Journal of Contemporary Psychotherapy, Vol. 27, No. 4, 1997

Traumatic Stress Personality Disorder (TrSPD): Intertheoretical Therapy for the PTSD/PD Dissociogenic Organization

Erwin Randolph Parson, Ph.D.

This article discusses a new personality disorder entity, "traumatic stress personality disorder," conceptualized as a composite organization with transactional properties that mutually structure post-traumatic stress disorder (PTSD) and personality disorders (PDs). The transactional/synergistic view of PTSD/PD comorbidity derives in part from scientific findings that PTSD's enduring biological effects are discernible in the personality of individuals 30 to 50 years or more after the overwhelming event, and from psychodynamic formulations on the development and structuring of personality defenses. An intertheoretical therapy model is also presented, and consists of multiple therapies actively integrated to meet the patient's complex post-trauma needs. This article argues for the development of theoretical, investigatory, and therapeutic measures to address PTSD/PD configurations in traumatized victims. Basically, the position espoused is that PTSD/PD should be measured as one rather than two entities, with neither component being considered as a confounding but integral factor in measurement. The eight components of traumatic stress personality disorder are discussed, along with a case study to demonstrate the model's clinical applications. The integration of cognitive, behavioral, psychodynamic, and existential treatment approaches is geared to assist the victim to developmentally progress to survivor status, and then beyond this level of integration to thriver, a person whose adaptational learning in therapy created a "vital psychological immune system" that consistently protects against dissociative regression in response to the daily stresses of life. Transference, countertransference, therapists' self-care and self-monitoring are seen as integral to the treatment of traumatic stress personality disorders.

Address correspondence to Erwin R. Parson, Ph.D., P.O. Box 62, Perry Point, Maryland 21902.

© 1997 Human Sciences Press, Inc.

At one time or another, PTSD may appear
to mimic every personality disorder
—Lawrence C. Kolb, M.D. (1989, p. 812)

INTRODUCTION

Janet (1919/1925) theorized that exposure to terrorizing traumatizing external events led to dissociation, a *doubling of the personality* (*dedoublement de la personnalite*). Clinicians and research scientists have for many years contemplated the significance of the co-occurrence of *symptomatic responses* and *personality disorders* (PDs) in victims of rape, criminal assault, exposure to inner city community violence, domestic and international terrorism, and war. In the context of stress, trauma, and post-traumatic stress disorder (PTSD), does "personality" really matter? Many practitioners and theorists believe personality in the trauma context is consequential, holding that the presence of personality pathology may significantly determine the nature of assessment, and the course, severity, and prognosis of chronic traumatic stress illness and comorbidity conditions (Bende & Philpott, 1994; Benveniste & Molteni, 1994; Brende, 1983; Gunderson & Sabo, 1993a; Hendin et al., 1983; Herman & Van der Kolk, 1987; Karp et al., 1995; Magnavita, 1997; Parson, 1984, 1987; Sherwood, Funari, & Piekarski, 1990; Singer, 1981; Southwick, Yehuda, & Giller, 1993; Ursano, 1981; Wilson, 1989). Horowitz et al. (1980) believe that patients with PTSD and comorbid personality disorders may suffer greater distress during the course of the illness than patients without personality disorders.

Assessment and treatment processes often disclose that PTSD/PD configurations are dynamic and interactive rather than static occurrences. When PTSD, as a relatively unstable condition (with its intrinsic neuronal pathology), co-occurs with a personality disorder, both disorders mutually structure the other, and both transactionally interact to contribute to the specific patterning of victim's post-traumatic adaptation. Character is the language of the self in trauma, and speaks to continuous distress, and basic enfeeblement of controls.

The PTSD/PD comorbidity structure is an area within general PD research in need of meaningful investigation to bring scientific illumination into the formation of trauma-shattered psychobiological structures (an admixture of stable and unstable elements), often observed in victims' cognitive deficits, affect dyscontrol, somatic symptoms, and behavioral abnormalities (Hyer, Woods, & Boudewyns, 1991; Parson, 1994a, 1995a; Piekarski, Sherwood, & Funari, 1993; Sherwood, Funari, & Piekarski, 1990; Southwick et al., 1993). Biological investigations, genetic studies, advances in operationalized diagnostic criteria, and the development of structured

clinical interviews have contributed to the current interest, enthusiasm, progress, and new possibilities in PD research (Hyler et al., 1990; Loranger et al., 1988; Overholser, 1994; Tyrer, Casey, & Ferguson, 1991; Weiss, 1993). Studies have amply demonstrated that personality variables are inextricably linked to the concepts of stress and coping, and to illness and health (Friedman, 1990; Wilson & Walker, 1990).

The *Diagnostic and Statistical Manual of Mental Disorders* (APA, 1994) employs two distinct diagnostic categories for syndromes (Axis I) and personality disorders (Axis II). Is this difference in axial organization suggestive of a veridical difference in level, structure, or persistence of maladaptive states or traits? Do they interact, producing a composite *state/personality syndrome*? These questions and related ones pose immensely complex conceptual, practical, and methodological issues. Certainly, a focus in this area would be congruent with the recent resurgence of empirical and theoretical interest in the study of PDs in general and in state/PD in particular (Cardena & Spiegel, 1993; Overholser, 1994; Kaplan & Sadock, 1994; Siever & Davis, 1991; Tyrer, Casey, & Ferguson; 1991).

Psychological trauma, PTSD, and dissociation, as consequences of exposure to overwhelming events, are also areas of great national and international interest to clinicians, research scientists, and policymakers (Danieli et al., 1996; Irving, 1985; Lindy, 1988; Parson, 1994a, 1994b; Van der Kolk, 1987). In this article, the author proposes a diagnostic category for clinical and scientific consideration. There is ample precedence for the introduction of new personality disorder entities based on extensive clinical experience and preliminary research studies (e.g., Huprich & Fine, 1996; Huprich et al., 1996; Hyer et al., 1991). The article discusses a proposed synthesized personality disorder or syndrome that incorporates the co-occurrence of state Axis I PTSD *and* trait Axis II PD diagnoses, and guidelines for treatment. As a synthesized structure in people with chronic PTSD, this personality organization is referred to as "traumatic stress personality disorder" (TrSPD), a syndromal continuous composite that features PTSD (symptoms/responses of intrusion, avoidance, and arousal) as a functional dimension of the victim's personality operations. The effects of trauma and character-altering sequelae were very perplexing to Sigmund Freud. This led him to call the entire area of psychological trauma and PTSD as "a dark and dismal subject." Kolb (1989), recognizing psychiatry's reluctance to embrace the disorder stated that PTSD "is to psychiatry what syphilis was to medicine," and later spoke of "personality disorganization" in severe cases. Perplexity still permeates this area of practice and investigation.

There is an emerging realization that traumatic stress reactions and PTSD cannot be continually ignored when personality functioning is clinically assessed (as is generally the case where clinicians *still* seldom ask about

prior traumatic episodes in the lives of patients). Some clinicians and scientists are beginning to appreciate the importance of filling this void in PTSD/PD clinical formulations. For example, Millon & Davis (1997) recently concluded that because of "its increasing importance in diagnostic work" PTSD will be added as a new clinical syndrome scale to the MCMI-III (p. 70). Additionally, the 10th revision of the *International Classification of Diseases and related Health Problems (ICD-10)*, the official classification in Europe developed by the World Health Organization (WHO, 1992), has entered among several new diagnostic categories, "Enduring Personality Change After Catastrophic Experience." This diagnosis is given to a victim who after two years following a catastrophic event show "inflexible and maladaptive features leading to an impairment in interpersonal, social, and occupational functioning" (Kaplan & Sadock, 1994, p. 750), as a direct outcome of a traumatic event and not related to pretraumatic personality factors.

The concept of traumatic stress personality disorder derives from a formulation based on a review of the phenomenological, conceptual, diagnostic, clinical, and empirical literature (Hyer & Boudewyns, 1985; Hyer, Woods. & Boudewyns, 1991; Piekarski, Sherwood, & Funari, 1993; Reich, 1989; Sherwood, Funari, & Piekarski, 1990; WHO, 1992; Wilson & Walker, 1990) and from the author's 20 years of theory-building, supervision, consultation, and direct treatment of hundreds of child and adult victims suffering the ill effects of physical and emotional family and community violence, war, sexual victimization, disasters, and of motor vehicle accidents. The focus is on the interactivity of PTSD and PD, on the presumed functional transactional effects between PTSD and the stable instability of personality structure in traumatized persons. Table 1 portrays the responses of traumatic stress personality disorder reflected in a complex array of biopsychobehavioral symptoms.

PERSONALITY DISORDERS AND POST-TRAUMATIC STRESS DISORDER

Cavenar and Nash (1976) wrote of the effects of war stress on the normal personality. The rising interest in PD research (Livesley & Jackson, 1992; Overholser, 1994) is matched by an increasing need among practitioners to better understand the clinical *syndrome/PD comorbidity* and *syndrome comorbidity.* Increasing scientific understanding of the relationship of acute stress responses to chronic PTSD and character changes, and the relationship of normal personality traits to psychopathology are essential

Table 1. Biopsychobehavioral Dimensions of Traumatic Stress Personality Disorder

Bioneurological Dimension

- Shrinking of the hippocampus, a brain structure essential to learning and memory functions.
- Hyperstimulation of limbic tissue and changes may result in a pathological expression at the gene or cell level.
- Sequelae to overstimulation of the limbic nuclei is what Post called "behavioral sensitization" associated with impaired ability to modulate arousal and strong emotions, affective lability, somatic disorganization, and anxiety disorders (Everly, 1994; Parson, 1994a, 1996c; Post, 1986).
- Altered immune system functioning.
- Persistent startle response.
- Conditioned emotional response mediated through cortical and subcortical pathways (Kolb, 1984; Shalev et al., 1992).

Psychological Dimension

- Constriction of general level of personality functioning (Kardiner, 1941).
- Black-white dichotomous thinking (Bradshaw, 1993).
- Catastrophic expectations in relation of the sense of unpredictability and uncontrollability.
- Terror of death: "psychotic anxieties" and vulnerability to biogenic regression (Brende & McCann, 1987) to continually engage in the management of terror to "ensure" mental and physical survival.
- A sense of internalized inescapable terror.
- Persistent sense of being an "endangered self" (A. Reich, 1960).
- Persistent nightmares as "royal road" to the traumatic unconscious and to the actual configurations of the event (Parson, 1988).
- Survivor's guilt and other guilt feelings.
- Intrusion: Fixation on the trauma (Kardiner, 1941).
- Constricted emotions and numbering: Anesthetization of painful affects.
- Intimacy problems: Fear of closeness with spouse, children, other family members, and friends.
- Ultimate narcissistic injury: Painful awareness of the inability to reliably regulate consciousness, and control perceived cerebral, motivational, and behavioral defects or symptoms (Parson, 1993).
- Autonomous split-off mental organization: Preeminence of dissociation over repression.
- Centrality of meaning (May & Yalom, 1995; Ursano et al., 1992).

Behavioral Dimension

- Wandering life style (Lapkin et al., 1982).
- Sensation-seeking behavior tendencies (Wilson, 1989).
- Social avoidance behavior
- Fight-flight behavioral predisposition: Restlessness and irritability
- Addictive behaviors.
- Difficulty falling asleep and entering relaxation mode.

for meaningful assessment and treatment (Digman, 1990; Strack & Lorr, 1997; Widiger & Trull, 1992).

Many psychiatric patients with personality disorder suffer comorbidities of depression, schizophrenia, panic disorder, eating disorders, or PTSD

(Blanchard et al., 1995; Kaplan & Sadock, 1994; Overholser, 1994; Parson, 1984). When DSM-IV Axis I and Axis II disorders co-occur, measurement, treatment, clinical data interpretation, and research design become very complicated (Hyer et al., 1991; Overholser, 1994; Mavissakalian, 1990; Reich et al., 1986; Parson, 1984). The influence of state mental syndromes on PDs, and the impact of PDs on syndromal diagnoses, remain unclear at the present time.

Research studies clarify, however, that "when the outcome of mental state disorders, of whatever type, is examined in groups with and without concurrent personality disorder, there is invariably a worse outcome in cases with personality disorder" (Tyrer, Casey, & Ferguson, 1991, p. 469). Casey, Tyrer, & Dillon (1984), employing a structured clinical interview format, found a PD rate of 34%, with the most common Axis I diagnoses being anxiety disorders and alcohol abuse among those with "conspicuous morbidity."

Weiss et al. (1983) also found poor outcomes in subjects with PDs who also suffered from Axis I anxiety disorders. Furthermore, Marlowe et al. (1997) reported that patients in cocaine dependence treatment with paranoid, chaotic, impulsive, predatory, and non-empathic personality traits tended to either terminate treatment early, or gain very little benefit from the program. The traumatic influence of early childhood abuse on the adult tendency to employ characterological dissociation as a coping device is a clear and convincing example of the transactional effects of trauma on personality (Irvin, 1994; Putnam, 1991; Spiegel, 1986).

Ecopathology of PTSD and Personality Disorder

There has been a gradual increase of articles published in the area of traumatic stress, and as mentioned above, in the area of PD as well. Over the 20-year period between 1970 and 1990, Blake et al. (1992) reported that 1590 references to PTSD appeared in the scientific literature! PTSD and PD are estimated to be significantly high in the general population as well as in specific subpopulations. Epidemiologically, Helzer, Robbins, & McEvoy (1987) found the prevalence of PTSD to be 1 to 2% (or approximately 2.4 to 4.8 million cases), a rate which many scientists and clinical observers report to be a low estimate where even severe PTSD cases were undetected due to lack of sensitivity of measurement devices (Kulka et al., 1991). Kulka et al. (1991) found higher rates of PTSD than those reported by Helzer et al. (1987) in a community sample of people exposed to traumatic events. They discovered a prevalence rate of 12.6 to 19.3%. Additionally, Breslau et al. (1991), using a structured interview format, asked

1007 adults, in a random community sample, about traumatic events in their lives. They also reported a PTSD prevalence rate of 23.6%, with a lifetime prevalence rate of 9.2% for the overall sample. Remarkably, more than one-third (39.1%) had experienced at least one traumatic life-event during their lives! The traumatizing events reported included: sudden injury/serious accident, physical assault, observing serious injury to a relative or friend, rape, natural disasters, and several other traumatic events. Other significant rates of PTSD were found in diverse populations: 10% in emergency medical personnel (Marmar et al., 1996), 10% in rescue workers (Durham et al., 1985), and 30% in Australian firefighters (McFarlane, 1988). Additionally, high estimates were also found in rape victims (31% found at some time after the rape; 11% at time of the assessment [National Victim Center and Crime Victims Research and Treatment Center, 1992]); in war veterans (15% among males classified as "white/others," almost 9% among women, 21% among African Americans, and 28% among Hispanics [Kulka et al., 1990]), in victims of motor vehicular accidents (27 to 44% depending upon which scoring rule was used [Blanchard et al., 1995; Hickling & Blanchard, 1992]), and in survivors of disasters (28.3% among survivors of the Buffalo Creek flood 14 years after!).

In addition to the high rates of PTSD, national and international scientific studies have shown significant rates of PDs (Loranger et al., 1994). Some studies have shown PD prevalence in the general population range from 10% to 18%, increasing to 48% to 50% in medical and psychiatric samples (Overholser, 1994; Merikangas & Weissman, 1986; Casey, 1988; Casey & Tyrer, 1990; Zimmerman & Coryell, 1989). Using a structured clinical interview format, Casey & Tyrer (1986) found PDs in 13% of adults in an urban setting in the United Kingdom.

PTSD/PD: "Only a Fraction of Clinical Reality"—Comorbidity or "Intermorbidity"?

The DSM-IV and the ICD-10 are categorical, rather than dimensional classification systems. This means that each disorder category is viewed as discrete with some imaginary boundary separating one psychiatric condition from the other. Without the categorical assumption to diagnostic entities, the comorbidity concept would not be possible. Maser et al.(1997) note that "The DSM-IV disputes the claim that 'each category of mental disorder is a completely discrete entity with absolute boundaries.' However, although its designers can make this statement with every honest intention, *researchers and insurance companies act if each category is a discrete entity*" (p. 6, italics added). For this reason many believe that the DSM-IV, as

important as it has become, is a contemporary diagnostic system that "represents *only a fraction of clinical reality* . . .[as clinicians] find that the boundaries of any given category are an inadequate match with the patients they treat" (Maser et al., 1997, p. 3, italics added).

Character and the persistence of PTSD symptoms over time have important implications for syndrome/PD comorbidity in general and for the proposed concept of traumatic stress personality disorder in particular. Thus, Green et al. (1990) found a PTSD rate of 44% among 120 survivors of the Buffalo Creek disaster two years after the event, and a rate of 28% after 14 years. Observing the tenacious nature of the course of PTSD, these writers concluded that PTSD may be almost 100% persistent in the life of victims. Populations of injury victims also suffered persisting symptoms, some becoming even worse on average over time (Perry et al., 1992). This degree of persistence is likely to indicate that PTSD shapes and is shaped by the individual's character structure and functioning. Since PTSD is regarded as "a scar for life" (D'Souza, 1995), it is expected to create a biopsychological imprint on the victim's personality organization. One manifestation of this imprint comes from the research studies of LeDoux et al. (1991) whose investigations on electrical stimulation of the amygdala led to the conclusion that "emotional memories are forever." Here, subcortical emotional memories that are associated with conditioned fear responses fail to reach extinction.

Since PTSD/PD may either exert "little or no [mutual] influence . . .substantial . . .influence, or a *transaction* . . .between personality and trauma" (Hyer et al., 1991, p. 173, italics added), viewing the "simple state/trait dichotomy" may prove to be basically flawed (Kudler, 1993). This is in part because the biopsychological instability intrinsic to PTSD significantly influences the development of a personality disorder. Kudler, consistent with this writer's position, argues that the "usual division between axes I and II *may not apply to the character pathology that follows psychological trauma*" (p. 1906, italics added). He also notes that "Clinical experience raises two objections to the simple state/trait dichotomy: (1) traumatic events . . .*interweave* with developmental forces to form *admixtures* of state and trait (as in adult survivors of childhood incest who often meet criteria for both PTSD and borderline personality disorder), and (2) reasonably normal adults suffering overwhelming events may develop profound and persistent symptoms *descriptively equivalent* to those of borderline patients" (p. 1906, italics added). In Gunderson and Sabo's (1993b) reply to Kudler, they acknowledged that the original purpose in separating the two axes may have in many instances outlived its utility, and so requires scientific review.

The traumatic stress personality disorder is conceptualized here as a continuous, transactional, dissociogenic syndrome in which the *classical signs and symptoms of the traumatic neurosis* and personality disorder traits

commingle to form a new dissociation-prone organization, an irreducible structure. Though PTSD is classified among the anxiety disorders, many believe it should be entered in the next DSM version as a *dissociative disorder* (Parson, 1994a).

Thus, this writer prefers to view PTSD/PD in terms of intermorbidity rather than comorbidity. Most clinicians would agree that in each case of PTSD there is a dynamic, fluid, interactive process in which PTSD symptoms, somatic responses, anxiety, depression, and personality elements do not constitute five clinical conditions, but as Davanloo (1990) would point out, one condition with five elements. Subsequently, PTSD may not be a "confounding factor" in personality measurement as anxiety and depression are said to be (Reich et al., 1986), but one element in the total clinical scheme of problems experienced by the patient. The inseparability of PTSD and BPD may be seen in common biochemical properties (Lonie, 1993; Van der Kolk, 1987). What's needed here is not PD measurement vs. PTSD measurement, but conceptually integrative and methodological enlightened pathways to understanding and treating PTSD/PD together. For clinicians and scientists to maintain the belief that PTSD/PD can be realistically separated into neat, discrete components, and studied and treated independently, is probably an example of "pseudoscientific fantasying."

TRAUMATIC STRESS PERSONALITY DISORDER (TrSPD): THE CORE PSYCHOPATHOLOGY

Studying personality in PTSD sufferers, researchers found an "abnormal personality" (Davidson et al., 1987), an altered structure in which authority or control over the organization of experience, attention, memory, and affects are diminished. Post-traumatic alterations in self governance is observed in disturbances of consciousness regulation (i.e., disintegrative experiences like dissociative amnesia, dissociative fugue, depersonalization, *ataque de nervios, latah, amok*, etc.), in the neurological, psychological, and behavioral deficits and meaning dimensions of the self.

Personality Structure in Trauma: "Probably Much Less Immutable"

Some years ago some theorists saw this writer as reluctant to unqualifyingly apply the traditional personality disorder criteria to trauma survivors (Brende, 1983), since psychic traumatization was understood as etiologically significant as negative early childhood experiences in the evolution of personality pathologies and conditions like "post-traumatic self disorders and narcissistic scarring" (Wilson, 1989, p. 109).

Many theorists view the individual's personality as a complex series of developmental reinforcements, producing a permanent installation that *once achieved, is always maintained*. This position naturally leads to the assumption that all post-traumatic symptoms (such as irritability and restlessness, sleep disturbance, preference for social isolation, work inhibitions, etc.) are due not to the toxicity of the event itself, but to vulnerabilities in the individual's character structure (or predisposition). Though most psychoanalysts held that traumatic symptoms were expressions of latent childhood-based conflicts reactivated by the traumatic event, Abraham Kardiner (1941) was among the first to view extreme stress as capable of precipitating a traumatic disorder even in persons with integrated personalities. Shatan (1977) concurs when he wrote that "survivors of concentration camps and of counterguerrilla warfare have taught us that psychic structure is probably *much less immutable than we used to think*" (p. 343, italics added). These significant changes have also been conceptualized within a behavioral/cognitive perspective (Foa et al., 1989; Keane et al., 1985).

Psychological trauma essentially assaults the character structure of the victim. This assault may produce negative alterations in rudimentary cognitive, affective, and behavioral elements that make up Millon's (1981) eight core types of personality disorders (based on the kind of reinforcement [pain or pleasure], source of reward [self or others], and instrumental style [active/passive]). Such fundamental alterations may lead to shifts in reinforcement from pain to pleasure, from pleasure to pain, from self-oriented reward to other-based reward; or from active to passive or from passive to active.

Reflecting on the nature of trauma and attendant personality changes, Kolb (1989) stated that "at one time or another, PTSD may appear to mimic every personality disorder (p. 812). Speaking more precisely about the character-altering effects of traumatic neurosis, Kardiner wrote that

> [T]raumatic experiences might precipitate any personality disorder but . . .no matter the features of that disorder the cardinal features of this traumatic . . .neurosis co-exist with and are always present in the clinical picture of any other pre- or co-existing syndrome (Kolb & Mutalipassi, 1982, p. 981, italics added).

The implications of the above are that (1) trauma may trigger schizoid, paranoid, borderline, or other PDs; (2) PTSD symptoms are persistent (up to five decades after the trauma) and co-exist or interact with personality traits; and (3) PTSD symptoms interact with pre- and post-traumatic personality traits/disorders or syndromes. Table 2 presents a description of the proposed diagnostic entity, "traumatic stress personality disorder," which may contribute to future scientific research in the area of PTSD/PD comorbidity.

Traumatic stress personality disorder's core dimensions are organized into a biopsychobehavioral conceptual framework. In the **biological domain**

are *post-traumatic stress disorder; terror of death—emotional conditioned response and avoidance*; *neurobiologic hypersensitivity, low affect tolerance, and emotional constriction*; and *body-record somatopsychic conditioned programming and symptoms.* In the **psychological domain** are *cognitive-phenomenologic deficits, traumatic dissociogenicity and identity fragmentation*; *noogenicity and changes in systems of meaning*; and *shattered central organizing beliefs: changes in self-perception.* And, in the **behavioral domain** is *dysattachment—disconnection, and pathology in empathy and mutual relating.* These domains naturally overlap, and are interactive in terms of their biological, psychological, and behavioral elements.

Post-Traumatic Stress Disorder (PTSD): Stressor, Etiology, Predisposition, Clinical Features and Impairments

The stressor in events such as rape, war, and disasters, is, by definition, the primary causative factor in post-traumatic stress disorder. Yet, not everyone exposed to traumatic stressors succumb to PTSD, though depression,

Table 2. Description and Preliminary Criteria Traumatic Stress Personality Disorder (TrSPD)

- Enduring personality change after an overwhelming or traumatic event.
- The traumatic stressor is to be extreme and extraordinary (it may be a single episode or prolonged exposure, exemplified by such untoward events as rape, incest, war, severe car accidents, criminal victimization, natural and human-engineered disasters, captivity in hostage, political torture, and prisoner-of-war situations, and continuous or sporadic urban community violence affecting children and families).
- Post-traumatic stress disorder must precede the diagnosis (TrSPD), and a manifestation of flexible, maladaptive, chronic, and irreversible biopsychobehavioral patterns (as outlined in Table 1) must be present, and markedly impair a victim/survivor's ability to live, work, and achieve self-actualizing prominence toward personal growth and well-being.
- These personality changes and associated responses are to be divergent from pretraumatic personality patterns that the issue of predisposition would be immaterial to explaining of the individual's neurological, psychological, and behavioral functioning.
- Affected individuals may be only minimally aware of the significant personality alternation others are able to see in them. It is usually a mother, father, sister, brother, spouse, or some other close relative or friend who has knowledge about the significant alterations in personality since the traumatizing experience. Specifically, in TrSPD these alternations are noted in symptoms not present before the event: (1) prominent neurobiological deficits/symptons such as irritability, hypervigilance, inability to relax, and sleep disturbance; (2) excessive self-preoccupation, and presistent social ambivalence and withdrawal; (3) persistent fears of terror over the return of elements of the dissociated past; (4) work inhibitions; (5) existential reactions of despair, emptines, and lack of meaning in life; and (6) persistent patterns of behavior and thinking that are maladaptive and inflexible.

anxiety, and grief states may later emerge in victims' functioning. Post-traumatic stress disorder is a syndromal array of intrusive, avoidance, and arousal symptoms whose etiology is rooted in one or more life-threatening, terror-inducing events, or a continuous toxic situation. The diagnosis is distinguished from other psychiatric disorders by its reliance on a presumed cause built into the criteria. Thus, for the diagnosis to be given an individual would have experienced a *severe life-threatening event* (Criterion A), and later respond with a specific *pattern of post-traumatic symptomatology* (Criteria B, C, and D).

In terms of the natural course of PTSD, immediately after the life-threatening experience, pangs of inner terror, anxiety, and heightened autonomic arousal emerge. The associated biphasic cognitive-affective processing of trauma elements involves alternating between intrusion and numbing over time. This compulsive process is motivated to master the trauma and regulate fear, but may become fixated on either numbing or intrusion, with persistent presence of arousal.

The disorder may begin immediately after exposure to an overwhelming event or be delayed for weeks, months, or even up to 30 to 50 years (Dinnen, 1993; Parson 1994a, 1996a). Thus, Kuch and Cox (1992) found that 46% of their total sample met criteria for PTSD some 50 years after the Holocaust. Studies reveal that about 30% of patients recover completely, 40% continue to have mild symptoms, and 10% remain unchanged or get worse (Kaplan & Sadock, 1994).

Terror of Death—Conditioned Emotional Response and Avoidance

Hypersensitizing Self-Preserving Biological Mechanisms

The most important motivating life-force in humans and in other species is the ensuring of survival. Overwhelming events tend to evoke "basic survival functioning" accompanied by "primitive or even subhuman defensive behavior, called biogenetic . . .regression" (Brende & McCann, 1987, p. 61). Overwhelming events trigger subcortical survival-ensuring mechanisms that register threat signals internally, and which activate self-preservative biological avoidance as responses to victims' sense of physical and psychological vulnerability, and the shattering of moral integrity (as seen in some cases severe child sexual victimization). One consequence of exposure to overwhelming events is the enduring internalized image of death. In addition to the well known signature psychophysiological responses in trauma situations, the self is also "stamped" with what Robert Jay Lifton

(1993) called the *death imprint*, which, he notes, is always associated with anxiety.

Terror management theory, based on the works of Otto Rank and Becker, holds that an exaggerated fear of death is rooted in an instinct for self-preservation (Harmon-Jones et al., 1997). However, when this instinct is overwhelmed in traumatic situations, the victim persists in living in the affective climate of the traumatic event with "enduring vigilance for and sensitivity to environmental threat" (Kardiner in Van der Kolk, 1987, p. 3). Even as a psychoanalyst Kardiner (1941) spoke of "conditioning" to explain the chronic, persistent PTSD pathology in survivors. Fear-processing, then, becomes an integral aspect of the therapeutic management of trauma symptoms in victims (Foa & Kozak, 1986).

Neurobiologic Hypersensitivity, Low Affect Tolerance, Emotional Constriction, and Numbing

Freud's Ruptured Stimulus Barrier and Kardiner's Physioneurosis

Freud (1916–1917), in his *Introductory Lecturers,* understood the cause of psychological trauma to be the "excessive magnitude of stimuli [that was] too powerful to be worked off in a normal way" (p. 210). By "excessive magnitude," Freud implied that the victim's personality organization was overwhelmed when exposed to traumatic terror. This external force produced "a disturbance . . .[due to] a break in an otherwise efficacious stimulus barrier" (p. 33). The stimulus barrier is an hypothetical biologic/neurologic structure, a forerunner concept to those identified neuroendocrine processes in contemporary neurosciences research on PTSD (Everly, 1989; 1993; Mason et al., 1990; Parson, 1984; Wilson, 1989; Van der Kolk, et al., 1985).

Regulation of affect and low affect tolerance are aspects of the total "human emotional damages" endured by victims (Krystal, 1984; Parson, 1984). In his "Introduction to Psychoanalysis and the War Neurosis," Freud (1919/1954) explained how the patients' dream life took them back to the traumatic event from which they awakens with "renewed terror." He concluded that the survivor had experienced a *physical* fixation on the traumatic event itself. Consistent with Freud's neurological hypothesis associated with traumatic neurosis (or PTSD), is Kardiner's formulation that "the nucleus of the neurosis [that is, PTSD) is a 'physioneurosis'" (Kardiner & Speigel, 1974, p. 42). More recently, Joel Brende (1984) was the first trauma scientist to conduct research on the relatively unrecognized psychophysiological alterations that accompanied psychic trauma and dis-

sociation. Other writers have addressed the psychoneuroendocrinology of PTSD (Mason et al., 1990; Van der Kolk et al., 1985).

Neuroendocrine Disturbances and "Behavioral Sensitization"

Though scientists have found neurological and biochemical factors to be associated with some personality disorders (Coccaro et al., 1994), according to scientists from the Neurosciences Division of the National Center for PTSD, "a key to PTSD lies in brain chemistry" (Goleman, 1990, p. C1). Viewing the brain "as a 'wet' hormonal gland rather than a 'dry' cybernetic computer control system" (Bergland, 1985), scientists are beginning to replace engineering sciences models with "nonideal systems, such as turbulence, climatic change, and wave motion that are almost chaotic or quasirandom" (Groves & Young, 1986, p. 18). Contemporary neurosciences research is discovering brain structures and biochemical processes that have important implications for PTSD and PD.

In the wake of uncontrollable stress, PTSD pathology is marked by imbalances in three brain systems/centers: (1) the locus ceruleus (a structure regulating the brain's secretions of two catecholamines, whose excessive hormonal secretions in PTSD give false signals to the body, mobilizing emergency response to danger when no threat is objectively discernible); (2) the hypothalamus and pituitary glands that secretes corticotrophin-releasing hormones, a key hormone in mobilizing the body to action against external threat that does not exist in reality; and (3) the overly hyperactive opiod center that controls pain. Solomon et al. (1997) thus reported psychoneuroimmunological changes in survivors exposed to a natural disaster (the 1994 Northridge earthquake in Southern California), while Gruen et al. (1997) found that self-criticism was related to stress-induced changes in biochemistry in a sample of women.

In contrast to ordinary PDs (that is, nontrauma related), traumatic stress personality disorders feature significant brain changes associated with increased sympathetic arousal (abnormal startle response, and a slower habituation to repeated presentations of stimuli); hypofunction of the hypothalamic-pituitary-adrenocortical (HPA) axis [decreased urinary cortisol levels; elevated urinary catecholamine/cortisol ratio], cardiac reactivity, persistent elevation of blood pressure, changes in immune and digestive systems functioning, increased sensitivity of HPA feedback; problematic regulation of the endogenous opiod system; and changes in physiology of sleeping and dreaming (Davidson & Baum, 1993; Everly, 1993; Kolb, 1987; Mason et al., 1990; Parson, 1994a; Van der Kolk, 1994).

"The Body Keeps the Score": Somatopsychic Conditioned Response

Research scientists indicate that trauma is stored in somatic memory record networks. The body's representation of the trauma is through hyperarousal, an ongoing remnant of the initial autonomic arousal that prepared the victim for defensive actions against the threat imposed by the traumatizing stimuli. A number of physical health problems have come from sympathetic nervous system arousal, neuroendocrine disturbance, and from "kindling." Thus, victims may suffer from cardiac reactivity, chronic elevations in blood pressure, changes in immune and digestive systems, and alterations in the physiology of sleeping. In the aftermath of trauma, "the body keeps the score" (Van der Kolk, 1994) of recorded somatic, hormonal, neurocognitive and affective programming.

Cognitive-Phenomenologic Deficits

In their article, "Life After Trauma: Personality and Daily Life Experiences of Traumatized People," Bunce et al. (1995) concluded that "traumatized and nontraumatized individuals are *different in their personalities and daily lives* . . ." (p. 180, italics added). Monitoring and regulation of memory is also problematic (Yehuda et al., 1995), marked by torment of remembrance—a "dilemma of memory" where fear of remembering, terror of not being able to forget, and an inability to recall important personal data persist. Hyer et al. (1991) found pervasive cognitive distortions associated with trauma themes, and faulty private logic—"an excessive amount of irrational beliefs" (p. 165) in a sample of traumatized veterans. In addition, Kilpatrick & Veronen (1984) found that among a sample of rape victims 64% felt they would be injured or killed by attack, 96% felt scared, 96% were worried, 92% were terrified, and 88% expressed a sense of helplessness. In two other studies rape victims and war veterans exhibited significant intrusive cognitive activity on a modified version of the Stroop test (McNally et al., 1990), while Wilkinson (1983) found concentration deficits in 42% of victims of the Hyatt Regency Hotel skywalk collapse. While Chemtob et al., 1997) reported on deficits in anger control, Bremner et al. (1993) found deficits in short-term memory in war veterans with PTSD.

Litz and Keane (1989) hypothesized that PTSD was linked to an information-processing response *bias* toward trauma-related stimuli during memory retrieval, rather than a memory retrieval deficit per se. Litz et al. (1996) later found that PTSD subjects demonstrated a generalized threat-related attentional bias, when compared with both well-adjusted and psychiatric control groups. Gil et al. (1990) found that among a sample of

survivors of terrorist attacks, war trauma, and car accidents there were significant cognitive deficits in the areas of intelligence, neurological functioning, verbal fluency, memory, and attention.

Traumatic Dissociogenicity and Identity Fragmentation

Pierre Janet's *L'automatisme psychologique* published in 1889 advanced his views about how stress, trauma, and dissociation contribute to chronic psychopathology in victims (Janet, 1889/1973, 1919/1925). He detailed the risk factors for long-term psychopathology. This is in contrast to the prevailing view among clinicians that dissociation protects the victim against long-term psychopathology. Using the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), the Modified Dissociative Experiences Questionnaire (DEQ-M), and other survey instruments, Bremner & Brett's (1997) findings were consistent with Janet's theoretical position: they found the presence of dissociation at the time of the traumatic event to be a marker for long-term illnesses. In agreement with this writer's position, Bremner & Brett (1997) concluded that dissociation does seem to have some short-term benefits, but becomes a vulnerability factor in the development of serious, chronic pathology over time.

Other studies have thus shown that dissociative symptoms present at the time of combat trauma were better predictors for post-traumatic pathology, even better than the intensity variable (shown as the best predictor of current trauma psychopathology in previous studies). Dissociative symptoms have been found in child and pediatric victims of abusive violence and neglect (Parson, 1995c, 1997a; Putnam & Guroff, 1986; of Suhr, 1986), of disasters (Cardena & Spiegel, 1993; Lindy & Titchener, 1983; Parson, 1995a, 1995c; Sanders & Giolas, 1991), of burn injury, of physical and sexual violence (Parson, 1996c; Perry et al., 1992), and in combat veterans (Bremner & Brett, 1997; Parson, 1984).

Noogenicity and Changes in Systems of Meaning

As a consequence of trauma, victims, like Leo Tolstoy, experience the absence of meaning as the shattering breakdown of the foundation of their philosophy of life. Without meaning the individual's inner sense of safety is lost, and, replacing it is internalized perpetual danger and further vulnerability. Everly (1993) thus writes that overwhelming events cause "a trauma-induced disruption, violation, and contradiction to one's personal *weltanschauung*, i.e., that which keeps us safe" (p. 276). Victor Frankl found that 20% of his patients' emotional symptoms were "noogenic" in nature;

that is, these problems had originated from the absence of meaning in life. The antidote for noogenicity was a successful search for meaning, the basis for his "logotherapy" (Yalom, 1980). Meaning is related to PTSD outcome (Ursano et al., 1992). The victim's appraisal process and *structure of meaning* in terms of *duration, threat, risk, and responsibility* (Fontana et al., 1992) are closely associated to the perceived role as "witness, participant, target, observer, [and] agent" (Ursano et al., 1992, p. 757). One consequence of the loss of meaning after traumatic experiences is an enfeeblement of cherished and sustaining central organizing beliefs about self and self in relation to world. Like Tolstoy, victims have experienced the ground on which they stood as crumbling with nothing to stand on. And, though they physically remain alive, they seek meaning in therapy to remain alive psychologically as well through acquiring new psychic structure and a sense of biopsychobehavioral coherence. Taylor (1983) believes that finding meaning is perhaps the most critical factor in coping after catastrophe. Shattering the narcissistic feeling of being personally invulnerable to being totally vulnerable undermines meaning. Many patients like Paul find meaning and increased coping through rituals, religious beliefs, and philosophical systems (Meichenbaum, 1994; Roe-Berning & Straker, 1997).

Shattered Central Organizing Beliefs—Changes in Self Perception and Narcissistic Injury

Alterations in victims' self perception are often observed clinically in victims' statements such as, "I am now a different person, and I've been changed beyond recognition by me or by anyone else"; "I am not a person, no, not anymore!"; "What will become of me, I have lost my anchors?"; "Is this what life has come to for me? I now feel so strange in the world"; "The world doesn't look the same anymore"; "Will I ever feel safe in this world again?" "I now wonder, is anyone anywhere trustworthy anymore?" "Why me?" Alterations in the systems of meaning often results in feelings of despair, hopelessness, loss of an inner sense of control, stability, and sense of safety, a shattering of values, and concommitant altered view of self, and self in relation to world. Changes are also noted in survivor's self-evaluation: "Something must be wrong, deeply wrong with me: I should not had been in that place"; "It was awful, but was it truly rape, or something else?" "I am trash"; "I'm a marked man"; "I'm dirty"; "I'm sure I am contaminated"; "I'm ugly and unlovable"; "I'm a 'good for nothing,'" etc.

The experience of living with painful memories in the absence of accessible integrative values, confidence, and self-control, constitute a *narcis-*

sistic insult/injury that leads to *narcissistic rage*, a powerful affective response of the narcissistically injured self (Parson, 1984; 1988). Rage emerges in response to the perceived shattering of central organizing beliefs—the sense of worthiness and competence, of inviolable specialness, and of the need to be admired, respected and loved by all, at all time. When trauma strikes, these beliefs are uprooted, and biopsychic decline and ineffectual defenses supervene. The immediate effects of post-traumatic narcissistic injury is comparable to Kohut's (1972) description of reactive narcissistic anguish and rage in a person who intuits or perceives cognitive and organic deficits in areas of previous competence. He notes, "The anger of a person which, due to cerebral deficit or brain injury, is unable to solve simple problems, and the anger of a child who suffered a minor painful injury." Moreover, flashbacks "are the equivalent of minitraumas which keep them [victims] psychically linked to the original . . .traumatic event in a helpless and hopeless manner, adversely affecting their self-esteem and self experience" (Parson, 1984, p. 32, 1996b). For many, the experience of losing the capacity to tolerate psychophysiological arousal, and being aware of deficits in the balance between stimulation/arousal and soothing, is narcissistically insulting and injurious (Parson, 1993).

Dysattachment—Disconnection, and Pathology of Empathy and Mutual Relating

Victims may suffer personality changes observed in secondary difficulties in interpersonal and social relationships. Meichenbaum (1994) notes that "survivors of prolonged abuse develop characteristic *personality changes* including 'deformations of relations and identity'" (p. 35, italics added), due to regressive fragmentation of trust, autonomy, and initiative. After trauma, problems in memory, impulsivity and affect regulation, persistent fears, and tendency to avoidance devastate interpersonal and social relations—in the home, workplace, community, and in all other spheres of human relating (Keene et al., 1985; Lindy, 1988; Parson, 1988, 1994a, 1994b; Wilson, 1989; Van der Kolk, 1987). Trauma is also associated with marital discord, problematic parenting, high divorce rates, and to problematic functioning in the workplace.

ASSESSMENT AND TRAUMATIC STRESS PERSONALITY DISORDER

Assessment in the context of traumatic stress begins with an accurate understanding of the problem, progressing to detailed personal and family

histories, which provide personality data for family members from which inferences are made concerning pretraumatic personality configurations and post-traumatic organization. Contemporary traumatic stress assessment may include, additionally, the *Rorschach*, the *Minnesota Multiphasic Personality Inventory* (MMPI), the *Millon Clinical Multiaxial Inventory* (MCMI), the *Structured Clinical Interview for the DSM-III-R* (Spitzer, Williams, & Gibbon, 1986), the *Impact of Events Scale* (Horowitz et al., 1979), the *Personality Disorder Examination* (PDE; Loranger et al., 1988), the SCID for Personality Disorders (SCID-II; Spitzer et al., 1990), the *Dissociative Experiences Scale* (DES; Bernstein & Putnam, 1986), and the *Clinician Administered PTSD Scale* (CAPS-1) (Blake et al., 1990). In terms of the measurement of the search for meaning, and salutogenetic effects (positive effects of the trauma), the World-Assumptions Scale (Janoff-Bulman, 1993), and the Social Adjustment Scale (Weisman et al., 1981) are recommended, respectively.

Physiological measures of victims' heart rate, cardiac reactivity, muscle tension, etc. (Blanchard et al., 1986), and neuroendocrine measures that detect levels of norepinephrine in proportion to cortisol are now regarded to be important dimensions of a comprehensive assessment of PTSD (PTSD patients are reported to be "super-suppressors" of cortisol [Yehuda et al., 1993]). Victims suspected of having head injury from traumatic assault, may suffer neurocortical damage. This requires an assessment of executive neurocognitive functions (involved in formulating goals and carrying out plans in an independent, creative, and socially constructive manner [Lezak, 1982]).

INTERTHEORETICAL THERAPY AND TrSPD: FROM CIRCULAR TRAUMA PROCESS TO LINEAR GROWTH EXPERIENCE

Solomon was correct that PTSD is a complex disorder that is "*highly resistant to cure by any of the treatment modalities available to date*," and that the "development of new modes of intervention is called for" (quoted in Meichenbaum, 1994, italics added). And because PTSD "does indeed have a complex and unique biological basis" (Freedman in *New York Times*, 1988, p. 10), the proposed treatment approach is *intertheoretical*. It is integrative in its multitheoretical, multitechnical, and multiphasic structure. The symptoms of intrusive-repetitive traumatic ideation is often described by patients as the "terror-go-round" (in contrast to the merry go-round), as they long for transitional relief that will take them in a "straight line to health." Mardi Horowitz (1986) had recognized the need for divergent theories and treatment approaches to manage circular trauma processes,

and has devised a system of care to promote growth in patient with *stress response syndromes*.

Like most people with personality pathology, victims with traumatic stress personality disorder are seen by many as treatment refractory. But some writers believe that not only are these disorders not treatment-resistant but that therapy can produce enduring personality change (Davanloo, 1990; Malan & Osimo, 1992) through procedures and experiences that "provide new structure or organization to a personality" (Magnavita, 1997, p. 17). The therapy proposed here for traumatic stress personality disorder focuses on *post-traumatic reconstruction* by impacting directly the patient's trauma-defense constellation, cognitive, affective, and behavioral avoidance, dissociogenic functioning, low affect tolerance, attachment dysfunctions, and trauma-driven central organizing cognitions. Basically, intertheoretical therapy for traumatic personality disorders involve gradual, incremental step-by-step actions, logical discourse, experimentation, empirical analysis, and collaborative empiricism in a safe, cohesive human relationship.

Clinical Vignette: Case of Hidden Traumatic Stress Personality Disorder

Paul Anson is a 48-year-old Caucasian entrepreneur who was hospitalized for major depression and persistent chronic anxiety. He left his job after 18 years at an aerospace corporation where he achieved the position and status of corporate vice president. He decided to work for himself to achieve personal freedom and financial independence. The patient's marriage of 15 years came to its demise due in part to financial stress and worries. After six weeks of antidepressant, anxiolytics, and anti-psychotic medications, and milieu therapy in the inpatient setting, the interdisciplinary team found the patient was not responding to the treatment, and believed a change in treatment strategy was required. In fact, the patient became increasingly dysfunctional: intensification of concentration problems, more hypervigilance, mistrust, irritability, with an increase in sleep disturbance, withdrawal, tremulousness, tearful lamentations, and symptoms often associated with an acute anxiety reactions or acute traumatic stress disorder (APA, 1994). There were no reports of psychiatric illnesses and hospitalizations in the patient's social and family history. He was the product of a fully functional, cohesive, and supportive family system—no history of physical or sexual abuse. Additionally, there were no warzone traumatic stressors, car accidents, nor any other life-threatening, catastrophic experience.

This writer was called in on a consultative basis to examine the patient to discover the true nature of his psychopathology, and to offer guidance to the clinical team in restructuring the patient's current treatment plan. The patient was given a battery of psychometric and psychodiagnostic tests, and psychiatric assessment procedures that were both self-report and clinician-administered. Specifically, the findings of the assessment showed that the patient was suffering from post-traumatic stress disorder and personality disorder pathology. In terms of *core traumatic stress responses,* the IES reflected significant levels of intrusion and distress; the CAPS and SCID reached criteria on all subscales for PTSD, the Rorschach showed empirically-derived PTSD patterns, reflected in high scores (compared to Exner's [1990] normative scores) on *m, M-, FC+CF+C+Cn, D-, Y, X-%, S, T,* and low *X+%* and *F+%* (e.g., Levin, 1993), with no convergence of evidence for psychosis. Moreover,

on the MMPI significant elevations on the F validity, D, and Sc scales were noted. Indicating *core traumatic personality configurations,* were the MCMI and PDE, reflecting the basic traumatic personality with schizoid, dependent, and narcissistic traits and defenses. These findings are also consistent with the scientific literature on PTSD and the MMPI (Hyer et al., 1986; Keane et al., 1984; Koretzky & Peck, 1990; McCaffrey et al., 1989), and PTSD and the MCMI (Hyer et al., 1991; Hyer & Boudewyns, 1985).

Paul's MCMI profile, 8-2-1-5, indicate that his traumatic stress personality disorder involves passive-aggressive, schizoid, avoidant, dependent, and narcissistic features. According Millon (1981), this code describes a person who is "oversensitive, fearful, self-preoccupied, disgruntled, uneasy, irritable, neat, traditional, moody, [and] unsettled," and also suffers interpersonal aloofness, behavioral lethargy, contrariness and avoidance, and narcissistic disturbance. Narcissistic disturbance in trauma victims is not usually associated with the arrogance, haughtiness, the taking advantage of others, and expectation of excessive admiration as described in the DSM-IV [APA, 1994]), but with a passionate desire to protect the self against anticipated narcissistically injurious encounters, and against the consequences of having lost a sense of trust, autonomy, and initiative in life (Wilson & Prabucki, 1983). These deficits tend to "assault" self-esteem and central organizing beliefs about self, others, and safety, and about predictability, and controllability.

In addition to the TrSPD symptoms above are *intense subjective distress, constricted depressive-avoidant affect*, and *regressive dissociogenic ideational intrusion* (MMPI). The Rorschach substantiated these above findings: it indicated the presence of peculiarities in thinking, disordered affect, helplessness, persistent arousal and irritability, hypervigilance, and impoverished reality testing. Close clinical scrutiny of these psychodiagnostic and psychometric findings shows a befuddled diagnostic matrix of syndrome-PD symptoms and traits that combined the symptoms of classical traumatic neurosis (i.e., nightmares, heightened autonomic hypersensitivity, dissociated somatic symptoms, etc.) and characterological traits resembling borderline, narcissistic, and psychotic-like conditions (Brende & Parson, 1985; Parson, 1984).

These unexpected and puzzling findings were later enlightened by a renewed effort to discover a traumatic event (or DSM-IV Criterion A) in Paul's life. The reassessment process on the patient's psychopathology and personal history were organized into an intensive year-by-year structured interview format that was chronologically-ordered. Detailed exploration and inquiry into specific events that may have occurred in his life (such as births, death, personal injuries [e.g., falls, battery, muggings]), car accidents, and physical and sexual abuse, finally provided some of the missing pieces of the diagnostic puzzle.

As a result of this process, the patient remembered that one night four years before, his wife, having become sexually involved with his best friend, had told him she was going out and not to wait up for her. The patient became very upset, angry, and decided to drink alcohol until he was "really drunk." He decided to confront his wife at her boyfriend's house. He arrived at the house, and walked up to the door. The door opened, and he saw his wife with a towel around her. The patient asked her to come home, but she ridiculed him, as she refused his request and shouted out that he leave. Paul had refused to leave. Suddenly, the other man, described as "a huge, 6 feet, 6 inches, awesome, and muscular specimen" (stating that "I'm only 5 feet, 7.5 inches") bolted out the front door, and threatened to beat him up if he didn't go away. The patient insisted on his wife returning home with him, and he refused to leave. The man took a baseball bat, chased the patient for about 20 yards, and repeatedly mauled and bludgeoned him, which was later classified by the authorities as "attempted murder." The patient was beaten severely, and he recollects "being beaten into a bloody mess, with blood running down the

slightly inclined road" when he was found after being unconscious for an unknown period of time. Paul sustained life-threatening internal injuries to his head and torso, and almost died in the assault. Paul also reported that his eye socket was cracked, and the damage resulted in severe excruciating headaches which he endures to the present time. His vision had progressively deteriorated after the assault. He has had several surgical procedures to correct his vision and reduce his pain syndrome, but relief has been little and temporary. Reflecting on his painful emotional experience, Paul stated, "When I think of what happened to me I feel like a wounded animal. I still feel this way." Assessment of Paul's executive functions was conducted to determine the nature of impairments associated with possible brain injury due to head and facial trauma (principles and procedures outlined and recommended by Muriel Lezak, 1982). Some neurocortical symptoms were noted on neuropsychological tests, and a referral for more definitive evaluation was effected.

Paul's traumatizing experience had been dissociated and therefore unavailable to the patient's conscious mind and memory for cognitive processing toward healing and integration over time, or for reporting an accurate history to hospital psychiatric staff. The patient had significant sleep problems, sleeping only three to four hours per night since the traumatizing incident. Paul had never discussed the incident with anyone before. The beating is understood here to have reached DSM-IV criterion, and had precipitated biopsychobehavioral responses associated with traumatic stress personality disorder. It is well known now that it is not the psychotoxic shock of a traumatic event alone produces PTSD, but the *meaning the victim gives to it* (Lifton, 1968; Meichenbaum, 1994; Parson, 1984; 1988; Ulman & Brothers, 1989; Ursano et al., 1992). Thus, from Paul's perspective, the high degree of betrayal by people who were so very close to him had assaulted and shattered central organizing narcissistic beliefs about self, others, and reality. The blatant, disrespectful, "in your face" attitude shown by his wife and former friend devastated the pillars of self-esteem, and a blow to his narcissism and sense of well-being. This narcissistic wound, along with the traumatizing physical battery itself, precipitated PTSD, and maintained attendant dissociative and fragmented character processes. With enlightened psychopharmacological intervention and therapy, the patient left the hospital in ten days and was referred for outpatient treatment. The course of the patient's treatment is later discussed in terms of an interphasic, intertheoretical, and interdisciplinary treatment model.

The Interphasic, Intertheoretical, and Interdisciplinary Structure for Phases I and II

Though it is true outcome studies on the treatment of chronic PTSD have been few, and are often inconsistent in their findings (Hyer et al., 1993; Lindy, 1988; Solomon, 1992), the present model explores the development of "new modes of intervention" that may be tested in future outcome research studies. What has been very consistent in the study and clinical treatment of PTSD is "the inevitable rigidification of unsuccessful coping modes" (Lindy, 1988, p. 295). PTSD/PD represents this rigidification of unsuccessful coping modes.

Generally, patients presenting for clinical care come in a state of hyperarousal, with high levels of anxiety, and intrusive symptomatology. How

the treatment begins depend in part on whether the patient's symptoms are mostly intrusion/arousal, or mostly numbing/avoidant, or "balanced." Still, other patients, like Paul, might experience a combination of responses: anxiety-intrusion-hyperarousal and depression-numbing-affective constriction. The relative unstable nature of traumatic personality disorder is observed in some patients' tendency to dramatically vacillate from one ego state of affective volatility to another during the same session, or from one session to another. Clinically, if numbing is the most salient symptom, the therapy promotes remembering and associated cognitions. In the intrusion phase, the therapist helps the patient to impose external structures, increase social "containing" support, remove environmental "reminders/stressors," increase therapist's credibility in mind of the patient, and employ clinical techniques that offer calm and control.

The proposed intertheoretical model of therapy purports to increase control over the circular power of traumatic processes (intrusive-repetitive) that induce feelings of mental confusion, stasis, and immobility in the patient, and to promote forward linear movement toward personal control and growth. The rationale for the intertheoretical approach espoused here is a pragmatic one: it recognizes that no single treatment approach (whether it be cognitive, behavioral, psychodynamic, etc.) will suffice (Parson, 1984, 1988, Truant, 1995). The model employs a set of comprehensive techniques geared to manage biological symptoms and the emotional conditioned response (characterized by irritability, explosive rage, arousal, and sleep problems); the psychological symptoms such as cognitive dysfunctions, paranoid defenses, automatic remembrances, numbing and dissociation; and behavioral symptoms (interpersonal and environmental avoidance, and social isolation and withdrawal) associated with the trauma and personality organization factors (both *before* and *after* the overwhelming event). For some victims, traumatherapy may incorporate legal, political, and vocational activities and services (Parson, 1996d). Though the focus of this model is on the individual victim, group and family therapy modalities are encouraged in most cases. Thus, the treatment incorporates psychopharmacological agents, cognitive-phenomenologic and behavioral procedures, supportive, and insight-oriented psychodynamic techniques. The phases of treatment are: the *stabilization, motivation, and hope-instillation phase* (Phase I), the *desensitization-exposure phase* (Phase II), the *completion-reintegration phase* (Phase III), and the *autonomous life skills practice phase* (Phase IV). Each phase may vary in terms of its duration—from weeks to months in Phases I and II to one or more years in Phase III.

Stabilization, Motivation, and Hope Instillation Phase

The major goal of Phase 1 is to initiate the integrative processing of the trauma to stabilize an internally disorganized, hyperaroused, and hypervigilant biopsychic system. Integration and changes in victims' traumatic stress personality organization are facilitated by *motivational and inspirational processes*, *biopharmacology*, and *cognitive* and *behavioral therapies* (in the context of a safe and facilitating relationship). Often, there are reactivating environmental stimuli, or intrapsychic representations that symbolize the original event that precipitate the need to seek clinical intervention. In Paul's case there was no ostensible triggering device that he was able to identify. It was later revealed, however, that a minor crisis in his home-based business had triggered memory networks linked to previous trauma, loss, and terror.

This phase may be regarded as the *crisis/emergency* period of the treatment, since most cases involve acute symptomatology, experienced by the victim as a breakdown of chronic traumatic behavioral patterns (Parson, 1984). Like most victims, Paul viewed therapy as an *invitation to breakdown*—to lose a most costly and painfully-acquired adaptation. Paul was therefore very resistive, or, more accurately, he was terrified of the meaning of psychotherapy. However, this phase builds trust and credibility in the treatment process, establishing a respectful and supportive therapeutic alliance, while moving to restore a sense intrapsychic, interpersonal, and environmental safety.

Motivational Factors and Hope Imbuing

The patient's motivation for change requires special assessment and an early and ongoing monitoring in the treatment (Rappaport, 1997). Whether the clinician employs cognitive, behavioral, psychodynamic, or experiential/existential psychotherapy, motivational processes do determine if the victim will come to the first scheduled session, or terminate soon after therapy begins. Thus, an early-phase therapist responsibility is to figure out, "How do I inspire this person to believe in the procedures of therapy?", "What do I say and do to 'prove' to him or her that life can be better, and that what we're going to do will help to change and secure a better life after the horrific event?"

Effective therapists understand that what is truly important in treating traumatized patients is *not* solely therapists' skill and competence, but also the *patient's motivational system and its availability as ally or foe in the psychotherapeutic venture.* These therapists are also willing to be fully present

in the emotional sense, despite the empathically-generated stress that often attends trauma work. Without motivation, even patients with dense, supportive social networks may be unable to use the available resources, especially when symptoms and life disruption are severe. Further, they may be unable to *use* therapy to ameliorate distress and conflicts. Motivation in psychotherapy is associated with such social psychological factors as the patient's desire for change, interpersonal attraction, tolerance for stigmatization, frustration tolerance, openness, realistic expectations, and other factors (Schaap et al., 1993).

But why is motivation important? Should it be developed, monitored, encouraged, and maintained over time in intertheoretical therapy? Expanding the patient's capacity to process and cope more effectively with anxiety, hyperarousal, pessimism, emotional blunting, anhedonia, oversensitivity, self-preoccupation, irritability, and moody disturbance, necessitates the nurturing, development and maintenance of motivation. The persistent subjective sense of vulnerability and pervasive fear over the *return of dissociated* affectivity and memories are *demotivating*, and so require the energizing presence of the patient's will *despite* anxiety and distress. Another reason in general why motivation should be given priority status in therapy (especially during the first two phases) is because motivation *never* lasts: it comes and vanishes quickly. This then requires continuous motivational renewal and monitoring because threats of *biopsychic dissociative regression* are experienced by victims as persistent. Helping Paul to focus on positive mental expectancy (for change, growth, and general well-being), while strengthening the belief that things will work out to his advantage, were important in improving his coping. This renewal functions as a counteracting presence that promotes positive character change, and the processing and integrating dissociative illnesses. Low motivation and the failure to maintain motivation as a positive energizing force in traumatherapy is perhaps the most important factor in poor outcome. A prevalent misconception among clinicians is that patient motivation is a naturally-occurring, stable phenomenon in therapy, that it aligns itself with the objectives of therapy. Some therapist, then, do not feel special efforts to systematically enhance motivation are necessary, despite findings that low motivation in therapy is a significant problem (Rappaport, 1997).

Hope is the confident expectation that something deeply desired will be realized. Since a patient with little or no hope usually does not engage in therapy long enough to benefit optimally, the instillation of hope by therapists is important for positive, sustained outcome. Therapists may have biology as their ally in directing the patient toward change-enhancing hope, according to anthropologist Lionel Tiger (1979), who sees hope as an intrinsic dimension of human evolution.

Biopharmacological Intervention

Drug treatment for chronic PTSD often begins with a good understanding of the patient's problems. An early-phase issue for the clinician is: "What drug agent is most likely to make this patient feel or function better?" Drug treatment is often a very important adjunct to psychotherapy. The medication of choice is usually an antidepressant as first-line treatment for PTSD. These medications are often preferred over benzodiapezines agents because they are less addictive. Antidepressants affect the underlying biological mechanisms in PTSD, while alleviating comorbid major depression, and sleep disturbance often found in early-phase traumatherapy (Parson, 1994a). Whether the antidepressants used are the tricyclics (helpful for sleep and nightmare problems, and the tendency among victims to avoid public places, crowds, and family social events [Davidson et al., 1993]), MAOIs, SSRIs, or triazolopyridines, the physician's decision is often based upon a number of factors, such as side effects, cost, calming-sedating properties, and safety from overdose in depressed and suicidal victims. The anxiolytics, primarily the benzodiazepines, are also used to help ameliorate anxiety, startle reactions, hypervigilance, panic attacks, sleep aids, and antipsychotics (Kudler & Davidson, 1994; Tyrer et al., 1983), while autonomic hyperarousal is improved by use of the α-adrenergic agonist, clonidine (for PTSD patients with opiate dependence [Marmar et al, 1993]), and the β-adrenergic blocker, propranolol (Kinzie & Leung, 1989). For Paul's chronic PTSD/PD, medications were prescribed and monitored for one year to manage depression, sleep disturbance, nightmares, fear of crowds, anxiety, and panic attacks. However, interdisciplinary efforts in this case were guided by the realization that, in the overall, psychopharmacological agents for PTSD symptoms are at best palliative. These agents alone are rarely capacious for total remission to occur (Solomon & Shalev, 1994).

Cognitive Techniques and Procedures

Cognitive techniques with Paul were used during this phase to begin to deal with damaged central organizing beliefs about personal safety, predictability, guilt, shame, and collective goodness. Generally, these techniques aim to reverse dysfunctional cognitive schemas—to restore a sense of coherence and mastery. These techniques are used, additionally, to address black-white dichotomous thinking (reported in the context of trauma and personality functioning [Bradshaw et al., 1993]), and the positive facilitating impact of the "completion tendency" (the cognitive processing

proclivity toward resolving differences between new traumatic information with enduring pretrauma schemata [Horowitz, 1982]).

Cognitive approaches include cognitive restructuring, psychoeducation, homework assignments, role-playing, bibliotherapy (including books and movies), systematic relaxation training, rescripting (via letter-writing), skills training, and thought-stopping. Through these procedures Paul learned about psychological trauma, the nature of PTSD, and the recovery process, the normalizing of his symptoms, and about the possible impact of symptoms on his concentration and attending, on his relationships with his parents and other family members, and on his business outlook as entrepreneur. Paul also learned about the risks of relapses and associated psychosocial and environmental "triggers." Symptom-reframing helped Paul to see his self-blaming, denial, numbing, flashbacks, arousal, and sleep disturbance as "tools of survival," while dissociation was understood as a form of "autohypnotic competence."

The Socratic Method was also helpful to Paul in that the systematic questioning contributed to a restructuring and expanding of his thinking, understanding, insight, problem-solving, and control. This systematic forms of therapeutic questioning, formulation, and participatory engagement, propelled Paul's treatment forward. Overholser (1993a) reported on the Socratic Method in psychotherapy and identified specific kinds of questions and their respective contents geared to help the patient's cognitive and emotional integration. During this phase the present writer recommends three types of Socratic procedures—analysis, synthesis, and evaluation—to recruit and strengthen higher-order cognitive operations to help the patient control dissociative affectivity and intrusive mental and somatic phenomena. These types of questions stimulate problem-solving capabilities through the bit-by-bit breakdown of a problem into components parts (in search for evidence), through creative-divergent thinking, and the clarifying and enlarging of value judgments.

Just prior to entering the next phase, Socratic memory type of questions further clarified what happened to the patient, while enhancing cognitive/affective processing of trauma elements. These techniques provided critical skills to be employed in the very challenging Desensitization-Exposure Phase. Anger, rage, grief, and loss were also explored during this phase with Paul, but were more directly addressed in the latter phase when greater biopsychic integration and grief (affect) tolerance had been achieved.

Desensitization-Exposure Phase: Altering CNS-Based Arousal, Irritability, and the Emotional Conditioned Response

This phase is ushered in when victims' post-trauma crisis functioning is ameliorated, trust has been developed, and trauma-"managing" sub-

stance abuse has come under complete control. This phase employs exposure therapies used in the treatment of panic disorder, agoraphobia, social anxiety, phobias, and obsessive-compulsive disorder. Whether referred to as "abreaction," "exposure," "regression in the service of self cohesion" (Parson, 1988), or some other term, most theoreticians and clinicians experienced in traumatic stress believe that a *revisiting* of the past trauma—either through psychogeography as in *in vivo* or adventure-based procedures, or in psychoimagery as in guided imagery-based procedures—is key to successful affectocognitive processing of the trauma. Despite the positive benefits associated with these procedures (Herman, 1992; Rothbaum & Foa, 1992), some writers caution about the risks involved in the use of these procedures (Yapko, 1993; Genderson & Chu, 1993). This writer holds that the these techniques are *both* beneficial and harmful, depending on the specific victim's needs. A thorough initial and subsequent "benchmarking" assessments will together yield sufficient quality and quantity of data to make appropriate clinical judgments in behalf of the patient. The relational elements inside and outside the therapeutic encounter traverse the entire treatment process, from beginning phases to termination. Programmed therapeutic journal writing (Baker, 1988; L'Abate, 1992; Torem, 1993), and behavioral assignments and compliance are also included during this phase to increase learning, control, and integration.

Behavioral Theory and Techniques

Behavior theory holds that PTSD symptoms represent a conditioned fear response (Keane et al., 1985; Shalev et al., 1992), which is expected to reach extinction over time. This view, additionally, holds that cues associated with the traumatic event became the conditioned stimuli (CS), which then evokes a conditioned emotional response (CR) as PTSD symptomatology. Clinical observation and the experience of victims reveal that extinction does not occur as time progresses, despite the absence of reinforcement through re-traumatization. When the trauma occurred, the classical conditioning first produced avoidance, but to only a few proximally-relevant cues present during the event. The persistence of PTSD symptoms occur because operant conditioning had induced avoidance based on many scattered bits and pieces of distally-associated stimuli. The victim's avoidance becomes so pervasively present that an increasingly large number of stimuli (places, things, people, etc.) are avoided, producing relief from psychobiological subjective distress but preventing extinction over time (Keene et al., 1985). Since avoidance reduces distress, it results in negative rein-

forcement, and undermines the cognitive and affective processing of trauma elements.

Behavior therapeutic techniques used with Paul were thus geared to disconnect the CS from the CR, which resulted in improvements in his physiological, cognitive, and behavioral functioning. After the trauma, he had avoided going to certain places, thinking certain thoughts, doing business with certain people, and avoiding certain sounds and other stimuli that had never reached extinction. Generally, behavioral approaches may include desensitization, *in vivo* systematic desensitization (exposure to the reactivated thoughts and memories), or *in vitro* systematic desensitization (exposure to the real traumatic object or environment), adventure-based interventions (e.g., like the "helicopter ride therapy"), eye movement desensitization and reprocessing (EMDR), and direct therapeutic exposure (DTE; Boudewyns & Hyer, 1990; Cooper & Clum, 1989; Fairbanks et al., 1983; Foa et al., 1991; Foa & Riggs, 1994; Meichenbaum, 1994; Parson, 1997a, 1997b; Rheault, 1980; Scurfield, 1992; Shapiro, 1993).

The Completion-Reintegration Phase

The Completion-Reintegration Phase is ushered in when the patient has successfully achieved psychobiological stability, but, as in previous phases, integration continues to require the *active* participation of the therapist whose presence and ministrations bridge the emotional gulf that often divides patients' pretraumatic identity from current post-traumatic dissociative functioning. Whereas techniques employed in previous phases with Paul initiated control over intrusion and hyperarousal and over numbing and affective constriction, build trust and credibility in the therapeutic process, and lay the foundation for DTE procedures (that contributes further to integration), the present phase was to achieve further integration and a cohesive identity. As in the previous phases, cognitive and behavioral techniques are also used in this phase, but added to these are experiential/existential and psychodynamic techniques. Personality rigidities associated with the patient's PTSD/PD *adaptive inflexibility* and *vicious circles* (Millon, 1981) are addressed directly to alter trauma-driven schemas to reduce and resolve the patients' character-maintaining distress. Here, the therapist recognizes the patient's traumatopsychic character symptoms as a homeostatic solution for the post-traumatic disorganization. When this balance is disrupted, anxiety and intrapsychic distress erupts.

"Re-Writing the Traumatic Script of Unedited Terror": Subphases of the Completion-Reintegration Phase

Traumatic stress personality disorder and the intrinsic terror-written script require intertechnical or eclectic approaches to intervention (Norcross & Goldfried, 1992; Parson, 1984, 1988; Solomon et al., 1992). The victim's script-rewriting task continues during this phase, which is organized to facilitate deeper intrapsychic exploration into three subphases: (1) *consolidating positive gains, and the practicing process,* (2) *restructuring meaning, and building values, generativity, and social proactivity, and* (3) *reattachment, human connectivity, and positive microinternalizations.*

Consolidating Positive Gains, and the Practicing Process. Consolidation here involves reviewing desirable and undesirable effects from the DTE sessions, identifying therapeutic gains, extracting the insights gleaned, and evaluating the patient's progress to this point. As in previous and subsequent junctures, Paul found this treatment "check-point" of value: it gave him a sense of progress, and the sense of correlating his courageous efforts with specific outcomes. Using previous techniques, to include the Socratic Method's inductive reasoning [Overholser, 1993b]), the therapist revisited the terrain traversed in the previous phases until specified goals had been met before entering fully the advanced aspects of the treatment dealing with meaning and attachment dysfunctions.

The practicing process refers to the repetition of growth-enhancing skills to acquire proficiency in coping with stress, anxiety, intrusive thoughts, arousal, and negative affects and mood. This repetitive action may approximate the persistence of biopsychic intrusions. Paul acquired coping skills in how to change the stressful situation when it occurred; how to change the meaning of the event, and how to change his emotional reactions (Lazarus & Folkman, 1984; Meichenbaum, 1994). Paul's problems were broken down into smaller manageable units, translated into behaviorally specific language, and self-monitor was encouraged and expected. This prepared him for Phase IV life skills practice.

Restructuring Meaning, and Restoring Values, Generativity, and Social Proactivity. The meaning given a particular traumatic experience begins with appraisal of the threat, which mobilizes the victim's specific coping style; that is, a problem-focused or an emotion-focused one (Lazarus & Folkman, 1984). During this subphase, experiential/existential techniques were employed with Paul to help him to re-examine and change responsibility-avoidance, to mourn for lost and wounded aspects of self, to recognize and own the good and the bad in his life, and to reconcile in his life shattered vital symbols and precious beliefs (Lifton, 1993; May & Yalom, 1995; Parson, 1976, 1988). To facilitate the acquisition of meaning, and clarify values for

script-rewriting, Paul was introduced to the *constructivist narrative perspective,* in which he was able to tell and re-tell his "trauma story" to ultimately construct a "new possibilities story," after replacing meaning and purpose to the meaninglessness of his suffering. This perspective is based on the theory that human beings do not merely respond passively to painful feelings and harsh events, but actively *create* or construct their own meaning (Meichenbaum, 1994). In addition to this cognitive-phenomenologic storytelling, were the positive benefits of therapeutic writing assignments which Paul found to be very beneficial to his ongoing recovery and integration.

Like most victims, Paul was exceedingly focused on himself due to excessive use of narcissistic defenses against disintegrative anxiety and loss of control (Lachmann & Stolorow, 1980; Parson, 1988, 1993). But as he gained insight, and increased motivation, Paul was able to continually strive for *engagement*, a precursor to restructuring the meaning system (Yalom, 1980). He developed interest, curiosity, and concern for other people's lives and for external national and international entities. As an integral part of Paul's growth-enhancing enterprise, he participated in *generativity prosocial activities,* in which he showed altruistic dedication to worthy causes, concern for guiding and nurturing the next generation (Erikson, 1963), and interest in the plight of homeless families and children.

Existentially, responsibility-avoidance is a key problem in the post-trauma lives of victims. Dealing with death imagery, terror, and the quest for inner freedom from guilt, shame, isolation, and meaninglessness were important concerns Paul struggled to integrate. Existential principles in responsibility-taking helped him exchange his victim identity for a survivor identity, in which he experienced an emerging sense of authorship over his experience: the author of his former sense of alienation and avoidance, the author of his rage and mental confusion, the author of his fate and future, and, finally, the author of the answer to the haunting and persistent question, "Why me!" How to will, to desire, to want, and to aspire were important issues in Paul's treatment. Before engaging in traumatherapy, Paul was unable to feel, to will, or to desire.

Reattachment, Human Connectivity, and Positive Microinternalizations. Trauma in most severe cases is the *undoing of attachment*—a reversing of human connectivity, replete with the biological and psychological changes Bowlby (1969) observed as sequelae to traumatic exposure. Internalized relationships with people is severely disrupted and attachment dysfunction emerges as a problem in severe trauma. Many patients have lost the sense of internal security, and the predictability that go with the knowledge and conviction that people can be counted upon to provide sensitivity, affection, and needed ministrations and care.

Psychotherapy in traumatic stress personality disorder may be seen in terms of Bowlby's biopsychological interpersonal paradigm for psychotherapy in which a secure base that processes affect, strengthens coping capabilities, and provides opportunities for resolving grief and loss (Holmes, 1993) is possible. Attachment disordered problems are addressed more directly and intensely during this phase. Because Paul now experienced the therapeutic relationship as safer and more reliable and sustaining, Phase III strategies increased affective tolerance to a greater degree to explore and integrate primitive emotional states like separation and annihilation anxieties, and grief, rage, and hate, as well as other affectocognitive remnants of the traumatic event.

Paul's initial reaction to getting close to the therapist was to employ dissociogenic splitting and avoidance to control *fear of breakdown* (Winnicott, 1980). But like other patients, Paul responded to such social psychological factors as therapist's credibility, expert status, and social influence (Schaap et al., 1993), the foundation for the patient's *idealizing transference*. The fear of regressive breakdown, makes the evolution of this form of transference imperative in managing terror. In the transference, the patient viewed the therapist as a very necessary container of virtue, perfection, and competence (Kohut, 1977; Parson, 1988). This transference phenomenon involves "the healthy process of gradual 'microinternalization,' which is perhaps akin to digestion at the physiological level." It is thus "distinguished from unhealthy macrointernalization, which seems more like a foreign body lodging inside the mind" (Mollon, 1993, p. 162). Later during this phase, this idealization changes to more realistic perception of the person of the therapist.

Trauma-Generated Transference Roles

The patient's psychobiological system encodes a *traumatic tripartite image* that consists of representations of self (as victim), of an all-powerful liberating figure (as rescuer), and of a villain (an insensitive/neglecting agent). The patient may *transfer* any or all of these representations onto the therapist during the course of the therapy, this assignment being more apparent and affectively immediate after Phase II processes. The therapist is expected to understand transference phenomena, how these manifest themselves in the trauma therapeutic experience, and to be open to the realities and fantasies transference presents to the therapy. The patient may perceive the therapist "as if" he or she were a victim, helper, and/or villain. Therapists may experience highly intense affective projections reflective of

victims' shattered, dissociated, and unacceptable identities, especially when transferences are of the villainous variety.

Paul's transference responses varied over time from the unconscious perception of the therapist as vulnerable to his own violent impulses, as a reliable source of assistance, and as one who betrays, abandons, and is dangerous and assaultive. Transference interpretation was used very sparingly, choosing instead to focus on relational scenarios at the original victimization scene, and on those relations being reactivated from the traumatic situation in the home, school, community, and in occupational settings and entrepreneurial activities (Hoglend, 1996; Parson, 1987, 1988). The therapist's responsiveness to the patient's dependency needs, and passive-aggressive, dependent, avoidant and narcissistic character traits was important during most phases of the treatment.

Therapists' Skills, Responsibility, Responses to the Victim, and Selfcare

The therapist provides the victim with the opportunity to *re*-learn the lessons of human attachment and security, and serve as a model of relational excellence and of possibilities for future healing attachments. Also, the therapist understands trauma factors that predict short- and long-term disabilities in victims (that is, the intensity, duration, pretraumatic personality organization, etc.), use both specific and nonspecific therapeutic elements (Strupp, 1986), and is generally grounded in theoretical orientations that sustain the work (i.e., restructuring traumatic personality pathology). Therapists invariably respond to powerful affectivity generated by the victim's trauma story—of grief, rage, helplessness, arousal, confusion, powerlessness, anger, shame, outrage, embarrassment, bewilderment, concrete/regressive thinking, and of induced dissociative feelings (e.g., a manifestation of which might show in being unsure of or disconnected from what he or she thinks and feels). Listening to stories of the grotesque, of raw human terror, maimings, and of large-scale brutality and human suffering, require the therapist to have *occupational attachment competence* (Heard & Lake, 1997; Parson, 1988).

Aside from required patient-knowledge is the therapist's equally required self-knowledge to guard against the "occupational hazard" of doing trauma work. Therapists also experience powerful images and affects which the dissociating patient had taken flight from; namely, death anxiety, annihilation anxiety, horror, abandonment, loss, and terror. The victim/survivor's trauma may activate the dynamics of previous relationships in therapists, transmitting to their minds and bodies the thoughts and feelings once programmatically established in relation to painful, traumatizing en-

counters with people living or dead. Acquiring self-knowledge, managing compassion fatigue, and developing traumatherapy selfcare skills are important prevention measures for the therapist, and for truly meeting the healthcare needs of survivors (Figley, 1995; Parson, 1988; Saakvitne & Pearlman, 1996).

Autonomous Life Skills Practice: Persistently Using and Developing a Vital Psychological Immune System Against Dissociogenic Regression

The Autonomous Life Skills Practice concept derives in part from the bleak picture portrayed by outcome studies in psychotherapy with victim/survivors. Clinical experience has also shown that therapeutic gains are fleeting after PTSD/PD therapy ends. Autonomous Life Skills Practice (LSP) are systematic, highly personalized plans of action developed with the patient to be implemented on a daily basis after termination of traumatic personality treatment. It is designed to give the person a sense of *integrative mastery* in the long-term, and is custom-tailored for the individual's ongoing developmental well-being. Like psychopharmacological prescriptions that aim to regulate mood and behavior by impacting underlying biochemistry, LSP represents a series of post-treatment prescriptions to also regulate thought, mood, and behavior. Unlike drug therapy, however, LSP is insight- and skills-based founded upon learnings acquired during the course of trauma psychotherapy. "Autonomous" refers here to the person's self-governing behavior that reflects *freedom* the disruptive influence of the *intrusive-repetitive trauma machine*, often reminiscent of Victor Tausk's schizophrenic "influencing machine," where "buttons are pushed, levers set in motion, [and] cranks turned" (Roazen, 1991, p. 187).

The Practice procedures are geared to create a psychological immune system that prevents negative changes in attitude, actions, and feelings, while having the ability to conduct ongoing risk assessment, prevention actions, maintain honesty, and reach out to others. LSP is in part based on the prevention objectives of "stress inoculation training," whose applications with sexual assault victims, UN soldiers, Israeli military recruits, and in the preparation of employees in high-risk occupations (Meichenbaum, 1994), offer regression-resistant training and skills. The LSP consists of two major aspects: (1) daily sustenance skills, and (2) minimizing crises skills. Paul learned how to respond before, during, and after a stressful event occurred. He first pondered the who, what, where, and when questions, and then took skills-based action to change the situation, the meaning he gave it, and the emotional responses induced by it (Folkman et al., 1986).

He had learned self-monitoring skills, relaxation skills, guided self-dialogue, thought-stopping or diversional procedures, and other meaningful skills.

At this phase, the person is now empowered to not only know how to handle stressful situations in terms of being able to *leave it, change it, accept it as it is,* and *reframe it* (Meichenbaum, 1994), but also how to efficiently conduct *preemptive skills deployment* for ongoing effective behavior and coping. These preemptive coping skills may also be regarded as strategic *self-intervention* skills, in which the individual consistently *practices to develop automatic countertrauma cognitions and behaviors* to increase freedom from the traumatic past.

The individual actively employs cognitive-behavioral coping skills to prevent or to early counteract the emergence of dysfunctional cognitions that undergirded prior depression, sense of helplessness, avoidance, numbing, and alienation. These prevention strategies involve self-knowledge regarding the recognition and management of psychosocial and environmental "triggers," and one's responses to them. Even in the absence of stressful or crisis events, Paul was encouraged to engage in self-monitoring, relaxation procedures, guided self-dialogue, and diversional procedures. He understood that consistent practice was essential to safeguard against the encroachment of coping-subverting traumatic distress, and loss of gains attained over the course of the therapy. Since trauma-influenced structures may develop into "autonomous chronic conditions" (Johnson et al., 1994; Long, et al., 1989), it is imperative that survivors use vigilance and persistence in *practicing* vital power skills to counterbalance the equally persistent threats to dissociogenic regression. Since cure after severe trauma is an untenable concept, the former trauma victim must continually strive to successfully *manage* mental, neurological, and behavioral revivifications of past terror and loss of control.

The effective implementation of the life practice presupposes that the treatment was relatively successful, and that the former trauma victim gained ample emotional maturity. This maturity would be seen in his or her ability to deal constructively with reality, adapt to change, to experience freedom from disabling symptoms, find a cause and purpose in life, to experience satisfaction in giving to others, and to go beyond trauma and anguish to community and responsibility.

SUMMARY AND CONCLUSIONS

The article discussed the necessity of developing theoretical, investigatory, and therapeutic measures to address state Axis I (PTSD)/trait Axis II (PD) configurations as a single composite unit (rather than as two sepa-

rate entities). This synthesized personality disorder was referred to as "traumatic stress personality disorder" (TrSPD), a syndromal continuous composite that features PTSD (symptoms of intrusion, avoidance, and arousal) as a functional dimension of the victim/survivor's total personality operations. The PTSD/PD co-occurrence reflects "personality changes . . .after the onset of PTSD" (Reich, 1989, p. 71). Since trauma theorists, practitioners, and scientists know that "multimodal integrated treatment offers the greatest hope for the treatment of post-traumatic personality disorder in trauma victims" (Marmar et al., 1992, p. 128), this writer introduced an *intertheoretical therapy* model that facilitates a restructuring of the victim/survivor's personality through the integration of psychopharmacological, cognitive, behavioral, psychodynamic, and existential interventions. A case study was presented to demonstrate the model's clinical applications.

Paul, a victim of violence, suffered traumatic stress personality disorder, as shown on the MCMI, MMPI, and on other trauma- and personality-detecting instruments. The assessment revealed passive-aggressive, schizoid, avoidant, dependent, and narcissistic features, which Millon (1981) interprets as a personality that is "oversensitive, fearful, self-preoccupied, disgruntled, uneasy, irritable, neat, traditional, moody, [and] unsettled," with interpersonal aloofness, behavioral lethargy, contrariness and avoidance, and narcissistic disturbance. Additionally, Paul showed intense subjective distress, *constricted depressive-avoidant affect*, and *regressive dissociogenic ideational intrusion,* peculiarities in thinking, disordered affect, helplessness, persistent arousal and irritability, hypervigilance, and impoverished reality testing. (A more detailed presentation on PTSD/PD assessment using the MMPI, MCMI, the Rorschach, and other instruments will be discussed in a 1998 issue of the Journal.) The intertheoretical therapy process was used to assist the patient manage and integrate traumatic stress personality disorder, while fostering stability, meaning, community, growth, and a sense of future possibilities.

REFERENCES

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

Baker, E. (1988). Use of journal writing for psychologists. In P. Keller & S. Heyman (Eds.), *Innovations in clinical practice: A sourcebook* (pp. 269-282). Sarasota, FL: Professional Resource Exchange.

Bende, B., & Philpott, R. (1994). Persistent post-traumatic stress disorder: Often missed but worth treating. *British Medical Journal, 309,* 526-528.

Benveniste, P., & Molteni, A. (1994). On the issue of personality context in the treatment of trauma survivors. (Commentary). *Journal of Traumatic Stress, 7,* 485-490.

Bergland, R. (1985). *The fabric of mind*. Ringwood: Penguin Books.
Bernstein, E., & Putnam, F. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease, 174,* 727-735.
Blake, D., Albano, A., & Keene, T. (1992). Twenty years of trauma: Psychological Abstracts 1970 through 1989. *Journal of Traumatic Stress, 5,* 477-484.
Blake, D., Weathers, F., Nagy, L., Kalpoupek, D., Klauminzer, G., Charney, D., & Keane, T. (1990). A clinician rating scale for assessing current and lifetime PTSD: The CAPS-I. *The Behavior Therapist, 13,* 187-188.
Blanchard, E., Hickling, E., Taylor, A., & Loos, W. (1995). Psychiatric comorbidity associated with motor vehicle accidents. *Journal of Nervous and Mental Disease, 183,* 495-504.
Blanchard, E., Kolb, L., Gerardi, R., & Pallmeyer, T. (1986). Cardiac response to relevant stimuli as an adjunctive tool for diagnosing post-traumatic stress disorder in Vietnam veterans. *Behavior Therapy, 17,* 592-606.
Boudewyns, E., & Hyer, L. (1990). Physiological responses to combat memories and preliminary treatment outcome in Vietnam veteran PTSD patients treated with direct therapeutic exposure. *Behavior Therapy, 32,* 63-87.
Bowlby, J. (1969). *Attachment and loss.* Vol. 1. *Attachment*. New York: Basic Books.
Bradshaw, S., Ohlde, C., & Horne, J. (1993). Combat and personality change. *Bulletin of the Menninger Clinic, 57,* 466-478.
Bremner, J., & Brett, E. (1997). Trauma-related dissociative states and long-term psychopathology in Post-traumatic stress disorder. *Journal of Traumatic Stress, 10,* 37-49.
Bremner, J. Scott, T., Delaney, R., Southwick, S., Mason, J., Johnson, D. (1993). Deficits in short-term memory in post-traumatic stress disorder. *American Journal of Psychiatry, 150,* 1015-1019.
Brende, J. O., & McCann, L. (1987). Regressive experiences in Vietnam veterans: Their relation ship to war, post-traumatic symptoms and recovery. In W. Quaytman (Ed.)., *The Vietnam veteran: Studies in post-traumatic stress disorders* (pp. 58-75). New York: Human Sciences Press.
Brende, J. O., & Parson, E. R. (1985). *Vietnam veterans: The road to recovery.* New York: Plenum Publishing Corporation.
Brende, J. O. (1984). The psychophysiologic manifestations of dissociation. *Psychiatric Clinics of North America, 7,* 41-49.
Brende, J. O. (1983). A psychodynamic view of character pathology in Vietnam veterans. *Bulletin of the Menninger Clinic, 47,* 197-216.
Breslau, N., Davis, G., Andreski, P., & Peterson, E. (1991). Traumatic events and post-traumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry, 48,* 216-222.
Bunce, S., Larsen, R., & Peterson, C. (1995). Life after trauma: Personality and daily life experiences of traumatized people. *Journal of Personality, 63,* 165-188.
Cardena, E., & Spiegel, D. (1993). Dissociative reactions to the San Francisco Bay Area earthquake of 1989. *American Journal of Psychiatry, 150,* 474-478.
Casey, P. (1988). The epidemiology of personality disorder. In P. Tyrer (Ed.), *Personality disorders: Diagnosis, management and course* (pp. 74-81). Boston: Wright.
Casey, P., & Tyrer, P. (1990). Personality disorder and psychiatric illness in general practice. *British Journal of Psychiatry, 156,* 261-265.
Casey, P., & Tyrer, P. (1986). Personality functioning and symptomatology. *Journal of Psychiatric Research, 20,* 363-374.
Casey, P., Tyrer, P., & Dillon, S. (1984). The diagnostic status of patients with conspicuous psychiatric morbidity in primary care. *Psychological Medicine, 14,* 673-681.
Cavenar, J., & Nash, J. (1976). The effects of combat on the normal personality. *Comprehensive Psychiatry, 17,* 674-653.
Chemtob, C., Novaco, R., Hamada, R., Gross, D., & Smith, G. (1997). Anger regulation deficits in combat-related post-traumatic stress disorder. *Journal of Traumatic Stress, 10,* 17-36.
Coccaro, E., Silverman, J., Klar, H., Horvath, T., & Siever, L. (1994). Familial correlates of reduced central serotonergic system function in patients with personality disorders, *Archives of General Psychiatry, 51,* 318-324.

Cooper, N., & Clum, G. (1989) Imaginal flooding as a supplementing for PTSD in combat veterans: A controlled study. *Behavior Therapy, 20,* 381-391.

Danieli, Y., Rodley, N., & Weisaeth, L. (1996). *International responses to traumatic stress: Humanitarian, human rights, justice, peace and development—Contributions, collaborative actions and future initiatives.* Amityville, NY: Baywood Publishing Company, Inc.

Davanloo, H. (1990). *Unlocking the unconscious.* Chichester: Wiley.

Davidson, J., & Baum, A. (1993). Predictors of chronic stress among Vietnam veterans: Stressor exposure and intrusive recall. *Journal of Traumatic Stress, 6,* 195-212.

Davidson, J., Kudler, H., & Smith, R. (1987). Validity and reliability of the DSM III criteria for post-traumatic stress disorder: Experience with a structured interview. *Journal of Nervous and Mental Disease, 177,* 336-341.

Digman, J. (1990). Personality structure: emergence of the five-factor model. *Annual Review of Psychology, 41,* 417-440.

Dinnen, A. (1993). The incident in Kure: A 40-year follow-up on post-traumatic stress disorder. *Medicine and Law, 12,* 369-374.

D'Souza, D. (1995). Post-traumatic stress disorder: A scar for life. *British Journal of Clinical Practice, 49,* 309-313.

Durham, T., McCammon, S., & Allison, E. (1985). The psychological impact of a disaster on rescue personnel. *Annual of Emergency Medicine, 14,* 664-668.

Erikson, E. (1963). *Childhood and Society.* New York: W.W. Norton.

Everly, G. (1993). Psychotraumatology: A two-factor formulation of post-traumatic stress. *Physiological and Behavioral Science, 28,* 270-278.

Everly, G. (1989). *A clinical guide to the treatment of the human stress response.* New York: Plenum.

Exner, J. (1990). *A Rorschach workbook for the Comprehensive System* (3rd ed.). North Carolina: Rorschach Workshops.

Fairbanks, J., Gross, R., & Keene, T. (1983). Treatment of post-traumatic stress disorder: Evaluation of outcome with a behavioral code. *Behavior Modification, 7,* 557-568.

Figley, C. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York: Brunner/Mazel.

Foa, E., & Riggs, D. (1994). Post-traumatic stress disorder and rape. In R. Pynoos (Ed.), *Post-Traumatic Stress Disorder: A clinical review* (134-165). Lutherville, MD: The Sidran Foundation.

Foa, E., Olsaov-Rothbaum, B., Riggs, D., & Murdock, T. (1991). Treatment of post-traumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology, 59,* 715-723.

Foa, E., Steketee, G., & Rothbaum, B. (1989). Behavioral/cognitive conceptualization of post-traumatic stress disorder. *Behavior Therapy, 20,* 155-176.

Foa, E., & Kozak (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99,* 20-35.

Folkman, S., Lazarus, R., Dunkel-Schetter, C., DeLongis, A., & Green, R. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology, 50,* 992-1003.

Fontana, A., Rosenheck, R., & Brett, E. (1992). War zone traumas and post-traumatic stress disorder symptomatology. *Journal of Nervous and Mental Disease, 180,* 748-755.

Freud, S. (1919/1954). Introduction to psychoanalysis and the war neuroses. *Standard Edition, 17,* 207-210. London: Hogarth.

Freud, S. (1916-1917). Introductory lecturers on psychoanalysis. In *Standard Edition, 15-16.* London: Hogarth.

Friedman, H. (1990). Personality and disease. New York: Wiley.

Gaston, L., Brunet, A., Koszycki, D., Bradwejn, J. (1996). MMPI profiles and chronic PTSD in a civilian sample. *Journal of Traumatic Stress, 9,* 817-832.

Genderson, J., & Chu, J. (1993). Treatment implications of past trauma in borderline personality disorder. *Harvard Review of Psychiatry, 1,* 75-81.

Gil, T., Calev, A., Greenberg, D., Kugelmass, S., & Lerer, B. (1990). Cognitive functioning in post-traumatic stress disorder. *Journal of Traumatic Stress, 3,* 29-45.

Goleman, D. (1990). A key to post-traumatic stress disorder lies in brain chemistry, scientists find. *The New York Times*, pp. C1-C3.

Green, B., Lindy, J., Grace, M., & Leonard, A. (1990). Buffalo Creek survivors in the second decade: Stability of stress symptoms. *American Journal of Orthopsychiatry, 60,* 43-54.

Grinker, R., & Speigel, J. (1945). *Men under stress.* New York: McGraw-Hill.

Groves, B., & Young, S. (1986). Neurons, networks, and behavior: An introduction. In L. Judd & P. Groves (Eds.). *Psychobiological foundations of clinical psychology.* New York.

Gruen, R., Silva, R., Ehlick, J., Schweitzer, J., & Friedhoff, A. (1997). Vulnerability to stress: Self-criticism and stress-induced changes in biochemistry. *Journal of Personality, 65,* 33-47.

Gunderson, J., & Sabo, A. (1993a). The phenomenological and conceptual interface between borderline personality disorder and PTSD. *American Journal of Psychiatry, 150,* 19-27.

Gunderson, J., & Sabo, A. (1993b). Drs. Gunderson and Sabo reply. [Letter to the editor]. *American Journal of Psychiatry, 150,* 1906.

Harmon-Jones, E., Pyszcynski, T., Solomon, S., & McGregor, H. (1997). Terror management theory and self-esteem: Evidence that increased self-esteem reduces mortality salience effects. *Journal of Personality and Social Psychology, 72,* 24-36.

Heard, D., & Lake, B. (1997). *The challenge of attachment for caregivers.* New York: Routledge.

Helzer, J., Robbins, L., & McEvoy, L. (1987). Post-traumatic stress disorder in the general population. *New England Journal of Medicine, 317,* 1630-1634.

Hendin, H., Haas, Singer, O., Gold, F., & Trigos, G. (1983). The influence of precombat personality on post-traumatic stress disorder. *Comprehensive Psychiatry, 24,* 530-534.

Herman, J. (1992). *Trauma and recovery.* New York: Basic Books.

Hickling, E., & Blanchard, E. (1992). Post-traumatic stress disorder and motor vehicle accidents. *Journal of Anxiety Disorders, 6,* 285-2291.

Herman, J., & Van der Kolk, B. (1987). Traumatic antecedents of borderline personality disorder. In B. Van der Kolk (Ed.)., *Psychological trauma.* Washington, DC: American Psychiatric Press.

Hoglend, P. (1996). Analysis of transference in patients with personality disorders. *Journal of Personality Disorders, 10,* 121-131.

Holmes, J. (1993). Attachment theory: A biological basis for psychotherapy?. *British Journal of Psychiatry, 163,* 430-438.

Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Events Scale: A measure of subjective distress. *Psychosomatic Medicine, 41,* 297-218.

Horowitz, M. (1986). *Stress response syndromes.* (2nd ed.) New York: Jason Aronson.

Horowitz, M., Wilner, N., Kaltreider, N., & Alvarez, W. (1980). Signs and symptoms of post-traumatic stress disorder. *Archives of General Psychiatry, 37,* 85-92.

Horowitz, M. (1982). Stress response syndromes and their treatment. In L. Goldberger & S. Breznitz *Handbook of stress.* New York: Free Press.

Huprich, S., & Fine, M. (1996). Self-defeating personality disorder: Diagnostic accuracy and overlap with dependent personality disorder. *Journal of Personality Disorder, 10,* 229-246.

Huprich, S., Margrett, J., Barthlemy, K., & Fine, M. (1996). The Depressive Personality Disorder Inventory: An initial investigation of its psychometric properties. *Journal of Clinical Psychology, 52,* 153-160.

Hyer, L., McCranie, E., & Peralme, L. (1993). Psychotherapeutic treatment of chronic PTSD. *PTSD Research Quarterly, 4,* 1-7.

Hyer, L., Woods, M., & Boudewyns, P. (1991). A three tier evaluation of PTSD among Vietnam combat veterans. *Journal of Traumatic Stress, 4,* 165-193.

Hyer, L., O'Leary, W., Saucer, R., Blount, J. Harrison, W., & Boudewyns, P. (1986). Inpatient diagnosis of post-traumatic stress disorder. *Journal of Consulting and Clinical Psychology, 54,* 698-702.

Hyer, L., & Boudewyns, P. (1985). The 8-2 code among Vietnam veterans. *PTSD Newsletter, 4,* 2.

Hyler, S., Skodol, A., Kellman, H., & Doidge, N. (1990). Validity study of Personality Diagnostic Questionnaire—Revised: Comparison with two structured interviews. *American Journal of Psychiatry, 147,* 1043-1048.

Irvin, H. (1994). Proneness to dissociation and traumatic childhood events. *Journal of Nervous and Mental Disease, 182,* 456-460.

Irvin, H. (1985). *Flight of mind: A psychological study of the out-of-body experience.* Metuchen, NJ: Scarecrow Press.

Janet, P. (1989/1973). *L'automatisme psychologique: Essai de psychologie experimentale sur les formes inferieures de l'activite humaine.* Paris: Societe Pierre Janet/Payot.

Janet, P. (1919/1925). *Psychological healing* (vols. 1, 2). New York: Macmillan.

Janoff-Bulman, R. (1993). *Shattered assumptions: Toward a new psychology of trauma.* New York: The Free Press.

Johnson, D., Feldman, S., Southwick, S., & Charney, D. (1994). The concept of the Second Generation Program in the treatment of post-traumatic stress disorder among Vietnam veterans. *Journal of Traumatic Stress, 7,* 217-235.

Kaplan, H., & Sadock, B. (1994). *Kaplan and Sadock's Synopsis: Behavioral Sciences and Clinical Psychiatry.* 7th ed. Baltimore, MD: Williams and Wilkins.

Kardiner, A., & Speigel, H. (1974). *The traumatic neurosis of war.* New York: Paul Hoeber.

Karp, S., Silber, D., Holmstrom, W., & Stock, L. (1995). Personality of rape survivors as a group and by relation of survivor to perpetrator. *Journal of Clinical Psychology, 51,* 587-593.

Kardiner, A. (1941). *The traumatic neurosis of war.* New York: P. Hoeber.

Keene, T., Fairbank, J., Caddell, J., Zimering, R., & Bender, M. (1985). A behavioral approach to assessing and treating post-traumatic stress disorder in Vietnam veterans. In C. R. Figley (Ed.), *Trauma and its wake: The Study and treatment of post-traumatic stress disorder* (pp. 257-294). New York: Brunner/Mazel.

Keane, T., Malloy, P., & Fairbank, J. (1984). Empirical development of an MMPI subscale for the assessment of combat-related post-traumatic stress disorder. *Journal of Consulting and Clinical Psychology, 52,* 888-981.

Kilpatrick, G., & Veronen, L. (1984, May). *Rape and post-traumatic stress disorder: A two-year longitudinal study.* Paper presented at the meeting of the American Psychosomatic Society, Hilton Head Island, SC.

Kinzie, J., & Leung, P. (1989). Clonidine in Cambodian patients with post-traumatic stress disorder. *Journal of Nervous and Mental Disorders, 177,* 546-550.

Kohut, H. (1977). *The reparation of the self.* New York: International University Press.

Kohut, H. (1972). Thoughts on narcissism and narcissistic rage. *Psychoanalytic Study of the Child, 27,* 360-400.

Kolb, L. (1989). Letter to the editor. *American Journal of Psychiatry, 146,* 811-812.

Kolb, L. (1987). A neurophysiological hypothesis explaining post-traumatic stress disorders. *American Journal of Psychiatry, 144,* 985-995.

Kolb, L. (1984). The post-traumatic stress disorders of combat: A subgroup with a conditioned emotional response. *Military Medicine, 149,* 237-243.

Kolb, L., & Mutalipassi, L. (1982). The conditioned emotional response: A subclass of chronic and delayed post-traumatic stress disorder. *Psychiatric Annals, 12,* 979-987.

Koretzky, M., & Peck, A. (1990). Validation and cross-validation of the PTSD subscale of the MMPI with civilian trauma victims. *Journal of Clinical Psychology, 46,* 296-300.

Krystal, H. (1984). Psychoanalytic views on human emotional damages. In B. Van der Kolk (Ed.), *Post-traumatic stress disorder: Psychological and biological sequelae.* Washington, D.C.: American Psychiatric Press.

Kuch, K., & Cox, B. (1992). Symptoms of PTSD in 124 survivors of the Holocaust. *American Journal of Psychiatry, 149,* 337-340.

Kudler, H., & Davidson, J. (1994). General principles of biological intervention following trauma. In J.R. Freedy & S. E. Hobfoll (Eds.). *Traumatic stress: From theory to practice.* New York: Plenum.

Kudler, H. (1993). Borderline personality disorder and PTSD. *American Journal of Psychiatry, 150, 1905.*

Kulka, R., Schlenger, W., Fairbank, J., Jordan, B., Hough, R., Marmar, C., & Weiss, D. (1991). Assessment of post-traumatic stress disorder in the community: Prospects and pitfalls from

recent studies of Vietnam veteran. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 3,* 547-560.

Kulka, R., Schlenger, W., Fairbank, J., Hough, R., Jordan, B., & Marmar, C. (1990). *Trauma and the Vietnam generation. Report of findings from the National Vietnam Veterans Readjustment Study.* New York: Brunner/Mazel.

Lachmann, & Stolorow (1980). *Psychoanalysis and developmental arrest.* New York: International Universities Press.

L'Abate, L. (1992). *Programmed writing: A self-administered approach for interventions with individuals, couples and families.* Pacific Grove, CA: Brooks/Cole.

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

LeDoux, J., Romanski, L., Xagoraris, A. (1991). Indelibility of subcortical emotional memories. *Journal of Cognitive Neuroscience, 1,* 238-243.

Levin, P. (1993). Assessing post-traumatic stress disorder with the Rorschach projective technique. In J. P. Wilson & B Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 189-200). New York: Plenum.

Lezak, M. (1982). The problem of assessing executive functions. *International Journal of Psychology, 17,* 281-297.

Lifton, R. J. (1993). *The protean self: Human resiliency in an age of fragmentation.* New York: Basic Books.

Lifton, R. J. (1968). *Death in life: Survivors of Hiroshima.* New York: Random House.

Lindy, J. D. (1988). *Vietnam: A casebook.* New York: Brunner/Mazel.

Lindy, J. D., & Titchener, J. (1983). "Acts of God and man": Character change in survivors of disasters and the law. *Behavioral Science and the Law, 1,* 85-96.

Litz, B., Weathers, F., Monaco, V., Herman, D., Wulfsohn, M., Marx, B., & Keane, T. (1996). Attention, arousal, and memory in post-traumatic stress disorder. *Journal of Traumatic Stress, 9,* 497-519.

Litz, B., & Keene, T. (1989). Information processing in anxiety disorders: Application to the understanding of post-traumatic stress disorder. *Clinical Psychology Review, 9,* 243-257.

Livesley, W., & Jackson, D. (1992). Guidelines for developing, evaluating, and revising the classification of personality disorders. *Journal of Nervous and Mental Disease, 180,* 609-618.

Long, R., Wine, P., Chew, D., Penk, W., Keane, T., Gerstein, C., O'Neill, J., & Nadelson, T. (1989). Chronicity: Adjustment differences of Vietnam combat veterans differing in rates of psychiatric hospitalization. *Journal of Clinical Psychology, 45,* 745-753.

Lonie, I. (1993). Borderline disorder and post-traumatic stress disorder: An equivalence? *Australian and New Zealand Journal of Psychiatry, 27,* 233-245.

Loranger, A., Sartorius, N., Andreli, A., Berger, P., Buchheim, P., Channabasavanna, S., Boid, B., Dahl, A., Loranger, A., Susman, V., Oldham, J., & Russakoff, M. (1988). The personality disorder Examination (PDE) Manual. Yonkers, NY: DV Communications.

Magnavita, J. (1997) *Restructuring personality disorders: A short-term dynamic approach.* New York: Guilford.

Malan, D., & Osimo, F. (1992). *Psychodynamics, training, and outcome in brief psychotherapy.* Oxford: Butterworth-Heinemann.

Marlowe, D., Kirby, K., Festinger, D., Husband, S., & Platt, J. (1997). Impact of comorbid personality disorders and personality disorder symptoms on outcome of behavior therapy for cocaine dependence. *Journal of Nervous and Mental Disease, 185,* 483-490.

Marmar, C., Foy, D., Kagan, B., & Pynoos, R. (1993). An integrated approach to treating post-traumatic stress. In R. Pynoos (Ed.), *Post-traumatic stress disorder: A clinical review.* Lutherville, MD: The Sidran Press.

Marmar, C., Weiss, D., Metzler, T., Ronfeldt, H., & Foreman, C. (1996). Stress responses of emergency service personnel to the Loma Prieta earthquake Interstate 880 Free Way collapse and control traumatic incidents. *Journal of Traumatic Stress, 9,* 63-85.

Marmar, C., Foy, D., Kagan, B., & Pynoos, R. (1993). An integrated approach for treating post-traumatic stress. In J. M. Oldham, M. Riba, & A. Tasman (Eds.). *Review of Psychiatry.* Washington, DC.

Maser, J., Cassano, G., & Michelini, S. (1997). Treatment implications of comorbid mental disorders (pp. 3-22). In S. Wetzler & W. Sanderson (Eds.), *Treatment strategies for patients with psychiatric comorbidity*. New York: Wiley.

Mason, J. W., Kosten, T. R., Southwick, S. M., & Giller, E. L. (1990). The use of psychoendocrine strategies in post-traumatic stress disorder. *Journal of Applied Social Psychology, 20,* 1822-1846.

Mavissakalian, M. (1990). The relationship between panic disorder/agoraphobia and personality disorders. *Psychiatric Clinic of North America, 13,* 661-683.

May, R., & Yalom, I. (1995). Existential psychotherapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies. 5th edition*. (262-292). Itasca, IL: P. E. Peacock, Inc.

McCaffrey, R., Hickling, E., & Marrazzo, M. (1989). Civilian-related post-traumatic stress disorder: Assessment related issues. *Journal of Clinical Psychology, 45,* 72-75.

McFarlane, C. (1988). The longitudinal course of post-traumatic morbidity: The range of outcomes and their predictors. *Journal of Nervous and Mental Disease, 176,* 30-39.

McNally, R., Kaspi, S., Riemann, B., & Zeitlin, S. (1990). Selective processing of threat cues in post-traumatic stress disorder. *Journal of Abnormal Psychology, 99,* 398-402.

Meichenbaum, D. (1994). *A clinical handbook/practical therapist manual for assessing and treating adults with post-traumatic stress disorder.* Waterloo, Ontario: Institute Press.

Merikangas, K., & Weissman, M. (1986). Epidemiology of DSM-III Axis II personality disorders. In A. Frances & R. Hales (Eds.), *Psychiatric update: The American Psychiatric Association annual review* (Vol. 5). Washington, DC: American Psychiatric Press.

Millon, T., & Davis, R. (1997). The MCMI-III: Present and future directions. *Journal of Personality Assessment, 68,* 69-85.

Millon, T., & Davis, R. (1993). How can knowledge of psychopathology facilitate psychotherapy integration? A view from the personality disorders. *Journal of Psychotherapy Integration, 3,* 331-352.

Millon, T. (1981). *Disorders of Personality—DSM III: Axis II.* New York: Wiley.

Mollon, P. (1993). *The fragile self: The structure of narcissistic disturbance and its therapy.* Hillsdale, NJ: Aronson.

New York Times (1988, May 12, 1988). Post-traumatic stress: Biological clues found, p. 10.

National Victim Center and Crime Victims Research and Treatment Center (1992). Rape in America: A report to the nation (Research Report #1992-1). Washington, D.C.: National Victims Center and Crime Victims Research and Treatment Center.

Norcross, J., & Goldfried, M. (1992). *Handbook of psychotherapy integration.* New York: Basic Books.

Overholser, J. (1994). The personality disorders: A review and critique of contemporary assessment strategies. *Journal of Contemporary Psychotherapy, 24,* 223-244.

Overholser, J. (1993a). Elements of the Socratic Method: I. Systematic questioning. *Psychotherapy, 30,* 67-74.

Overholser, J. (1993b). Elements of the Socratic Method: II. Inductive reasoning. *Psychotherapy, 30,* 75-85.

Parson, E. R. (1997a). Post-traumatic child therapy (P-TCT): Assessment and treatment factors in clinical work with inner-city children exposed to catastrophic community violence. *Journal of Interpersonal Violence, 12,* 172-194.

Parson, E. R. (1997b). *Survivors of Violence 2001: Responses, intrinsic strengths, resilience, assessment, and intervention.* Presented at Psychiatry and the Behavioral Sciences Section, National Medical Association Annual Convention and Scientific Assembly, Sheraton Waikiki Hotel, August 2-7, 1997.

Parson, E. R. (1996a). Post-traumatic stress disorder. In B. Wolman (Ed.), *The Encyclopedia of Psychiatry, Psychology and Psychoanalysis* (pp. 406-412). New York: Henry Holt Company.

Parson, E. R. (1996b, March). *Urban violence traumatic stress response syndrome: A Model for post-traumatic child therapy for children exposed to violence.* A Masters Class conducted at the Second Annual Conference on Trauma, Loss, and Dissociation: Foundations of 21st Century Traumatology, Georgetown University Medical Center and Kairos Ventures II, Ltd.

Parson, E. R. (1996c, March). *Trauma and dissociogenic functional impairments: Cognitive miscalculations and affective misalignments in victims of physical and sexual violence.* A Masters Class conducted at the Second Annual Conference on Trauma, Loss, and Dissociation: Foundations of 21st Century Traumatology, Georgetown University Medical Center and Kairos Ventures II, Ltd.

Parson, E. R. (1996d, March), *The economic consequences of wartime service: Unemployment among veterans with traumatic war stress.* Presented at the Veterans Public Policy Forum, Puerto Rican Leadership Summit, Capitol Hill, Washington, D.C.

Parson, E. R. (1995a). Mass traumatic terror in Oklahoma City and the phases of adaptational coping, Part I: Possible effects of intentional injury/harm on victim's post-traumatic responses. *Journal of Contemporary Psychotherapy, 25(3),* 155-184.

Parson, E. R. (1995b). Mass traumatic terror in Oklahoma City and the phases of adaptational coping, Part II: Integration of cognitive, behavioral, dynamic, existential and pharmacologic interventions. *Journal of Contemporary Psychotherapy, 25(4),* 267-309.

Parson, E. R. (1995c). Post-traumatic stress and coping in an inner-city child: Traumatogenic witnessing of interparental violence and murder. *Psychoanalytic Study of the Child, 50,* 272-307.

Parson, E. R. (1994a). Post-traumatic stress disorder: Its biopsychobehavioral aspects and management. In B. Wolman & G. Stricker (Eds.), *Anxiety and related disorders: A handbook* (pp. 226-385). New York: Wiley.

Parson, E. R. (1994b). Inner city children of trauma: Urban violence traumatic stress response syndrome (U-VTS) and therapists' responses. In J. Wilson and J. Lindy (Eds.), *Countertransference in the treatment of post-traumatic stress disorder* (pp. 151-178). New York: Guilford.

Parson, E. R. (1993). Post-traumatic narcissism: Healing traumatic alterations in the self through curvilinear group psychotherapy (821-840). New York: New York: Plenum Publishing Corporation.

Parson, E. R. (1988). Post-traumatic self disorders. In J. Wilson, Z. Harel, & B. Kahana (Eds.), *Human adaptation to extreme stress: From the Holocaust to Vietnam.* New York: Plenum.

Parson, E. R. (1987). Transference and post-traumatic stress: Combat veterans' transference to the Veterans Administration Medical Center. *Journal of the American Academy of Psychoanalysis, 14,* 349-375.

Parson, E. R. (1984). The reparation of the self. Clinical and theoretical dimensions in the treatment of Vietnam combat veterans, *Journal of Contemporary Psychotherapy, 14,* 4-51.

Parson, E. R. (1976). *The daseinanalytic treatment of the black patient and the concept of responsibility.* Unpublished manuscript.

Pennebaker, J. (1990). *Opening up: The healing power of confiding in others.* New York: Morrow.

Piekarski, A. M., Sherwood, R. J., & Funari, D. J. (1993). Personality subgroups in an inpatient Vietnam veteran treatment program. *Psychological Reports, 72,* 667-674.

Perry, J. (1992). Problems and considerations in the valid assessment of personality disorders. *American Journal of Psychiatry, 149,* 1645-1653.

Perry, S., Difede, J., Musngi, G., Frances, A., & Jacobsberg, L. (1992). Predictors of post-traumatic stress disorder after burn injury. *American Journal of Psychiatry, 149,* 931-935.

Putnam, F. (1991). Dissociative disorders in children and adolescents. In S. Lynn & J Rhue (Eds.). *Dissociation: Theoretical, clinical, and research perspectives* (pp. 175-189). New York: Guilford Press.

Putnam, F., & Guroff, J. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry, 47,* 285-293.

Rappaport, R. (1997). *Motivating clients in therapy: Values, love, and the real relationship.* New York: Routledge.

Reich, J., Noyes, R., Coryell, W., & O'Gorman, T. (1986). The effects of state anxiety on personality measurement. *American Journal of Psychiatry, 143,* 760-763.

Reich, J. (1989). Personality disorders and post-traumatic stress disorder. In M. Wolf & A. Mosnaim (Eds.), *Post-traumatic stress disorder: Etiology, phenomenology, and treatment.* Washington, DC: American Psychiatric Press.

Rheault, B. (1980). Outward bound as an adjunct to therapy in the treatment of Vietnam veterans. In T. Williams (Ed.), *Post-traumatic stress disorders: A handbook for clinicians.* Cincinnati, OH: Disabled American Veterans.

Roazen, P. (Ed.) (1991). *Sexuality, war and schizophrenia: Collected psychoanalytic papers—Victor Tausk.* New Brunswick, NJ: Transaction.

Roe-Bernng, S., & Straker, G. (1997). The association between illusions of invulnerability and exposure to trauma. *Journal of Traumatic Stress, 10,* 319-327.

Rothbaum, B., & Foa, E. (1992). Exposure therapy for rape victims with post-traumatic stress disorder. *The Behavior Therapist, 15,* 219-222.

Saakvitne, K., & Pearlman, L. (1996). *Transforming the pain: A workbook on vicarious traumatization.* New York: Norton.

Sanders, B., & Giolas, M. (1991). Dissociation and childhood trauma in psychologically disturbed adolescents. *American Journal of Psychiatry, 148,* 50-54.

Schaap, C., Bennun, I., Schildler, L., & Hoogduin, K. (1993). *The therapeutic relationship in behavioral psychotherapy.* New York: Wiley.

Scurfield, R. (1992). An evaluation of the impact of "Helicopter Ride Therapy" for inpatient Vietnam veterans with war-related PTSD. *Military Medicine, 157,* 67-73.

Shalev, A., Rogel-Fuchs, Y., & Pitman, R. (1992). Conditioned fear and psychological trauma. *Biological Psychiatry, 31,* 863-865.

Shapiro, F. (1993). Eye movement desensitization and reprocessing (EMDR) in 1992. *Journal of Traumatic Stress, 6,* 417-423.

Shatan, C. (1977). Bogus manhood, bogus honor: Surrender and transfiguration in the United States Marine Corps. *Psychoanalytic Review, 64,* 585-610.

Sherwood, R. J., Funari, D. J., & Piekarski, A. M. (1990). Adapted character styles of Vietnam veterans with post-traumatic stress disorder: Initial findings on a long-term outcome study. *Psychological Reports, 66,* 623-631.

Siever, L., & Davis, K. (1991). A Psychobiological perspective on the personality disorders. *American Journal of Psychiatry, 148,* 1647-1658.

Singer, M. (1981). Vietnam prisoner of war, stress, and personality resiliency. *American Journal of Psychiatry, 138,* 345-346.

Solkoff, N., Gray, P., & Keill, S. (1986). Which Vietnam vets develop post-traumatic stress disorder. *Journal of Clinical Psychology, 42,* 687-698.

Solomon, G., Segerstrom, S., Grohr, P., Kemeny, M., & Fahey, J. (1997). Shaking up immunity: Psychological and immunologic changes after a natural disaster. *Psychosomatic Medicine, 59,* 114-127.

Solomon, S., Gerrity, E., Muff, A. (1992). Efficacy of treatments for post-traumatic stress disorder: An empirical review. *Journal of the American Medical Association, 268,* 633-638.

Solomon, Z., & Shalev, A. (1994). Helping victims of military trauma. In J. Freedy & S. Hobfoll (Eds.), *Traumatic stress: From theory to practice.* New York: Plenum.

Southwick, S., Yehuda, R., & Giller, E. (1993). Personality disorders in treatment-seeking combat veterans with post-traumatic stress disorder. *American Journal of Psychiatry, 150,* 1020-1023.

Spiegel, D. (1986). Dissociating damage. *American Journal of Clinical Hypnosis, 29,* 123-131.

Spitzer, R., Williams, J., & Gibbon, M. (1987). *Structured clinical interview for DSM III. NP-V.* New York: New York State Psychiatric Institute. Biometrics Research Department.

Spitzer, R., Williams, J., Gibbons, M., & First, M. (1990). Structure Clinical Interview for DSM-R—Personality Disorders (version 1.0). Washington, DC: American Psychiatric Press.

Strack, S., & Lorr, M. (1997). Invited essay: The challenge of differentiating normal and disordered personality. *Journal of Personality Disorders, 11,* 105-122.

Suhr, M. (1986). Trauma in pediatric populations. *Advances in Psychosomatic Medicine, 16,* 31-47.

Taylor, S. (1983). Adjustment to threatening events: A theory of cognitive adaptation. *American Psychologist, 38,* 1161-1173.

Tiger, L. (1979). *Optimism: The biology of hope.* New York: Simon and Schuster.

Torem, M. (1993). Therapeutic writing as a form of ego-state therapy. *American Journal of Clinical Hypnosis, 35,* 267-276.

Truant, G. (1995). Therapeutic models of psychopathology. Part I: Introduction, overview of the model, and personality organization. *American Journal of Psychotherapy, 49,* 7-18.

Tyrer, S., Casey, P., & Ferguson, B. (1991). Personality disorder in perspective. *British Journal of Psychiatry, 159,* 463-471.

Ulman, R., & Brother, D. (1989). *The shattered self.* Northvale, NJ: Analytic Press.

Ursano, R., Kao, T., & Fullerton, C. (1992). Post-traumatic stress disorder and meaning: Structuring human chaos. *Journal of Nervous and Mental Disease, 180,* 756-759.

Ursano, R. (1981). The Vietnam era prisoner of war: Precaptivity personality and the development of psychiatric illness. *American Journal of Psychiatry, 138,* 315-318.

Van der Kolk, B. (1994, January/February). The body keeps the score: Memory and the evolving psychobiology of traumatic stress. *Harvard Review of Psychiatry,* pp. 253-265.

Van der Kolk, B. (1987). *Psychological trauma.* Washington, DC: American Psychiatric Press.

Van der Kolk, B., Greenberg, M., Boyd, H., & Krystal, J. (1985). Inescapable shock, neurotransmitter and addiction to trauma: Towards a psychobiology of post-traumatic stress. *Biological Psychiatry, 20,* 314-325.

Weisman, M., Scholomskas, D., & John, K. (1981). The assessment of social adjustment. *Archives of General Psychiatry, 38,* 1250-1258.

Weiss, D. (1993). Structured clinical interview techniques. In J. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 179-188). Plenum.

Weiss, J., Davis, D., & Hedlund, J. (1983). The dysphoric psychopath: A comparison of 524 cases on antisocial personality disorder with matched controls. *Comprehensive Psychiatry, 24,* 355-369.

Widiger, T., & Trull, T. (1992). Personality and psychopathology: An application of the Five-Factor Model. *Journal of Personality, 60,* 363-393.

Wilkinson, C. (1983). Aftermath of a disaster: The collapse of the Hyatt Regency Hotel skywalk. *American Journal of Psychiatry, 140,* 592-598.

Wilson, J., & Walker, A. (1990). Toward an MMPI Trauma Profile. *Journal of Traumatic Stress, 3,* 151-167.

Wilson, J. (1989). *Trauma, transformation, and healing: An integrative approach to theory, research, and post-traumatic therapy.* New York: Brunner/Mazel.

Wilson, J., & Prabucki, K. (1983). Psychosocial antecedents of narcissistic personality syndrome. *Psychological Reports, 53,* 1231-1239.

Winnicott, C. (1980). Fear of breakdown: A clinical example. *International Journal of Psychoanalysis, 61,* 351-357.

World Health Organization (1992). *The ICD-10 Classification of Mental and Behavioral Disorders: Clinical Descriptions and Diagnostic Guidance.* Geneva: World Health Organization.

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

Yapko, M. (1993). The seductions of memory. *Networker,* Sept./Oct., 31-37.

Yehuda, R., Keefe, R., Harvey, P., Levengood, R., Gerber, D., Geni, J., & Siever, L. (1995). Learning and memory in combat veterans with post-traumatic stress disorder. *American Journal of Psychiatry, 152,* 137-139.

Yehuda, R., Giller, E., & Mason, J. (1993). Psychoneuroendocrine assessment of post-traumatic stress disorder: Current progress and new directions. *Progress in Neuro-Psychopharmacology and Biological Psychiatry, 17,* 541-550.

Zimmerman, M., Coryell, W. (1989). DSM-III personality disorder diagnoses in a nonpatient sample. *Archives of General Psychiatry, 46,* 682-689.