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The Psychosocial Context of Trauma in Treating PTSD Patients

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Many patients do not improve in psychiatric treatment because they are improperly or inadequately medicated (1). A smaller but significant number who are medicated properly do not improve until their serious psychosocial problems are addressed (2). The case of "Ms. A" illustrates this point.

Case Description

Ms. A was a tall, extremely thin, 42-year-old married woman suffering from posttraumatic stress disorder (PTSD) and a major depressive disorder. After an automobile accident 4 years earlier, she had developed psychiatric symptoms for the first time in her life. Her husband was driving when a woman pulled out from a stop sign and struck their car on the driver's side. Ms. A remembered screaming, "It's going to hit us!" and thinking she was dying at the moment of collision. Although her seat belt was buckled, she was thrown to the front and side of the car. The driver's side of the car was smashed; her husband climbed out of the car through the rear door to let her out. She was so shaken she was unable to stand; he helped her sit down on the curb. She had severe neck and some shoulder pain that subsided slowly over several months. Neither her husband nor the other driver was seriously injured.

Ms. A's recurrent nightmares about the accident compromised her sleep. She had frequent distressing recollections of the accident that she struggled to shut out. She fearfully avoided being in a car if she was not the driver. She also avoided television and the movies because the frequent scenes of violent death upset her. Although always a hard and reliable worker, Ms. A could not now concentrate on her job in customer relations for a manufacturing company. Depressed and tearful much of the time, she developed severe anorexia and lost a great deal of weight. She lost all sexual desire and went through her day dully and mechanically. She said her husband had tried to be supportive, but he felt rejected so that tension had developed between them.

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Ms. A had grown increasingly hopeless over her failure to improve; she often thought she would be better off dead. She considered suicide a sin but thought she would be driven to it if she could not find relief from her anhedonia, affective "deadness," loss of pleasure in her daily activities, including her relationship with her children—a son of 23 lived at home and an older married daughter was expecting her first child—a total loss of appetite, and recurrent nightmares about the accident.

Ms. A had been receiving psychiatric treatment for several years with a combination of psychotherapy and medication from a psychiatrist who had experience in treating PTSD. At the time she was first seen in our program, her treatment included an antidepressant to reduce her depression and a sedative to help her sleep and diminish the frequency of her nightmares. A behavioral approach was employed to induce her to eat more. This combination of medications had helped her sleep a little better, and her nightmares were less frequent, but her other PTSD symptoms were no better, her mood had not improved significantly, and her appetite had not returned.

Ms. A was the fourth of six children raised by her mother and grandparents on her grandfather's farm in the South. Her mother had never married, and several different men appear to have fathered her children. She said her mother, who worked making fabric in a cotton mill, was devoted to all her children but was devalued by her fundamentalist family, which included two uncles who were Baptist ministers. Ms. A was regularly reminded of her illegitimacy and taught to be grateful that the grandfather permitted the family to live in his home. She was particularly hurt by her grandfather's angry, contemptuous disapproval of her mother.

When Ms. A was 14, her mother left the farm and brought the children north. She told them to tell the neighbors that their father had died. Much happier after the move, her mother went to work as a nurse's aide, and Ms. A attended a local high school. During this period, she met her husband-to-be, a high school shop teacher, who was 7 years older than she. They married right after her graduation, and she immediately became pregnant. Ruefully, she remarked that she wished she had known more about birth control, but her mother, who had died a year before the accident, was not someone you could talk to about such things. Ms. A described her husband as an "ideal man" with whom she was happy before the accident. She said he was protective of her, but he was not someone to discuss problems or feelings with.

Treatment

Ms. A's continuing nightmares, unrelieved depression, suicidal thinking, and weight loss led to her referral to a research/treatment program that included brief psychotherapy. She was assigned to "Dr. P," who saw her once a week. Since her medication regimen was providing some relief, it was provisionally continued. Her low self-esteem, difficulty in self-assertion, and a more accurate picture of her relationship with her husband soon became evident.

Ms. A's husband had been pressing her to get better in a hurry because he wanted to sell their home and build a log cabin and needed her help. She resented the pressure and preferred to live in a house you could paint and vary the wall colors of, but he disregarded her feelings. After a few sessions, she began to give a more general picture of a marriage in which her needs were not noticed and usually went unmet. They only vacationed at places Mr. A chose. She liked the theater, but he did not and did not want her to go without him.

Tying the past to the present, Ms. A remembered her grandfather treating her with a similar disregard for her feelings. She had a vivid, unpleasant memory of his telling her that he would have to get rid of her dog after it bit a child. Although she tried to tell her grandfather that the child had been hitting the dog with a stick and the dog had barely scratched the surface of the child's arm, he told her to keep quiet, ignored her grandmother's entreaties, took the dog to the woods, and shot it. Ms. A also recalled an aunt who would bring her laundry to the house for Ms. A to wash and iron, implying that she had to do it because she was "illegitimate" and had better make herself useful. When she was 13 and talking to some boys, her aunt passed by and took her aside to tell her that she would end up a whore just like her mother.

Ms. A felt such incidents expressed the attitude of that aunt and her grandfather that she was a "whore's child with no right to live" and no right to complain since she was being fed and housed out of the charity of her grandfather. She learned to accept mistreatment believing she deserved nothing better.

She related these childhood experiences to her relationship with her husband. Even before the accident, Mr. A had been insensitive to her sexual feelings. Recently, however, they had been out socially, and he had been drinking. When they came home and were in bed, he coldly and obscenely demanded that she comply with intercourse since she "did not feel anything anyhow" and might as well give in. Ms. A did what he wanted, not feeling she could object because she was afraid to upset him and make him angry. She said she should feel grateful to him since she "was nothing when he met her." Dr. P encouraged her to express what she felt about his treatment of her. She was pleased with this support and said she would work on the problem.

Soon afterward Ms. A told Dr. P that she had decided to tint and restyle her hair, had made an appointment to do so, and had only told her husband about the appointment after making it. Mr. A had been surprised and asked her if she was sure she wanted to. He also asked why she did not ask his opinion, and she replied she had "just decided to do it." She said he was shocked since he was so accustomed to her doing nothing without checking with him first, but after the initial reaction, he accepted it, and she was pleased with having made the decision herself.

Early in her sessions, Ms. A had told Dr. P that about 3 weeks after the accident she had started to have a recurrent nightmare that persisted to the present. In her dream, the accident had just happened; she and her husband were lying slightly apart on the road, and blood was running slowly over her body and that of her husband. A policeman told her that her husband was dead. She then died, and as he put a blanket over her face, she would wake up screaming.

Ms. A reported in one of her sessions that she had been making herself think about the accident, although for several years, she struggled to avoid doing so. She remembered she had been thinking "something bad" just before the collision but could not recall what it was. She seemed to feel she had deserved the accident. Dr. P asked her to reflect if there was anything happening in her life at that time that might be making her feel that way.

Soon after, Ms. A remembered the "evil thoughts" she had been having when the accident happened. She had a secret date to meet a man scheduled a few days after the accident at the house of a friend with whom she worked. Her friend, who was divorced and had been involved with several men, often told Ms. A that she had been involved with one man her whole life, that she knew nothing about life, and that she had to live a little. The woman had met Ms. A's husband and said he was too overpowering and that Ms. A was too obedient. Ms. A had accepted the offer of the date and was planning and looking forward to an affair when the accident occurred. Sitting on the curb after the accident, she thought the accident was punishment for having such evil thoughts, for which she deserved to die. Ms. A said that her husband would leave her if he ever found out, and if he did not leave her, he would never trust her again.

Ms. A's recurrent nightmare began to make more sense. It reflected feelings that were becoming conscious. She felt that although she deserved punishment for her sexual plans, she could now see how angry she was with her husband and that she wanted to punish him as well. Dr. P observed that given how constricted she felt in her marriage, having such thoughts proved not that she was evil but only human. He referred to the incident in which she decided to change her hair without her husband's permission and how good it made her feel. He pointed out that there were other ways she could be more free and expressive of her needs without doing something as radical as jumping into an affair with someone she did not know.

Ms. A appeared at the next session with the tinted hair style she had been anticipating. She asked Dr. P how he liked it, and he complimented her on it. She was pleased with the result and pleased that she had told her husband in advance what she was going to do rather than asking for his permission or being afraid that he would talk her out of it. This was a forerunner of many such independent choices and experiences. She had planned to buy tickets for a show and invited her husband to join her. When he refused, she said she would invite a friend, but he soon thought better of his refusal and said he would like to come along.

At this point, Ms. A had been seen over a 3-month period in a research program that included short-term therapy. We had the option of extending treatment a few

months if it seemed indicated. That was done in her case. Over the next few months, Ms. A and Dr. P continued to work on problems in her marriage. Progress was not in a straight line. Although she had now confidently determined not to live in a log cabin, there were other times when she returned less confidently to her thoughts of being evil, but without the same conviction.

Ms. A no longer had thoughts of wishing to die and said she wanted very much to live. She had resumed eating and gained weight, slept now with infrequent use of a sedative, and on her initiative, supported by Dr. P, gradually discontinued her prescriptions with no ill effects.

Ms. A narrowly escaped a second driving accident when a truck and a car in front of her crashed and glass was strewn all over her car. The truck driver was badly hurt and trapped in the truck. Although she was unable to get him out of his van, she sat with him until the ambulance came. Although shaken, she was able to continue on her way to work. She had a dream on consecutive nights somewhat recapitulating the accident: a dazed stranger seemed to wander around the scene. Dreaming the next week, she pictured herself walking around the wreck but not dazed. Although the dreams woke her up, she felt no distress and felt it significant that she did not seem to fear death or think that she was dying. Furthermore, she no longer felt she deserved to die. She said many unhappy women have thoughts about affairs and even act on them. "That's only normal," she said, although she was glad she had not gone ahead with her planned sexual liaison.

Discussion

Sleep disturbances have been considered the hallmark of posttraumatic stress disorder for decades (3). Since insomnia has been observed in 90% of PTSD cases (4) and nightmares related to the trauma in 70% (with or without comorbid depressive disorder [5]), this is understandable. Both pharmacologic and psychotherapeutic approaches to the disorder have concentrated on improving sleep and reducing nightmares.

Pharmacotherapy, primarily with antidepressants, has been shown to have beneficial effects in improving sleep and reducing nightmares in patients with PTSD (6, 7). So too have various forms of trauma-focused cognitive behavior therapy, ranging from exposure therapy, which seeks to desensitize the patient to the traumatic experience, to cognitive-processing therapy, which seeks to change the patient's perception of the experience, often through teaching patients to restructure the nightmares (8, 9). According to meta-analyses of psychotherapy trials for PTSD, 67% of the patients who complete treatment no longer meet criteria for PTSD (10). Interpersonal psychotherapy, which focuses on current social and interpersonal functioning in treating PTSD, has had comparable results (11).

There is also some evidence that in treating PTSD, a combination of both medication and psychotherapy is better than either alone (12) and stronger evidence that in the treatment of depressed patients, a combined approach is preferable (2, 13, 14). Before implementing a treatment intended to reduce a patient's nightmares, it would seem desirable first to attempt to understand the nightmare in the context of the patient's traumatic experience. The specific content of the nightmare itself, which tends to be ignored, can be a valuable help in this process (15).

In about half of the cases, patients' dreams exactly recapitulate the trauma; in the other half, there will be some alteration in what actually occurred (16). We often see patients whose recurrent nightmares are related to the trauma but involve features that express both guilt and the need for punishment (17). Discussing the nightmares with patients reveals that guilt reflects something the patient feels in connection with the trauma. The guilt may be connected to the patients' believing they had done something wrong or, as in Ms. A's case, their thinking of doing something they felt was wrong or, more commonly, their having done something they felt was wrong during the traumatic event.

Ms. A, raised in a constricted fundamentalist home, was made to feel she was a bad illegitimate child who should expect little and deserved to suffer as the daughter of a promiscuous mother. This self-attitude provided the emotional framework for understanding her reaction to the automobile crash. Emotionally and otherwise abused children often grow up thinking they deserve to suffer and feel long-term guilt. But knowing her background alone would not have been sufficient to help Ms. A without knowing about, and being able to help her deal with, the events preceding the car crash. Exploring the nightmare led her to feel free to reveal these events.

Ms. A said she never had anyone to talk to, particularly referring to her mother and her husband, but implicitly including her first psychiatrist. She was grateful for the minimal relief the medication the psychiatrist prescribed provided but seemed relieved to be talking about herself without focusing on her eating, sleeping, or medications. She appeared to see her first therapist as a milder version of her grandfather and her husband, insensitive to her feelings but someone to whom she should be grateful for whatever she received since she deserved no better.

Dr. P, on the other hand, seems to have been perhaps the first paternal figure in her life whom she saw as understanding and supportive. Their therapeutic alliance, which recent research has shown to be a critical factor in the progress in any psychotherapy and pharmacotherapy (18), was certainly a key factor in Ms. A's progress, enabling her to tell Dr. P about the "evil thoughts"—fantasies of adultery and resentment of her husband—she had just before the accident. The crash seemed to her like a divine judgment coming down on her. Dr. P's interest in her recurrent nightmare, the content of which had been ignored by her first therapist, deepened their rapport. With his help, Ms. A came to see that thinking of an affair was an understandable reaction to her husband's insensitive, overbearing behavior.

Although it might have been possible to uncover the source of the guilt that underlay her condition without the help of the dream, it would have been difficult. It would have required psychotherapy that was not so exclusively focused on symptom reduction that what was driving the symptoms was ignored. It is not warranted, however, to

conclude that medication played no role in her recovery. The symptomatic relief she was receiving from the medications when she began therapy with Dr. P, even if not great, may have played a role in making her more accessible to psychotherapy.

Bringing to light the events that preceded the accident was a necessary first step in Ms. A's improvement, but it was also necessary to help her deal with her husband more effectively. Gradually, she became more self-assertive and less obsequious. In some ways, she saw Dr. P as treating her as she wished her husband would treat her. That led to some anxiety when after 5 months treatment was ending, but she was able to resolve it, and when Dr. P last heard from her, she was doing well and had no further nightmares.

In evaluating what was responsible for the success of psychotherapy with Ms. P, it should be kept in mind that despite her chronic PTSD symptoms, severe depression, and painful childhood, Ms. A had more strength and resiliency than many patients who have the disorder. Before the development of PTSD, she was a relatively high-functioning individual despite inhibitions and conflicts centering around self-esteem, difficulties in self-assertion, and repressed sexuality. She had no history of substance abuse, personality disorder, or impulsive or self-destructive behavior. She raised two children who appeared to be well adjusted and to whom she was devoted. Starting on a clerical level, she had risen to a responsible administrative position at work, where her performance had been appreciated, and her confidence had been growing.

Beyond the issue of PTSD, however, Ms. A's case is a reflection of what appears to be an increasing tendency to treat symptoms while neglecting the psychosocial problems of patients. Although the relative value of split treatments versus integrated treatment, conducted by one psychiatrist, or team treatment have yet to be evaluated, the trend toward split treatments in which a psychiatrist concentrates on symptoms and prescription writing and leaves psychosocial problems to an auxiliary therapist contributes to the problem (19).

Yet we see the same problem among the many psychiatrists who employ an eclectic approach that incorporates psychopharmacology with cognitive behavior and interpersonal techniques, with varying degrees of reliance on psychodynamic principles (20). Moreover, the psychiatric history forms commonly used in hospitals have often become symptom checklists that provide no picture of patients' lives but seem aimed simply at matching symptoms with medications to address them. Such forms do not provide a helpful training experience for residents entering practice. The profession is increasingly recognizing that all psychiatrists need both psychosocial and psychopharmacological knowledge and skill in order to treat patients as well as their symptoms (21).

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