



# BE VERY AFRAID

A new therapy for trauma victims is causing experts to rethink how we treat depression, anxiety, and all of life's blows: reimagining them, again and again.

By Louisa Kamps

froze. I kept thinking, *No!* I don't want this to happen," says Janie, a slight, pretty college student with shiny dark hair. She's sitting in the corner of a large armchair, eyes clenched shut. "He was on top of me taking off my clothes. I kept saying, '*Please. Stop. You're gonna break my neck.*'"

Raped on the first day of her senior year of college by a former boyfriend, Janie still has nightmares months later about the assault, often feels detached from the people and activity around her, and avoids elevators, because it was while waiting for one that she first casually bumped into her ex—all classic symptoms of post-traumatic stress disorder.

Janie is a poignant reminder that the disorder, which tends to conjure images of grizzled, gun-shy ex-soldiers flinching at every loud noise, afflicts one in 10 women at some point in their lives, and is diagnosed in women twice as frequently as men. The therapy she is undergoing—re-creating her rape, detail by harrowing detail—may seem like it's merely perpetuating the pain, but a growing body of data suggests that the best way for PTSD patients to recover from their darkest experiences is to deliberately relive them.

Seated next to Janie as she zeros in on the particulars of her rape—her usual MO is to avoid them—is renowned anxiety expert Edna Foa, the founder of what's known as "prolonged exposure" therapy. Foa and fellow psychologists at the University of Pennsylvania Center for the Treatment and Study of Anxiety started developing the method in the 1980s and later brought it to survivors of terrorist attacks in Israel. These days, Foa is in high demand in the United States, beset as it's been by large-scale disasters such as 9/11 and Hurricane Katrina and home to legions of veterans returning from Iraq and Afghanistan, an estimated 30 percent of whom have PTSD. There is also a new recognition that many more people are subject to traumatic events than once believed—more than half of American adults, according to one

survey. The most common are "threats to bodily integrity," such as getting raped or mugged, and the witnessing or suffering of potentially mortal injury—everything from being mowed down by a bike to being on the scene of a nasty car accident.

In her early seventies, with a thick Israeli accent and the strong-boned good looks of a grande-dame actress, Foa instructs Janie to reprise her rape again but to delve even deeper into her thoughts and feelings. To heighten the immediacy, Foa gently prompts her client to speak in the present tense. "So, what is happening now?"

"I'm going with him to his dorm room," Janie replies. "Everything looks fine—he still has some things unpacked." She and her ex hang out for a while, amiably swapping stories about summer vacation. He puts on some music. He tries to kiss her and put his hand up her shirt. She asks him to stop. He pins Janie to the bed and strips her. Approaching the point where she forcibly loses her virginity, Janie is practically keening.

When it's over, Foa asks Janie to tell her story *one more time*. "As he's taking off his pants," she says, arriving at the worst part again, "the look in his eyes is so scary." Finally, after a long pause—and something like a mild sigh—Janie concludes: "I feel so small and so helpless. I can't do anything. He just keeps going and going."

Foa touches Janie's knee and smiles, telling her she did well with the exercise. When she first asked Janie to rate her anxiety on a scale of one to 100, Foa reminds her that it was 50, fairly anxious, then shot up to 90 during her first description of the assault, close to where it would've been during the rape itself. But by the third and final go, Janie's anxiety had slid to 70, Foa says encouragingly, "even though it was the same memory."

This was a mock therapy session (I'm watching on DVD) staged at a psychological conference, the part of "Janie"—whose rape was based on an actual case—played by a grad student who deserves



a golden statuette for her depiction of anxiety's ebb and flow. The theory behind Foa's approach is that people need to viscerally learn that they can withstand what they think they can't, that their emotional turmoil won't "spiral in their mind forever," the therapist says, "until they fall apart completely." By reactivating excruciating memories in a therapeutic setting, PTSD sufferers eventually become, if not bored by them, then at least less distressed.


Exposure therapy may sound familiar: It has been used for years to treat obsessive-compulsive disorder and discrete phobias such as the fear of flying. But because PTSD sufferers may be in extremis, crippled by their fear and sometimes violent, the idea of doing anything to make them feel worse, even temporarily, has been slow to catch on. Foa is aware of her colleagues' hesitancy, and as she wraps up Janie's case, she admits to the packed room of psychologists that exposure therapy "can seem very cruel." Indeed, she says, patients are asked to do "exactly what they don't like to do."

Her answer to those objections is simple: Prolonged exposure works. While a 2008 Institute of Medicine panel concluded that "evidence is inadequate" to recommend medication such as SSRIs to treat PTSD—and there is practically no data on the impact of traditional psychodynamic techniques—solid research demonstrates the efficacy of exposure therapy. It reduces the severity of symptoms by 70 percent, a number of studies have

found, and with relative dispatch. Foa's guidelines call for nine to 12 sessions of "imaginal" exposure, plus homework in which patients venture to places they've been avoiding for fear of evoking their trauma. Some doctors prescribe medication to even patients out before starting exposure, but Foa says that benzodiazepines, for instance, can be counterproductive if they're so relaxation-inducing that they block reengagement with a traumatic memory.

Foa's method may ring bells for another reason. A form of therapy known as "debriefing," in which patients are encouraged to pore over a trauma shortly after it occurs, was all the rage in the wake of the World Trade Center attacks. In fact, the method was mandatory for some office workers and rescue personnel, but reviews since then have shown that debriefing not only fails to prevent PTSD, but, by compounding stress when people are most vulnerable, might actually *cause* it. Exposure therapy, by contrast, isn't offered unless PTSD symptoms persist for about 90 days.

Speaking after the conference by phone, Foa says she has no desire to become a professional "pot-stirrer": "I don't enjoy getting into polemics; it's a waste of resources." Yet she also points out—flashing a bit of the rhetorical steel that has made her a legend among grad students—the folly of doggedly, indefinitely applying old-school talk therapies to PTSD simply because they seem kinder and gentler. "We don't have evidence that they work for PTSD. That doesn't mean that they don't, but we're at a stage in the field where it's not enough to say, 'I'm going to do a treatment that I think is going to work for four weeks, and if it doesn't work in four, we'll try 10 weeks. And if it doesn't work in a year, we'll try 10 years.'" Still, it isn't surprising that confusion and debate persist about



Reactivating traumatic memories, patients may become almost bored by them.

how to treat PTSD, a fairly new diagnosis. "Battle fatigue" was for years the euphemistic explanation for the violent flashbacks that struck war veterans; "rape survivors syndrome" the handle for skitterish withdrawal post-sexual assault; "phobic" the term for people who suffered panic attacks driving or flying after major accidents. When psychologists recognized that many trauma-triggered maladies shared similar symptoms—avoidance (detaching and never mentioning the calamity), reexperiencing (flashbacks, nightmares), and hyperarousal (insomnia, violent outbursts)—PTSD joined the catalog of official psychiatric conditions in 1980.

Since then, Foa and her colleagues have learned that about 85 percent of people recover from trauma without professional intervention, usually within a few weeks or months. The natural trauma "cures" are as simple as writing about what happened or talking to friends about it, Foa says, and while such "emotional processing" won't ever make a disaster into a happy memory, the interior mental work strips away its power to devastate.

The best proof of our innate resilience may be the great psychological experiment otherwise known as 9/11: New Yorkers were initially expected to develop PTSD in droves, but in a March 2002 phone survey, only 1.7 percent of the population reported experiencing flashbacks, sleeplessness, or any other PTSD symptom.

When emotional processing is stymied, people develop two "erroneous cognitions" that together create and maintain PTSD, Foa says: The world is an entirely dangerous place, and I'm incapable of surviving in it. "The avoidance really maintains the thinking," Foa says of this, yes, bitter irony. So Foa devised an antidote that simultaneously ramps up anxiety and gives people information to "disconfirm the feared consequence." For instance, when veterans who encountered car-bomb attacks are petrified to get behind the wheel back home, Foa has them steer into increasingly dense traffic, since it's typical for Iraqi and Afghani insurgents to swerve close to vehicles before detonating. For Janie, the kernel disconfirming her helplessness as her fear climbed was the realization that she was sitting in a comfortable chair, not being pinned to a bed. "You really want to give [people] an experience of competence," Foa explains.

Foa doesn't spend much time speculating about what might be happening inside the trauma-addled brain—studies exploring the involvement of specific genes and neurotransmitters are still in their infancy, she points out. That said, her emotional processing theory dovetails nicely with another intriguing line of research on the nature of new learning, aka neuroplasticity.

"What I think is going on in the brain with exposure—and there's a lot of evidence for it—is that people are building up new associations," says Jack Nitschke, an assistant professor of psychiatry and psychology at the University of Wisconsin. "You can talk about those associations being psychological, but they are also brain-based. They're about new neuroconnections."

Given that, you might almost expect to hear sharp *tzzzaps* with every new, positive thought forged in exposure. But Foa and Nitschke both say that the changes tend to be subtle and difficult for patients to capture in words. Kimi Olmstead, however, has no problem explaining her transformation. After losing her hand in a factory accident two years ago, she had severe panic attacks entering her laundry room. "The washer had a similar agitator to the machine that took off my hand," the 37-year-old mother says. "But that became the exercise. I'd walk into the laundry room, stand a few feet away, and say, 'It's not going to hurt me. If I don't open the [washer] door, it can't hurt me.'" Olmstead, who now wears a prosthetic, says therapy curbed her hypervigilance and, in the process, restored her confidence. "Each little thing I can overcome is good.



I want to be safe. I want to take care of myself so my daughter will be okay. I have learned that I can."

Why PTSD is more prevalent among women than men is an open question. One theory is that women have a higher lifetime risk of sexual assault, which increases their susceptibility to PTSD caused by ordeals that may have nothing to do with sex. Another is that men might become violent or abuse drugs in response to trauma—and therefore be misdiagnosed. A third possible explanation lies in the "conservation of resources" theory advanced by Chicago psychologist Stevan Hobfoll, which compares how much energy people devote to caring for themselves versus others. For a mix of biological and cultural reasons, women tend to be more socially connected than men, which has been shown to be protective of their health, but too much tending to others may burn women out. Interestingly, for example, while women are diagnosed with depression twice as frequently as men, when researchers control for the amount of caretaking the subjects deliver, the depression-rate differential between the sexes vanishes.

A traumatized woman, Hobfoll continues, likely will expend considerable emotional energy worrying about the same misfortune befalling everyone she knows and loves: friends, sisters, nieces, coworkers. This not only amplifies her pain, he says, but may leave her with neither the wherewithal nor time to care for herself. So for all their rewards, close relationships carry real burdens—keeping the costs and benefits in balance can be tricky.

The story of serious mental illness is often...depressing. Patients aren't completely cured—depression seems to be particularly chronic, with each episode potentially worse than the last and requiring a lifetime on medication. That's why academic psychologist Patricia Resick's survey of PTSD sufferers an average of six years post-treatment is so remarkable. Of the 171 women who had received Foa's exposure therapy or Resick's own slightly altered version (she combines exposure with cognitive-therapy techniques, such as Socratic questioning to correct faulty thinking), Resick was able to track down 127—80 percent of whom showed no symptoms of PTSD. "It is a great new story that once you treat the PTSD, it's treated," says Resick, who heads the women's division of the National Center for PTSD at Boston's VA hospital.

Debate that's already brewing over where to draw the line on PTSD will likely get hotter as publication of the next *Diagnostic and Statistical Manual*, expected in 2012, approaches: Some therapists want to stick with the current criteria for diagnosis—which say a person must have suffered a trauma involving serious injury or threat to life or self, with multiple symptoms. Others argue that what matters is not how big the bang, or the symptom-count, but rather the impact on daily functioning: Is someone immobilized by flashbacks, say, or cowering in their home, afraid to risk a reminder of what sent her reeling in the first place?

In some ways it's a classic case of what's called "diagnosis creep": A disorder is named, and then doctors begin to see it here, there, and everywhere. The question usually is whether that qualifies as progress, such that heretofore unrecognized emotional disturbances are noticed and vanquished, or whether the new label is actually creating illness. It makes sense, however, that while the PTSD was originally conceived as the outcome of a single, potentially lethal blow, slower, steadier, arguably smaller agonies—workplace bullying, being stalked by a persistent ex, regularly encountering mangled bodies in a VA hospital—could be equally devastating.

Many doctors, Foa and Resick included, are already treating the fallout from cumulative "stressors," and—more good news—exposure seems to help with multilayered PTSD, too. In another study, Resick found that women with long histories of being sexually and/or physically abused dramatically improved with a single round of

therapy targeting their worst memories. "They didn't have to come back and get treatment for each trauma," she says.

Finally, exposure therapy may even be making some inroads with that old black dog, depression. Inspired by Foa, University of Delaware professor Adele Hayes designed a protocol for her depressed patients. First, she trained them in mindfulness meditation, to help them calmly "sit with" difficult emotions rather than repressing or ruminating over them, she says. Then Hayes had patients recount experiences that capture "what the world looks like when they're depressed." As she predicted, the storytelling at first caused a surge in depressive symptoms. But after people reinterpreted their negative self-views in that aroused state, with Hayes lending a therapeutic hand, their symptoms showed a "nice decrease."

Going into the storm of one's emotions and memories, Hayes says, "and doing it steadily, can apply to all different situations. It's the conceptual opposite to rumination and avoidance, which tend to keep people stuck. There are lessons here for anyone in how to deal with life's blows."

Resick agrees: A century ago, she points out, babies and mothers routinely died during childbirth; serious injuries occurred frequently in pre-regulation factories. And it's possible our relative "illusion of control" is one reason we see more PTSD today—along with other anxiety disorders, commingling as they often do with depression. "When something bad happens, people think they must have done something wrong to deserve it," she says. "I wish we taught Balanced Thinking 101. Being resilient is understanding how to cope with whatever life throws at you. We need healthy thinking—which is that sometimes crap happens."

Recovering the person one used to be—albeit never quite the same after trauma—can be a thing of beauty, for all the human strength and will it reveals. Verbally abused and sexually assaulted by her former husband to the point where she was "reduced to little more than a blow-up doll," Kim McGillivray, 53, a writer in Seattle, initially recoiled at the idea of prolonged exposure: "Spend two hours doing the play-by-play of the nadir of my life—and this works? I had a lot of resistance. But there was another part of me that understood what I'd been doing was a placeholder; if I really wanted to heal, I'd have to look back into the fire."

Mostly, McGillivray says the changes she noticed in herself over 10 weeks of therapy last fall are hard to articulate. But there was one "big benchmark," the evening she finished her fifth session and walked out onto the steps of the University of Washington's psychology building. She had just been repeating and repeating a story about the night, shortly before her marriage ended in 2003, when she awoke from an Ambien-drugged sleep to discover her husband sodomizing her. "Here I am with eyes still puffy, fists full of balled-up Kleenex. But I realized I hadn't gone through *quite* as many Kleenexes, and that my eyes weren't *quite* as puffed up," McGillivray says of her breakthrough.

Later that night, out picking up pizza—a celebratory dinner for her and her kids—she happened to spot her ex-husband across the street, wearing tiny jogging shorts and tube socks pulled up snug to his knees. "I had that instant flash of recognition," McGillivray says, with a quick intake of breath, "but in the second flash, I just thought, Dork! I was sitting there in the car, laughing, going, 'Oh my God. Whatever is happening is working, it's taking root.' I could finally see him as other people did—as just this nerd who didn't have the right athletic equipment—instead of as the monster he was to me. After years of being told I was utterly useless, it's like I've been given another shot. And that I'm able to say all this without weeping—to view things in my past without having to be totally rolled—is testament to the process. I'm back in the human race." ●