

An Example of Client-Centered Therapy for Post-Traumatic Stress Disorder

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Abstract. *This paper presents a rationale for offering Client-Centered Therapy to a female medical clinic patient with symptoms of Posttraumatic Stress Disorder (PTSD), who was not seeking psychotherapy. Her therapy is on-going, and her progress during the first three years is presented. It is thought that many, if not most, people with PTSD do not seek treatment. It is hoped that this paper will provide a useful model for reaching out to them. Client-Centered Therapy can help clients feel safe to live authentically and/or feel safe enough to pursue other treatments designed specifically for PTSD.*

Introduction

Post-Traumatic Stress Disorder (PTSD) is the name given to symptoms that develop in response to an event involving perceived threat of death, serious injury, or other threats to one's physical integrity, or in response to witnessing an event involving the same threats to another person, or learning about those events happening to a close associate or family member (American Psychiatric Association, 1994). The diagnosis requires intense fear, helplessness or horror in response to the event. Symptoms include persistent re-experiencing, avoidance of things that are associated with the trauma, numbing of general responsiveness, and persistent symptoms of increased arousal, all resulting in impaired social, occupational or other significant

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functioning. One to 14% of the USA population experience PTSD at some time in their life. Combat veterans and victims of severe natural disasters have prevalence rates ranging from three to 58 percent. (American Psychiatric Association, *op. cit.*).

Military sexual trauma (MST) (including both sexual harassment and sexual assault that occurs in military settings, predominantly between military personnel from the same country) has been found to occur by 38% of men and 78% of women in the U.S. military (Street & Stafford, 2009). "Rates of attempted or completed sexual assault were 6% of women and 1% for men." Prevalence rates are difficult to determine. Victims are often reluctant to report sexual trauma due to perceived stigma and self-blame. This tendency is exacerbated in military culture that stresses toughness, a persona of invulnerability, and survival. Skinner, Kressin, Frayne *et al.* (2000) found 55% of female veterans reported a history of sexual harassment and 23% reported sexual assault while serving in the military (2000). In 2003, the Department of Veterans Affairs began universal screening of all patients for military sexual trauma. Positive responses were reported for 21.5% of women veterans and 1.1% of men (Kimerling, Gima, Smith, *et al.*, 2007.) Kimerling and her associates found a strong correlation between history of MST and PTSD, particularly for women. In a prospective study, Shipherd, Pineles, Gradus & Resnick (2009) found both male and female US Marine Corps recruits reporting sexual harassment experienced increases in PTSD symptoms six months later.

Treatment Options

Prolonged Exposure Therapy (sometimes referred to as "flooding" with noxious stimuli and "extinction" of maladaptive conditioned responses), Acceptance and Commitment Therapy, and various cognitive therapies have all demonstrated good rates of success in empirical studies of PTSD treatment. Unfortunately, these interventions involve remembering, discussing and to varying degrees, re-experiencing traumatic experiences in the process of recovery. As mentioned above, victims of sexual trauma are often reluctant to discuss their experience, and avoidance is a common symptom of

PTSD. As a result, many people with PTSD decline treatment. Furthermore, discontinuation of exposure therapy for PTSD (e.g., drop-out) before completion of the therapy can result in enhanced fear.

Deblinger et al. (2006) compare outcomes for children with PTSD due to repeated sexual and additional traumas treated with Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) or Child-Centered Therapy (CCT) for 12 weeks. Post-treatment outcomes and outcomes at 6 and 12-month follow-up were superior for TF-CBT in that children had significantly fewer PTSD symptoms and less shame than those treated with CCT. The children's caregivers also reported "less severe abuse-specific distress during the follow-up period than those who had been treated with CCT" (p. 1474).

Motivational Interviewing (Miller & Rollnick, 1998) is an offshoot of Client-Centered therapy that seeks to make clients more aware of ambivalence toward change and increase self-efficacy about entering treatment or making behavioral changes. In a sense, it is therapist-directed preparation for therapy using client-centered techniques¹. Motivational Interviewing may facilitate the successful referral of clients for prolonged exposure or cognitive PTSD therapies, or it may be used as an adjunct intervention to improve treatment retention and adherence (Slagle & Gray, 2007).

This paper describes the use of traditional Client-Centered Therapy to provide a safe relationship, allowing a survivor of military sexual trauma with symptoms of PTSD to experience herself in the present and openly share her thoughts and feelings. That experience can lead to increased self-confidence, self-care, improved communication with others and readiness to engage in treatments that confront PTSD more directly and perhaps more completely.

¹ This is an oversimplification. Motivational Interviewing can also be used as a comprehensive treatment approach and can provide the necessary assistance to allow clients to become genuine in their expression of thoughts and feelings. See Miller & Rollnick, *op cit.*

Outreach

Integrated Care refers to mental and physical health care services delivered in same setting by an *interdisciplinary* (as opposed to *multidisciplinary*) team of health care providers. Physicians, psychologists, social workers, occupational therapists, nurses and other providers work collaboratively to diagnose physical and psychological health problems, plan and provide treatment, and evaluate whether or not treatment is effective. This model of care is important because studies have shown that most people with mental health problems do not seek psychotherapy or psychiatry. Emergency rooms and primary medical care clinics are likely to be the first place that mental illness or stress is identified. Primary care physicians are usually not prepared to offer comprehensive mental health services, and their patients are typically reluctant to follow-through with referrals (U.S. Department of Health and Human Services, 1999). The American Psychological Association is advocating for structural changes in U.S. healthcare that would promote integrated care (American Psychological Association, 2008).

The Spinal Cord Injury Clinic of the VA Palo Alto Health Care System uses an integrated care model. When a client is seen by any health care professional in our clinic, no referral is needed to receive care from another discipline. Health care is delivered with a team approach. For example, if a nurse practitioner is concerned about a client showing symptoms of depression, she simply speaks to the psychologist in our common office suite, and the psychologist goes into the treatment room to see the client. The client does not need to go anywhere, or sign any forms. Communication between team members is on a personal level – notes are for documentation, not communication. Clients are informed that confidentiality is at the team level. There are no secrets between providers. That helps us to coordinate care for the client's benefit.

Integrated care was introduced to the United States Department of Veterans Affairs (V.A.) by its Geriatric Research Educational and Clinical Centers in the 1980s. It is currently conceived as the model of care for most VA health programs, though the degree of implementation varies greatly.

The Setting

The case example presented here comes from an integrated clinic specializing in life-long health care services for military and Public Health Corps Veterans with spinal cord injuries. All patients are seen by all disciplines at least once per year. Minimum services are guaranteed by national directive (VA directive 1176), enforced by Congress. A Congressionally chartered consumer service organization (The Paralyzed Veterans of America/PVA) has a National Service Representative on-site to monitor the quality and availability of care. The PVA's national office makes annual site visits, and reports their findings to VA Central Office in Washington, and to Congress. Local and national PVA officers are also clients in the clinic and our inpatient hospital service.

The New Client

In January 2006 we received the following referral information from the General Medicine Clinic: "51 year old female veteran seen in clinic for estab, moved from IL."

The veteran, Jane (pseudonym), was scheduled for an interdisciplinary new patient evaluation. One of our nurse practitioners saw her first and noted the following history:

"...paraplegia secondarily to a motor vehicle accident in January of 1994. She has recently moved from the Midwest and is establishing care through the spinal cord injury center here. She has no chief complaints today in regards to her spinal cord injury, other than chronic low back pain, ...and...neuropathic pain to bilateral lower extremities in right greater than left. ...Upon review of systems with patient, she has allergies related to thiopental [sodium pentothal]." Additional observations were noted regarding Jane's physical functioning: "Walks with a cane and an ankle-foot orthotic [to compensate for right foot drop.] Poor stamina due to weakness in both legs. Neurogenic bowel, treated with

diet. Urgent urination, no incontinence.” Jane’s medications were noted to include Prozac and One-a-day vitamin with ECGC metabolism accelerant.

The nurse practitioner also took a social history. She noted that Jane had moved with her elderly mother from the Midwest to a local mobile home park to save money. Jane’s mother reportedly wanted to be closer to her other daughters and grandchildren in California. The mother was in reasonably good health and drove a car. She was taking an antidepressant to cope with moving. Jane had a brother in another state.

When Jane was 14, her father died of a heart attack. Jane completed a year and a half of college. She had been separated from her husband since 1977. She served in the Army from 1977 – 1984. Prior to her spinal cord injury she drank 3-4 beers daily. At the time of intake at our clinic she drank only a small glass of wine with dinner.

In January 1994, Jane acquired a spinal cord injury and fractured hip in an automobile accident. She was a passenger when her step-father rear-ended a semi. She sustained a TBI (traumatic brain injury) at the same time, but did not lose consciousness

The nurse practitioner made the following observations:

- “Rapid speech and tangential thought. Patient appears hypomanic today. Patient declines [sic] previous history of diagnosis of mania or bipolar disorder. However, has currently been referred to mental health service for individual therapy.
- New heart murmur identified through general medicine service.
- Overweight with minimal activities as patient predominantly spends time watching TV. I recommend the patient have referral to SCI home care service through our recreation therapist to assist with adaptive PE program versus adaptive therapeutic swim. Patient wishes to think on this.”

The nurse practitioner shared her findings with me, and I reviewed Jane's responses to a screening questionnaire given annually to all clinic patients.

Questionnaire data:

- In the past year, the patient reports that her health was good.
- Her ability to do things she wants, e.g., recreation, ADLs was fair.
- Depression limited her weekly activity 0 hours per week.
- She has gotten out of the house daily.
- Her overall satisfaction with life was good.

With the above information, I began my initial interview with Jane. I learned additional history. She married 1975, but her husband is gay. She discovered his orientation when he was diagnosed with AIDS in 1977. She left him and joined the Army. Jane described herself as "reformed," having been "bad" 20 years ago. She did not elaborate. Jane said she usually got along with her three sisters and brother. She became angry when they criticized her past behavior or her relationship with their mother, whom they think she exploits.

Jane was unable to support herself financially. She had been an Army supply specialist from 1978 - 1984. She completed a medical transcription program after her injury in 1995, then worked until she was fired in 2003 for saying she had completed two reports that she had not. She said her temper was also a problem at work.

Since 2003 she has received disability insurance (SSD) payments for hearing problems that made her transcription work difficult. She worked occasional temporary jobs as a food demonstrator, and wanted to find such a job in California for 8 hours per week in order to buy a car.

Jane was unsure of how her SCI affected her sexual functioning, having had no partner since the mid 1990s.

I performed a mental status examination. That is standard practice for our clinic, and I thought it was particularly important due to Jane's history of TBI. She was alert and oriented to person, place, time and purpose of the examination. She was appropriately dressed

and groomed, and eye-contact was also appropriate. Jane's affect was cheerful. She was cooperative with the interview. Her memory / concentration appeared grossly intact. For example, she recalled my name, though only after being reminded and told I'd ask again. She readily recalled the past 3 presidents. She kept a calendar of her appointments, demonstrating ability to plan and organize. Her speech was pressured and her thought process was mildly tangential. She was easily re-directed to the topic at hand. Jane was responsive to questioning. She denied experiencing auditory or visual hallucinations, and none were evident. She said she slept from 1 to 5:30 A.M. nightly. Insight appeared within normal limits, but judgment was sub-optimal.

Jane reported her mood as euthymic and stable. She denied any history of mania, but said she has always been "hyper." She had taken valproic acid when she was first menopausal, but stopped when she started hormone replacement therapy. She had been taking Prozac for four years and said that helped with anger management. She had found individual psychotherapy very helpful in the Midwest. Jane had been referred to an anxiety group at our medical center, but she had tried group therapy once before and was not comfortable disclosing to peers.

Substance abusers often under-report use, so I routinely repeat the nurse practitioner's substance use assessment. Jane told me she smoked occasionally when anxious or in the company of others who did so. She was not interested in abstaining. She drank a glass of wine nightly with her mother. She drank 64 oz. of sugar-free cola per day, and ate "lots" of chocolate. She wanted to lose weight.

Jane's spinal cord injury is incomplete. She is able to walk, but tires quickly, and needs to be careful to avoid falling. I asked how she coped with this. She said that her primary coping strategy was to avoid thinking about her injury and other things that distress her. She also walked 10 minutes daily.

We ask all new clinic patients if they have experienced abuse or neglect related to their disability, and also if they have experienced military sexual trauma. Jane disclosed that she had been raped once during basic training and again at her "basic and permanent party." She had bad memories from time to time, occasional nightmares, and

found it difficult to let men get close. She said she had not been abused since military discharge.

I asked Jane if she was interested in psychotherapy. She was, and readily identified goals of experiencing stable mood and relationships with family, maintaining her current or lesser weight, and learning to function fully despite intermittent chronic pain.

The Diagnosis

In order to offer psychotherapy (or any other health care intervention), the VA requires assignment of a diagnosis. The Client-Centered literature has debated the wisdom of diagnosing clients, and I will digress briefly to review what I see as the advantages and disadvantages of this practice, beyond meeting an administrative requirement.

By their nature, diagnoses are reductionistic. No diagnostic label can convey the full experience of a client's experience, or even of their problems. Diagnoses can be a form stereotyping, prejudicing the therapist against recognizing the client's strengths and immediate experience. Diagnoses can elevate the therapist in his or her relationship to the client, labeling one as "sick" and the other "healthy." As a result of these problems, diagnoses can impede the therapist's capacity for empathy, and may blind the therapist to the client's true self.

On the other hand, diagnoses can provide advantages. They provide a framework for understanding the client's experience. If accepted as hypothetical rather than absolute, this framework can enhance empathy. They can give the client an identity, helping him or her realize that they are not alone in the symptoms they experience. Accurate diagnosis can assist in the coordination of care between disciplines and clinics. They can also result in financial benefit to the client. That is particularly true in the VA, where disabled veterans may be eligible for financial assistance depending on the diagnosis, severity and circumstances of a disability.

Given the history I knew at the time, and Jane's presentation during the initial examination, I believed she was experiencing Posttraumatic Stress Disorder secondary to military sexual trauma. It

seemed difficult for her to discuss her trauma, and whatever behavior she had alluded to when saying she had been “bad” in the past. For those reasons, I thought she would be best served by a female therapist.

As mentioned above, Jane had already been referred to the Mental Health Clinic (MHC) by General Medicine. I encouraged her to keep that appointment and use it as an opportunity to clarify her goals and see what services they could offer. She could then decide if individual treatment at the Spinal Cord Injury Clinic with my female trainee made sense in addition to what MHC could offer.

A Second Opinion

The intake worker at MHC wrote the following assessment after her interview with Jane:

“Patient exhibits mild to moderate psychomotor agitation and speech is slightly pressured. She is looking for individual treatment (someone to vent to). She reports some family communication problems and is quite frustrated by this. She reports limited social support. She reports some explosive anger, usually verbal outbursts and one incident of throwing a glass at her sister last summer before they moved to California. She reports no other physical outbursts and denies any physical violence towards anyone (hitting, kicking). She reports sleeping only 5 hours each night (1 a.m. to 6 a.m.) but states that she sometimes takes naps during the day. She reports some irritability and boredom. She states that she is not able to get out of the house very often. She denies any suicidal or homicidal ideation. She was raped twice in the military. She reports some avoidance (won't go out alone after dark, has some difficulty talking about the rapes), some exaggerated startle response (i.e. if someone walks up behind her and taps her on the shoulder), a history of nightmares

(last one was a month ago). She abruptly changed the subject after questioning her about her symptoms.”

Regarding her treatment history, “She denies any history of hospitalization, suicide attempts, and physical violence. She reports the first time she sought psychiatric help was in the 1970's for depression and marital problems, but it was a group session and she did not feel comfortable speaking in front of the group. She only went once or twice. Three or four years ago she sought treatment again in order to "talk about family matters and have a sounding board". She says that her anger was better because she had someone to talk to.”

The intake worker obtained further information regarding Jane's history of substance abuse:

“She reports that 20 years ago she used crack cocaine and marijuana because she was in a relationship with someone who used, but she quit 20 years ago and has not had any trouble staying clean since then. She denies any current drug use.”

The intake worker had the following DSM-IV diagnostic impressions:

Axis I: hypomania vs. anger/anxiety due to PTSD
Axis II: deferred
Axis III: past MVA, back pain, menopausal difficulties
Axis IV: limited social support, family difficulties
Axis V: GAF: 50

They agreed on a prescription for Paxil 20 mg daily and monthly case management. Jane declined individual therapy with my trainee.

One month later at the Mental Health Clinic:

“...client reports that things have been going better since her dose of antidepressant was increased. She has been doing a lot of gardening which is physically exhausting on the one hand but very satisfying. She reports that one of her major stressors had been having contact with her two sisters who live in the area. While they are both going to be traveling coming up she has generally been able to get along better with them and less reactive. She reports that they have a sleep over planned... [and they enjoyed a live musical together]. Client is feeling good about her mother as well. There seems to generally be less stress. Client has a trip planned to go back to a friend's daughter's wedding in the Midwest as well. Client reports that sleep, concentration and mood are improved.”

The diagnosis was changed to “Mood disorder not otherwise specified.” The treatment plan was to continue case management every two months, see a psychiatrist every three months, continue taking Paxil, and use music and exercise to cope when her mood is depressed.

More Outreach

Jane returned to our clinic in March 2007 for her annual evaluation. She was seen by my student, Laura, who decided to ask for a more complete history. Laura wrote:

“Patient reports that she has been feeling sad since the death of her uncle this week. She reports that her uncle is the brother who looked most like her deceased father and as such his death has brought up sad memories. Patient reports that she continues to experience conflict with her siblings who she feels judge her and don't understand her. She reports that for many years she has been trying to ignore the bad things that have

happened to her, but she has noticed that over the last couple of years she finds this harder to do and as such she feels sad more often.”

Developmental history: Jane is the youngest of five siblings. “She reports that she sometimes got along well with [one of them] in her childhood, but mostly she felt as though she was different to her siblings and they were never particularly close. She reports that her siblings were all "A" students and she feels as though she was always being compared negatively to them.”

“Patient also reports that she had a difficult relationship with her father with whom she was in constant conflict. She now attributes this to them both being determined, and similar personalities. Patient reports that on Homecoming night when she was in 9th grade, her father died unexpectedly from an aortic stenosis. Earlier that day, patient reports that they had fought and she had called him names and stormed out of the home. She reports that this left her feeling very guilty and also angry at her father for leaving her. She reports that she still feels some of this guilt and anger.”

“...[Jane] reports that two years following her father's death, her mother remarried to a man who she liked. However, she reports that she did not get along with her new step-brother ...who is her age. She reports that her step-father often negatively compared her to [him] and, although she liked him, this caused conflict. Patient reports that her step-father died three years ago and that she still misses him. During high school, patient reports that in addition to not being as good academically as her siblings, she got into a lot of trouble, including smoking pot and mescaline. She denies any legal trouble.”

“Following high school, patient reports that she married her high school boyfriend. She reports that her family did not approve of this because he was African American and so they were not very supportive when he told her two years later that he was gay. Patient left him at this point and joined the military. ...She reports being raped twice. The first instance occurred during basic training. Patient reports remembering little about this instance but knows that there were two men. She reports that it is possible that they had been drinking which was against the rules of basic training and as such she did not report the incident. She was later raped following basic training by four men. She reports that someone with whom she served lured her into a building where she was then assaulted by him and three other men that she did not know. She reports that one of them choked her and threatened to kill her if she ever reported this and so she never told anyone.”

“After leaving the military in 1984, patient reports working for the post office. She reports that she dated several men casually and would not allow anyone to touch her sexually or to get close to her emotionally. However, she reports that she then met a man with whom she fell in love before realizing that he was married. They were involved for two years, during which time he physically abused her. When she lost her job, she reports that she moved down to San Diego to live with her sister and left this man. At that time, she became friendly with a girl who introduced her to crack cocaine. Patient reports that she has no clear recollections of what happened to her during the two years that she was using crack cocaine, but has vague memories of waking up in terrible places and hating herself for doing this. After about two years, patient reports that she decided one day to get away from this

lifestyle and stopped seeing her friend and just stopped using crack.”

“Behavioral Observations: Patient presented casually but appropriately dressed and appears to be her stated age. Her speech... rate is fast. Despite the painful nature of the subject matter, her affect was inappropriately cheerful throughout. Her thought process was somewhat tangential, but she was easily redirected and it seemed more to needing an outlet....

“Impressions: ...[Jane] has experienced an inordinate amount of trauma in her life that she has been trying to deny. She is likely to have experienced complicated grief symptoms when her father died, and this combined with her sense of being unable to live up to her siblings may have contributed to her acting out in school. The consequent criticism that this produced seems likely to have compounded the sense of worthlessness she reports feeling from a young age. This is likely to have led to her exercising poor judgment and placing her at risk for the later traumas that she has endured. Her denial of the pain she has experienced, and the later use of drugs are suggestive of an avoidant coping style. Having someone with whom to talk, without judgment or criticism is likely to be extremely beneficial to beginning to counter her beliefs of being worthless and unlovable.”

Laura considered several diagnostic options, including Major Depressive Disorder, Cyclothymic Disorder, and subthreshold (because not all DSM IV criteria were observed) Posttraumatic Stress Disorder. Jane felt good about their first meeting, and agreed to begin weekly psychotherapy.

Then-current social stressors included unemployment, poverty, social isolation and conflict with siblings. Due to the history of successive traumas each associated with increasing social avoidance

(including avoiding intimate relationships with men), avoidance of negative emotions by tangential responses, depressed mood, chronic anxiety, and hyperarousal, I assigned the diagnosis of Posttraumatic Stress Disorder.

Jane had declined referral to group therapies for PTSD at the Mental Health Clinic. She did not trust peers with her history and experience. She generally avoided discussion of her traumas, and we did not think it wise to push her toward doing that before she was ready. Client-centered therapy offered us the opportunity to show Jane that we could trust her to decide what was best to talk about, and show her that we could value what and how she chose to communicate.

Client-Centered Therapy Begins

In her first session with Laura, Jane discussed problems with social isolation and conflicts with her family.

“Patient reports that the only people that she currently spends any time with are her family. She attributes this to having difficulties knowing how to build relationships now because she has learned that she is not good at knowing who she should trust. She acknowledges that this is not good for her since her siblings and mother are major sources of ongoing stress for her. She reports feeling as though they are constantly nagging and judging her.”

... “Her particular difficulty relates to her sense that they consistently bring up her past actions such as her drug use and use this to put her down. Patient reports that she often becomes defensive when this happens which escalates the conflicts and that she knows that she needs to simply disengage. Patient reports that she thinks that she has heard so much criticism of herself as a person over the years that she has just learned to believe that it is true.”

Jane also spent much of the session berating herself for not going to the gym to exercise three times weekly as planned. She was very concerned about her weight, and felt she had failed. Laura proposed in supervision to help Jane break her weight reduction plan into small steps that she was likely to complete successfully (behavior therapy). I suggested that she share this idea with Jane and let her choose. Jane decided to accept Laura's offer to coach her in weight reduction. Notably, Jane's plan also involved increased socialization by going to the gym at her trailer park.

The next three sessions were characterized by rapid behavioral gains. Jane heard Laura's disclosure that Laura would prefer her to go slowly and she went to the gym once the first week, then three times the following two weeks. She felt better about her interactions with her sisters because she changed the subject when they brought up her past, and she started asking about their activities and feelings.

Progress?

In March 2007, Jane's MHC Case manager administered the VA's annual screening questionnaire for PTSD.

PTSD Screen:

Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you:

- Have had any nightmares about it or thought about it when you did not want to? Yes
- Tried hard not to think about it or went out of your way to avoid situations that remind you of it? Yes
- Were constantly on guard, watchful, or easily startled? Yes
- Felt numb or detached from others, activities, or your surroundings? No
- A four-question Primary Care PTSD screen was positive.

For the first time since beginning care at our medical center, Jane endorsed sufficient criteria for the standard DSM-IV diagnosis of PTSD. Does that mean Jane was getting worse? I think not. Instead, I think that due to her work with Laura, Jane was more comfortable thinking about and disclosing her symptoms.

In the next psychotherapy session Jane reported she'd gone to the gym every day. Besides benefiting from exercise, she enjoyed socializing with women there. However, she was hurt and puzzled that another woman abruptly rejected her suggestion that they meet socially outside the gym. Jane concluded that people need to be cautious. She said she continues to experience some ambivalence about discussing her trauma history. She acknowledges that the constant presence of these memories allows them to have control over her but she fears losing control if she were to begin talking about them and processing her emotional response to them. Patient reports the belief that it is better to just let them all out at once, but fears that this will be overwhelming for her.

The next session Jane introduced a plethora of mundane topics. She said her relatives were out of town, so nothing was bothering her except a toothache. At the end, she blamed Laura for an unproductive session due to making uninteresting responses. Laura empathized, and then replied that she thought her responses reflected what Jane had expressed. Laura and I wondered if this was a client-centered comment (genuineness expressed to disclose the client's impact on the therapist), or a comment made by Laura to defend herself. I found Laura to be remarkably non-defensive, and Jane's report in the next session indicated that she had not felt blamed or attacked.

In the next session, Jane announced that she had quit smoking, and lost her cell phone. Her thoughts about people who might take advantage of this led to self-disclosure about having stolen to buy crack cocaine. At first she blamed the influence of her friend, but then she stated she was responsible for her own choices.

The following session was characterized by changing the topic so rapidly that I had great difficulty understanding the content. Her speech was rapid with loose associations, though the content was not delusional. Jane mentioned nightmares about being unable to escape

from someone trying to harm her, looking for an affordable apartment on Craig's List, and being shocked by the personal ads she saw. She said she did not understand why she felt so vulnerable at this time.

Like many clients, significant progress by Jane is often followed by regression to more familiar behavior in the next session or longer. Psychodynamic therapists think of this as a way of clients reassuring themselves that they can still deploy ego defenses against painful experience if they choose to do so. I find that concept useful in the client-centered relationship as well, to prevent *myself* from being discouraged by the client's present experience. In client-centered therapy it is not necessary to share this interpretation with the client.

Next session Jane said she was lonely and she feared it would be difficult to trust a new therapist after Laura left.

Jane said she believes that her experiences of being raped contribute to her sense of distrust for people. She now keeps her distance from men and will not consider engaging in an intimate relationship. She expressed the belief that she deserved to be raped in some way and that the second rape served to compound this belief. She acknowledged that she perhaps it is not really her fault, but expressed the belief that it is normal for her to blame herself because she put herself in the position where she was at risk and perhaps did not fight hard enough on either occasion. She also expressed that since she did not report either incident this contributes to her responsibility. She repeated this content the following week.

The last week of June was another of rapid, pressured, loosely associated content. In the last 5 minutes, Jane acknowledged her anxiety about changing therapists when Laura's training rotation ended in August 2007, and stated she was confident she would open up again despite the difficulty because she knew she had made much progress with Laura.

The following week, she said her progress came from being able to discuss difficult topics without being judged, and she knew she needed to continue this though it was easier to suppress.

Next session she was able to talk about her sadness about losing Laura, and her life-long loneliness.

Reflecting on her sense of progress, she said that by occasionally referring to her trauma history, she had begun the process

of "letting the skeletons out of the closet" and she believed that with time, she will reach a place where she is more ready to fully address the issues around her experiences.

A Change of Therapists

August 23, 2007 was a transitional session with Laura and the new therapist, Erin.

Jane stated that she enjoyed having a non-judgmental listener, and (referring to sessions when she disclosed nothing personal) was sometimes uncomfortable when the feedback Laura gave her was not as expected.

She'd had to euthanize her cat, but felt okay because it was the "right thing to do." She'd started smoking again, and declined a referral for smoking cessation.

Jane's presentation was similar to our first meeting. She was loquacious and tangential, describing herself as "the baby" of her family as the youngest of five children. She said that she "did some bad things" in the past, and that her older siblings often remind her of her mistakes which bothers her quite a lot. She also reported that according to her mother she was a bright, precocious young child, but that she went on to not do very well in school and was diagnosed with learning disabilities.

Two sessions continued the theme of "safe" material that was difficult to follow. Jane commented in passing that although she talked mostly about other people in her life, she still found therapy helpful because this content had been on her mind. In supervision, I focused on helping Erin be patient and trust that Jane would know when she was ready to delve into more of her immediate experience and trauma history.

In mid-September 2007, Jane brought up her rapes halfway thru the session. She recounted the events, adding that another factor in not filing complaints was that she expected to be looked down upon and blamed. In the years since her traumas she had done her best to keep the memories "locked up," but that they came back to her at certain times, like when she heard a particular song or saw a man that reminded her of one of her perpetrators. She also mentioned that in

her experience most men have a tendency to be "rough during sex," so she doesn't miss" being involved with a man.

Subsequent sessions were characterized by appearing happier, avoidant and difficult to follow. She occasionally touched on traumatic experiences in a superficial manner. She also started talking about important practical matters (e.g. housing and savings) in a trivial way. Already bankrupt, Jane had been the victim of identity theft. She also spoke critically of her best friend, whom she saw as irresponsible and self-absorbed. The Mental Health Clinic started seeing her every three months instead of monthly, and Jane missed several therapy sessions due to transportation problems.

In November, Jane spoke to her banker and worked out a way to establish credit. She bought a car and began to lose weight. She described psychotherapy as cleansing. However, by late December she injured herself after drinking too much at a party, and was over-drawn from not keeping track of how much she spent on Christmas gifts. She was up-beat and expressed confidence that her problems would work themselves out.

In January, Jane shared the story of her father's death. She opened her wallet and shared pictures of him, her mother and her husband. Similar to when she told her other trauma stories, her affect remained cheerful. She said she occasionally felt "down" due to the weather. In February, 2008, Jane talked about several times that her mother's dog had bitten her. She blamed herself for being intrusive. To her credit, Erin resisted the temptation to interpret this as Jane allowing herself to be abused. She trusted that Jane would eventually take care of herself if she were trusted to do so.

Next session, Jane talked about a visit by one of her sisters. The sister had told her that she needs to treat their mother better, make more of an effort to think of others versus only herself, do more to keep up the house, and be more "social" instead of watching so much TV. Jane admitted she could do more around the house. She then explained to Erin (her therapist) that she gets frustrated with her mother because she does not hear very well and often misunderstands what she says, and her sisters literally do not understand her. She reported that her friends do not have a problem understanding her in conversation, even when she "goes off on tangents". She said that she

can say the most straightforward thing and her family still will say that they are confused and question her. This frustrates her, so she watches T.V. to avoid an argument. Weeks later, she said she was grateful to be able to express herself freely in therapy because she feared being judged if she did so with her family.

A Breakthrough

In March (27 months after intake), while talking to a friend, Jane realized that her three best friends always say the same old thing, and that she is getting tired of hearing it. She also said that they primarily talk about themselves, and only occasionally ask about how she is doing. She reported that she had an "aha moment," in which she realized that the way she was feeling during their conversation -- ignored, bored, and annoyed, is how her family must often feel in speaking with her. She said that she actually said the word "aha" aloud upon making this realization. Jane reported with some incredulity that she has never thought about her relationship with her family from this perspective before. She expressed hope that her relationship with them will improve as she begins to change her approach to interacting with them.

The next week she was particularly tangential in session. Later, she said she realized she was being superficial, and blamed Erin.

Jane's world continued to be fragile and uncertain. On March 31, 2008 a spot on her lung was reported after x-ray for her SCI annual evaluation. She quit smoking. She denied being anxious, but was more difficult to understand. Her same-aged cousin killed himself. Jane quit exercising and Weight-Watchers. In April she began to prepare for a change of therapists when Erin's training ended in August.

In the end of June, Jane borrowed \$500 from her mother for car repairs, and did not have \$700 she needed for dental work. She told Erin she was "fine."

In the end of July, Jane had begun to save money. She held a birthday party for her mother and got along well with her sisters.

August 1, 2008 was her last session with Erin. Jane's mother had accidentally killed the dog. Jane said she looked forward to playing with her sister's dogs when she and her mother traveled to see her. She

acknowledged making progress in therapy, and agreed to see a new therapist after visiting her sister.

The Third Therapist

Jane met her new therapist, Olga, late in August 2008. She discussed her new role as caregiver due to her mother's new health problems. She seemed to be effective in this role. She seemed empathic toward her mother, and insightful regarding the impact of her empathy. However, Jane became increasingly tangential in subsequent sessions. She was sad that her mother was preoccupied with death, and also worried about being homeless when her mother died, yet her affect remained cheerful.

Putting the Mask Aside (For A Bit)

In October 2008, Jane got a puppy to cheer her mother up. This became an unexpected source of stress, as Jane had taken a second part-time job and had not anticipated how much work it is to care for a puppy. Additionally, her mother was not pleased at having a new pet. For the first time, Jane's affect was congruent with her thought content. In November her MHC visits were decreased to every 4 months.

In December, Jane planned to drive somewhere new for recreation. She explained that this was a big step because she had a serious fear of being lost. She decreased her work hours because she did not think it safe to leave her mother alone. She requested help from our SW to find subsidized housing for after her mother died, having refused this three years earlier. She also re-started gapapentin for pain, having stopped it two years earlier.

Instrumental Support

On March 25, 2009, at my suggestion, Olga told Jane about the possibility of filing a claim for Service-connected compensation for the consequences of military sexual trauma.

Jane reported that she had lost both her jobs due to the economy. She felt emotionally prepared to discuss the events surrounding her military trauma. She noted that she had not thought of these events for a long time and was concerned that "jumping in cold turkey" would cause her marked distress. Olga offered to discuss her traumatic experiences in therapy prior to disclosing this information to the PVA benefits representative.

Was this a Client-Centered therapy intervention? Jane was concerned about her finances, and had begun to seek additional resources. She might have found out about her eligibility to make a service-connected disability claim from her Social Worker. However, the process of making a claim involves providing detailed information about the relevant traumas in writing, defending the claim in correspondence with the VA Regional Benefits Office, and discussing the trauma with a disability evaluator. Providing this information to Jane, along with empathy for her choices and the consequences, in the context of her search for resources, seemed both Client-Centered and caring. While education and referral go beyond Rogers' core therapy conditions, I think these interventions are consistent with the model as long as they follow the client's lead. Olga did not recommend that Jane apply for benefits. She only informed Jane of the option and what it would require, and made herself available to support Jane whether she chose to pursue this or not.

Another Transition

Over the next two weeks, Jane looked worse, but was unusually coherent. She said that she no longer thinks about these events daily but can feel their effect on her current functioning. Jane stated that she "is a broken person," whose personhood "was violently taken" from her. She shared that the rapes made her feel "guilty, dirty, ashamed" and that she felt "empty, as if they left me with a shell of myself, nothing inside." She spoke about not sharing with anyone because she was threatened by her assailants (told her they would "simply kill you if you talk, throw you out the window in the barracks"). Patient described the emotional and physical damage that resulted from the assaults. She was forced to return to military service with the men who

raped her (both during the basic training and later at her post abroad) as she did not feel safe to report the rapes to her commanding officers. She described the importance of small tangible things from home that gave her comfort and were the only source of emotional safety while she was in the military. She felt "damaged, unable to trust any man for the rest of my life," unable to sustain a meaningful interpersonal relationship with a man, always suspecting that she could be raped again.

She described episodes of intense fear followed by detachment/depersonalization, "acting like robot." Jane stated that for many years following the trauma, she experienced intrusive and distressing flashbacks and dreams of the rapes. She has withdrawn from social contact and only felt safe staying at home. She was not able to maintain a job that required her to be outside of her house. Jane reported that she has been avoiding anything that reminded her of these traumatic events and that it took her years to be able to compartmentalize the memories related to her sexual abuse. She also shared that she has not had a satisfactory sexual relationship since being raped as she is unable to trust others or allow herself to enjoy intimacy, which she associated with feeling "dirty and guilty." At the end of the session, Jane summed up that the rapes robbed her of "full life and good future" but that she was able to survive and has slowly put the pieces of life back together. Jane noted that she "was a broken puzzle" when she was discharged from the military. She is now able to recognize the sort of tremendous effort it took to "get all the pieces together." She ended by saying that she was hoping she "was doing well enough."

After two more sessions, Jane met with an advocate, and brought a benefits application to fill out with Olga. She also made plans to deal pro-actively with problems she anticipated in dealing with A, who planned to help her care for their mother.

In her most recent session (June 2009), Jane discussed concerns related to a request from the VA for more information concerning her benefits claim. She has no documentation to support her claim, and has forgotten many details. While anxious, she did not report an increase in other symptoms, and has begun to discuss termination with her third therapist.

Regarding her rapes, on 6/17/09 Nancy concluded that, although it is not likely that she "would ever be able to get over it," she is content with being able to talk about it now "without falling apart."

Future Plans

Making an official report of her rapes is an important step toward Jane revealing her true self to others. Her long-standing fear that she will not be believed may be realized due to her lack of documentation and inability to recall the names of her assailants. Jane will continue to discuss this with her therapist, and will integrate that experience with her efforts to be more authentic with her siblings and friends. She has declined a referral for peer support, but may reconsider that in the future. She will soon need to talk about plans to transition to another therapist, and may eventually be ready to try therapies developed specifically for PTSD. As she faces the inevitable prospect of living without her elderly mother and needing to support herself financially, Jane has begun to discuss housing options with her social worker. An empathic ear may help her overcome her resistance to signing onto the long waitlists for subsidized housing, and establish financial independence from her family of origin.

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The subject of this paper has reviewed the paper and given permission for its publication.

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