which then results in PTSD symptoms (Kimerling et al., 2004). Kimerling et al. highly suggest that clinicians routinely screen clients for SUD when PTSD is suspected.

POSTTRAUMATIC STRESS DISORDER AND CHILDHOOD TRAUMA

Estimates of childhood sexual abuse are varied, ranging from 16 percent to 30 percent of women and 10 percent to 15 percent of men in the general population (Bremner, 2002; Courtois, 1995; Whealin, 2003). These estimates follow years of reports of incest and sexual molestation having been obscured by the taboo surrounding them. Courtois believes this taboo applies to disclosure and discussion of the events rather than the actual occurrence of them.

Volpe (2005) discusses Terr’s description of “Type I” and “Type II” traumatic events. While single, short-term events such as rape, assault, or a severe beating are referred to as Type I trauma, repeated or prolonged exposure such as child sexual abuse is referred to as Type II. It is suggested that Type II trauma has a greater impact on an individual’s functioning than Type I.

Today, sexual abuse is considered to be a major public health problem with numerous personal and societal implications. All forms of child abuse are considered to be risk factors for psychological, social, and physical effects, both short term and long term in nature for both men and women (Courtois, 1995). Short-term effects often take the form of children acting out, agitated behavior, being cruel to others, showing seductive or sexual behavior that is inappropriate for their age, and experiencing frightening dreams. Some injure themselves or attempt suicide (Whealin, 2003).

Long-term effects, with symptoms persisting into adulthood, include PTSD, anxiety, depression, sexual anxiety, poor body image, low self-esteem, and unhealthy behaviors such as alcohol and drug abuse, self-mutilation, and eating disorders (Whealin, 2003). Beall (1997) refers to Dusty Miller’s book, *Women Who Hurt Themselves*, where the phrase “trauma reenactment syndrome” (TRS) was coined. Miller (1994) denotes women in this category as being “at war with their bodies” and struggling for control. This quest for control within a woman can be one explanation for the development of criminal behavior. As Marcus-Mendoza and Wright (2004) report on Dougherty’s work in 1998, even though feeling internally powerless, abused women in the judicial system will create an external toughness and commit crimes to survive. The abused woman also minimizes the effect that the abuse has had on her.

POSTTRAUMATIC STRESS DISORDER AND THE FEMALE JUDICIAL CLIENT

Kubiak (2004) expresses concern that trauma is rarely considered in relation to incarceration, either as a cause of imprisonment or the result thereof. Zlotnick, Najavits, Rohsenow, and Johnson (2003) indicate that the rates of PTSD and SUD are higher for incarcerated women than the general population

of women, with PTSD and SUD being the most common disorders among female detainees who are awaiting trial. Zlotnick et al. report that the prevalence of PTSD in the female prison population occurs at a rate of 33.5 percent for lifetime experience of PTSD symptoms and 22.3 percent for current PTSD symptoms. This, they note, is more than twice as high as the rate among nonincarcerated women.

Marcus-Mendoza and Wright (2004) assert that the majority (up to 90 percent) of women prisoners in the United States have suffered physical, sexual, or emotional abuse prior to their imprisonment. Zlotnick et al. (2003) also report that between 78 percent and 85 percent of incarcerated women have experienced at least one traumatic event in their lives, compared to 69 percent of the general female population. Childhood abuse is highly correlated with PTSD and is commonly reported by women offenders, with 23 percent to 48 percent of them reporting having been abused as a child (Zlotnick et al.). In California prisons, approximately 80 percent of women inmates experienced some type of abuse, with 29 percent reporting childhood sexual abuse and 23 percent experiencing physical abuse as an adult; 40 percent reported emotional abuse as a child and 48 percent as an adult (Covington, 1998a).

As Marcus-Mendoza and Wright (2004) stated, abuse is frequently thought to be a “precursor to criminality.” They cited findings that support the belief that abused girls were significantly more likely than nonabused girls to:

- ▶ Become runaways to escape from abuse
- ▶ Score lower on intelligence and reading tests
- ▶ Have substance-abusing parents
- ▶ Lack social and psychological resources, and
- ▶ Engage in criminal behavior

Also discussed by Marcus-Mendoza and Wright (2004) is a pattern among delinquent girls showing that childhood victimization results in running away, drug and alcohol abuse, prostitution, selling drugs, and, to support their drug or alcohol habit, robbery. Marcus-Mendoza and Wright point toward Zaplin’s assertion that “this cycle of events leads to emotional stress, self-hatred, anxiety, depression, and aggressive

and impulsive behaviors, with girls at risk of not being able to develop empathic or caring attitudes for themselves or others” (p. 251). In addition, those with the highest risk of recidivism reported more substance abuse, parenting problems, and mental health needs, all of which are consequences of physical, sexual, and emotional abuse. Zlotnick et al. (2003) concur, reporting that in addition to high rates of drug use, women prisoners have long histories of physical and sexual abuse. Marcus-Mendoza and Wright reinforce that abuse and traumatic early life experiences are the context from which women develop criminal behavior.

Female prisoners are reported to be five to eight times more likely to abuse alcohol than women in the general population, 10 times more likely to abuse drugs, and 27 times more likely to use cocaine (Zlotnick et al., 2003). Zlotnick et al. also reported that studies show the rate of women’s drug possession convictions increased by 41 percent between 1990 and 1996. Further, a 1997 study showed that more than 40 percent of female inmates were under the influence of drugs at the time of their offence, compared to 32 percent of male inmates. Zlotnick et al. noted that the high rate of recidivism among women prisoners can be explained, in part, by their use of illegal substances along with high levels of physical and sexual abuse. Covington (1998a) asserts that traditional addiction treatment does not effectively deal with abuse issues, causing relapse to occur more often in these women.

ALLOSTASIS AND THE ALLOSTATIC LOAD FACTOR

Allotasis, meaning maintaining stability or homeostasis through change, was first introduced by Sterling and Eyer (1988) to describe the resting and active states of the cardiovascular system. Focal research by McEwen and associates at Rockefeller University has explored the relationship of the psychobiology of stress to allotasis and the allostatic load factor (McEwen, 1998, 2000, 2004). Wilson, Friedman, and Lindy (2001), having seen these concepts as important to the understanding of PTSD and its treatment, defined allotasis as “the body’s effort to maintain stability through change when loads or stressors of various types

place demands on the normal levels of adaptive biological function” (p. 9).

McEwen (1998, 2000, 2004) explained that allostasis is the psychobiological adaptation to the challenge of internal and external stress and is an essential component to maintain homeostasis. The moderators of the stress response are hormones and neurochemicals produced by the adrenergic and hypothalamic-pituitary-adrenocortical (HPA) systems, such as catecholamine and cortisol, that, in the short run, serve to meet the challenge of external and internal stressors. This allostasis response is inherent within the psychobiological system’s effort to achieve stability and to adaptation through change. In a sense these are “first responders” to stress and provide short-term protection from potential damage due to stress.

The important part of this process is the “shutting down” or inactivation of the allostasis response, which allows the cortisol and catecholamine secretion to return to baseline levels. This is the normal response when the external threat or challenge is over and is the short-run benefit of allostasis. However, as McEwin explained, if each inactivation is “inefficient,” or doesn’t shut down to a normal level of hormones, and if, over the long run, this process is called upon frequently with repeated inefficiency, there is long-term exposure (over years) to the imbalance of stress hormones and this exposure can lead to an allostatic load and its wear and tear on the psychobiologic system (McEwin, 1998, 2000, 2004).

McEwin (2000) identified four dysfunctional allostatic conditions that can lead to allostatic load and result in impairment of the psychobiological system. These are

1. Frequent and repetitive activation of the stress response pattern due to exposure to multiple stressors
2. The breakdown of normal adaptation to stress due to the allostatic load’s “wear” on the system
3. A persistent and prolonged stress response or responses resulting in a failure to turn off the responses or shut down the activation of the stress hormones in a timely manner

4. Inadequate response or system failure resulting in the inadequate production of hormone mediators or moderators of the stress response; this leads the system to produce other mediators that cause compensatory hyperactivity that is counterproductive to the mediation of stress

McEwen (2000) identified early childhood experiences of abuse and neglect as major risk factors for these conditions that can potentially lead to the increase of allostatic load in adulthood. There is a growing body of research to support the relationship between allostatic load and psychobiologic disorders, including cardiovascular disorders, depression, anxiety, aggression, and PTSD (e.g., Friedman, 2001; Glover, 2006 Kubzanski, Koenen, Spiro, Vokonas, & Sparrow, 2007; McEwen, 2004).” Friedman (2001) described eight psychobiological examples of allostatic load in PTSD and a rationale for PTSD pharmacotherapy based on allostatic load.

Wilson et al. (2001) see allostasis and the allostatic load as “fundamental to the understanding of stress-related psychobiological behaviors” (p. 9). Individuals with PTSD are vulnerable to sudden changes in their sense of well-being that, based on triggers or cues, internal or external, result in rapid switching back and forth between states of “relative calmness to states of hypervigilance, anxiety, anger, and extreme arousal” (p. 10). Wilson et al. see one of the “major challenges” of the treatment of PTSD is “to facilitate a reduction or ‘switching off’ of persistent hyperarousal mechanisms associated with allostatic load that are readily reactivated and amplified by traumatic memories (conscious or unconscious) stored in the brain” (p. 10).

RECOVERY FROM TRAUMA

The recovery process discussed herein may be difficult at best and impossible at worst to apply to the female prisoner because of the controlled physical environment as well as the female prisoners’ lack of trust for others. It is, however, an important aspect for understanding the rationale behind current treatment methodologies as well as the struggles a prisoner with PTSD will encounter. As Marcus-Mendoza and Wright (2004) point out, “Although helping women

heal wounds from abuse in an abusive environment would seem impossible, scholars and practitioners are working, and must continue to work together to achieve this ambitious goal” (p. 115). It is with this in mind that the following is offered in order that the reader may understand the process women experience during their recovery from trauma.

Recovery from traumatic events is described by Herman (1997) as unfolding in three stages, the first being establishing safety. The second stage includes the tasks of remembrance and mourning, while the third stage encompasses reconnection with ordinary life. As with any abstract concept, the stages are not followed exactly, nor are they linear. Herman describes traumatic syndromes as “oscillating and dialectical in nature...defy[ing] any attempt to impose such simpleminded order” (p. 155). These stages are defined in an attempt to assist clients and clinicians alike in simplifying and gaining control of a seemingly uncontrollable process. While other writers identify five and some eight, we focus on Herman’s three.

Safety

Survivors of victimization must shift their surroundings from that of unpredictable danger to reliable safety. This includes recognizing and naming the demon. As Herman (1997) discussed, some may feel relieved to learn that there is a name for their problems. Others, however, resist the diagnosis out of fear of the stigma associated with any psychiatric diagnosis; some may deny the condition out of a sense of pride. Many survivors of physical or sexual abuse do not connect the fact that their experience of abuse is directly related to their symptoms or behaviors. Herman went on to emphasize that the process of developing a framework that relates the client’s problems with the traumatic history is beneficial, as it assists in developing a therapeutic alliance.

Establishing safety includes allowing the victim to regain control. While the female prisoner may have attempted to regain control through illegal acts, true control is accomplished when victims feel safe in relation to others as well as with their own thinking and feeling. As Herman (1997) suggested, gradually

developing a safe and trusting therapeutic relationship is key. In addition, family, friends, and lovers who were *not* involved in abuse of the victim should be mobilized to act as a support system. Further, any attachment to those involved in the victimization must be disconnected, as must use of illicit drugs or alcohol (assumed, in the case of incarcerated victims).

Herman (1997) has pointed out that the process of establishing safety may be hampered if the survivor is in a hostile or nonprotective environment. This may be the case within the prison system. The legal process is obviously outside of the victim’s control, thus disrupting this initial stage of safety.

Remembrance and Mourning

After having regained a sense of control, developed a feeling of safety within and among others and self, and discontinuing self-destructive behaviors, trauma victims can gradually move on to stage 2: remembrance and mourning. This is the phase where victims verbally tell the whole, in-depth, sordid story. As Herman notes, the difference between remembering the trauma and retelling the trauma is likened to a series of still snapshots as opposed to full cinema movies with the inclusion of words and music.

Retelling the story must be repetitive; eventually, the story no longer will arouse such intense feelings (Herman, 1997). Eventually, it becomes only a part of the survivor’s experience rather than the focus of it. The memory fades and grief loses its strength. The victim’s life story begins to take on other aspects rather than only one. This, indeed, is a simple explanation of a complex process, but one that can be accomplished with a knowledgeable and trained clinician who can look past the anger and hatred that may accompany PTSD and its accompanying symptoms.

Reconnection

The third stage, reconnection, may not occur for inmates until their release; however, it is an important part of the process of recovering from trauma. After mourning the loss of the person they were before the trauma, they must create a new self and a new future. As quoted by Herman (1997), psychiatrist Michael

Stone described this task (specific to his work with incest survivors) thusly:

All victims . . . have, by definition, been taught that the strong can do as they please, without regard for convention. . . . *Re-education* is often indicated, pertaining to what is typical, average, wholesome, and “normal” in the intimate life of ordinary people. Victims . . . tend to be woefully ignorant of these matters, owing to their skewed and secretive early environments. Although victims in their original homes, they are like strangers in a foreign country, once “safely” outside. (p. 196)

Herman (1997) believes the statement “I know I have myself” is the anchor of the third stage. No longer possessed by past trauma, the survivor understands the results of the damage done to her and now becomes the person she wants to be. Imagination and fantasy, desire and initiative are at the core of this stage, where hopes and dreams are weaved into reality.

Herman emphasizes that resolution of the trauma is never final and recovery is never complete; the impact of trauma will “reverberate throughout the survivor’s lifecycle” (p. 211). While incomplete, recovery will allow the survivor to return to the normal tasks of life. Becoming more interested in the present and future than the past, a survivor of trauma overcomes her fear and opposition and gradually engages in new and healthy relationships.

In summary, as psychologist Mary Harvey has described, there are seven criteria for the resolution of trauma (Herman, 1997):

1. The physiological symptoms of PTSD have been brought within manageable limits.
2. The survivor is able to bear the feelings associated with traumatic memories.
3. The person has authority over the memories; for example, she can either remember the event or put it aside.
4. The memory is coherent and linked with feeling.
5. The survivor’s self-esteem has been restored.
6. Important relationships have been reestablished.
7. A coherent system of meaning and belief concerning the trauma has been constructed.

CORE AREAS AND TREATMENT GOALS FOR POSTTRAUMATIC STRESS DISORDER

Before looking at specific approaches and modalities for addressing PTSD for women in corrections, it is helpful to look at the general core areas and goals that are addressed in the treatment of PTSD.

Wilson et al. (2001) described these in the context of and in relationship to allostatic load. As these goals relate to recovery as described by Herman (1997), they are as follows:

1. Identify and address the psychobiological alterations with the goal of reestablishing a normal (healthy) stress response. These psychobiological alterations include: hypervigilance, irritability, proneness to anger and depression, sleep disturbances, problems in concentration, dissociation, and exaggerated responses to external cues. As Herman (1997) noted, an important treatment component of establishing a stable and normal stress response is to provide an environment of safety. This safety factor will help mitigate the allostatic load and “wear and tear” on the system by helping to reduce the “repeated hits” (Wilson et al., 2001) by external multiple stressors.

2. Focus on traumatic memory including nightmares, affective memories, reliving the trauma, and so on, with the goal of helping clients identify the triggers for these memories and understand and change the cognitive appraisals of these memories that lead to pathological behavior. The allostatic load around these memories can be reduced through the client retelling her story in a way that there becomes an efficient “shutting down” to normal levels of hormones. *The goal* is to retrain the system to return to a normal response and level of hormones once the external or internal threat is over, that is, after her story is told. Additionally, identification of the triggers and management of them through cognitive reappraisal will prevent neurochemical and hormonal systems from cascading to a level where the allostatic load is compounded.

3. Numbing, avoidance, and denial can take on extreme states such as amnesia, withdrawal from others, and a variety of pathological responses including substance abuse and obsessive-compulsive responses. *The goal* is to help the client gain insight into the use of these defenses and establish a sense of

identity that includes seeing oneself as a person who is a survivor rather than a victim.

4. Another area to address is the trauma-producing damage to the ego process and structure, ego fragmentation, demoralization, engagement in dissociative thinking, helplessness, and vulnerability. These can all lead to depression, excessive guilt, and hopelessness. *The goal* is to restore personal integrity and energy, reduce the sense of injury to self, and replace faulty thinking about self and the world by promoting understanding of oneself within the process of change and growth as well as to help establish a renewed sense of vitality and hopefulness.

5. Trauma can lead to detachment, social isolation, difficulty in establishing intimacy, alienation, distrust, fear of abandonment, difficulty in establishing boundaries, and engagement in destructive relationships. *The goal* is to confront and change these relationships, replacing them with positive relationships that are based on healthy boundaries. As Wilson et al. (2001) pointed out, the critical factor in this goal is to “understand the connection between vulnerability states (e.g., fears, feelings, perceived threats) and dispositional tendencies in social encounters” (p. 23).

TREATMENT MODALITIES

Marcus-Mendoza and Wright (2004) pointed out how difficult and challenging creating treatment programs for women in prison can be. Because so many of these women have been hurt by those whom they have trusted in the past, they lack trust and respect for those in authority. Additionally, the authors point out the importance of a gender-specific, holistic approach that includes assessment and diagnosis and “supportive, educational, and custodial service” (p. 113). They note that by not utilizing a holistic approach when treating women prisoners, frustration and failure will follow.

Marcus-Mendoza and Wright (2004) stated that it isn't an option of whether or not to treat women prisoners for trauma and abuse; the question is *how* to do it. A variety of treatment styles have been utilized with survivors of extreme trauma who exhibit symptoms of PTSD. Outcome studies are infrequent, however, so intervention methods may rightly take

the form of multimodal techniques. As Marcus-Mendoza and Wright (2004) state, it is important to treat each issue as if it were a part of the larger context of a woman's life. They continue:

To effectively help incarcerated women, it is important to acknowledge that abuse and other life experiences are often the context in which these problems develop. Decontextualizing the problems of women prisoners leads to treatment that may only address the symptoms while ignoring the underlying experiences and psychological trauma. (p. 253)

Harrison, Jessup, Covington, and Najavits (2004) discuss gender-responsive treatment, an integrated approach to women's alcohol and drug programs that creates an environment and program content so as to understand the realities of women's lives. These authors describe the “Self-in-Relation” theory that was based on work in the mid-1970s by Jean Baker Miller. This model purports that the psychological development of women differs from that of men, namely, that relationships are the basis for women's psychological health. Pathologies, they propose, are often traced to “disconnections or violations within relationships, arising at personal/familial levels as well as at the socio-cultural level” (p. 58).

Cognitive-Behavioral Treatment for Co-Occurring Posttraumatic Stress Disorder and Substance Use Disorder: An Exemplary Model: *Seeking Safety*

The most-studied treatment model specifically for clients with PTSD and substance abuse is called “Seeking Safety” (Harrison et al., 2004). Najavits began developing this 25-session cognitive-behavioral therapy (CBT) model in 1993, when no published treatment studies or empirical evaluations for this population (PTSD and SUD) existed (Najavits, 1999).

Key Principles

Najavits describes the program title as expressing the program's philosophy, in that when an individual has substance abuse issues as well as PTSD, “the most urgent clinical need is to establish safety”

(p. 40). This is the *first* of the five key principles of the program. Najavits utilizes the term *safety* as relating to:

- ▶ Discontinuing substance use
- ▶ Reducing suicidality
- ▶ Minimizing HIV exposure risks
- ▶ Discontinuing dangerous relationships
- ▶ Controlling extreme symptoms such as dissociation, and finally
- ▶ Stopping self-harm behaviors

These behaviors are often reenactments of earlier trauma, particularly childhood abuse. This “first-stage” treatment of learning how to be safe is exhibited by teaching clients coping skills, by utilizing Safe Coping Sheets and a safety plan, and by reporting unsafe behaviors.

The *second* key principle of Seeking Safety is the integration of treatments for both PTSD and substance abuse. Despite the fact that most treatment programs do not treat disorders concurrently, it is the recommendation of clinicians and researchers that an integrated model is more likely to be effective, is more sensitive to clients’ needs, and is more cost effective (Brown, 2000; Najavits, 1999). Even client surveys conclude that simultaneous treatment for both disorders is preferred. Najavits points to the example of one of her clients who had to lie in order to be enrolled in a PTSD treatment program because active substance abusers were not to be admitted.

Najavits (1999) emphasizes that while attention is given to both disorders at the first stage, it is done so in the present rather than detailing the past trauma, with the latter being done in second-stage treatment, which is outside of the realm of Seeking Safety. She explains that while exposure therapy for PTSD is efficacious, it is preferred that this not begin until there is a period of abstinence and stable functioning. Dwelling on past trauma may indeed trigger substance abuse in a continued effort to cope. Instead, clients are helped to understand why the two disorders frequently occur and are taught coping skills in order to decrease current symptoms of PTSD and substance abuse. In addition, the first-stage treatment focuses on explaining the relationship between the

two disorders as well as helping clients understand how becoming healthy will require attention to both disorders (Najavits).

The *third* key principle of Najavits’s program involves the focus on ideals. Steps are taken to instill confidence and to restore clients’ recognition of the potential for a better life. Having been so demoralized by childhood or adult victimization, clients have lost sight of values such as respect, care, integration, and healing. Through motivation and insight, clients take steps toward the hard work necessary to recover from both disorders.

The *fourth* key principle of Seeking Safety involves the addition of two issues to the original cognitive-behavioral focus, thus embracing four content areas: cognitive, behavioral, interpersonal, and case management. Because PTSD most commonly comes from trauma inflicted by others, whether childhood physical or sexual abuse, combat, or crime victimization, all revolve around interpersonal issues than can interfere with trust, expectations, and power. Substance abuse also is often associated with interpersonal relationships, since many of these clients grew up in homes with substance-abusing family members or may use substances to manage interpersonal conflicts. Case management was an added component, as the need was seen for helping clients with life problems such as housing, job counseling, HIV testing, domestic violence, child care, and other such issues (Najavits, 1999).

The *fifth* and final key principle is attention to the role of therapist processes. Najavits (1999) reports that research shows that the effectiveness of treatment for both substance abusers and those in psychotherapy in general is determined equally or more by the therapist than by the specific theoretical orientation or by patient characteristics. Effective therapy is difficult to provide to this “severe” or “extreme” population. Therefore, the following therapy skills are emphasized in Seeking Safety:

- ▶ Building an alliance with the client
- ▶ Compassion for the client’s experience
- ▶ Using coping skills in one’s own life so as to lead by example
- ▶ Giving the client as much control as possible

- ▮ Meeting the client more than halfway, doing as much as possible to help him or her succeed, and
- ▮ Obtaining feedback from the client about the treatment

Najavits (1999) warns of possible countertransference issues that can arise and interfere with effective treatment, particularly with severe or extreme clients. Problems that may arise include harsh confrontation, where the therapist insists on his or her own point of view, an inability to hold clients accountable because of misguided sympathy, becoming “victim” to the client’s abusiveness, power struggles, and allowing a client to be a scapegoat in group settings.

Twenty-five session topics, each including a clinician guide and client handout, are broken down into four areas:

1. Interpersonal topics
 - Asking for Help
 - Honesty
 - Setting Boundaries in Relationships
 - Healthy Relationships
 - Community Resources
 - Healing From Anger
 - Getting Others to Support Your Recovery
2. Behavioral topics
 - Detaching From Emotional Pain: Grounding
 - Taking Good Care of Yourself
 - Red and Green Flags
 - Commitment
 - Coping With Triggers
 - Respecting Your Time
 - Self-Nurturing
3. Cognitive topics
 - PTSD: Taking Back Your Power
 - Compassion
 - When Substances Control You
 - Recovery Thinking
 - Integrating the Split Self
 - Creating Meaning
 - Discovery

4. Combination topics
 - Introduction to Treatment/Case Management
 - Safety
 - The Life Choices Game (Review)
 - Termination

Najavits (1999) indicates that a variety of treatment formats have been used, including group and individual, open and closed group, 50- and 90-minute sessions, singly and co-led, and outpatient and residential.

An uncontrolled pilot study of the effectiveness of Seeking Safety was conducted with 18 volunteers from a residential substance abuse treatment program in a minimum-security wing of a woman’s prison, the goal being to evaluate its initial feasibility, acceptability, and efficacy (Zlotnik, Najavits, Rohsenow, & Johnson, 2003). It was to be used as an adjunct to “treatment as usual” for women with SUD and PTSD. It was expected that after Seeking Safety treatment, the inmates would report satisfaction with the program, an alliance with the providers, and decreased severity of PTSD symptoms and substance use. Najavits supervised the trained therapists throughout the study (Zlotnick et al., 2003).

Follow-up reports were available from 17 participants, with the data suggesting that Seeking Safety appears to be appealing to incarcerated women with SUD and PTSD and that the program has the potential to be beneficial, especially for improving PTSD symptoms, with 53 percent no longer meeting the criteria for PTSD diagnosis at the end of treatment and 46 percent no longer meeting the criteria at the 3-month follow-up. Thirty-five percent of the women reported use of illegal substances within 3 months after release. Unfortunately, a high recidivism rate was found, with 33 percent reoffending within 3 months (Zlotnick et al., 2003). These results are promising, particularly in light of the fact that PTSD is typically a chronic disorder and those who receive treatment require an average of 36 months to recover from their symptoms (Zlotnick et al., 2003). Najavits reported that four additional outcome studies have been completed and that all showed improvements in substance abuse as well as general psychiatric symptoms,

suicidal thoughts and plans, problem-solving ability, sense of meaning, social adjustment, and depression. These studies also showed high treatment attendance and satisfaction. In the one randomized control trial by Hein, Cohen, Miele, Litt, and Capstick (2004), Seeking Safety was shown to be effective at relapse prevention, performing significantly better than treatment-as-usual. Najavits also notes that several other studies are currently underway, utilizing larger samples and control or comparison conditions.

Following are methods being used for treating PTSD that are not specific to women and particularly not appropriate for those who also exhibit substance abuse disorders.

Psychopharmacology

A variety of drugs have been used in the treatment of PTSD. These include selective serotonin reuptake inhibitors (SSRIs), other serotonergic agents, antiadrenergic agents, tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs), benzodiazepines, anticonvulsants, and antipsychotics (see Friedman, 2001, pp. 94–124). Few randomized controlled trials have, however, been conducted with medications (Friedman, 2001; Herbert & Sageman, 2004). The general finding is that antidepressants such as SSRIs and MAOIs, anti-anxiety agents such as benzodiazepines, and anticonvulsants such as carbamazepine, all lead to general improvement of PTSD symptoms. However, due to the frequency of comorbidity among PTSD patients with depression or panic disorder, it is unclear which symptoms the drug therapy is addressing. In addition, only two drugs have been approved by the Food and Drug Administration (FDA) specifically for PTSD: the SSRIs sertraline and paroxetine. It is also important to note that subject selection for studies eliminates those involved in litigation or receiving compensation for PTSD so these important populations are not being studied. In addition, the potential harmful effects of these drugs have not been addressed (Herbert & Sageman, 2004). Friedman (2001) pointed out that no drugs specifically designed to target allostatic load (discussed previously) have been tested. He further expressed concern that since testing of older drugs such as tricyclics and MAOIs has been abandoned in favor of SSRIs and new anticonvulsants, the possible efficacy of older medications may be ignored.

Herman (1997) emphasizes the importance of informed consent when prescribing drugs to PTSD patients. She reminds readers that simply ordering the patient to take medication will again take away the necessary feeling of power so important to the recovering victim. In addition to assisting in building a client-therapist alliance, involving the client with decisions concerning the use of pharmaceuticals will enhance her general sense of efficacy and control.

Exposure

Exposure therapy is based on the natural tendency of humans to avoid distressing thoughts. Emotional avoidance is a key feature underlying much psychopathology, particularly PTSD. Borrowing principles from Buddhism, exposure therapy recognizes the importance of facing one's inner pain and tackling the damaging effects of avoidance (Herbert & Sageman, 2004). While Najavits (1999) resists using exposure as a treatment technique during the initial stages of treatment for PTSD when substance abuse is involved, it has been shown to be effective when used for PTSD alone (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Herbert & Sageman, 2004). Studies do show exposure-based therapies are effective in traumatized populations, including victims of accidents, natural disasters, and, most important, *nonsexual* assault. Clients are assisted with imagining exposure to trauma memories by speaking in the first-person present tense about what they had undergone (imaginal exposure). They describe their response to the trauma, its meaning, what they smelled, heard, saw, felt, or tasted (*in vivo* exposure). This imagining of the trauma is held on to until distress levels drop, typically in about 20 minutes (Marks et al., 1998). Exposure interventions are often conducted as part of CBT, where cognitive restructuring and relaxation training is integrated into the program.

Herbert and Sageman (2004) reported that the precise mechanism by which exposure operates is unclear but that the client's expectancies are an important aspect of exposure. This was shown in a control study in which PTSD patients given an expectation of "treatment" demonstrated more rapid and greater improvement than those given the expectation of

“assessment,” hence suggesting the importance of maintaining optimistic therapeutic expectancies (Herbert & Sageman, 2004).

Hypnosis

Maldonado and Spiegel (1995) reported that therapists may use hypnotic methods as a simple tool to help clients access repressed and dissociated memories. Described as a “psychophysiological state of arousal,” hypnotic phenomena are similar to many of the symptoms presented by victims of childhood sexual trauma, including dissociation and absorption.

Beall (1997) points out that in Maggie Phillip’s *Healing the Divided Self: Clinical and Ericksonian Hypnotherapy for Post-Traumatic and Dissociative Conditions*, Phillip believes that failure to access unconscious memories may leave PTSD patients vulnerable to returning to problem symptoms and behaviors. In addition, it is reported that hypnosis reduces the length of treatment (Beall). Maldonado and Spiegel (1995), however, emphasize that hypnosis by itself is not therapy and that there is nothing a therapist can do with hypnosis that cannot be done without it, but they admit that the relaxing state one achieves can help create a safe environment for retrieving painful memories.

Eye Movement Desensitization and Reprocessing

Negative and/or mixed results from studies of eye movement desensitization and reprocessing (EMDR) have caused this complex treatment method to receive less than full acceptance by the scientific community. EMDR was devised by Francine Shapiro in 1995 and consists of manualized steps involving imaginal exposure exercises combined with visual stimulation in the form of tracking the back-and-forth motion of the therapist’s finger across the client’s visual field (Herbert & Sageman, 2004; Scheck, Schaeffer, & Gillette, 1998). Or as described by Friedman (2001), “it involves the elicitation of rapid, saccadic eye movements during the imaginal exposure sessions...” (p. 163).

After building rapport with the client and talking about the procedures, a relaxation exercise of envisioning a safe

place is conducted. The client is asked to then focus on the trauma, to verbalize the event, and to identify associated feelings. Associated cognitions are also recognized. While maintaining a mental image of the traumatic event, the client follows the movement of the therapist’s finger as it passes from left to right in front of the client (Scheck, et al., 1998).

As Herbert and Sageman (2004) report, EMDR has been found to be no more effective than standard exposure treatments and that the eye movements are superfluous to its effects. Studies that compare the EMDR protocol leaving out the eye movements to complete EMDR protocol with the eye movements show no difference in efficacy. Herbert and Sageman assert that there is no need for “unnecessary rituals” and that EMDR’s effectiveness lies in the effects that are common to most psychotherapies, again emphasizing the importance of positive expectations leading toward improvement. Friedman (2001) concurs that EMDR use for chronic PTSD remains questionable.

THERAPIST CHARACTERISTICS

Recognizing the importance of therapist characteristics in working with populations with a dual diagnosis of PTSD and substance use disorder (SUD), Najavits (2002) looked at four issues that might shed light on the training of clinicians in delivery of services to this group. These issues are:

1. How difficult and how gratifying is treatment of clients with these diagnoses?
2. What are the characteristics of those who find this treatment most difficult?
3. What characteristics may explain clinician perception of treatment difficulty and gratification?
4. What are the most difficult dilemmas and emotions when working with these clients?

Najavits (2002) findings indicate that dual diagnosis is more difficult to treat than either alone; however, clinicians found higher gratification than perceived difficulty. Even those who found their work to be the most difficult were no less gratified than the others. (Respondents may have been biased toward

gratification as they chose to attend the workshops and complete the survey, indicating they probably were positive about their work.)

Clinicians with a personal history of trauma and SUD (either singularly or concomitantly) were clearly influenced and had a more positive view of their work. Those reporting the most difficulty treating the dual diagnosis had a lower frequency of trauma, suggesting that therapists' personal experiences with these disorders allows them to have greater identification with their clients and to understand their often unpredictable affects.

It is often thought that it is a positive feature for SUD clinicians to have had a history of SUD. This does not appear to be a positive predictor of patient outcomes, as more than 50 studies have shown (Najavits, 2002). Najavits goes on to warn that while clinicians' perceptions of difficulty and gratification may be important to their work satisfaction, as yet there is no clear relationship to treatment outcome.

As opposed to the general thinking about clinicians' SUD history, a history of PTSD is rarely acknowledged among or thought to be of value to clinicians, probably due to the stigma or blame about traumatic events.

Najavits's work showed that those clinicians who were more positive about their work with PTSD were more likely to have a 12-step orientation, to work in a dual diagnosis setting, to be non-PhDs, to be younger, to feel more energized, and to *not* be in a mental health setting. She concludes that these characteristics likely reflect familiarity, training, and experience with the dual diagnosis. Many clinicians do not receive much, if any, formal instruction and supervision in the treatment of PTSD and SUD, particularly in the mental health field, which she finds distanced from the substance abuse field. Clients are often referred to deal with substance abuse before attempting treatment of co-occurring disorders. This leaves clinicians to struggle with dual diagnosis issues, not uncommonly resulting in a negative perception of SUD treatment.

The three major difficulties named by the surveyed clinicians were client's self-destructiveness, case

management needs, and dependency. One third of the respondents reported their work with dual diagnosis as extremely difficult. Najavits suggested that for this one third, attention is needed in training in handling client self-destructiveness and case management. She also noted that it is important to determine who those clinicians are, as they were not identified by other factors such as training, experience, or orientation or in their overall view of their work.

Clinicians reported their highest gratification was to be teaching new coping skills, developing expertise, and helping clients achieve abstinence. Najavits recognizes that these are action-oriented strategies as opposed to the lowest-rated gratifications, such as acting as a parent figure or listening to trauma histories, which are more passive activities. Najavits concluded that while this sample of clinicians reported high satisfaction with their work in general, a low burnout rate and a positive feeling about their work, difficulties treating those with the dual diagnosis are many.

Finally, Hein et al. (2004) reported that additional studies are needed to find out whether Seeking Safety therapy is feasible for community providers. Hein et al. is working with the National Institute on Drug Abuse (NIDA) Clinical Trials Network to conduct a study in which community drug abuse counselors will offer a modified form of Seeking Safety in typical patient populations and treatment settings. Patients are currently signing up to participate in this nationwide study.

CHAPTER REVIEW

This chapter began with a historical perspective of PTSD, explaining how conceptualizations of causality have evolved from organic explanations (for example, damage to brain or spinal chord) to psychobiological responses to such horrific events as natural disasters, rape, or exposure to war.

The chapter continues on to explore the symptoms of PTSD, which include reexperiencing the trauma, emotional numbing, avoidance, increased arousal, neurobiological changes, physiological changes, physical manifestations, and disturbances in psychological

and social functioning. Complex PTSD is defined as a more severe form of the disorder, usually associated with more extreme problems with affect regulation, depersonalization, and difficulty assessing and receiving social support.

PTSD assessment is often complicated by the client not having full recall of trauma-related childhood events; however, clinicians who suspect a diagnosis of PTSD are encouraged to share this with the client. By giving the client words to describe and attach to her feelings and experiences, the client can feel not alone, not crazy, and can expect to recover as others have. Gender-sensitive assessment measures are discussed as means to gather data in two primary aspects of the disorder: (1) those that measure trauma history, and (2) those that measure symptom history. In addition to being twice as likely to suffer from PTSD as men, women experience more chronic forms of the disorder, with some differences in the appearance of co-occurring disorders: men are more likely to manifest alcohol dependence and antisocial personality disorder; women are more

likely to experience depression, phobias, and more adverse medical conditions.

Treatment is discussed in the context of a gender-specific, holistic approach that includes assessment and diagnosis and a supportive, educational, and custodial environment. This chapter summarizes key principles from Seeking Safety, the most-studied treatment model for clients with PTSD and substance abuse.

Treatment effectiveness is attributed more to the qualities of the therapist than to the specific theoretical orientation or to patient characteristics. Additional strategies for treating PTSD are discussed such as psychopharmacology, exposure, hypnosis, and Eye Movement Desensitization and Reprocessing.

The chapter concludes by exploring the personal characteristics of therapists who find satisfaction in working with dually diagnosed clients and the relationships among personal experience with substance abuse, trauma, job satisfaction, and treatment outcomes.

