Emery, P., and Smith, J. (1987). *The Treatment of Post-Traumatic Stress Disorder Based on Ten Propositions.*
Eth, S., and Pynoos, R. (eds.) (1985). *Post-Traumatic Stress Disorder in Children,* American Psychiatric Press, Washington, D.C.
Green, A. (1985). Children traumatized by physical abuse. In Eth, S., and Pynoos, R. (eds.), *Post-Traumatic Stress Disorder in Children,* American Psychiatric Press, Washington D.C., pp. 137-138.
Green, A. (1983). Dimensions of psychological trauma in abused children. *Am. Assoc. Child Psychiat.* 22: 231-237.
Khan, M. (1983). The concept of cumulative trauma. *Psychoanal Study Child* 18: 54-58.
Kris, E. (1956). The recovery of childhood memories. *Psychoanal Study Child* 11: 54-58.
Littner, N. (1956). Some traumatic effects of separation and placement. Child Welfare League of America pamphlet, Child Welfare League of America, Inc., 67 Irving Place, New York.
Quinn, P. (1984). *Cry Out,* Abingdon Press, Nashville, Tenn.
Redl, F., and Wineman, D. (1950). *Children Who Hate,* The Free Press, New York.
Terr, L. (1983). Chowchilla revisited: The effects of psychic trauma four years after a school bus kidnapping. *Am. J. Psychiat.* 140: 1543-1550.
van der Kolk, B. A. (ed.) (1984). *Post-Traumatic Stress Disorder: Psychological and Biological Sequelae,* American Psychiatric Press, Washington, D.C.
van der Kolk, B. A. (1987). *Psychological Trauma.* American Psychiatric Press, Washington, D.C.

Journal of Traumatic Stress, Vol. 2, No. 3, 1989

Differentiating Intervention Strategies for Primary and Secondary Trauma in Post-Traumatic Stress Disorder: The Example of Vietnam Veterans

Donald R. Catherall[1]

Accepted February 6, 1989

A model of treatment of PTSD is presented. Two central psychological issues are addressed: (1) the conflict between ego forces oriented toward recalling and assimilating the traumatic material (thereby achieving ego integration) versus ego forces oriented toward repressing and avoiding the reexperience of the trauma (thereby defending against ego disintegration); and (2) the loss of self-cohesion which results from the breakdown between the trauma survivor's self and his social milieu. Clinicians are advised to use two different theoretical orientations (ego psychological and self psychological) in treating these two basic issues. The concepts of primary and secondary trauma refer to the initial traumatic experience and the subsequent breakdown in the relationship between the survivor and his social environment and are offered as tools for distinguishing which issue is uppermost in the patient's material at any given time.

KEY WORDS: PTSD treatment; Vietnam veterans; integrative treatment model.

INTRODUCTION

Models of treatment of Post-Traumatic Stress Disorder (PTSD) have focused on the precipitating traumatic event and its effect upon the individual's psychological functioning. In the case of Vietnam veterans, many writers

[1]Department of Psychiatry and Behavioral Sciences, Northwestern University Medical School, Chicago, Illinois 60657.

0894-9867/89/0700-0289$06.00/0

have emphasized the need to address the effects of a hostile homecoming experience, which has been implicated in the ensuing breakdown in the individual's relationships with his social environment (Polner, 1971; Lifton, 1973; Symonds, 1980; Dermatis and Kadushin, 1986). However, no approach has been offered that distinguishes between methods to be employed in dealing with the precipitating event and the later rupture in the individual's relationship with his social environment. The premise of this paper is that the original traumatic event and the subsequent rupture in the trauma survivor's relationship with his social environment can be conceptualized as separate trauma and are best treated from different models of treatment. In this model, the original traumatic event(s) and its sequelae are viewed as the primary trauma and understood and treated from an ego psychological perspective. The rupture of the trauma survivors's relationship with his social environment is viewed as the secondary trauma and is conceptualized and treated from a self psychological perspective.

DIFFERENTIATING PRIMARY FROM SECONDARY TRAUMA

The symptoms of PTSD can be viewed as falling into three categories: (1) symptoms related to the overwhelming affective nature of the traumatic event, (2) symptoms related to the individual's efforts to control the internal sequelae of the event, and (3) symptoms of the impaired relationship between the individual and his social environment. The first two groupings are both viewed as aspects of the primary trauma and the third grouping refers to the secondary trauma.

The conceptualization of the primary trauma is well suited to an ego psychology model because the breakdown is seen as occurring within the individual's relationship with himself. Intrapersonal forces (toward integration vs defending against disintegration) are in conflict and the individual's symptoms can be viewed as dysfunctional attempts at managing the conflict. The secondary trauma is defined as a breakdown in the individual's relationship with his (perceived) social world and the symptoms are manifestations of this breakdown. Consequently, a model of the self seems better suited to described this impaired relationship because the self is a social construct. Ego refers to a conglomerate of functions that can be in conflict with one another. Self refers to a singular entity that is defined in terms of its relationship with others. These distinctions are overly simplified since the ego is viewed as a singular entity in its dealings with id and superego and the self is capable of fragmenting into its component nuclei. Nevertheless, the general distinction seems applicable, an ego model better describes intrapersonal conflict and a self model better describes interpersonal breakdowns.

CONCEPTUALIZING THE PRIMARY TRAUMA AND ITS SEQUELAE

The primary trauma consists of some event(s) which precipitates such an overwhelming affective state that the individual is not capable of assimilating the entirety of the emotional experience at the time of the event (Furst, 1967; Solnit and Kris, 1967; DeFazio, 1984). The individual perceives himself as needing to maintain immediate functioning and, consequently, the ego employs various mechanisms to stifle the paralyzing reaction to the traumatic stimulus. This is the beginning of psychic numbing as the ego struggles to maintain reasonable reality testing (perception and judgment) and capacities for action while isolating and containing the spontaneous emotional response.

The Overwhelming Nature of the Traumatic Stimulus

Depending upon the severity of the situation (i.e., as it is perceived by the ego), certain areas of ego functioning may become repressed and unavailable to the conscious ego. This is particularly true when the individual is repeatedly exposed to traumatic stimuli, such as in the circumstances of war. The general contraction of ego functioning as a consequence of exposure to war trauma has been identified by numerous authors (Kardiner, 1941; Lipkin *et al.*, 1982; DeFazio, 1984). Areas of ego functioning which are affected lie primarily in the capacity to spontaneously experience various emotions but may also include memory and other cognitive functions which are linked to the experience of emotion.

Reexperiencing the Trauma

Once the individual is beyond the traumatic situation, the ego attempts to recover the inaccesible functions through recalling and assimilating the traumatic material. However, other aspects of the ego resist the recollection of this material because the reexperience of the affect-laden memories continues to threaten ego functioning through the creation of an overwhelming, disorganizing affective state. The ego is thus in conflict with itself. The growth mechanisms attempt to bring the traumatic material into consciousness so that it may be assimilated and allow the ego to reachieve integration. The defense mechanisms attempt to suppress and avoid the traumatic material in order to protect the ego from disorganization. The result is that recollections of the trauma periodically intrude on consciousness and symptoms created by ego defenses intensify when the individual is exposed to stimuli that remind him of the traumatic material.

Containing the Traumatic Material

The ego's efforts to contain the traumatic material have been described as providing a "trauma membrane" (Lindy, 1985). The trauma membrane refers to the constellation of defense mechanisms and associated behaviors which surround the trauma-related affects and cognitions and prevent their emergence into consciousness. Symptoms such as psychic numbing, drug and alcohol abuse, hyperalertness, and avoidance of trauma related stimuli are part of the trauma membrane. Thus, many of the symptoms that accompany the PTSD syndrome are manifestations of the ego's efforts to avoid the overwhelming traumatic memories. The construction of the trauma membrane serves to separate further the conscious ego from the traumatic affect. The traumatic affect becomes encapsulated and virtually autonomous from conscious ego processes. Jung (1928) discussed the autonomous nature of traumatic affect, noting that it is often represented in dreams as a wild and dangerous animal.

TREATING THE PRIMARY TRAUMA

Treatment of the primary trauma entails aiding the growth mechanisms of the ego in their effort to bring the traumatic material into consciousness and assimilate it. In order to accomplish this, the therapist must be allowed to penetrate the trauma membrane and lend the individual auxiliary ego support (Lindy *et al.*, 1988). Lindy refers to the therapist-patient unit as providing a "temporary, cohesive self" that is capable of managing greater doses of trauma than the patient alone. For purposes of theoretical clarity in the present paper, the concept of the therapist lending auxiliary ego has been used instead so that the concept of self cohesion can be reserved for the discussion of the secondary trauma.

The objective of the therapist is to form a strong therapeutic alliance with the individual and then encourage exploration of the traumatic material. Concomitantly, the therapist must evaluate and respect the individual's level of tolerance for experiencing the disorganizing affects. If a strong alliance is formed, the individual will be more willing and more able to probe the traumatic material. But the therapist must continue to be aware of the patient's limits for reexperiencing the traumatic affects and should be prepared to help the patient pull away and reconstitute if the experience becomes too disorganizing.

Assimilating the Traumatic Material

The assimilation process itself involves a thorough examination of the traumatic material and its impact upon the individual. In addition to recovering access to the buried memories, the trauma survivor must have an opportunity to process the material and give it meaning. Figley (1983) has identified five steps in the self-examination process whereby the individual considers what happened, why it happened to him, why he behaved as he did at the time, how he has changed as a result of what happened, and what he will do if it happens again. In order for the traumatic material to become completely assimilated into the individual's personality, the cognitive process of self-examination must be accompanied by an emotional process of mourning the losses associated with the trauma (Catherall, 1986).

THE THERAPEUTIC RELATIONSHIP

The assimilation of the traumatic material can only take place in an environment in which the individual feels safe and supported. The quality of the therapeutic or working alliance is thus a key factor in the successful treatment of trauma survivors. In his discussion of the working alliance, Greenson (1965) distinguished between the experiencing and observing functions of the ego. He suggested that it is with the observing ego that the therapist allies. As treatment progresses, the patient's observing ego grows through identification with the observing function of the therapist, thus bringing the patient greater control over those aspects of his ego that are absorbed in immediate experience.

The distinction between observing and experiencing egos is similar to the distinction being drawn between the forces oriented toward ego integration and those forces whose purpose is defense against disintegration. While the observing ego measures and interprets an event (or its memory) and its concomitant affects, the experiencing ego becomes involved in the event and enmeshed in reexperiencing the event. It is the experiencing ego that is vulnerable to the disintegrating effects of the overwhelming traumatic affects. The therapist of the trauma survivor must ally with those aspects of the patient's ego which are oriented toward assimilating (via reexamination) the traumatic material and achieving personality integration. The forces oriented toward assimilation and eventual integration are more available in the form of the patient's observing ego, as the experiencing ego continues to fear disintegration. As the therapeutic relationship grows and the trauma survivor's observing ego feels connected to and strengthened by the therapist's ego, then the experiencing ego becomes less subject to being disorganized by the traumatic affects and more able to examine and experience the traumatic material.

It should be emphasized that the quality of the therapeutic connection with the patient's experiencing ego is also vital, particularly during examination of the traumatic material. If the therapist finds that his own ego processes are shying away from the patient's traumatic material, perhaps through distancing maneuvers such as daydreaming, then the therapist should not

pursue further exploration until coming to terms with his own resistance to the material (Haley, 1978). Trauma survivors are very sensitive to the feeling of being connected to the therapist because of their longstanding experience of having others distance from their affect laden presentations (Catherall, 1986). If the therapist becomes inattentive and does not appear to be closely following the patient's material – as seen in the nonverbal expressions of understanding which the effective listener manifests as he tracks the speaker – then the patient is likely to perceive it. It would be preferable to have a superficial session than for the patient to probe deeply into his traumatic memories and suddenly feel abandoned by the therapist. This would reinforce the patient's belief that the traumatic material is too overwhelming to be experienced and embed him further in his maintenance of the trauma membrane.

RESPECTING INDIVIDUAL TOLERANCE FOR EGO DISRUPTION

In addition to a strong alliance and a personal ability to experience the traumatic material, the therapist must have a keen sensitivity to the strength of the patient's ego functioning. The therapist encourages the patient to explore the traumatic memories and related material, but the therapist must be able to recognize when the patient is in real danger of being overwhelmed. It is the therapist's responsibility to know when the patient is at his limit and, if necessary, needs the therapist's help in backing away from overwhelming material. The therapist can help the patient dissociate from the experiencing ego state by making comments and asking questions which reengage the patient's observing ego, e.g., "Why do you think you behaved as you did?" as opposed to "What are you feeling now?" The therapist must monitor the patient's pacing through the course of the session and see to it that the session ends with the patient's ego functioning once more intact. This may entail a wind-down period at the end of the session and/or therapist flexibility in regard to session length.

CONCEPTUALIZING THE SECONDARY TRAUMA

The secondary trauma refers to the breakdown that occurs in the trauma survivor's relationship with his social world. Symptoms of this damaged relationship are seen in the individual's social withdrawal, lack of pleasure in previously pleasurable activities, feelings of alienation, identity diffusion, lowered self-esteem, and interpersonal difficulties (particularly problems with intimacy and authority). These symptoms all relate to an individual's view

of himself and how he fits into his social environment. Every individual has some conception of himself and of the community to which he belongs. Both his self-image and his self-esteem are influenced by his perception of community standards and his personal standing in the community. Trauma survivors who develop PTSD often perceive themselves as less valued by the community and experience a reduced feeling of belonging.

Failures in the Self-Selfobject Relationship

Kohut has suggested the concept of self cohesion as measure of self functioning (1971; Kohut and Wolf, 1978). A cohesive self has the necessary internal structure to enable the individual to provide himself with feelings of worth and self-esteem, and to be able to withstand life's inevitable assaults on self-esteem, which Kohut refers to as narcissistic injuries. Individuals with noncohesive selves are vulnerable to narcissistic injuries and react by becoming enfeebled, temporarily dysfunctional, or disproportionally outraged (Kohut and Wolf, 1978; Kohut, 1972). The internal structure that underlies a cohesive self is acquired through relationships in early life, primarily with parental figures. These people serve an important function in helping the developing child defend against the debilitating effects of narcissistic injuries. Kohut terms these individuals as selfobjects, as opposed to simply objects. Whereas the objects of traditional Freudian theory are the targets of the child's instinctual drives, Kohut's selfobjects are experienced as admiring, approving, idealized aspects of the child's self. The child is thought to merge his internal representations of himself and the selfobject; he does not distinguish the attitudes of the selfobject from his own attitudes about himself.

Noncohesive selves are generally viewed as the result of early failures in parenting, particularly in the relationship between the child's self and the child's experience of the parent as a selfobject (the self-selfobject relationship). The failure is usually localized in the mirroring process, in effect, a failure of the parent figure to respond to the child's unique needs empathically. The child then proceeds through life in search of relationships that provide him with the opportunity to be merged with figures who offer admiration or who can be idealized. The individual with a defective self thus continues to seek self-selfobject relationships in order to maintain self cohesion and avoid states of fragmentation, weakness, or disharmony.

Maturity does not constitute a total relinquishment of self-selfobject relationships; rather, it is seen as a refinement in the use of these relationships. The individual with a healthy self moves beyond the use of merger in his contacts with selfobjects and is sustained through a non-merger mode of contact which Kohut terms "empathic resonance" (1984). The individual

feels empathically understood and accepted while still maintaining a separateness between the internal representations of self and selfobject. At this level of contact, the individual is able to maintain self cohesion through relating to a broad selfobject milieu, including family, friends, work situations, and the cultural resources of the group to which he belongs.

The Impact of Trauma upon a Healthy Self

Kohut focuses his work on the empathic failures of childhood, contending that a healthy adult self is not prone to become fragmented, weakened, or disharmonious. However, he acknowledges one possible exception, "as an outcome of the most severe forms of traumatization such as prolonged confinement in concentration camps and other protracted dehumanizing experiences" (1984, p. 70). The vast and well-documented dehumanizing experiences of the Vietnam veterans (Figley, 1978; Lipkin *et al.*, 1982; Keane and Fairbank, 1983) confirms that many of them experienced such a trauma. Hence, many of these individuals may have achieved levels of mature self cohesion only to have their functioning reversed by events experienced in adulthood. Additionally, most Vietnam veterans were still in their late adolescence at the time of their exposure to the trauma and were probably still in the process of solidifying their identity (Erikson, 1968) and refining their use of a mature selfobject milieu.

Kohut notes that the "cultural selfobjects" of adults consists of "the writers, artists, and political leaders of the group—the nation, for example—to which a person feels he belongs" (1984, p. 220). Hence, the loss of a sense of belonging to the country and disenchantment with government manifested by so many Vietnam veterans might be seen as a failure in the self-selfobject relationship between the veteran and his country. And the loss of that particular self-selfobject relationship could have devastating implications for the individual veteran's self cohesion. This is expecially true when one considers the importance of the concept of country in giving meaning and approval to the actions required in wartime. The abrupt fragmentation of ideals normally modified over protracted life experience can have a traumatic effect on the individual's sense of self.

Breakdown between Self and Cultural Selfobject

An example of the importance of the self-selfobject relationship between the warrior and his country is the case of the soldier being held by enemy powers, the POW (prisoner of war). The captor's attempts to psychologically break down the POW depend upon being able to convince him

that his country has abandoned him and no longer cares about his welfare. The POW, on the other hand, is able to resist the efforts to break him down (fragment his self cohesion) by clinging to his belief that he is not forgotten, that he still belongs, and that his country still values and cares about him.

Even in the absence of representatives of his country, the POW is able to endure the psychological torture of the enemy as long as he experiences a positive self-selfobject relationship within his own intrapsychic world. If, however, he encounters events that cause him to lose his sense of a reciprocal feeling on the part of the selfobject (his country), then he can lose his inner faith and become vulnerable to the mind-altering manipulations of the enemy. The war veteran's perception that he is valued by his country is a major factor in the veteran's efforts to cope with the trauma he endured during his war experience (Egendorf, 1982). Just as with the POW, the veteran's internal sense of belonging contributes to his ability to maintain self cohesion in the midst of exposure to extreme stressors.

Application to Other Traumatized Populations

The importance of the self-selfobject relationship between an individual and his country has been discussed in order to accent its role in PTSD among Vietnam veterans. However, this phenomenon applies to any trauma survivor who encounters a nonempathic response by cultural selfobjects. Traumatized populations which fit this category include crime victims, AIDS victims and other traumatized groups who receive blame instead of sympathy.

A breakdown can occur in any instance in which a trauma victim experiences an inadequate response by significant others, whether they be a cultural selfobject or an individual who has a more personal selfobject relationship with the victim. For example, the rape victim whose husband no longer sees her as a sexually desirable partner has suffered a breakdown in a very important self-selfobject relationship. Similarly, the rape victim who is pictured as inviting the rape (by the perpetrator's defense attorney) may suffer a breakdown in an important self-selfobject relationship with the community if she feels the jury holds her responsible for getting raped. The result of such breakdowns is that the trauma victim has a decreased availability of social mechanisms to employ in the process of dealing with the primary trauma and is thus at greater risk of developing PTSD (Dermatis and Kadushin, 1986).

TREATING THE SECONDARY TRAUMA

The treatment of the primary trauma was conceptualized in terms of aiding the natural growth mechanisms of the ego in its efforts to assimilate

the traumatic material. Similarly, the treatment of the secondary trauma involves aiding the natural growth mechanisms of the self in its efforts to reestablish harmony and self cohesion. This is accomplished by engaging in a self-selfobject relationship that will allow the trauma survivor to establish self-esteem and reengage in the developmental process that leads from contacts based upon merger to mature contacts based upon empathic resonance.

The clinician must bear in mind that all levels of relations between the self and others ultimately center upon individuals. The notion of a relationship between the self and the country is built upon relations between the self and individuals who are seen as representing the country. These individuals include both those involved in bilateral relationships, such as parents, teachers, neighbors, etc., and unilateral relationships, such as those manifested with media figures, political figures, sports figures, etc. In unilateral relationships, the individual self has no direct opportunity to influence the figures but can nevertheless be influenced by them. For many members of the Vietnam generation, President John Kennedy was a significant cultural selfobject. His 1960 inaugural dictum to "Ask not what your country can do for you. Ask what you can do for your country." has been reported by many Vietnam veterans to be the singlemost memorable sentence of their lives (MacPherson, 1984). These young people were able to survive the stresses of war in part because they felt valued, supported, and approved of by Kennedy and the country he represented.

The Therapeutic Relationship

The recovery of more mature self-selfobject relations will begin in the individual relationship with the therapist if the therapist provides the trauma survivor with the experience of being understood, valued, and cared about. The treatment of the traumatized self is similar to the treatment of the self disordered by failures in early childhood. The main differences is that the adult trauma survivor may have achieved more mature levels of relating to selfobjects but has regressed as a result of the trauma. DeFazio (1984) emphasizes that regression is a key factor in all traumatic situations. The goal of treating the disordered self of the trauma survivor is to overcome the regressive influence of the trauma and reachieve the levels of self cohesion that the individual maintained prior to the trauma. If the individual had premorbid defects in the self, then treatment may need to continue beyond premorbid levels.

The treatment of the trauma survivor's self is centered upon the therapist's empathy. The therapist must strive to understand and demonstrate his appreciation of what it is like to be in the patient's shoes. When the patient feels that the therapist truly understands his sense of alienation, then he is

no longer alienated. If the therapist suggests that the patient is not really so alienated, that he should try and look at things differently, that others really do care, etc., then the therapist is not being empathic to the patient's experience and the patient's self can not feel adequately understood. The therapist must strive to understand rather than to change the patient. It is only when the patient feels understood, valued, and cared about that the patient's self can grow.

The Role of the Empathic Failure

The therapist's job is to understand the patient's experience, yet all therapists inevitably misunderstand and behave in ways that reflect a lack of empathy for the patient. Kohut gives these empathic failures a prominent role in the treatment of the self. He contends that such therapeutic failures precipitate a temporary turning back from the patient's reliance on empathy to a remobilization of the need for merger with the selfobject. However, in a properly conducted treatment, this regression is always followed by the reestablishment of an empathic connection. Kohut refers to this process as "optimal frustrations" and contends it leads to the formation of self structure via a process he terms "transmuting internalization" (1971). The patient's self has the experience of repetitively moving from contact based upon merger to contact based upon empathic resonance.

The reason that the patient is able to recover from the therapist's empathic failures is that the therapist takes responsibility for his mistakes. This allows the patient to once again feel understood, valued, and cared about. Hence, it is vital that the therapist recognize his empathic errors and accept responsibility for them nondefensively and without blaming the patient. Sometimes the therapist will see his mistake and be able to bring it up on his own. More often, the therapist does not immediately see his mistake and needs the patient's help in learning what he has done wrong. Usually, the therapist's main clue that an empathic failure has occurred is when he senses a withdrawal by the patient. Hence, the therapist must stay sensitive to any withdrawal by the patient. Once a withdrawal is recognized, the primary concern of the therapy is to discover where the therapist failed and to take responsibility for it. No other progress will be made until this event is resolved.

The Establishment of Mature Self-Selfobject Relations

Successful individual treatment of a traumatized self will be manifested in life contexts beyond the therapy relationship. As the patient's self is strengthened, he should begin to establish empathic contact with mature selfobjects in other areas of his life. This process is reflected in the trauma sur-

vivor's sense of belonging to societal groups. Many trauma survivors overcome their total alienation and make contact with other survivors but continue to feel an outsider in most societal contexts. They join formal groups such as Vietnow and Vietnam Veterans of America or informal groups such as those gathered at MIA-POW rallies but they still experience themselves as alienated from mainstream society. The treatment of the self should continue, if possible, until the patient has achieved a level of integration into society that is equal to or greater than premorbid levels.

AN INTEGRATED TREATMENT APPROACH

The model of treatment being advocated in this paper goes beyond either an ego psychology or self psychology approach alone because it attends to the two central aspects of personality reintegration following a trauma: (1) reintegration of the trauma survivor's ego and ability to cope with disturbing affective states and (2) reintegration of the trauma survivor's sense of self and involvement with his social world. The model recognizes both of these factors as necessary to the total reintegration of the personality. In order to apply both ego and self psychology approaches, the clinician needs tools for determining when to employ which approach. The main tool offered by the model is the distinction between primary and secondary trauma. Once the clinician identifies which trauma is currently most operative, he will be able to choose the appropriate approach.

The author's experience is that one or the other of the trauma will be predominant in the patient's material in any given session. This is probably due to the patient's recent experiences prior to the session, i.e., exposure to stimuli reminding the patient of either the primary or secondary trauma. From the moment the patient enters the room, the clinician should be paying attention to the patient's concerns, whether expressed directly or metaphorically. Eventually, the clinician will be able to decide whether the patient is dealing with an ego conflict or a disruption in self cohesion. The next two paragraphs pose some questions the clinician can consider in order to make this distinction.

Indications of an Ego Conflict

Is the patient talking about the primary trauma or about sensory or interpersonal stimuli that are reminders of the primary trauma? Is the patient struggling to control affects that were surfaced by stimuli that are reminiscent of the primary trauma? Is the patient reporting impairments in ego functioning or expressing concern about his ability to cope with his daily

life? Is the patient primarily concerned with symptoms that are associated with the primary trauma (e.g., flashbacks, emotional numbing, intrusive memories, etc.)? Affirmative answers to any of these questions lead us to look in the direction of ego conflicts.

Indications of a Disruption in Self-Cohesion

Is the patient complaining of not being understood? Is the patient complaining about the superficial lives of others or otherwise describing feelings of alienation from others? Is the patient describing interpersonal problems, particularly in his current life? Is the patient struggling with fluctuations in self-esteem? Is the patient struggling to control feelings of rage or bitterness? Does the patient show a lack of awareness for the feelings of others; does he convey an attitude that he is entirely alone in feeling miserable? Affirmative answers to any of these questions lead us toward a self psychology perspective.

Determining the Relevant Issue

The foregoing questions are offered as aids in helping the clinician determine the essential nature of the patient's current struggle. The questions are not intended to describe the exclusive territorial boundaries of ego and self. They are meant to draw the clinician's attention to possible areas of concern. There is, of course, a grey area of overlap in which concerns of both ego integrity and self cohesion are liable to be manifest. It is the author's assertion that one or the other of these two concerns will eventually rise to the surface and dominate the patient's current psychic struggle. Often, concerns relating to the patient's struggle to control the effects of the primary trauma lead the patient to associate to the secondary trauma. This happens as the patient's focus on the primary trauma reminds him of the difference between himself and his current social environment and of the ways in which he feels his current social environment is failing him.

One common example of overlap between the struggles for ego integrity and self cohesion is found in the withdrawn patient. The behavioral manifestations of the withdrawn trauma survivor may reflect the increased interpersonal distance of a disabled self or simply the emotional numbing of a traumatized ego. Indeed, similar behaviors in an individual may be manifested for different reasons at different times. The only way the clinician can know which concern is paramount at the moment is to examine the content of the patient's material and wait for a revealing theme to emerge. Each time the behavior is exhibited, the clinician needs to reevaluate the source

and determine whether the behavior stems from ego conflicts or defenses or from a breakdown in self-functioning.

Choosing Interventions

Once the clinician has decided which trauma is currently dominating the patient's experience, it is possible to select interventions that are consistent with either an ego or self psychology model. If the patient is dealing with the primary trauma, then the clinician seeks to provide auxiliary ego support while encouraging exploration of the traumatic memories and a process of self-examination and mourning. The clinician may be required to actively encourage the patient to delve into painful and undesirable aspects of his blocked experience and to interpret the ways in which the patient defends against experiencing fearful affects. If the patient is dealing with the secondary trauma, then the clinician focuses his efforts on being an empathic self-object. The clinician's primary concern is whether the patient is currently feeling understood and accepted by the clinician and the clinician must assume responsibility for his failures to be empathic.

The following paragraphs offer two more means of differentiating between ego psychological and self psychological interventions into the two traumas. The distinctions drawn are overly simplified and exceptions can be found but the contrasted interventions may help guide the clinician.

"Part of You" Interpretations

Patients and therapists frequently speak in terms of the patient's "parts." We are usually describing a conflict when we speak in this manner, e.g., "Part of you would like to recall the trauma and part of you is scared to death of recalling it." Speaking about different parts of the patient is a way of describing ego conflict and helping the individual integrate opposed needs. Contrariwise, we tend to speak directly to the "whole" self when we are relating to the patient's feelings of alienation. Their experience is that they are not understood, not that a part of them is not understood. Speaking directly to this individual who feels alone and different is a means of relating to the patient's self. In effect, we are serving as a selfobject by understanding and perceiving the patient's self and the result is increased cohesion of the self.

Thus, the focus of our intervention—the patient's whole self or the parts—determines which aspect of the patient's experience we are strengthening. Focusing on the parts (in conflict with one another) strengthens ego integration, focusing on the individual (vis-a-vis other individuals) strengthens self cohesion.

Two Kinds of Understanding

The quality of the therapist's understanding can be viewed differently according to the two models. The ego psychology model focuses on the nature of the survivor's conflicts. The therapist's task is to help the patient understand himself better. The self psychology model focuses on the trauma survivor's experience of feeling different. The therapist's task is to convey his understanding of what it is like to be the patient, thereby eroding the patient's experience of alienation. Thus, it can be said that treatment of the two traumas involves two kinds of understanding. The therapeutic goal in the treatment of the primary trauma is to help the patient understand himself better. The therapeutic goal in the treatment of the secondary trauma is to help the patient feel understood by someone else.

SUMMARY

This paper has offered an integrated model for understanding the psychic struggles of the trauma survivor and choosing appropriate interventions. The two models recommended for primary and secondary trauma have both been advanced in the literature on the treatment of Vietnam veterans. The ego psychology model has been well described by Lindy (1985, 1986, Lindy *et al.,* 1988) and a self-psychology model has been adavanced by Parson (1984). The separate trauma of the initial experience and the subsequent social reaction have also been described in the literature, notably by Symonds (1980) who referred to the secondary trauma as the "second wound." In the current paper, the author has attempted to devise a model of treatment for trauma survivors which differentiates between ego conflicts and disruptions in self cohesion and prescribes which theoretical orientation should guide the clinician at any given moment in treatment.

ACKNOWLEDGMENTS

The author wishes to gratefully acknowledge the contributions of Christopher Lane, M.S.W., Robert Shelton, Ph.D. and Betsy Tolstedt, Ph.D., for their very helpful reviews of the manuscript. The notion of separate traumas evolved from a discussion with Dr. Tolstedt.

REFERENCES

Catherall, D. R. (1986). The support system and amelioration of PTSD in Vietnam veterans. *Psychotherapy* 23(3): 472-482.

DeFazio, V. J. (1984). Psychoanalytic psychotherapy and the Vietnam veteran. In Schwartz, H. J. (ed.), *Psychotherapy of the Combat Veteran,* Spectrum Publications, New York.
Dermatis, H., and Kadushin, C. (1986). Is the Vietnam generation politically alienated? In Boulanger, G., and Kadushin, C. (eds.), *The Vietnam Veteran Redefined: Fact and Fiction,* Lawrence Erlbaum Associates, Hillsdale, N.J.
Egendorf, A. (1982). The postwar healing of Vietnam veterans: Recent research. *J. Hosp. Commun. Psychiat.* 33(11): 901-908.
Erikson, E. H. (1968). *Identity, Youth and Crisis,* Norton, New York.
Figley, C. R. (1978). *Stress Disorders among Vietnam Veterans,* Brunner/Mazel, New York.
Figley, C. R. (1983). Catastrophes: An overview of family reactions. In Figley, C. R., and McCubbin, H. I. (eds.), *Stress and the family, Volume II: Coping with Catastrophe,* Brunner/Mazel, New York.
Furst, S. (ed.) (1967). *Psychic Trauma,* Basic Books, New York.
Greenson, R. R. (1965). The working alliance and the transference neurosis. *Psychoanal. Quart.* 34: 155-181.
Haley, S. A. (1978). Treatment implications of post-combat stress response syndromes for mental health professionals. In Figley, C. (ed.), *Stress Disorders among Vietnam Veterans,* Brunner/Mazel, New York.
Jung, C. G. (1928). *Contributions to Analytical Psychology,* Routledge and Kagen Paul, London.
Kardiner, A. (1941). *The Traumatic Neurosis of War,* Hoeber, New York.
Keane, T., and Fairbank, J. (1983). Survey analysis of combat-related stress disorders in Vietnam veterans. *A. J. Psychiat.* 140: 348-350.
Kohut, H. (1971). *The Analysis of the Self,* International Universities Press, New York.
Kohut, H. (1972). Thoughts on narcissism and narcissistic rage. *The Psychoanalytic Study of the Child, Vol. 27,* Quadrangle, New York, pp. 360-400.
Kohut, H. (1977). *The Restoration of the Self,* International Universities Press, New York.
Kohut, H. (1984). *How Does Analysis Cure,* The University of Chicago Press, Chicago.
Kohut, H., and Wolf, E. (1978). The disorders of the self and their treatment: An outline. *Int. J. Psychoanal.* 59: 413-425.
Lifton, R. J. (1973). *Home from the War,* Simon and Schuster, New York.
Lindy, J. D. (1985). The trauma membrane and other clinical concepts derived from psychotherapeutic work with survivors of natural disasters. *Psychiat. Annu.* 15(3): 153-160.
Lindy, J. D. (1986). An outline for the psychoanalytic psychotherapy of post traumatic stress disorder. In Figley C. R. (ed.), *Trauma and Its Wake II: Traumatic Stress Theory, Research, and Intervention,* Brunner/Mazel, New York.
Lindy, J. D., Green, B. L., Grace, M. C., MacLeod, J. A., and Spitz, L. (1988). *Vietnam: A Casebook,* Brunner/Mazel, New York.
Lipkin, J. O., Parson, E. R., Blank, A. S., and Smith, J. (1982). Vietnam veterans and post-traumatic stress disorder. *Hosp. Commun. Psychiat.* 33: 908-912.
MacPherson, M. (1984). *Long Time Passing: Vietnam and the Haunted Generation,* New American Library, New York.
Moses, R., and Cohen, I. (1984). Understanding and treatment of combat neurosis: The Israeli experience. In Schwartz H. J. (ed.), *Psychotherapy of the Combat Veteran,* Spectrum Publications, New York.
Parson, E. R. (1984). The reparation of the self: Clinical and theoretical dimensions in the treatment of Vietnam combat veterans. *J. Contem. Psychother.* 14(1): 4-56.
Polner, M. (1971). *No Victory Parades,* Holt, Rinehart and Winston, New York.
Shapiro, R. B. (1984). Transference, countertransference, and the Vietnam veteran. In Schwartz, H. J. (ed.), *Psychotherapy of the Combat Veteran,* Spectrum Publications, New York.
Solnit, A. J., and Kris, M. (1967). Trauma and infantile experiences. In Furst, S. (ed.), *Psychic Trauma,* Basic Books, New York.
Symonds, M. (1980). The "second injury" to victims. *Evaluation and Change,* Special Issue, 36-38.