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RESTORING THE ARCHITECTURE OF CHARACTER IN COMPLEX PTSD AFTER COMBAT

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I. Introduction 2
II. The core treatment issue is social trust 2
III. Destruction of normal narcissism 3
  A. "Combat ages you" 6
  B. Destruction of the combatant's community 6
    1. Destruction of unit cohesion 6
    2. Aversion to returning veterans is an old story 7
    3. Consequences of shattered trust—no safe place 8
    4. What community offers 8
  C. How lack of social trust becomes a problem for mental health professionals. 8
  D. A brief history of VIP 9
  E. The paradox of therapy for trauma 11
IV. VIP Team Treatment Model 11
  A. Our posture toward new members 11
  B. Stage I: Safety, Sobriety, Self-care 12
  C. Aside: Pharmacotherapy of combat PTSD 13
  D. Stage II: Constructing a cohesive narrative and grieving 14
  E. Stage III: Reconnection 14
V. Defining concepts and practices of the VIP Team Treatment Model 15
  A. Restoration of community 15
    1. Community is more than any number of dyads 15
    2. Suspicion of words 16
  B. Tests of trust 16
    1. Boundary maintenance—Tests of rules, observing if power is abused 16
    2. Professional trust—Do therapists trust each other? 17
    3. Secondary trauma ("compassion fatigue") is NOT a secondary issue—three mechanisms of injury to mental health professionals 18
    4. Therapist self care 19
  C. Team as community and team plus community 19
  D. The rhetoric of treatment for combat PTSD 20
  E. Summary of VIP team practices 21
VI. Divergences in the team model from the value pattern of the professional 22
  A. Universalism (opposite: particularism) 23
  B. Functional specificity (opposite: diffuseness) 23
  C. Collectivity orientation (opposite: self-orientation) 24
  D. Achievement (opposite: ascription) 25
  E. Affective Neutrality (opposite: affectivity) 26
  F. Are we kicking sacred cows? 26
VII. Aristotle again—human is *politikón zôon* 26
VIII. References 27

I. Introduction

We do not claim to address treatment issues for all trauma survivors, nor do we aspire to—we see the world through the tiny keyhole of the clinical population with which we work: American male combat veterans of the Vietnam War (hence the masculine pronoun throughout) with chronic post-traumatic stress disorder *and* "enduring personality change after catastrophic experience." (WHO, 1992, p. 209) If what we say translates to the readers' other clinical or public health populations, we are gratified, but the reader must make the translation. In part, this reflects our philosophic position that we should not pretend to universal, eternal scientific knowledge about these things, when such a claim cannot be well-founded—nor shall we covertly claim this knowledge through the use of an unlocated authoritative textbook "voice." We (J.S. and J.M.) have worked together for almost ten years, and speak from a specific time and place with lives and works in progress, not like gods from the edge of the universe. When later in this chapter we speak of our treatment program called "VIP," it is not to advertise for patients nor even to offer it as a model to be cloned, but rather as an example to be assimilated to the character of the reader's patients, colleagues, and institutions.

Personality ("character") changes have made these veterans huge consumers of resources for hospitalization, incarceration, family and workplace disruption, and clinical crisis management. Of all aspects of these veterans' psychological injuries, their enduring post-traumatic personality changes—damage to good character—impose the greatest social, economic, political, clinical costs. These veterans' damaged characters *can* be restored—well enough, at least, to provide a safer world for their families, employers, and communities—and well enough to enhance the quality of life as they themselves experience it. However, as we shall describe below, this restoration entails clinical practices at odds with much of our culture's normative value pattern for the professional.

Our patients were all participants in the exercise of state military power in and around Vietnam between 1965 and 1972, and trace their injuries to this participation. Because of the dominating element of power, the context of their injury is thus in every sense political; we shall argue that important features of their injury are political. We shall take position that the treatment we provide is political—we consciously foster an empowered community among the veterans that we treat. Our position with respect to the veterans is one defined by a very ancient term. We aspire to be *rhêtor* in the rich form laid out by Aristotle in the *Rhetoric*: our task is to create *trust (pístis)* for fellow citizens. As Aristotle uses *"pístis"* in the *Rhetoric,* it means variously, trust, persuasion, proof, credibility, belief, and the processes or means that bring about persuasion (Garver, 1994b, p. 142; Cary, p. 299). For Aristotle, the contrasting opposite to the *rhêtor* was the sophist. The sophist was, in quite modern terms a professional who applied a *technê*—that is, a teachable, ends-rational skill available for hire from the holder of credentials certifying mastery (Garver, 1994b pp. 206-231).

This chapter addresses the encounter of the psychologically injured Vietnam combat veteran and the mental health professional.

II. The core treatment issue is social trust

The key manifestation of the veterans' psychological injuries *in the treatment setting* is destruction of the capacity for social trust. How the veterans' incapacity for trust plays out in the family, workplace, government office, commercial establishment, has been well described

elsewhere (Lifton, 1973; Shatan, 1985; Mason, 1990; Matsakis, 1996). In the clinic, social trust is the readiness to repose trust in

- Professional credentials
- Institutional position
- The value pattern of the professional

We shall explain below what we mean by the value pattern of the professional. But at this point it suffices to say that veterans we work with have had the *real* experience of being exploited and betrayed by people holding the right professional credentials, in fulfillment of their institutional positions, in a context of 24-hour-a-day danger that meant that there was “no safe place.” Our veterans live in perpetual expectation of physical attack, interpersonal coercion, and institutional exploitation, deceit and betrayal. *Because their psychological injuries have destroyed social trust, the most severely injured veterans are least able to get and retain access to treatment.*

The combination of PTSD symptoms (American Psychiatric Association *Diagnostic and Statistical Manual*, 1980, 1987, 1994, hereafter collectively “DSM”) *plus* personality changes has been well characterized by others under the terms “complex PTSD”, “DESNOS,” and other locutions reviewed by Herman (1993). We offer nothing new here in nosology. This combination has not been accepted in the DSM, but not for lack of its being described and studied. In the rest of this chapter we shall use Judith Herman’s term, “complex PTSD,” for our patients with post-combat complex PTSD. *Many* veterans who have served in war do not have even “partial” PTSD, and many who meet the full diagnostic criteria for PTSD, do not have complex PTSD. Our patients meet the DSM criteria for PTSD and have in addition other bio-psycho-social changes that Herman (1992b, pp. 115-129) describes:

- Altered affect regulation, such as persistent dysphoria, chronic suicidal preoccupation, explosive or extremely inhibited anger, which may alternate
- Altered consciousness, such as transient dissociative episodes, amnesia or hypermnesia for traumatic events
- Altered self-perception, including a sense of helplessness, paralysis of initiative, shame, guilt, and self blame, a sense of defilement or stigma, a sense of complete difference from others, which may include sense of elite specialness
- Altered perception of the perpetrator, including preoccupation with revenge and/or idealization or paradoxical gratitude toward the perpetrator
- Altered relations with others, such as repeated search for a rescuer, which may alternate with isolation and withdrawal, persistent distrust, repeated failures of self-protection
- Altered systems of meaning, including loss of sustaining faith, sense of hopelessness and despair (Herman, 1992b, p 121)
- Somatization (Herman, 1993, pp. 216f)

III. Destruction of normal narcissism

Mental health professionals who have casually encountered combat veterans with PTSD are often unpleasantly struck by their “narcissism,” as manifested by some of the following—

- Demands for honor and acknowledgment
- “Entitlement”
- Self-important claims to having been players in the most significant events in human history
- Readiness with which they take offense at what they take to be slights
- Occasional insistence that they will deal only with the Chief of Service (“the head of the snake”)

- "Global" destructiveness of their fantasies, wishes, and occasionally, behavior
- Vulnerability to collapses of morale which leave them so apathetic that they cannot want or will anything at all
- Hypochondriacal preoccupations and psychosomatic disorders

This unappealing portrait of "narcissistic" combat veterans has important roots in reality, which if properly understood, teach us much about working with them and much about ourselves. The word "narcissism" was introduced in the writings of late 19th century psychologists and sexologists, primarily to talk about auto-erotic phenomena. It was used theoretically by Freud in several ways including his developmental theory of normal infancy. The generation of psychoanalysts after Freud—most notably Kohut, but many others as well—decisively broke the concept away from its sexological roots and associated the word with the rise and fall of self-esteem, self-confidence, and self-respect. More generally the term came to be associated with a psychology of the experience of the self in general, including *healthy* self-esteem, self-confidence, and self-respect. The concept also broadened beyond the valuative sense of pride and shame, to include the strength or weakness of the self's coherence, continuity in time, moral agency, creative efficacy, and the capacity for empathic grasp of other people as real and significant (Pulver, 1970). Thus narcissism is not exclusively an infantile or pathological phenomenon, but infuses essential elements in human flourishing. When clinicians use the term "narcissistic" to damn veterans who are easily enraged, boastful, or demanding, it is as though they have utterly forgotten the importance of narcissism in any good life.

In the post-Freud sense of the word, the psychological issues involved in combat trauma and in recovery from it, *are* in the territory of narcissism. We strongly agree that narcissism is part of the psychic economy of the healthy adult, and wish to point out that it is intimately bound up *with the moral and social world that the adult inhabits*. As such, "narcissism" is simply the most recent term for a notion with a long history in the attempts to understand the human being. Working backwards in time, this notion has been called, "desire for recognition" (Hegel), *"amour-propre"* (Rousseau), pride or vainglory (Hobbes), *"thumoeidés"* (Plato), *"thumós"* (Homer).

The features of the normal adult world which control narcissistic emotions and moods are *ideals, ambitions, and affiliations.* Here, when we use the word "character," we refer descriptively to the following, taken together—

- the historically and socio-culturally constructed *content* of the commitments embodied in ideals, ambitions, and affiliations
- the intensity with which the commitments are energized
- the narcissistic emotions aroused by cognitive appraisal of the condition (particularly improvement or deterioration) of these commitments in the world.

How *stable* character is, depends largely on the ecology of social power, upon the good-enough fulfillment of the culture's moral order by those who hold *power*. The normal adult's cloak of safety and guarantor of narcissistic, hence characterologic, stability is the normative structure of the society, its implementation by powerholders, and the concrete social support of a face-to-face community. Good-enough realization in the world of these commitments is the foundation of ordinary self-respect and of the sense of self-worth that we expect in the normal adult. Sudden, undreamed of fulfillment in any of these three realms, will usually make a healthy adult euphoric. And serious, high-stakes destruction in any of these three realms—especially when the threat originates in betrayal of the moral order by powerholders or in abandonment by those to whom one is attached and socially affiliated—is the basis of the damaging changes to character which are the principle subject of this chapter. We do not offer

character stability as a goal or good in itself—the post-traumatic changes in character we attempt to reverse are sometimes horrifyingly robust—and it is only the continuing fluidity of adult character that provides an opportunity for treatment.

Some readers will reflexively reject the very *idea* that good character, once formed by good upbringing in childhood, can ever be damaged by any events that merely happen to the adult. The idea that adult good character is inviolable is an old and disputed philosophic position or a useless tautology, not a scientific fact (Shay, 1995b).

Narcissism, the allegedly most "primitive" of psychological phenomena, much entwined with the body, is therefore deeply enmeshed with the social, moral, and political. Social betrayal and isolation in a high stakes situation has profound physiological, as well as psychological consequences. To chronically live in "no safe place," made unsafe by other people, damages the body.

In ancient Greece, the emotions and commitments embodied in ideals, ambitions, and affiliations were subsumed under the single Homeric word *thumós.* This has often been unhelpfully translated by the single word, "spirit." It has also been translated "temper," *"animus,"* "spiritedness," "aspiration." Professor Amélie Rorty (personal communication, 1996) has been kind enough to provide a more informative translation: "the energy of spirited honor." To be *entirely* deprived of honor has been described as "social death." (Patterson, 1982). It was Achilles' "large" *thumós* (*Iliad* 9:255) that led him to become so enraged with Agamémnon when the latter betrayed the shared military norms of their culture by dishonoring him and seizing prize of honor awarded to him by acclaim of the troops. Plato's Socrates posits the "high-spirited principle" *(thumoeidés)* as one of the three divisions of every human psyche in his famous tripartite division of the soul (*Republic* IV, 435e-444e). In *Politics* VII.6.1327b39ff Aristotle says, "*Thymos* is the faculty of our souls which issues in love and friendship….it is also the source … of any power of commanding and any feeling for freedom." (Garver trans. 1994a, p. 177n8) The normal narcissism of the healthy adult can now help us understand characterological changes in complex PTSD after combat.

The conditions which cause complex PTSD, persistent human betrayal and rupture of community in high-stakes situations of captivity, destroy *thumós,* destroy normal narcissism. Modern battle *is* a condition of captivity (even when it has been entered voluntarily), a fact that has escaped notice because the captives move about in the open carrying powerful weapons, and because the role of *captor* is cooperatively shared by the two enemy military organizations—which are presumed to cooperate in nothing. (Shay, 1994*,* pp. 35-37) Modern combat itself is a condition of enslavement and torture. Until we end the practice of war itself, this will be the case.

What replaces normal narcissism when it is impaired? Our own answer to this must be taken as limited by the patient population we work with, who over the decades have been both sought treatment and been involuntarily enrolled in the mental health system. Most have cycled repeatedly through several of the following, sometimes quickly, sometimes slowly—

- Demoralization [*athumía*], death to the world, apathy, ennui, and aboulia, anhedonia, dysthymia—sickened *thúmos*
- Loss of self-respect
- Self-loathing
- Social withdrawal
- Pervasive "raw" feeling of vulnerability
- Blind obedience, which may turn into a fanatical "mission"
- Grandiosity and entitlement

- Rage at small slights, disappointment, lapses
- Coercive attempts to establish power dominance
- Coercive demands for respect, honor, acknowledgment
- Danger-seeking, fight-seeking
- Mortal risk-taking to divine the status of one's "luck"

It is possible that most men who remained in only *one* of these, would never have come to our attention in a specialized PTSD clinic, because they would be dead, incarcerated, stably reclusive, famous and powerful on a small or large scale, or misdiagnosed as schizophrenic. If complex PTSD after combat appears to be marked by repetitive cycling, it may be because the veterans themselves or the social system directs those who do not cycle elsewhere.

A. "Combat ages you"

Several pieces of the personality pattern we have described here were touched on with painful clarity by Aristotle when he sketched his portrait of the elderly in the *Rhetoric* II.13.1389b13ff:

> "Because they have …been deceived many times…they are malignant…[that is, they] interpret everything in the worst light. Furthermore, they are excessively suspicious because of their lack of trust (*apistían*), and lacking in trust because of their experience. … And they are small of soul….And they are self-loving more than is appropriate; for this too is a kind of smallness of soul…. [T]hey think every suffering is waiting for them….For this reason they are given to grieving, and are neither charming nor fond of laughter." (Nussbaum translation, 1986, p 338, emphasis added)

It is not mere word-association to quote what we have often heard veterans say: "Combat ages you. You get old real fast."

Rupture of community and "betrayal of what's right" (Shay, 1994) are responsible for layering characterologic, narcissistic injury on to PTSD that the intrinsic terror, grief, privation, and horror of war inflicts on those who fight. In the discussion that follows, we focus on community, because restoration of community is the core of our treatment model.

B. Destruction of the combatant's community

1. Destruction of unit cohesion

In Vietnam, whatever group cohesiveness developed within small units was left behind as soldiers rotated home quickly by air, as individuals rather than as a unit (Shay, 1994). They returned truly alone, in planes packed with strangers. There was no "debriefing," no opportunity to communalize the terrors, the losses, the might-have-beens and should-have-dones. A recent paper by a leading military historian and two active duty Army officers in Parameters: Quarterly Journal of the US Army War College speaks of debriefing, decompression, and three forms of validation (*substantive*, *institutional*, and *memorial*) as essential for soldiers returning from combat duty (Kirkland, Halverson, and Bliese, 1996). These protective practices of cohesive military units were systematically denied to American combatants returning from Vietnam, through a combination of neglect, ignorance, culturally-driven blindness, and unintended consequences of well-intended policies. We shall return to these practices of cohesive units in our discussion of the VIP treatment model for combat veterans.

2. Aversion to returning veterans is an old story

Acts of war generate a profound gulf between the combatant and the community he left behind. The veteran carries the taint of a killer, of blood pollution, that many cultures other than our own recognize in purification rituals. Both he and his community may question the wisdom of return. The community worries about his control. The veteran, knowing what he is capable of, may also fear losing control. He may fear that if people knew what he had done, they would reject him or even lock him up. Both the veteran and the community collude in the belief that he is "no longer one of us". Many veterans express the feeling that they died in Vietnam and should not have returned.

Both the trauma of war, and recovery from it, are social, not individual events. Many authors have emphasized the importance of social supports and community in recovery from traumatic events (Lifton, 1967, 1979; Erikson, 1976; Keane, Scott, Chavoya, Lamparski, & Fairbank, 1985; Janoff-Bulman, 1985; Figley, 1988; Catherall, 1989; van der Kolk, Brown, & van der Hart, 1989). Shatan (1985) wrote that war "tears the fabric of human trust asunder." Janoff-Bulman (1992) proposed that trauma undermines the survivor's basic assumptions that the world is benevolent, meaningful, and that the self is worthy. Erik Erikson's (1963; 1967) theory of normal psychosocial development describes "basic trust" as the first of eight stages. It is at this stage that the child develops a sense of community which then allows further development to occur. The parents give the child "a firm sense of personal trustworthiness within the trusted framework of their community…." The parents also communicate "a deep, almost somatic conviction that there is meaning to what they are doing," and a belief in "Fate's store of good intentions." Collectively, these authors describe the link between trauma and loss of community. It is not the loss of a specific community, but the loss of the ability to belong to *any* community. Belonging to a community requires the mutual belief that members will look out for each other.

Some of the disconnection and alienation between returning Vietnam veterans and their home communities came from the rapid social changes at the time and the gulf of experience that separated veterans from their peers. However, it is more nearly *typical* for returning American war veterans to be shunned by the communities they returned to (Severo and Milford, 1990), than to be celebrated by them. The experience of the World War II veterans—the fathers of the Vietnam veterans—is the historical *anomaly*. At the end of World War II, politicians with fresh memories of the Bonus Army of World War I veterans, worried about so many returning soldiers looking for jobs. Congress appropriated unprecedented benefits, which then declined in real terms to half their value by the time of the Vietnam War.

Farmers from the Revolutionary war returned to find banks foreclosing their farms because the money the government gave them was no good. Civil war veterans had trouble finding employment and were accused of being drug addicts. Supposedly, our word "hobo" comes from homeless Civil War veterans—called "hoe boys"—who roamed the lanes of rural America with hoes on their shoulders, looking for work. World War I veterans who marched on Washington and camped on the Mall to demand their bonuses had their camp burned and were driven out with tanks and bayonets. Korean veterans were accused of being too weak to win, and in the wake of McCarthyism, were suspected of communist sympathies from brainwashing as POWs.

With increasing polarization over the Vietnam War, veterans returned home to protesters who accused them of being torturers, perpetrators of atrocities, and baby killers. For every returning veteran who encountered this personally, there were many more who saw highly selected scenes of it in the news or heard n^{th}-hand stories. The media presented a barrage of images portraying the Vietnam veteran as crazy, drug addicted, and violent. For many veterans who had joined up because it was their duty as citizens, who had grown up on John Wayne and Audie Murphy, and

because they thought what they would be doing was right, rejection by the community was infuriating. In their fathers' VFW and Legion posts, some were greeted with derision even more devastating than the criticisms leveled by the war protesters: "We won our war. What the fuck's wrong with you?"

The supposedly traditional idea of honoring returning veterans ran afoul of deep divisions over the justice and wisdom of the war as a whole, making honor to the veterans seem an endorsement of the war policy. From the hawks on the political right to the doves on the political left, the nation as a whole lost sight of the fundamental importance of social esteem—embodied no less in private gestures of respect than in public rituals of honor and recognition—in rebuilding the capacity for social trust in a person who has come home from war.

3. Consequences of shattered trust—no safe place

When "basic trust" is destroyed, what replaces it is perpetual mobilization to fend off attack and to figure out other people's trickery. In the world of Homer's warriors, the world was seen primarily in two dimensions, *biê,* might, and *mêtis,* cunning; Achilles embodied the former and Odysseus the latter. Our patients construct the world similarly. Civil society, founded in a third dimension of trust and trustworthy restraints, seems to them a deceptive veneer to hide a violent and exploitative reality (Munroe, 1991). Alertness and suspicion anticipate attack and deception. This is easily mistaken for paranoia, but in our patients it is the persistence into civilian life of a valid adaptation to the *real* environment of war that they have experienced. Lying and deceit are valuable military skills, for which Odysseus boasted, "Men hold me formidable for guile…this fame has gone abroad to the sky's rim." (Homer, ca. 800 B.C.E./1961, Book 9, Lines 20f) In war, "they"—the enemy—really *are* out to kill you. The modern soldier's own military organization propels him, terrified, into the presence of that enemy. After such experience, friendliness and cooperation may only look like manipulations to trick inexperienced rubes into a position where they can be exploited or injured.

4. What community offers

Communities offer safety. At the crudest level of physical security, other people share alertness to threat, so that each individual does not have to be constantly vigilant. Within the defensive group, safety lies in the predictability of boundaries and normative restraints of behavior. But beyond this there may be some as-yet unclarified aspect of human brain biology at work in the subjective sense of safety that accrues when there is mutual social recognition and esteem. To be secure in the esteem of your community and of your identity within it—basic satisfaction of *thumós*—reads as being secure, *simpliciter.* In our ancestral environment where the human brain evolved to its present form, this connection may have prevailed at the most basic level of survival. Contrawise, moral danger of betrayal and abandonment are read in the body as *physical* danger. Moral betrayal, social isolation, and lack of social support enter into a self-feeding cycle with fear and suspicion of other people.

C. How lack of social trust becomes a problem for mental health professionals

Lack of social trust leads to a characteristic impasse between mental health professionals and combat veterans with complex PTSD. This impasse is the main obstacle to treatment.

The veteran is, by reason of injury inflicted by real experience in war of betrayal by those with credentials and institutional position, *unable* to trust clinicians on the basis of their credentials and institutional position. The veteran enters the relationship with a big question

mark after the word "trust"—"Should I trust you?"—and sets about making observations and setting up tests of trust to answer the question.

On the other hand, the clinician has *ideals* of professional conduct, feels justifiably proud of having fulfilled *ambitions* to attain a responsible job title, usually aspires to advancement in his or her institution and profession, and draws a sense of personal value from membership (*affiliation*) in the collectivity of the profession. In a word, the clinician is a normal adult of the modern world with *thumós*—ideals, ambitions, and affiliations. The normal mental health professional takes offense at being treated as a question mark—is this person trustworthy?—rather than as an established certainty, what the clinician is entitled to as a matter of credentials and institutional title. The predictable result is a counter-transference narcissistic rage. The clinician's hurt feelings in encounters with combat veterans make it easy to apply derogatory labels, such as "borderline," "character disordered," "anti-social," which, despite precise operational definition, mostly function as synonyms for troublesome, bad, vile, evil—and hopelessly untreatable. Diagnoses of personality disorders, may carry less information about the veteran, than about the way the clinician relates to the veteran.

D. A brief history of VIP

We tell this story about VIP to emphasize that the treatment we engage in cannot be abstracted from the historical and political context in which it occurs. (Also, we do not tell our story in the hope of soliciting referrals.) One of us—J.M., with Michelle Clopper, and the late Lillian Rodriguez, M.D.—invented the Veterans Improvement Program (VIP) as a response to those same troublesome, bad, vile, and "untreatable" Vietnam veterans who were referred to our Day Treatment Center in the mid- to late-70's after many hospitalizations and detoxes. Recall that at the time, the official nosology (DSM-II) had no place for persisting, severe post-combat mental disorder. The VA (Veterans Administration, now, Department of Veterans Affairs) as an institution was at the pinnacle of its post-WWII growth in response to the needs and culture of the WWII generation. Almost all of the Vietnam vets referred to the Day Treatment Center carried one or more of the following diagnoses at the time: paranoid schizophrenic, schizoaffective disorder, sociopath, borderline, and polysubstance abuse. At some time in their careers as voluntary and involuntary VA and state hospital patients, almost all had been treated with high dose neuroleptics, and/or high doses of benzodiazepines. They were usually referred to the Day Treatment Center because they were disruptive and uncooperative. Some had assaulted staff; some had multiple arrests and periods of incarceration; some had been escorted by security guards to and from their outpatient appointments. Most had previously been fired from treatment for "non-compliance" and had otherwise kindled the countertransference narcissistic rage of VA professionals, whose expertise they challenged. The late Sarah Haley, a pioneer advocate for recognition of combat PTSD in psychiatric nosology, educated and influenced each of the original founders of VIP, but was never a part of it.

The Vietnam veterans were also disruptive to the Day Treatment Center's program which was geared toward the chronically psychotic. Veterans with combat PTSD had no programmatic place at the time—unless "Get this guy away from me!" can be said to be a program. These veterans' rageful perception that they were unwelcome at the VA was well-founded in reality; and their rejection at the individual emotional level by VA mental health professionals was also not without reason either—who in their right mind wants constantly to work with someone who is abusive, intimidating, demanding, suspicious, out-of-control? The force of their challenges and demands led to a small group of us (J.M. speaking now) in the Day Treatment Center staff to band together to support each other. Our staff group had no official existence, and our time to meet

together and with the Vietnam veterans was bootlegged from other duties. We began to think of ourselves as a team. We soon came to notice that treatment plans designed and delivered by the whole team worked better than any plans developed by individuals. Around 1980, we coined the name Veterans Improvement Program (VIP) consciously evoking the alternate meaning, Very Important People, in the hope of giving these veterans some sense of being valued, rather than rejected. Their anger and "acting out" (psychobabble for misbehaving) became less overt after we designed a program specifically for them—but they continually challenged the team and its treatment plans.

As we banded together more and more, we noticed that the veterans attempted a great deal of splitting among team members, and between the VIP team and the VA. The tight-knit team and it's strong advocacy for these veterans to the VA frequently led to our being viewed as disruptive or uncooperative by professional colleagues and by the administration. We were very tempted to bond with the veterans around our trouble-maker status. However, we also recognized that this was not a good role model for the veterans, to join them in their perception of the government and VA as "the enemy" in an us-versus-them stance. We became increasingly aware that the veterans were observing our behavior toward each other in the team, and as members of the VA institution. They were testing our ability to trust each other and the larger world, and to be our own people, before they were willing to trust us. These tests also forced us to define clear boundaries and limits within the program itself.

The veterans immediately pounced upon our every mistake or inconsistency. The team's willingness openly to struggle through the many challenges and crises have eventually led to a point where the tests became more playful and much more time could be devoted to treatment. In retrospect, we realized that the veterans had pushed us into creating a community where they felt safe enough to begin the process of healing.

The other of us (J.S.) joined VIP as the team psychiatrist in roughly the tenth year of its existence in early 1988, after the unexpected cancer death of Lillian Rodriguez,M.D. Most of the team development, community cohesion, and functional presence in the VA was already a fact-in-being. I (J.S. speaking now) learned the team model and embraced it with enthusiasm, and in retrospect can see the following:

- VIP had achieved a strong informal existence, ambivalently acknowledged throughout the Boston VA
- As team psychiatrist, the ecology of power would have enabled me to destroy VIP, but not to create it
- The VA was in the early stages of long-term shrinkage (for example, the Day Treatment Center now no longer exists)
- The legitimization of PTSD in the official APA nosology, to which our Boston VA colleague Terence Keane, Ph.D. made major scientific contributions, significantly improved the institutional perception of Vietnam veterans
- The prestige and active presence of the National Center for PTSD Behavioral Sciences Division in the Boston VA Medical Center has had multiple beneficial effects for psychologically injured veterans

After a turbulent period and crisis in 1989 and 1990 when the VIP nearly ceased to exist, it was made a regular program within the institution, and the team no longer had to bootleg its time. The ecology of power for institutions like a VA clinic and medical center is extraordinarily complex. I find it impossible to assess the impact of my public activities (see below) on the situation of VIP within its institutional setting, but the impact of these activities on the veterans is easy to gauge: they have increased trust.

E. The paradox of therapy for trauma

Complex PTSD destroys the resources necessary for its successful treatment. Therapy requires that the trauma survivor trust the therapist. The veterans have reason, based on their experience, to distrust therapists and to expect to be exploited. They will assume, for example, that a therapist is only interested in them to get a graduate degree, to earn VA salary money, or to write a book. (In the last ten years, J.M. did earn his doctorate, and J.S. did publish a book—periods of intense anxiety followed both of these events, with veterans watching to see if we each would leave, having accomplished our "real" purpose in being there.) These veterans' social world is based on an expectancy of exploitation, rather than trust (Munroe, 1991).

Therapists usually find that their efforts are not well received. Such "resistance" by combat survivors results in their being declared poor treatment candidates in the medical record, in the informal institutional memory and often to the veterans' faces. This is a form of blaming the victim. Therapists who demand "compliance" *prior to the establishment of trust* and terminate resistant veterans simply add one more layer of violated trust and rejection. Severe trauma *requires* an infrastructure of trust before traditional therapies can proceed.

The requirement for trust for treatment to begin is doubly true of *randomized treatment trials*. In order for a veteran to give informed consent to participate in a randomized trial he must, among other things—

- View written disclosure documents as truthful, rather than deceitful
- Believe assurances that he can withdraw from the trial without justification, penalty, or institutional prejudice ("in his record")
- Believe that the randomization is honest and not rigged
- Believe assurances that if the active treatment is found beneficial, he will ultimately receive it
- Be willing to be assessed, and in some studies, even treated by people he has never met and tested
- Believe that if something goes wrong, he will not be sacrificed to the goals of the researchers

Participation in blind trials requires a degree of trust beyond what many non-traumatized people will extend. Because American Psychiatric Association nosology lumps together simple and complex PTSD, lumps together trauma survivors with and without personality changes, conclusions have been drawn that purport to apply to *all* patients with PTSD. We believe that veterans with complex PTSD have systematically been excluded and excluded themselves from blind clinical trials. We submit that we know virtually *nothing* from blind studies about what works with the very patients who cause us the most worry, the most effort, expense, and trouble.

IV. VIP Team Treatment Model

A. Our posture toward new members

Compared to ten years ago, the amount of provocative and dangerous behavior thrown off by members of our program has declined very sharply. The VIP has been running now for almost twenty years and we are unable to parcel out the effect of our good reputation among local veterans, the effects of aging on the veterans, FDA approval of selective serotonin uptake inhibitors, the settling presence of old hands among the veterans in VIP—who function as unofficial peer counselors—and what comes from incremental improvement in our ongoing practices and philosophy. Here are some of the things that we either make explicit or simply have in mind when a new member joins the program—

- We do not expect blind, automatic trust

- We expect that we have to earn trust through time, observation, and testing
- We are not angry back at him for not trusting us
- We expect that trust will be based on observation of how we treat other veterans
- We expect that trust will be based on observation of how we treat each other
- We are willing to be observed and judged

Just as in a military unit, where there is no privacy in the leader's qualities of trustworthiness—the troops are always watching—the team has no privacy in the way it deals with individual veterans and in the way team members deal with each other. Veterans will mostly do as we do, and little of what we say.

We find the VIP team treatment model is well suited to work with chaotic, crisis-ridden patients and with people who have learned to survive through violence and intimidation. It provides both physical safety, through its moral effect in veteran community support—the VIP veterans do not tolerate even the smallest threat against the team—as well as psychological safety. The model presupposes that trauma survivors must test the trustworthiness of anyone claiming good intentions, particularly where power is involved. Most of the "acting out" by combat veterans is a *test* of the team's trustworthiness. *Trust can only be earned, never assumed from job titles or degrees.*

The VIP team treatment model aims at building community among the veterans, demonstrating that they do not have to go through it alone, establishing the value of each veteran's life to others. In parallel, the treatment team strives for a strong community within itself, and to create a partnership of mutual respect between the veterans' community and the team community.

Among ourselves and in speaking with veterans we use the three-stage description of recovery, developed by Judith Herman (1992): Stage I, establishment of safety, sobriety, and self-care; Stage II, trauma-centered work of constructing a personal narrative and of grieving; Stage III, reconnecting with people, communities, ideals and ambitions. Although we think and speak of these stages, the VIP is not programmatically built around them, and each veteran progresses at his own pace.

B. Stage I: Safety, Sobriety, Self-care

We ask the veteran to start with the body and move outward—

- Lay down weapons
- Maintain sobriety (they must be a few months sober to be admitted)
- Terminate current violence as perpetrator and/or victim
- Meet health, nutritional needs
- Terminate danger-seeking behaviors

These are goals and results of successful Stage I recovery.

In group therapies with Stage I veterans, we are active and didactic as group leaders, assisting members in gaining authority over the pacing of traumatic disclosure, so it is safe. Meanwhile, we build the theme, "You are not alone; you don't have to go through it alone." Like-trauma peer recognition is central at this stage, but disclosure of new trauma history is not an active goal. We relate the inevitable disclosures back to the you-are-not-alone theme and to the individual veteran's recognition of links to trauma-driven failures of safety and self-care. We seek the delicate balance between silencing the veteran and allowing him to become flooded by re-living the trauma, which only retraumatizes the patient. We establish the VIP culture of mutual respect for all veterans. No individual's branch of service, military function, battles, suffering is more "significant" than any other's.

From the beginning, other veterans provide what Kirkland and his colleagues (1996, p.86) call "substantive validation," a knowledgeable audience (even if they were not in the same specific units or operations), to whom the veteran's experience matters, and who are able to support him through the confusion, doubt, and self-criticism that seem intrinsic to having survived the chaos of battle. The team provides practical support for veterans to obtain their military records, unit diaries, and after-action reports when the situation demands. Surprisingly, this often provides the first "institutional validation" that the veterans have been able to take in, sometimes learning for the first time of awards and decorations for valor that they had earned, but had never been personally presented. VIP runs an annual trip to the Vietnam Veterans Memorial ("The Wall") in Washington, DC which provides a focus for "memorial validation"—the opportunity to grieve for and commune with dead comrades in a safe and sober fellowship, where the importance of keeping faith with the dead through authentic emotion and respectful remembrance is understood without explanation or justification.

With each other's support, the veterans finally, decades later, experience the three forms of validation that current U.S. Army doctrine on "combat stress control" declares that every soldier should receive promptly after combat (Headquarters, Department of the Army, 1994). Need this be said? *Prevention* is better than treatment.

C. Aside: Pharmacotherapy of combat PTSD

An integral part of Stage I is the achievement of safety. This means safety *for* one's self and safety of others *from* one's self. Together, violence and the avoidant strategies that veterans use to protect others from themselves, has blighted the lives of most of the men in VIP. Past pharmacotherapeutic attempts have sometimes been literal chemical straight-jackets, such as dosing with anti-psychotics to the point that extrapyramidal rigidity made assaults physically impossible, or heavy daytime dosing with sedating drugs, such as trazodone. These treatments cut veterans off from themselves and from the world, and have been almost universally rejected by them. We rely more on the moral power of the veteran community in VIP as a robust restraint on violence both in and out of the program, than on such medication. One of us (Shay, 1992, 1995a) has written on our experiences with medication and violence in this group.

Pharmacotherapy provides valuable benefits to men with combat PTSD, providing that a basic principle of the treatment program is followed: return control to the veterans. In practice this means the following—

We provide a strong, honest educational component on the effects of the various available drugs on combat PTSD. Education includes both prescribed and non-prescribed drugs. The goal is to increase the veteran's intelligent choice on what drugs he is going to ingest. The VIP veteran milieu provides a setting in which veterans who have *benefited* from medication can pass on this information. Our goals for every veteran who takes medication are that [A] *he* has made the decision to take it [B] on the basis of *trustworthy* reasons to suppose that it may improve some aspect of his life and [C] that the drug is worth the risk of side-effects and adverse reactions. We do not force medication on anyone.

The psycho-educational component gives the reasons why certain categories of prescription drugs are relatively contraindicated in combat PTSD, such as opiates, barbiturates, benzodiazepines, and yohimbine (which is absolutely contraindicated). Here too, the role of other veterans is critical. The purpose is to empower the veterans to speak. In traditional one-on-one medication consultations in a private office behind a closed door, veterans are frequently too mistrustful, or simply afraid. Medication evaluation and consultation in the presence of the other men creates the safety to talk about side-effects and complications, fear of being

experimented on, fear of medical incompetence, despair and shame at the idea of taking psychiatric medications, etc. The shift in the power balance in favor of the patients has been an unqualified success, in our experience.

The single most useful family of medications for complex PTSD after combat has been the serotonin reuptake inhibitors, of which fluoxetine (Prozac®) is the best known. The principle benefit that the veterans report is a many-faceted change in the economy of anger. A number of our veterans regard fluoxetine as having saved the lives of *other* people in civilian life, whom these veterans say that formerly they would, literally, have killed. Quite apart from the benefit that the patients themselves receive from reduced explosiveness, the public health benefit in reduced family, workplace, and public violence is one that we dare not ignore.

Trustworthy information and the dignity of free choice are by-words of the pharmacotherapy part of the VIP treatment program.

D. Stage II: Constructing a cohesive narrative and grieving

When a veteran has tested the community and the team sufficiently, he is often able to venture beyond the safety of we-all-went-through-the-same-thing into the particularity of his own experience, and his partial responsibility for both events and the course that his life has taken. The catalyst for construction of a personal narrative is sometimes the practical requirements of applying for a disability pension. The process of constructing a narrative invariably arouses intense emotions, particularly of grief, not only for comrades lost during and since the war, but almost always some mix of the following—

- Irretrievable losses of pre-war relationships after return to civilian life
- Ambitions, ideals, and relationships blighted by alcohol and drug abuse, and their consequences
- Ambitions, ideals, and relationships blighted by violence and its consequences
- Lost innocence
- Lost youth and health, waste

This is not a smooth process, but one that cycles through periods of renewed testing, sometimes with breaks in safety, sobriety, and self-care, which must then be restored. In the group therapies leaders serve to assure “air time,” and safeguard the VIP culture that every person’s suffering is significant and cannot be measured against any other person’s suffering. VIP tradition strongly discourages “pissing contests.” We monitor the emotional state of the veteran making the disclosure, as well as that of other veterans who may be triggered by it. Very often, the first disclosure of traumatic material occurs in individual therapy, and is only later taken into a group. In imparting fragments of trauma narrative to the group, veterans experience, “My story has meaning and value to others. I can trust them to understand and remember it. They are trustworthy witnesses to my grief, rage, and guilt and experience enough of these emotions with me that I know I am understood.”

E. Stage III: Reconnection

The first two stages of recovery turn the veterans inward both toward themselves and toward the other veterans in VIP. In the third stage, veterans selectively reconnect with people, activities, ideals, ambitions, and group identities from which they had become isolated, or make new connections. The core of this is the negotiation of safe, non-violent attachments in the family. This often entails reunion with, or renegotiation of relationships with long-estranged children and parents. Sometimes the ruptures are irretrievable, or have been rendered so by death. When Odysseus meets the ghost of his dead mother in the underworld, he learns she died

of grief during his long inexplicable vagrancy after the end of the Trojan war (*Odyssey* 11:220ff, Fitzgerald trans.). This can be taken as a metaphor of such irretrievable losses that veterans must now face after their protracted, tormented *nóstoi,* "homecomings." The veterans of VIP strongly support a therapeutic culture in the program aimed at preventing the intergenerational transmission of trauma (Ancharoff, Munroe, and Fisher, in press)—support born of guilt and sorrow at the damage that they did in past years to parents, spouses, and children.

Some veterans, by no means all, have taken satisfaction in educating youngsters on war, or in active peace advocacy. Several engage in regular volunteer work with homeless veterans, particularly those who have recently been homeless themselves. A great many have participated in educational activities for mental health professionals at various levels, as well as medical students.

We have already spoken of "validation," which plays important and varying roles in all three stages of recovery. The veteran community offers other resources that cut across all three recovery stages:

- "Venting" the full range of feelings associated with trauma and its aftermath,
- "Value" that comes from having something to give to others,
- "Views" that are disparate from and even contradictory to those of any given traumatized veteran, but held and expressed by someone the veteran nonetheless continues to treat with respect, usually another veteran.

One of us (Munroe, 1996) has called these four—validation, venting, value, views—the "four Vs" offered by the veterans' community.

We have been influenced in the way we conceptualize the dimensions of recovery by Mary Harvey's account (1996, pp. 11-13):

- Authority over the remembering process
- Integration of memory and affect
- Affect tolerance
- Symptom mastery
- Self-esteem and self-cohesion
- Safe attachment
- Meaning-making

We do speak to our patients of these dimensions as future, expected results of treatment—in concrete language arising from the veteran's own experience. All of our patients struggle against chronic despair. One cannot "give hope" of recovery, without giving understandable content to that hope. Over a period of time, veterans readily understand Harvey's dimensions of recovery.

V. Defining concepts and practices of the VIP Team Treatment Model

A. Restoration of community

1. Community is more than any number of dyads

Basic trust (J.M.'s preferred term), social trust (J.S.'s preferred term), the capacity to attach to a community, requires at least *three* people. We are not playing logical games when we say that the dyadic trust between two people, no matter how many times it is pair-wise created, does not make a community. A community begins with the addition of the third person, and with the belief of *each* individual that when alone together the *other two* will continue to safeguard the interests of each even when that person is *absent*. The trauma-world assumption is that they will plan some exploitation or attack. Good-enough nurturance in childhood produces basic trust as a matter of

course; bad-enough trauma *at any age* destroys it. The main task in treating combat complex PTSD is to create a family of re-origin (Munroe, Shay, Makary, Clopper, & Wattenberg, 1989) where the veteran can relearn basic trust.

2. Suspicion of words

It is not enough to talk about trust and tell patients verbally what they need to do. Vietnam combat veterans, like veterans of many other wars and other traumatized populations, were deceived by words as part of their trauma. Our patients were told many idealistic things about the war, but were not told of the horrors. They were told about codes of conduct, but they quickly saw that the rules did not apply. They were told the enemy was weak and ill equipped, but they saw how competent the enemy's tactics and weapons were. They were told in many voices that it was noble to be a warrior and that they would come home as heroes, but they learned they were not wanted. Veterans learned not to trust words, but to observe behavior. They observe the behavior of therapists who profess to offer therapy. They observe how well the therapist models basic trust.

B. Tests of trust

Our patients with complex PTSD, like good researchers, skeptically assume that there is no trust among professionals, and proceed to test this assumption. This is their "null hypothesis." The veterans replicate and re-test any finding that there *is* trust with many variations before they draw firm conclusions. The trauma world-view—"expectancy of exploitation"—is well-founded for survivors. They view evidence to the contrary with suspicion.

These testing procedures are well known to therapists—impatiently endured as obstacles to therapy. For combat trauma survivors with complex PTSD, these tests *are* the therapy. Therapists who are in a hurry and expect the survivor to be past this stage will guarantee their own ineffectiveness, missing opportunities to establish the infrastructure of trust necessary for further therapy. Once the survivor "experimentally" confirms that the therapist is *un*trustworthy, the perceived relationship reverts, by default, to mutual exploitation. Survivors then cycle endlessly through suspicion and testing. The survivor will manipulate to get whatever is expedient, such as a medication that makes him feel good, a letter to divert bill collectors, help with disability compensation, getting him out of trouble, or a place to vent out rage. Without basic trust, therapy will never move beyond these.

Tests of trust generally fall into four categories: (1) boundary maintenance, (2) professional trust, (3) secondary trauma ("compassion fatigue," Figley, 1995), and (4) therapist self-care (Munroe, 1995, Yassen, 1995).

1. Boundary maintenance—Tests of rules, observing if power is abused

The traumatized combat veteran, who has observed the repeated violation of rules and boundaries *without* sanction, is keenly interested in whether the professional community can police its boundaries. Tests might revolve around the time that sessions start or stop, times outside of scheduled sessions, how threats or intimidation are handled, or whether violations of rules are condoned. Wherever lines are drawn, veterans venture across them. The test is not so much about where the lines are drawn but rather, how the community deals with violations. Are the consequences clear, and will the community enforce them? Veterans also test to determine whether the rules are fair and how the team responds if rules are demonstrated to be unfair. Can the team acknowledge error and correct it or will clinicians deny it and blame the patient? For the veteran, unclear boundaries, irrational rules, and inflexible authorities who will not listen are reminiscent of the war zone and become triggers for intrusive and hyperarousal symptoms.

2. Professional trust—Do therapists trust each other?

Veterans observe how treaters treat each other. Our patients create tests to discover if we trust the other members of the team. It is *very* difficult for civilians to grasp the *mortal* stakes that enlisted men have in their officers and NCOs trusting each other in combat: when it's not safe for a junior leader to tell his boss the truth, people *die.*

Control of information (including disinformation) and of emotional self-presentation are powerful social techniques for survival in extreme situations. These are the principal means by which trauma survivors *split* therapists from each other and from their institutional setting (Munroe, Shay, Fisher, Makary, Rapperport, & Zimering, 1995). Splitting maneuvers usually seek out the *actual* ecology of power in the treatment setting. These often include trying to get one therapist to agree that another is incompetent or uncaring. They may also give conflicting information to different team members to see if they will communicate. Sometimes veterans engage one therapist to disagree with the treatment plan of another, or they ask about various theories or treatment approaches favored by others. Members of the team are pitted against one another on whatever issue is convenient.

These maneuvers can be directed at existing staff tensions, such as occupational or gender rifts, or treatment issues where there is plenty of room for different approaches. The content is secondary to testing whether professionals trust each other and can work out disagreements. It is an excellent opportunity for clinicians to model trust by openly dealing with splits. VIP team practices require forthright exchange of information and expression of feelings among team members and aim to *make it safe for team members with different degrees and kinds of power to struggle together.*

Splitting is a fundamental survival skill in a situation of captivity—which, modern combat *is*. As an adaptive move it plays one powerholder against another and gets them to fight with each other, or gets one to ally with the captive against the other. Splitting moves are complex strategies that control the information (and disinformation) the splitter gives on both fact and emotion, presenting one picture to one person, and another picture to another. The usual aim is to insert a wedge into an already existing fault line in the ecology of power and open it up into a chasm. The veteran who splits is not evil—he is simply applying his survival skills.

The team, when working well, assists its members in managing the powerful emotions aroused by splits. Falling for the "positive" side of a split, is intensely pleasurable and inflating—almost everyone doing this work for any length of time has experienced near hypomania from being on the "positive" side of a split. A clinician who buys into this loses the veteran's trust as surely as the angry, counter-attacking clinician on the "negative" side of the split, who has fallen into that. The clinician who takes in the "negative" side of a split as a valid judgment, can descend into painful despondency and self-doubt. Clinicians who have known and liked each other for years, find themselves flaring in naked hatred. The tensions and animosities that successful splitting creates can injure therapists and are a major cause of secondary trauma.

Here we want to remind readers that they should critically examine whether our experience in a long-term outpatient setting is suited to the character of their population, staff, and institutional setting. It is entirely possible, for example, that the staff of an inpatient setting with little control over their own intakes, a short length of stay devoted to "stabilization," and with no meaningful enduring relationships among the veterans or between the veterans and staff, would be much better served by a clear and rigid hierarchy of power than the fluid, egalitarian structure that works well for us. We are not recruiting disciples.

There is *no possibility* of removing the differences among team members that veterans exploit to create splits. This would deprive the team and veterans of diversity, even if it were possible. Working alone in private practice cannot eliminate splits, because splits can always be engineered between the therapist and other patients, health insurers, police, the therapist's family.

3. Secondary trauma ("compassion fatigue") is NOT a secondary issue—three mechanisms of injury to mental health professionals

Secondary trauma, psychological injury to the caregivers from doing the work, is intrinsic in the work itself. In our view, no degree of training, no degree of personal maturity, no perfection in the termination of a personal psychoanalysis, no perfected personal virtue or religiosity can protect an *isolated* mental health worker in *any* discipline from secondary trauma. A workplace community of trust, support, and safe struggle confers protection. And even that is not absolute. In public health terms, a well-functioning team provides secondary prevention of secondary trauma: it prevents injury from becoming permanent and disabling by supporting recovery *pari passu* with the injury, but does not remove the injurious factor from the environment (which would be primary prevention).

Work with trauma survivors injures therapists through three mechanisms—

1. The patients' narrative of traumatic life events make the therapist a witness to atrocities. The VIP model of team function allows its members to communalize these trauma disclosures with the team. Therapists' emotional and physical reactions to things heard are expected and normal, and are valuable clinical data. Unless the patients' material is "processed," i.e., communalized, it will injure the therapist. This is an Occupational Health and Safety practice in the workplace, not "group therapy."
2. Veterans with complex PTSD perceive the clinic in terms of situations in which they were injured and apply survival skills and strategies that *were* adaptive in the past traumatic situation. Common examples of these strategies are intimidation and splitting. Taken together, trauma-based ways of perceiving and adaptive strategies add up to *re-enactment* of trauma themes. As they play themselves out, these can be extremely damaging to the therapist.
3. When a treatment team is in continuous contact with a community of veterans, processes occurring in the veteran community develop in the treatment team as well. Because these processes manifest a world view that assumes exploitation and victimization—sees everything in and us-against-them light—the world view of the therapists can be damaged.

Occupational psychological injury to trauma workers has also been called vicarious trauma (McCann and Pearlman, 1990), secondary trauma (Rosenheck and Nathan, 1985; Munroe, 1991; Catherall, 1992) and countertransference (Wilson and Lindy, 1994). Danieli, a pioneer in demonstrating the importance of countertransference and secondary trauma in work with Holocaust survivors since 1980, has reviewed this subject in 1994.

Trauma survivors are well aware that reporting their stories affects those that hear them (Munroe, Makary, Rapperport, 1990). They are *very* interested to see how therapists protect themselves from this exposure. They look for ways to do this, as a model for how they should deal with their own trauma. They will often say such things as "I can't tell my wife about these things," or "my last therapist cried or changed the subject when I brought these things up." We often see a veteran vacillate between overexposing others to his traumas—so *someone* will understand—and keeping it all to himself to protect others from the fate of experiencing these events. How the clinician handles this is of primary interest to combat survivors. If they observe that therapists deny

the impact and keep it to themselves, therapy is unsuccessful. If they observe that professionals acknowledge the effects and help each other as a community, they have a model for recovery.

Trauma survivors test whether the therapist is isolated or engages the support of a community. We regard the standard image of the expert clinician who acts alone and is not bothered by trauma material to be detrimental to the veteran because it implies that if he were as well-informed, well-educated, or otherwise as strong and fortunate as the therapist, there would be no symptoms of PTSD. There is good empirical evidence that therapists are *not* immune from the effects of their patients' trauma material (Munroe, 1991; Chrestman, 1994; Kassam-Adams, 1995; Schauben and Frazier, 1995; Pearlman and McIan, 1995) and therefore an image of invulnerability is *counter-factual*. Knowingly to pass it on to students and trainees is *unethical.*

4. Therapist self care

For war veterans, trustworthiness in combat was measured by whether one would risk his life for the other. In the clinic, veterans frequently induce therapists to move toward extremes of demonstrating the sacrifices they will make. Therapists often get caught up in trying to rescue trauma survivors at their own expense. However, in doing so they model devaluing their own worth and they reenact the trauma theme of exploitative or lethally self-sacrificial relationships. This can take the obvious form of placing the clinician in the position of rescuing the patient from a suicide attempt, or more subtle forms such as moving appointments around, bringing up important material at the end of sessions, or calling the therapist at home or on weekends. The test is whether the therapists will allow themselves to be abused. Crises do occur in the normal course of treatment, and this is often where the real therapy begins. If clinicians are unable to practice self-care, the survivor is unlikely to take them seriously. Crisis intervention may be necessary, but the issue is safety, not therapy.

Survivors may also ask self-care questions directly, such as when the therapist takes vacation, or how he or she handles all the trauma material, or what the therapist does to relax. Conventional training in most mental health disciplines teaches us to turn away these questions as *diversions* from therapy or *inappropriate* intrusiveness into the life of the clinician. However, these are opportunities for direct modeling of self-care. Survivors require that therapists practice what they preach. In VIP, we can truthfully answer these questions by reference to the team.

C. Team as community and team plus community

The VIP veterans now have a strong system of rules, devoted primarily to safety, sobriety and self-care, developed over many years by the veterans, and mainly enforced by them in cooperation with the treatment team. The community rules are continuously a work in progress. The core of VIP is its group therapies. However, we use a "behavioral" point system as well, which awards points for attendance, constructive participation, and other pro-recovery activities. The point system embodies the principle that each veteran earns his place in VIP by his efforts toward recovery and by the contributions he makes to the recovery of others. Failure to make point requirements leads to mandatory meetings with the team as a whole. Persistent non-participation leads to discharge from the program. Despite periodic complaints that the point system is childish, petty, "chickenshit," or demeaning, the veterans support it as a means of making sure that the team is *paying attention*, and that the veterans have not been forgotten as members of the community.

Rebuilding the capacity for trust is a process of re-socialization. Like the child's socialization in his original family, the ways team members conduct themselves toward each other—their capacity to negotiate, the uses and abuses of power, mutual accommodation through

expression and understanding of emotion, the trustworthiness of words, how they support or defeat each other's self-care -- are an essential part of the VIP team treatment model. The famous aphorism of Sarah Haley's (1974) "The therapeutic alliance *is* the therapy," can be adapted as "The team *is* the treatment."

D. The rhetoric of treatment for combat PTSD

We see ourselves engaged with the veterans as our fellow citizens of a democratic polity, which puts us squarely in the territory described by Aristotle in the *Rhetoric* (Rorty, 1996). We are going for the veterans' trust, to establish ourselves as trustworthy. In this context of free citizenship, Aristotle says—correctly in our experience—we have three *interrelated* means of achieving their trust—

- Appeal to their reason *(lógos)*
- Appeal to their character *(êthos)*
- Appeal to their emotions *(páthos)*

These are *not* separate, because reason pertains primarily to means, while the ends of action arise from the ideals, ambitions, and affiliations—which is to say, the character—of the veterans, and their emotions arise primarily from their cognitive assessments of the improvement or deterioration of these commitments. In this context, how we formulate our appeals gives evidence to them for *our* character, and in particular gives the veterans evidence of our—

- Good sense [*phronêsis*]
- Personal integrity and competence [*aretê*]
- Good will for and toward the veterans we are persuading [*eunoia*]

The centrality of persuasion, rather than coercion or deception, is a manifestation of the team's *respect* for our fellow citizens, these veterans, an aspect of our good will. What arguments and examples we choose from the infinity available, and how we develop them, provide evidence for our *phronêsis* and *aretê* and overall provide evidence for our own character. *The persuasive power of sincere appeals to reason comes more from the evidence which it provides for our respect toward the veterans than from any intrinsic ability of reason to compel assent, or having compelled assent, to guide or restrain behavior.* This, too, is one of the points Aristotle makes in the *Rhetoric* (Garver, 1994b, pp139-171, "Why Reasoning Persuades").

One aspect of *aretê,* integrity and competence—excellence in general—calls for comment here, both because it seems critical to a combat veteran feeling safe in the treatment program, and because it throws light on the clash between the ethos of the professional and what it takes to work with this patient population. This dimension of *aretê* in the clinician is a matter of the clinician's *thumós* (spirited self-respect). To trust the person offering care, combat veterans need to feel that this person is his or her "own person," not a *slave* to the rules, goals, and authorities of the institution in which he or she serves. (The word "slave" is not used lightly as a cheap hyperbole here—see Garver, 1994a.) The veterans' fearful sensitivities on this are understandable in terms of their real experience in war, when a leader who gives blind obedience to an irrational or illegal order can get the soldier killed or irretrievably tainted by commission of atrocities. *Many* tests of trust are set up as splits between the clinician and his or her boss, institution, professional code of ethics, licensure and reimbursement rules. While there is an occasional veteran who appears to be saying, in effect, "I can never trust you unless you are an outlaw like me," most are satisfied with knowing that we personally and freely (not slavishly) support the *substance* of the rules.

We are open *in* our persuasion and also open *to* persuasion, when what we recommend, or an action that we take seems wrong-headed or unjust to the veteran. Aristotle's account of

persuasion, of reaching for trust is useful and unsentimental—so long as we look back to the *context* in which we seek trust: We are in this together and are parts of each other's future as fellow citizens.

What we do is political in the richest senses of the word. We foster community among the veterans and join that community to the community of the treatment team. In doing so we establish the *possibility* of attachment to the larger social world because *we* (the treatment team) sincerely believe in that larger world and show that it is possible to participate in it with perceptive good judgment. We must do this as *rhêtor*—a citizen openly and undeceptively seeking the trust of fellow citizens and sharing in their fate—not as hireling sophist or as a slave of the institution and its rules. We speak to the veterans as free fellow citizens, not hired agents of social control or slaves of the state. The veterans know that we all receive VA salaries, and are more or less currently dependent upon them for our livelihoods, but all team members have truthfully made it clear that we can be working elsewhere, and do this work because we want to, and choose to, not because "it's a paycheck."

Our work is political also in the sense that we encourage the veterans' participation in the democratic political life of the country that they fought for. As one of us has pointed out (Shay, 1995c), unhealed combat trauma disables the basic social and cognitive capacities required for democratic participation—

- being able to show up at an appointed time and place, possibly in a crowd of strangers
- being able to experience words as trustworthy
- seeing the possibility of persuasion, negotiation, compromise, concession
- seeing the possibility of winning without killing, of losing without dying
- seeing the future as real and meaningful

To work with American combat veterans, injured in the service of their country, and not to find incapacity for democratic participation a meaningful clinical issue, strikes us as an odd blind spot on the part of many clinicians in the field.

The team is also publicly and politically active in education of other mental health professionals on trauma treatment in general, and work with combat veterans in particular. The veterans have participated with great satisfaction in video education projects for mental health professionals—one such video formed a presentation at a professional meeting. As a whole team we have published and presented at professional meetings, with full knowledge of the veteran community. One of us (J.S.) publicly testifies on veterans' concerns at Congressional hearings, lectures and organizes conference panels on prevention of psychological injury for active duty military audiences, writes for the trade press and does media appearances on the themes of combat trauma and on prevention of psychological injury in military service. The veterans in VIP are particularly supportive of these "missionary" educational and hortatory activities to the active duty military. They don't want other young kids to be wrecked the way they were wrecked.

We see these public and political activities as integral to the treatment; in terms of Aristotle's analysis, as a team we achieve trust on the basis of our character, and our public activities are one *evidence* of our character.

E. Summary of VIP team practices

- Authority resides in the team, not in any single individual. There is no "head of the snake."
- Functional roles among team members are intentionally blurred and traded from time to time.

- Hierarchy empowers some to speak and silences others, empowers some for the possession of information and forbids it to others. The team acknowledges *no* hierarchy within itself, and strives for working equality of team members.
- *Feelings* are essential discourse among team members. These include feelings and countertransference experiences aroused by the patients' traumatic material, feelings toward the patients, and, most important, feelings aroused between team members. The latter is essential to uncover and heal splits.
- The goal of team process is clarity, *not* unanimity. A team accustomed to safe, affectively honest struggle will not remain split. A team has been successfully split when there is an *unacknowledged* disagreement, negative emotion, or adverse value judgment within it.
- Team members with different degrees and kinds of power are encouraged to *struggle* together. The goal of the team culture is to render this *safe*. The slogan, "Safe Struggle," places equal emphasis on both words.
- Veteran information is shared among the team, along with the feelings aroused in the clinician toward the information, toward the veteran, and toward others working with the veteran.
- More than one team member is always actively working with the veteran—this is important protection for both the therapist and the veteran.
- Therapist self-care is essential to work with survivors of severe trauma. The team culture encourages this self-care. It actively works against the constant pressure on therapists to become rescuers who are out there all alone with the veterans. The by-word is "I need to know you are taking care of yourself, for me to do my work."
- Multiple relationships and value commitments outside the team are essential to individual well-being and to prevent the team from becoming a totalitarian cult. The team strongly supports value-richness and views workaholism as a failure of self-care, a sign of injury.
- The team model is inherently vulnerable to impairment by *any* of its members, regardless of the degree and kinds of power that person has from institutional or other sources. Team trust is thus fundamentally dependent upon unanimity of support for the team model itself—even though the team model encourages forthright disagreement over any other issue.

VI. Divergences in the team model from the value pattern of the professional

The VIP team model for long-term treatment of complex PTSD after combat is difficult for mental health professionals to carry out because it diverges from the psychologically internalized and socially institutionalized value pattern of the professional in our society. Most parts of this value pattern seem so pervasively "true" that they are as invisible to us as water is to a fish. We shall attempt to bring them to awareness using the classic description given by Talcott Parsons (1951, Page 343 and other references indexed under "pattern variable"). His description is still on the nose; not much has changed.

Parsons analyzed this professional value pattern through a series of dichotomous variables, and claimed that any given social position (such as "doctor") could usefully be characterized by the particular pattern of value commitments the person in that position is expected to fulfill. Parsons' dichotomous value "pattern variables" were universalism/particularism, functional specificity/functional diffuseness, collectivity orientation/self-orientation, achievement/ascription, affective neutrality/affectivity. We shall

take up each one in turn and show how it obstructs the creation of trust in our population of combat veterans for whom the destruction of the capacity for trust is the most disabling aspect of their injury. Centuries of historical change and struggle lie behind each pattern variable, not only institutionalizing norms that serve the interests of powerholders in modern industrial societies, but also often institutionalizing fairness, rationality, and protection for the powerless. Why should combat veterans react so badly to clinicians' loyal adherence to them?

A. Universalism (opposite: particularism)

A mental health professional is expected to relate to a patient on the basis of technical rules governed by having identified the patient as a subsumable example of an abstractly defined category. Once the VA has applied the rules declaring a man or woman to be a "veteran" and "eligible," the mental health professional applies an institutionalized set of rules known as "diagnosis" to the patient's history and current life. These abstract, universalistic standards are claimed to "transcend" the particularity of the patient's history, situation, and future. Many combat veterans—especially at the beginning of their treatment when trust is absent—vocally resent being lumped with incest survivors, concentration camp survivors, auto wreck survivors, battered women, who are all conceived as having the "same" diagnosis. The veteran's angry insistence upon the therapist knowing the specifics of his military service, upon knowing who the 1st Battalion, 9th Marine Regiment were, or the aviation company of the 101st Airborne Division known as the Commancheros, is often taken by clinicians as a repellent narcissistic claim of "specialness." According to their professional training in the abstract universalistic system of diagnosis, and in the treatments claimed to be applicable to any exemplar of a diagnostic class, the clinicians are doing the right thing. Why does this veteran so perversely insist upon "being treated like an individual," when in the mind of the clinician, the veteran "ought to know" that scientific professionalism will provide him with the best possible outcome based on his universalistically defined diagnosis, not on the accidental particulars of his life? Is this just ignorance, or narcissism?

The answer is usually *fear.* These veterans have had the real experience of lives being lost, and people maimed, when a person in a position of power "went by the book," rather than looking first very sharply at the particulars, and then applying the book to them with flexibility and good sense. (Aristotle: "The doctor cures a particular [i.e., not universal] man." *EN* I.6, 1097a13.) Most veterans will not insist that a therapist be or become a subject-matter expert on every technical detail of the Vietnam era military, but only that the therapist be willing to "listen."

Universal rules were sometimes—in reality—what got people killed.

B. Functional specificity (opposite: diffuseness)

"Division of labor" and "specialization" are often thought to be crowning achievements of the historic process of modernization. It is deeply ingrained in our common sense and institutionalized in law and in work rules. The voice of common sense says, "You do your job, and I'll do mine, and together we'll get the work done." Functional specificity is largely invisible to us as a *value* posture; we experience it more like a feature of the natural landscape, like gravity. Many readers may be scratching their heads wondering how the division of labor between, say, psychiatrists, psychologists, nurses, and social workers, could possibly be a trust issue for combat veterans.

In fact, the division of labor is a key element in the processes that support state-sponsored *atrocities and torture* (Kelman, 1994). Veterans who had the misfortune of witnessing or participating in these were told, “none of your business,” or “not my job,” or “just do your job” if they raised questions. Many of those who crossed into the heart of darkness are now dead by their own hand.

Probably the most frequent “boundaries” that combat veterans openly or subtly demand we cross—as a test of trust—is the boundaries of functional specificity, professional specialization, division of labor. Masters level counseling psychologists are importuned for advice on medication; psychiatrists are pressured to locate Section 8 housing, and so on. No wonder well-socialized mental health professionals see these patients as demanding and narcissistic. However, the engine behind these demands is fear, not vanity. In the VIP team we intentionally blur disciplinary lines, and each of us strives to see the whole veteran as significant, with no predetermined limits to the dimensions of his welfare that are our concern.

Functional specificity is deeply institutionalized in licensure, departmental organization of the VA, and career paths in the professions. For many combat veterans with complex PTSD, the careerism of officers, the career management systems of the military services (manifested then as six-month rotations in troop command positions) were the visible sources of their betrayals.

C. Collectivity orientation (opposite: self-orientation)

In the professionalized, bureaucratic society of “modernity,” *thumós* is not completely erased, it is tamed and channeled into the institutions (collectivities) of the society. One expects to find identity, satisfaction, pride, recognition, accomplishment, solidarity—but also material compensation—embodied in these institutions. Collectivity orientation channels ideals, ambitions, and affiliations through collectivities, not through personal relationships. The dichotomous opposite that Parsons chose for his jargon, “self-orientation” begs to be read simply as “selfishness,” even though he carefully defines it in less moralizing terms. The moralizing is not completely off-base. Examples of corrupt self-orientation would be personally taking money from a VA patient to perform a clinical or administrative service one ought to be doing anyway. Under the normative value pattern variable, the mental health professional may receive his material compensation *only* from the collectivity. Or if clinician became romantically, sexually, or narcissistically involved with a veteran, this would be a clear example of self-orientation, taking gratification from the specific relationship with the veteran rather than channeling all gratification through the collectivity and in the licit forms that the collectivity grants. These are the easy cases.

It gets murky when the veterans’ welfare matters to the clinician more than that of his or her employer, or the veterans’ esteem matters more than the esteem of professional colleagues. Such a mental health professional is likely to find him or herself under suspicion by colleagues and supervisors, even if no steps have been taken in the real world that impair the institution or reject the colleagues. It’s not hard to detect the lack of a collectivity-orientation; the professional who lacks it, is “not with the program.”

During the Vietnam War, officers who resisted rotation out of dangerous troop command billets at the end of their six months were labeled as having “gone native,” that is, having developed more commitment to the troops than to the officer corps and to personal career advancement. This label was a career-ending stigma. Ironically, in some instances it was ideals of purely professional competence that led to such refusals, because the six-month rotation

policy *guaranteed* that no one in command of a company or battalion had the time to learn what they had to learn to do the job well—in purely military terms.

The veterans we treat, who are all enlisted men, treasure the memories of the officers who were more devoted to their substantive military tasks and to the men under their command than to the reward system of their military service. More to the point clinically, any sign of collectivity-orientation by a clinician is liable to be a traumatic trigger, bringing back memories of having been put in lethal danger to get body count—or worse, to fill out the denominator of a kill ratio, where the *presence* of American casualties was rated as positive evidence of the commander's "aggressiveness" and "balls."

The urgency of fear lies behind the veterans' need to know that we are working in VIP because we *want* to, because it gives us personal pleasure and satisfaction *for its own sake.* Parsons would probably have called this "self-orientation" rather than "collectivity orientation."

This pattern variable also has a subtle influence on the interactive style of clinicians. Normative avoidance of "self-orientation" seems to call for a degree of modesty in dealing with trauma survivors that may *not* serve the patients best. The narcissistic dimension of the veterans' injuries not only drives them demand *timê* (Homer's heavy-freighted word for honor), but calls for the clinician to be able to *accept* with graceful good humor the idealizing, admiring reactions that veterans develop toward those whom at long last they have come to trust. Kohut (1971) was the first to point this out, and it accords with our experience. A clinician's professional colleagues are liable to react negatively not only to the idealization itself, but to the reluctance of the clinician, the object of the idealization, to disparage and rebuff it as pathological.

D. Achievement (opposite: ascription)

Modern clinicians attain to their professional credentials and institutional position through achievement of the standards of their respective disciplines. No one, least of all the injured veterans in the VA, want to be treated by people whose only qualification is that they are a relative of someone powerful in the government, by some accident of birth. Such nepotism would be a textbook example of "ascription." "Achievement" is institutionalized in examinations, training program standards for accreditation, credentialing laws and rules. The veterans *do* insist on competence—one dimension of the *aretê* on which they found their trust—so how does this normative value pattern variable get the mental health professional into a bind with combat veterans?

Again, *fear* is the problem. Veterans experienced lethal incompetence at the hands of officers and bureaucrats who had all the right credentials but whose competency in examinations and management science did not equip them for the reality of war against a resourceful human enemy who progressively figured out how to turn each textbook solution into a death trap. The veterans insist that there is something *personal* (read "ascribed") that makes someone trustworthy as a combat leader or as a clinician. Our institutions treat professionals who have the same "achieved status" evidenced by the same credentials, as fungible—absolutely substitutable—for one another. The veterans reject this. Their trust is personal, non-transferable.

When you ask what personal quality made trustworthy officers worthy of trust, the most frequent answer is their willingness to *listen*. In the combat situation, it was willingness to listen to the particularity of the local and current knowledge of the most experienced person in the unit, regardless of rank. In the clinician it is the willingness to listen to the particularity of the veteran's own experience. They don't ask us to be universal experts, and will be less trusting of

a widely-read clinician who is smug about this knowledge, than of someone who knows the limits of what he or she.

E. Affective Neutrality (opposite: affectivity)

The normative expectation that the professional will be emotionally detached, coldly rational, has been under attack for a long time and from many quarters, not the least of them being the recognition that even the simplest rational social judgments and self-restraints are flatly impossible for someone truly devoid of emotion (Damasio, 1994). The problem for our work lies less in some official insistence that professionals be affectively neutral, than in the difficulty of allowing emotions a full place at the table with our patients and our colleagues. One of us (Shay, 1994, pp. 188f) has argued elsewhere that the communalization of trauma requires authentic emotion in the *hearer* of traumatic material. Even harder to overcome is the posture of affective neutrality in the presence of and toward professional colleagues. Yet, as we have explained above, treatment team members *must* make the emotions stirred toward each other by the veterans' splitting maneuvers a part of the team's work. The emotions stirred by veteran narratives, re-enactments, and tests of trust carry valuable clinical information, which is lost at everyone's peril.

F. Are we kicking sacred cows?

Some readers may wonder if a delight at kicking sacred cows is at work here. While neither of us is above such perverse pleasures, the main point of this review of Talcott Parsons' classic sociological analysis is to bring home the mismatch between our acculturation to professional norms and the psychological make up combat veterans with complex PTSD, and perhaps of any severe, human-caused prolonged trauma in a condition of captivity.

In her lucent analysis of the relationship of complex PTSD to the ecology of power, Judith Herman (1994b, Chapter 1) has pointed out that professionals who devote themselves to the care of these patients risk becoming tainted and stigmatized by association with those whom the powerholders have victimized. In countries ruled by tyrants, this can be literal and life-threatening, as when a general practitioner is questioned by the political police for setting the broken bone of the *wife* of an executed enemy of the state. In less extreme conditions it can be simple social ostracism, lack of otherwise merited recognition or advancement, and embarrassed discomfort of colleagues, such as Freud experienced when he took seriously the childhood sexual exploitation of his female patients. Judith Herman's observations stand firmly as the most important single thing to know about this matter, if we were limited to knowing but one thing about it.

Here, we have added a different sort of insight on the difficulties arising in the treatment of combat veterans with complex PTSD. These veterans may suffer unbearable terror when they encounter unthinking obedience by their care-givers to the normative value pattern of the professional. Even when these terrors can be allayed, the normative value pattern promotes the illusion of the invulnerable expert, able to work in social and emotional isolation—a Lone Ranger. This is a poor role-model for the veterans, to whom we advocate the support and nourishment of a community.

VII. Aristotle again—human is *politikón zôon*

We take seriously that the human being is a bio-psycho-social-cultural whole *at every moment*. This restates Aristotle's zoological observation (*Politics* I:1: 1252a3) that the human is the *animal* of the political community. Body, mind, society, culture are not separate "realities,"

even less are they hierarchical "levels," which underlie each other, making some fundamental and others epiphenomenal. Our physical brains are biologically evolved to make us culture bearers and users; it is our biological nature to live in relation to culturally constructed moral codes; our social lives remodel our brains; cognitive assessments and their related emotional states influence bodily health, and so on. The very fact that we speak in terms of body, mind, society, culture is no more than a reflection of the methodological and institutional history of our intellectual worlds. They are temporary guides to perception and communication. They are throwaways, not eternal realities existing beyond the Platonic veil. What we do at this moment of writing and what you do at this moment of reading is at one and the same moment physiological, psychological, social, and cultural.

Whatever one may hope from future developments, it is fair to say that at the present time there is no conclusive and comprehensive theory of the human that sanctions the hegemony of any one mental health discipline's approach to our patients.

As a clinical matter, our bio-psycho-social-cultural understanding is in harmony with our multi-modal treatment that incorporates the practices of numerous schools of thought. To offer settings in which veterans can communalize despair and grief, does not contradict offering the same veterans serotonin reuptake inhibitors, or making the group in which grief is communalized part of a "behavioral point system," or offering concrete assistance with public transport passes and disability pension hearings. This is not flabby eclecticism—it's the best we can do with the knowledge that we have. The distinction between "real treatment," and "mere support" blurs when we treat the whole person.

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