TRAUMA AND RECOVERY

Judith Lewis Herman, M.D.

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Herman, Chapter 2

chronic arousal of the autonomic nervous system. He also interpreted the irritability and explosively aggressive behavior of traumatized men as disorganized fragments of a shattered "fight or flight" response to overwhelming danger.

Similarly, Roy Grinker and John Spiegel observed that traumatized soldiers of the Second World War "seem to suffer from chronic stimulation of the sympathetic nervous system.... The emergency psychological reactions of anxiety and physiological preparedness . . . have overlapped and become not episodic, but almost continuous. . . . Eventually the soldier is removed from the environment of stress and after a time his subjective anxiety recedes. But the physiological phenomena persist and are now maladaptive to a life of safety and security."[9]

After the Vietnam War, researchers were able to confirm these hypotheses, documenting alterations in the physiology of the sympathetic nervous system in traumatized men. The psychiatrist Lawrence Kolb, for example, played tapes of combat sounds to Vietnam veterans. The men with post-traumatic stress disorder showed increased heart rate and blood pressure when the tapes were played. Many became so distraught that they asked to discontinue the experiment. Veterans without the disorder and those who had not experienced combat were able to listen to the combat tapes without emotional distress and without significant physiological responses.[10]

A wide array of similar studies has now shown that the psychophysiological changes of post-traumatic stress disorder are both extensive and enduring. Patients suffer from a combination of generalized anxiety symptoms and specific fears.[11] They do not have a normal "baseline" level of alert but relaxed attention. Instead, they have an elevated baseline of arousal: their bodies are always on the alert for danger. They also have an extreme startle response to unexpected stimuli, as well as an intense reaction to specific stimuli associated with the traumatic event.[12] It also appears that traumatized people cannot "tune out" repetitive stimuli that other people would find merely annoying; rather, they respond to each repetition as though it were a new, and dangerous, surprise.[13] The increase in arousal persists during sleep as well as in the waking state, resulting in numerous types of sleep disturbance. People with post-traumatic stress disorder take longer to fall asleep, are more sensitive to noise, and awaken more frequently during the night than ordinary people. Thus traumatic events appear to recondition the human nervous system.[14]

INTRUSION

Long after the danger is past, traumatized people relive the event as though it were continually recurring in the present. They cannot resume the normal course of their lives, for the trauma repeatedly interrupts. It is as if time stops at the moment of trauma. The traumatic moment becomes encoded in an abnormal form of memory, which breaks spontaneously into consciousness, both as flashbacks during waking states and as traumatic nightmares during sleep. Small, seemingly insignificant reminders can also evoke these memories, which often return with all the vividness and emotional force of the original event. Thus, even normally safe environments may come to feel dangerous, for the survivor can never be assured that she will not encounter some reminder of the trauma.

Trauma arrests the course of normal development by its repetitive intrusion into the survivor's life. Janet described his hysterical patients as dominated by an "idée fixe." Freud, struggling to come to grips with the massive evidence of combat neuroses after the First World War, remarked, "The patient is, one might say, fixated to the trauma.... This astonishes us far too little."[15] Kardiner described "fixation on the trauma" as one of the essential features of the combat neurosis. Noting that traumatic nightmares can recur unmodified for years on end, he described the perseverative dream as "one of the most characteristic and at the same time one of the most enigmatic phenomena we encounter in the disease."[16]

Traumatic memories have a number of unusual qualities. They are not encoded like the ordinary memories of adults in a verbal, linear narrative that is assimilated into an ongoing life story. Janet explained the difference:

> [Normal memory,] like all psychological phenomena, is an action; essentially it is the action of telling a story. . . . A situation has not been satisfactorily liquidated . . . until we have achieved, not merely an outward reaction through our movements, but also an inward reaction through the words we address to ourselves, through the organization of the recital of the event to others and to ourselves, and through the putting of this recital in its place as one of the chapters in our personal history. . . . Strictly speaking, then, one who retains a fixed idea of a happening cannot be said to have a "memory" . . . it is only for convenience that we speak of it as a "traumatic memory."[17]

The frozen and wordless quality of traumatic memories is captured in Doris Lessing's portrait of her father, a First World War combat veteran

who considered himself fortunate to have lost only a leg, while the rest of his company lost their lives, in the trenches at Passchendaele: "His childhood and young man's memories, kept fluid, were added to, grew, as living memories do. But his war memories were congealed in stories that he told again and again, with the same words and gestures, in stereotyped phrases. . . . This dark region in him, fate-ruled, where nothing was true but horror, was expressed inarticulately, in brief, bitter exclamations of rage, incredulity, betrayal."[18]

Traumatic memories lack verbal narrative and context; rather, they are encoded in the form of vivid sensations and images.[19] Robert Jay Lifton, who studied survivors of Hiroshima, civilian disasters, and combat, describes the traumatic memory as an "indelible image" or "death imprint."[20] Often one particular set of images crystallizes the experience, in what Lifton calls the "ultimate horror." The intense focus on fragmentary sensation, on image without context, gives the traumatic memory a heightened reality. Tim O'Brien, a combat veteran of the Vietnam War, describes such a traumatic memory: "I remember the white bone of an arm. I remember the pieces of skin and something wet and yellow that must've been the intestines. The gore was horrible, and stays with me. But what wakes me up twenty years later is Dave Jensen singing 'Lemon Tree' as we threw down the parts."[21]

In their predominance of imagery and bodily sensation, and in their absence of verbal narrative, traumatic memories resemble the memories of young children.[22] Studies of children, in fact, offer some of the clearest examples of traumatic memory. Among 20 children with documented histories of early trauma, the psychiatrist Lenore Terr found that none of the children could give a verbal description of the events that had occurred before they were two and one-half years old. Nonetheless, these experiences were indelibly encoded in memory. Eighteen of the 20 children showed evidence of traumatic memory in their behavior and their play. They had specific fears related to the traumatic events, and they were able to reenact these events in their play with extraordinary accuracy. For example, a child who had been sexually molested by a babysitter in the first two years of life could not, at age five, remember or name the babysitter. Furthermore, he denied any knowledge or memory of being abused. But in his play he enacted scenes that exactly replicated a pornographic movie made by the babysitter.[23] This highly visual and enactive form of memory, appropriate to young children, seems to be mobilized in adults as well in circumstances of overwhelming terror.

These unusual features of traumatic memory may be based on alterations in the central nervous system. A wide array of animal experiments

show that when high levels of adrenaline and other stress hormones are circulating, memory traces are deeply imprinted.[24] The same traumatic engraving of memory may occur in human beings. The psychiatrist Bessel van der Kolk speculates that in states of high sympathetic nervous system arousal, the linguistic encoding of memory is inactivated, and the central nervous system reverts to the sensory and iconic forms of memory that predominate in early life.[25]

Just as traumatic memories are unlike ordinary memories, traumatic dreams are unlike ordinary dreams. In form, these dreams share many of the unusual features of the traumatic memories that occur in waking states. They often include fragments of the traumatic event in exact form, with little or no imaginative elaboration. Identical dreams often occur repeatedly. They are often experienced with terrifying immediacy, as if occurring in the present. Small, seemingly insignificant environmental stimuli occurring during these dreams can be perceived as signals of a hostile attack, arousing violent reactions. And traumatic nightmares can occur in stages of sleep in which people do not ordinarily dream.[26] Thus, in sleep as well as in waking life, traumatic memories appear to be based in an altered neurophysiological organization.

Traumatized people relive the moment of trauma not only in their thoughts and dreams but also in their actions. The reenactment of traumatic scenes is most apparent in the repetitive play of children. Terr differentiates between normal play and the "forbidden games" of children who have been traumatized: "The everyday play of childhood . . . is free and easy. It is bubbly and light-spirited, whereas the play that follows from trauma is grim and monotonous. . . . Play does not stop easily when it is traumatically inspired. And it may not change much over time. As opposed to ordinary child's play, post-traumatic play is obsessively repeated. . . . Post-traumatic play is so literal that if you spot it, you may be able to guess the trauma with few other clues."[27]

Adults as well as children often feel impelled to re-create the moment of terror, either in literal or in disguised form. Sometimes people reenact the traumatic moment with a fantasy of changing the outcome of the dangerous encounter. In their attempts to undo the traumatic moment, survivors may even put themselves at risk of further harm. Some reenactments are consciously chosen. The rape survivor Sohaila Abdulali describes her determination to return to the scene of the trauma:

> I've always hated feeling like something's got the better of me. When this thing happened, I was at such a vulnerable age—I was seventeen—I had to prove they weren't going to get me down. The guys who raped me told

> me, "If we ever find you out here alone again we're going to get you." And I believed them. So it's always a bit of a terror walking up that lane, because I'm always afraid I'll see them. In fact, no one I know would walk up that lane at night alone, because it's just not safe. People have been mugged, and there's no question that it's dangerous. Yet part of me feels that if I don't walk there, then they'll have gotten me. And so, even more than other people, I *will walk up that lane.*[28]

More commonly, traumatized people find themselves reenacting some aspect of the trauma scene in disguised form, without realizing what they are doing. The incest survivor Sharon Simone recounts how she became aware of a link between her dangerous risk-taking behavior and her childhood history of abuse:

> For a couple of months, I had been playing chicken on the highway with men, and finally I was involved in an auto accident. A male truck driver was trying to cut me off, and I said to myself in the crudest of language, there's no f——ing way you're going to push your penis into my lane. Like right out of the blue! Boom! Like that! That was really strange.
>
> I had not really been dealing with any of the incest issues. I knew vaguely there was something there and I knew I had to deal with it and I didn't want to. I just had a lot of anger at men. So I let this man smash into me and it was a humongous scene. I was really out of control when I got out of the car, just raging at this man. I didn't tell my therapist about it for about six weeks—I just filed it away. When I told I got confronted—it's very dangerous—so I made a contract that I would deal with my issues with men.[29]

Not all reenactments are dangerous. Some, in fact, are adaptive. Survivors may find a way to integrate reliving experiences into their lives in a contained, even socially useful manner. The combat veteran Ken Smith describes how he managed to re-create some aspects of his war experience in civilian life:

> I was in Vietnam 8 months, 11 days, 12 hours, and 45 minutes. These things you remember. I remember it exactly. I returned home a much different person from when I left. I went to work as a paramedic, and I found a considerable amount of self-satisfaction out of doing that work. It was almost like a continuance of what I had been doing in Vietnam, but on a much, much lower capacity. There was no gunshot trauma, there was no burn trauma, I wasn't seeing sucking chest wounds or amputations or shrapnel. I was seeing a lot of medical emergencies, a lot of diabetic emergencies, a lot of elderly people. Once in awhile there would be an auto accident, which would be the juice. I would turn on the sirens and know I'm going to something, and the adrenalin rush that would run through my body would fuel me for the next 100 calls.[30]

There is something uncanny about reenactments. Even when they are consciously chosen, they have a feeling of involuntariness. Even when they are not dangerous, they have a driven, tenacious quality. Freud named this recurrent intrusion of traumatic experience the "repetition compulsion." He first conceptualized it as an attempt to master the traumatic event. But this explanation did not satisfy him. It somehow failed to capture what he called the "daemonic" quality of reenactment. Because the repetition compulsion seemed to defy any conscious intent and to resist change so adamantly, Freud despaired of finding any adaptive, life-affirming explanation for it; rather, he was driven to invoke the concept of a "death instinct."[31]

Most theorists have rejected this Manichaean explanation, concurring with Freud's initial formulation. They speculate that the repetitive reliving of the traumatic experience must represent a spontaneous, unsuccessful attempt at healing. Janet spoke of the person's need to "assimilate" and "liquidate" traumatic experience, which, when accomplished, produces a feeling of "triumph." In his use of language, Janet implicitly recognized that helplessness constitutes the essential insult of trauma, and that restitution requires the restoration of a sense of efficacy and power. The traumatized person, he believed, "remains confronted by a difficult situation, one in which he has not been able to play a satisfactory part, one to which his adaptation has been imperfect, so that he continues to make efforts at adaptation."[32]

More recent theorists also conceptualize intrusion phenomena, including reenactments, as spontaneous attempts to integrate the traumatic event. The psychiatrist Mardi Horowitz postulates a "completion principle" which "summarizes the human mind's intrinsic ability to process new information in order to bring up to date the inner schemata of the self and the world." Trauma, by definition, shatters these "inner schemata." Horowitz suggests that unassimilated traumatic experiences are stored in a special kind of "active memory," which has an "intrinsic tendency to repeat the representation of contents." The trauma is resolved only when the survivor develops a new mental "schema" for understanding what has happened.[33]

The psychoanalyst Paul Russell conceptualizes the emotional rather than the cognitive experience of the trauma as the driving force of the repetition compulsion. What is reproduced is "what the person needs to

feel in order to repair the injury." He sees the repetition compulsion as an attempt to relive and master the overwhelming feelings of the traumatic moment.[34] The predominant unresolved feeling might be terror, helpless rage, or simply the undifferentiated "adrenaline rush" of mortal danger.

Reliving a trauma may offer an opportunity for mastery, but most survivors do not consciously seek or welcome the opportunity. Rather, they dread and fear it. Reliving a traumatic experience, whether in the form of intrusive memories, dreams, or actions, carries with it the emotional intensity of the original event. The survivor is continually buffeted by terror and rage. These emotions are qualitatively different from ordinary fear and anger. They are outside the range of ordinary emotional experience, and they overwhelm the ordinary capacity to bear feelings.

Because reliving a traumatic experience provokes such intense emotional distress, traumatized people go to great lengths to avoid it. The effort to ward off intrusive symptoms, though self-protective in intent, further aggravates the post-traumatic syndrome, for the attempt to avoid reliving the trauma too often results in a narrowing of consciousness, a withdrawal from engagement with others, and an impoverished life.

CONSTRICTION

When a person is completely powerless, and any form of resistance is futile, she may go into a state of surrender. The system of self-defense shuts down entirely. The helpless person escapes from her situation not by action in the real world but rather by altering her state of consciousness. Analogous states are observed in animals, who sometimes "freeze" when they are attacked. These are the responses of captured prey to predator or of a defeated contestant in battle. A rape survivor describes her experience of this state of surrender: "Did you ever see a rabbit stuck in the glare of your headlights when you were going down a road at night. Transfixed—like it knew it was going to get it—that's what happened."[35] In the words of another rape survivor, "I couldn't scream. I couldn't move. I was paralyzed . . . like a rag doll."[36]

These alterations of consciousness are at the heart of constriction or numbing, the third cardinal symptom of post-traumatic stress disorder. Sometimes situations of inescapable danger may evoke not only terror and rage but also, paradoxically, a state of detached calm, in which terror, rage, and pain dissolve. Events continue to register in awareness, but it

is as though these events have been disconnected from their ordinary meanings. Perceptions may be numbed or distorted, with partial anesthesia or the loss of particular sensations. Time sense may be altered, often with a sense of slow motion, and the experience may lose its quality of ordinary reality. The person may feel as though the event is not happening to her, as though she is observing from outside her body, or as though the whole experience is a bad dream from which she will shortly awaken. These perceptual changes combine with a feeling of indifference, emotional detachment, and profound passivity in which the person relinquishes all initiative and struggle. This altered state of consciousness might be regarded as one of nature's small mercies, a protection against unbearable pain. A rape survivor describes this detached state: "I left my body at that point. I was over next to the bed, watching this happen. . . . I dissociated from the helplessness. I was standing next to me and there was just this shell on the bed. . . . There was just a feeling of flatness. I was just there. When I repicture the room, I don't picture it from the bed. I picture it from the side of the bed. That's where I was watching from."[37] A combat veteran of the Second World War reports a similar experience: "Like most of the 4th, I was numb, in a state of virtual disassociation. There is a condition . . . which we called the two-thousand-year-stare. This was the anesthetized look, the wide, hollow eyes of a man who no longer cares. I wasn't to that state yet, but the numbness was total. I felt almost as if I hadn't actually been in a battle."[38]

These detached states of consciousness are similar to hypnotic trance states. They share the same features of surrender of voluntary action, suspension of initiative and critical judgment, subjective detachment or calm, enhanced perception of imagery, altered sensation, including numbness and analgesia, and distortion of reality, including depersonalization, derealization, and change in the sense of time.[39] While the heightened perceptions occurring during traumatic events resemble the phenomena of hypnotic absorption, the numbing symptoms resemble the complementary phenomena of hypnotic dissociation.[40]

Janet thought that his hysterical patients' capacity for trance states was evidence of psychopathology. More recent studies have demonstrated that although people vary in their ability to enter hypnotic states, trance is a normal property of human consciousness.[41] Traumatic events serve as powerful activators of the capacity for trance.[42] As the psychiatrist David Spiegel points out, "it would be surprising indeed if people did *not* spontaneously use this capacity to reduce their perception of pain during acute trauma."[43] But while people usually enter hypnotic states under

controlled circumstances and by choice, traumatic trance states occur in an uncontrolled manner, usually without conscious choice.

The biological factors underlying these altered states, both hypnotic trance and traumatic dissociation, remain an enigma. The psychologist Ernest Hilgard speculates that hypnosis "may be acting in a manner parallel to morphine."[44] The use of hypnosis as a substitute for opiates to produce analgesia has long been known. Both hypnosis and morphine produce a dissociative state in which the perception of pain and the normal emotional responses to pain are severed. Both hypnosis and opiates diminish the distress of intractable pain without abolishing the sensation itself. The psychiatrists Roger Pitman and van der Kolk, who have demonstrated persistent alterations in pain perception in combat veterans with post-traumatic stress disorder, suggest that trauma may produce long-lasting alterations in the regulation of endogenous opioids, which are natural substances having the same effects as opiates within the central nervous system.[45]

Traumatized people who cannot spontaneously dissociate may attempt to produce similar numbing effects by using alcohol or narcotics. Observing the behavior of soldiers in wartime, Grinker and Spiegel found that uncontrolled drinking increased proportionately to the combat group's losses; the soldiers' use of alcohol appeared to be an attempt to obliterate their growing sense of helplessness and terror.[46] It seems clear that traumatized people run a high risk of compounding their difficulties by developing dependence on alcohol or other drugs. The psychologist Josefina Card, in a study of Vietnam-era veterans and their civilian peers, demonstrated that men who developed post-traumatic stress disorder were far more likely to have engaged in heavy consumption of narcotics and street drugs, and to have received treatment for problems with alcohol or drug abuse after their return from the war.[47] In another study of 100 combat veterans with severe post-traumatic stress disorder, Herbert Hendin and Ann Haas noted that 85 percent developed serious drug and alcohol problems after their return to civilian life. Only 7 percent had used alcohol heavily before they went to war. The men used alcohol and narcotics to try to control their hyperarousal and intrusive symptoms—insomnia, nightmares, irritability, and rage outbursts. Their drug abuse, however, ultimately compounded their difficulties and further alienated them from others.[48] The largest and most comprehensive investigation of all, the National Vietnam Veterans Readjustment Study, reported almost identical findings: 75 percent of men with the disorder developed problems with alcohol abuse or dependence.[49]

Although dissociative alterations in consciousness, or even intoxication, may be adaptive at the moment of total helplessness, they become maladaptive once the danger is past. Because these altered states keep the traumatic experience walled off from ordinary consciousness, they prevent the integration necessary for healing. Unfortunately, the constrictive or dissociative states, like other symptoms of the post-traumatic syndrome, prove to be remarkably tenacious. Lifton likened "psychic numbing," which he found to be universal in survivors of disaster and war, to a "paralysis of the mind."[50]

Constrictive symptoms, like intrusive symptoms, were first described in the domain of memory. Janet noted that post-traumatic amnesia was due to a "constriction of the field of consciousness" which kept painful memories split off from ordinary awareness. When his hysterical patients were in a hypnotic trance state, they were able to replicate the dissociated events in exquisite detail. His patient Irene, for example, reported a dense amnesia for a two-month time period surrounding her mother's death. In trance, she was able to reproduce all the harrowing events of those two months, including the death scene, as though they were occurring in the present.[51]

Kardiner also recognized that a constrictive process kept traumatic memories out of normal consciousness, allowing only a fragment of the memory to emerge as an intrusive symptom. He cited the case of a navy veteran who complained of a persistent sensation of numbness, pain, and cold from the waist down. This patient denied any traumatic experiences during the war. On persistent questioning, without formal use of hypnosis, he recalled the sinking of his ship and the many hours he had spent awaiting rescue in the icy water, but he denied having any emotional reaction to the event. However, as Kardiner pressed on, the patient became agitated, angry, and frightened:

> The similarities between the symptoms of which he complained . . . and his being submerged in cold water from his waist down, were pointed out to him. He admitted that when he closed his eyes and *allowed himself to think* of his present sensations, he still imagined himself clinging to the raft, half submerged in the sea. He then said that while he was clinging to the raft, his sensations were extremely painful and that he thought of nothing else during the time. He also recalled the fact that several of the men had lost consciousness and had drowned. To a large extent, the patient obviously owed his life to his concentration of the painful sensations occasioned by the cold water. Hence the symptom represented a . . . reproduction of the original sensations of being submerged in the water.[52]

In this case, the constrictive process resulted not in complete amnesia but in the formation of a truncated memory, devoid of emotion and meaning. The patient did not "allow himself to think" about the meaning of his symptom, for to do so would have brought back all the pain, terror, and rage of narrowly escaping death and witnessing the deaths of his comrades. This voluntary suppression of thoughts related to the traumatic event is characteristic of traumatized people, as are the less conscious forms of dissociation.

The constrictive symptoms of the traumatic neurosis apply not only to thought, memory, and states of consciousness but also to the entire field of purposeful action and initiative. In an attempt to create some sense of safety and to control their pervasive fear, traumatized people restrict their lives. Two rape survivors describe how their lives narrowed after the trauma:

> I was terrified to go anywhere on my own. . . . I felt too defenseless and too afraid, and so I just stopped doing anything. . . . I would just stay home and I was just frightened.[53]

> I cut off all my hair. I did not want to be attractive to men. . . . I just wanted to look neutered for awhile because that felt safer.[54]

The combat veteran Ken Smith describes how he rationalized the constriction in his life that occurred after combat, so that for a long time he did not recognize how much he was ruled by fear: "I worked exclusively midnight to eight or eleven to seven. Never understood why. I was so concerned about being awake at night, because I had this thing about being *afraid of the night.* Now I know that; then I didn't. I rationalized it because there wasn't as much supervision, I got more freedom, I didn't have to listen to the political infighting bullshit, nobody really bothered me, I was left alone."[55]

Constrictive symptoms also interfere with anticipation and planning for the future. Grinker and Spiegel observed that soldiers in wartime responded to the losses and injuries within their group with diminished confidence in their own ability to make plans and take initiative, with increased superstitious and magical thinking, and with greater reliance on lucky charms and omens.[56] Terr, in a study of kidnapped schoolchildren, described how afterward the children came to believe that there had been omens warning them of the traumatic event. Years after the kidnapping, these children continued to look for omens to protect them and guide

their behavior. Moreover, years after the event, the children retained a foreshortened sense of the future; when asked what they wanted to be when they grew up, many replied that they never fantasized or made plans for the future because they expected to die young.[57]

In avoiding any situations reminiscent of the past trauma, or any initiative that might involve future planning and risk, traumatized people deprive themselves of those new opportunities for successful coping that might mitigate the effect of the traumatic experience. Thus, constrictive symptoms, though they may represent an attempt to defend against overwhelming emotional states, exact a high price for whatever protection they afford. They narrow and deplete the quality of life and ultimately perpetuate the effects of the traumatic event.

THE DIALECTIC OF TRAUMA

In the aftermath of an experience of overwhelming danger, the two contradictory responses of intrusion and constriction establish an oscillating rhythm. This dialectic of opposing psychological states is perhaps the most characteristic feature of the post-traumatic syndromes.[58] Since neither the intrusive nor the numbing symptoms allow for integration of the traumatic event, the alternation between these two extreme states might be understood as an attempt to find a satisfactory balance between the two. But balance is precisely what the traumatized person lacks. She finds herself caught between the extremes of amnesia or of reliving the trauma, between floods of intense, overwhelming feeling and arid states of no feeling at all, between irritable, impulsive action and complete inhibition of action. The instability produced by these periodic alternations further exacerbates the traumatized person's sense of unpredictability and helplessness.[59] The dialectic of trauma is therefore potentially self-perpetuating.

In the course of time, this dialectic undergoes a gradual evolution. Initially, intrusive reliving of the traumatic event predominates, and the victim remains in a highly agitated state, on the alert for new threats. Intrusive symptoms emerge most prominently in the first few days or weeks following the traumatic event, abate to some degree within three to six months, and then attenuate slowly over time. For example, in a large-scale community study of crime victims, rape survivors generally reported that their most severe intrusive symptoms diminished after three to six months, but they were still fearful and anxious one year following

to demonstrate that she is in fact capable of taking good care of herself and that the therapist is being overly cautious. If, on the contrary, the therapist minimizes the danger, the patient may be forced to demonstrate her lack of safety in a dramatic way.

To counter the compelling fantasy of a fast, cathartic cure, the therapist may compare the recovery process to running a marathon. Survivors immediately grasp the complexities of this image. They recognize that recovery, like a marathon, is a test of endurance, requiring long preparation and repetitive practice. The metaphor of a marathon captures the strong behavioral focus on conditioning the body, as well as the psychological dimensions of determination and courage. While the image may lack a strong social dimension, it captures the survivor's initial feeling of isolation. It also offers an image of the therapist's role as a trainer and coach. While the therapist's technical expertise, judgment, and moral support are vital to the enterprise, in the end it is the survivor who determines her recovery through her own actions.

Patients often wonder how to judge their readiness to move on to the next stage of the work. No single, dramatic event marks the completion of the first stage. The transition is gradual, occurring in fits and starts. Little by little, the traumatized person regains some rudimentary sense of safety, or at least predictability, in her life. She finds, once again, that she can count on herself and on others. Though she may be far more wary and less trusting than she was before the trauma, and though she may still avoid intimacy, she no longer feels completely vulnerable or isolated. She has some confidence in her ability to protect herself; she knows how to control her most disturbing symptoms, and she knows whom she can rely on for support. The survivor of chronic trauma begins to believe not only that she can take good care of herself but that she deserves no less. In her relationships with others, she has learned to be both appropriately trusting and self-protective. In her relationship with the therapist, she has arrived at a reasonably secure alliance that preserves both autonomy and connection.

At this point, especially after a single acute trauma, the survivor may wish to put the experience out of mind for a while and get on with her life. And she may succeed in doing so for a time. Nowhere is it written that the recovery process must follow a linear, uninterrupted sequence. But traumatic events ultimately refuse to be put away. At some point the memory of the trauma is bound to return, demanding attention. Often the precipitant is a significant reminder of the trauma—an anniversary, for instance—or a change in the survivor's life circumstances that brings her back to the unfinished work of integrating the traumatic experience. She is then ready to embark upon the second stage of recovery.

CHAPTER 9

Remembrance and Mourning

IN THE SECOND STAGE OF RECOVERY, the survivor tells the story of the trauma. She tells it completely, in depth and in detail. This work of reconstruction actually transforms the traumatic memory, so that it can be integrated into the survivor's life story. Janet described normal memory as "the action of telling a story." Traumatic memory, by contrast, is wordless and static. The survivor's initial account of the event may be repetitious, stereotyped, and emotionless. One observer describes the trauma story in its untransformed state as a "prenarrative." It does not develop or progress in time, and it does not reveal the storyteller's feelings or interpretation of events.[1] Another therapist describes traumatic memory as a series of still snapshots or a silent movie; the role of therapy is to provide the music and words.[2]

The basic principle of empowerment continues to apply during the second stage of recovery. The choice to confront the horrors of the past rests with the survivor. The therapist plays the role of a witness and ally, in whose presence the survivor can speak of the unspeakable. The reconstruction of trauma places great demands on the courage of both patient and therapist. It requires that both be clear in their purpose and secure in their alliance. Freud provides an eloquent description of the patient's approach to uncovering work in psychotherapy: "[The patient] must find the courage to direct his attention to the phenomena of his illness. His illness must no longer seem to him contemptible, but must become an enemy worthy of his mettle, a piece of his personality, which has solid ground for its existence, and out of which things of value for his future life have to be derived. The way is thus paved . . . for a reconciliation with the repressed material which is coming to expression in his symptoms,

while at the same time place is found for a certain tolerance for the state of being ill."[3]

As the survivor summons her memories, the need to preserve safety must be balanced constantly against the need to face the past. The patient and therapist together must learn to negotiate a safe passage between the twin dangers of constriction and intrusion. Avoiding the traumatic memories leads to stagnation in the recovery process, while approaching them too precipitately leads to a fruitless and damaging reliving of the trauma. Decisions regarding pacing and timing need meticulous attention and frequent review by patient and therapist in concert. There is room for honest disagreement between patient and therapist on these matters, and differences of opinion should be aired freely and resolved before the work of reconstruction proceeds.

The patient's intrusive symptoms should be monitored carefully so that the uncovering work remains within the realm of what is bearable. If symptoms worsen dramatically during active exploration of the trauma, this should be a signal to slow down and to reconsider the course of the therapy. The patient should also expect that she will not be able to function at the highest level of her ability, or even at her usual level, during this time. Reconstructing the trauma is ambitious work. It requires some slackening of ordinary life demands, some "tolerance for the state of being ill." Most often the uncovering work can proceed within the ordinary social framework of the patient's life. Occasionally the demands of the therapeutic work may require a protective setting, such as a planned hospital stay. Active uncovering work should not be undertaken at times when immediate life crises claim the patient's attention or when other important goals take priority.

RECONSTRUCTING THE STORY

Reconstructing of the trauma story begins with a review of the patient's life before the trauma and the circumstances that led up to the event. Yael Danieli speaks of the importance of reclaiming the patient's earlier history in order to "re-create the flow" of the patient's life and restore a sense of continuity with the past.[4] The patient should be encouraged to talk about her important relationships, her ideals and dreams, and her struggles and conflicts prior to the traumatic event. This exploration provides a context within which the particular meaning of the trauma can be understood.

The next step is to reconstruct the traumatic event as a recitation of fact. Out of the fragmented components of frozen imagery and sensation, patient and therapist slowly reassemble an organized, detailed, verbal account, oriented in time and historical context. The narrative includes not only the event itself but also the survivor's response to it and the responses of the important people in her life. As the narrative closes in on the most unbearable moments, the patient finds it more and more difficult to use words. At times the patient may spontaneously switch to nonverbal methods of communication, such as drawing or painting. Given the "iconic," visual nature of traumatic memories, creating pictures may represent the most effective initial approach to these "indelible images." The completed narrative must include a full and vivid description of the traumatic imagery. Jessica Wolfe describes her approach to the trauma narrative with combat veterans: "We have them reel it off in great detail, as though they were watching a movie, and with all the senses included. We ask them what they are seeing, what they are hearing, what they are smelling, what they are feeling, and what they are thinking." Terence Keane stresses the importance of bodily sensations in reconstructing a complete memory: "If you don't ask specifically about the smells, the heart racing, the muscle tension, the weakness in their legs, they will avoid going through that because it's so aversive."[5]

A narrative that does not include the traumatic imagery and bodily sensations is barren and incomplete.[6] The ultimate goal, however, is to put the story, including its imagery, into words. The patient's first attempts to develop a narrative language may be partially dissociated. She may write down her story in an altered state of consciousness and then disavow it. She may throw it away, hide it, or forget she has written it. Or she may give it to the therapist, with a request that it be read outside the therapy session. The therapist should beware of developing a sequestered "back channel" of communication, reminding the patient that their mutual goal is to bring the story into the room, where it can be spoken and heard. Written communications should be read together.

The recitation of facts without the accompanying emotions is a sterile exercise, without therapeutic effect. As Breuer and Freud noted a century ago, "recollection without affect almost invariably produces no result."[7] At each point in the narrative, therefore, the patient must reconstruct not only what happened but also what she felt. The description of emotional states must be as painstakingly detailed as the description of facts. As the patient explores her feelings, she may become either agitated or withdrawn. She is not simply describing what she felt in the past but is reliving

those feelings in the present. The therapist must help the patient move back and forth in time, from her protected anchorage in the present to immersion in the past, so that she can simultaneously reexperience the feelings in all their intensity while holding on to the sense of safe connection that was destroyed in the traumatic moment.[8]

Reconstructing the trauma story also includes a systematic review of the meaning of the event, both to the patient and to the important people in her life. The traumatic event challenges an ordinary person to become a theologian, a philosopher, and a jurist. The survivor is called upon to articulate the values and beliefs that she once held and that the trauma destroyed. She stands mute before the emptiness of evil, feeling the insufficiency of any known system of explanation. Survivors of atrocity of every age and every culture come to a point in their testimony where all questions are reduced to one, spoken more in bewilderment than in outrage: Why? The answer is beyond human understanding.

Beyond this unfathomable question, the survivor confronts another, equally incomprehensible question: Why me? The arbitrary, random quality of her fate defies the basic human faith in a just or even predictable world order. In order to develop a full understanding of the trauma story, the survivor must examine the moral questions of guilt and responsibility and reconstruct a system of belief that makes sense of her undeserved suffering. Finally, the survivor cannot reconstruct a sense of meaning by the exercise of thought alone. The remedy for injustice also requires action. The survivor must decide what is to be done.

As the survivor attempts to resolve these questions, she often comes into conflict with important people in her life. There is a rupture in her sense of belonging within a shared system of belief. Thus she faces a double task: not only must she rebuild her own "shattered assumptions" about meaning, order, and justice in the world but she must also find a way to resolve her differences with those whose beliefs she can no longer share.[9] Not only must she restore her own sense of worth but she must also be prepared to sustain it in the face of the critical judgments of others.

The moral stance of the therapist is therefore of enormous importance. It is not enough for the therapist to be "neutral" or "nonjudgmental." The patient challenges the therapist to share her own struggles with these immense philosophical questions. The therapist's role is not to provide ready-made answers, which would be impossible in any case, but rather to affirm a position of moral solidarity with the survivor.

Throughout the exploration of the trauma story, the therapist is called

upon to provide a context that is at once cognitive, emotional, and moral. The therapist normalizes the patient's responses, facilitates naming and the use of language, and shares the emotional burden of the trauma. She also contributes to constructing a new interpretation of the traumatic experience that affirms the dignity and value of the survivor. When asked what advice they would give to therapists, survivors most commonly cite the importance of the therapist's validating role. An incest survivor counsels therapists: "Keep encouraging people to talk even if it's very painful to watch them. It takes a long time to believe. The more I talk about it, the more I have confidence that it happened, the more I can integrate it. Constant reassurance is very important—anything that keeps me from feeling I was one isolated terrible little girl."[10]

As the therapist listens, she must constantly remind herself to make no assumptions about either the facts or the meaning of the trauma to the patient. If she fails to ask detailed questions, she risks superimposing her own feelings and her own interpretation onto the patient's story. What seems like a minor detail to the therapist may be the most important aspect of the story to the patient. Conversely, an aspect of the story that the therapist finds intolerable may be of lesser significance to the patient. Clarifying these discrepant points of view can enhance the mutual understanding of the trauma story. The case of Stephanie, an 18-year-old college freshman who was gang-raped at a fraternity party, illustrates the importance of clarifying each detail of the story:

> When Stephanie first told her story, her therapist was horrified by the sheer brutality of the rape, which had gone on for over two hours. To Stephanie, however, the worst part of the ordeal had occurred after the assault was over, when the rapists pressured her to say that it was the "best sex she ever had." Numbly and automatically, she had obeyed. She then felt ashamed and disgusted with herself.
>
> The therapist named this a mind rape. She explained the numbing response to terror and asked whether Stephanie had been aware of feeling afraid. Stephanie then remembered more of the story: the rapists had threatened that they "just might have to give it to her again" if she did not say that she was "completely satisfied." With this additional information, she came to understand her compliance as a strategy that hastened her escape rather than simply as a form of self-abasement.

Both patient and therapist must develop tolerance for some degree of uncertainty, even regarding the basic facts of the story. In the course of reconstruction, the story may change as missing pieces are recovered.

This is particularly true in situations where the patient has experienced significant gaps in memory. Thus, both patient and therapist must accept the fact that they do not have complete knowledge, and they must learn to live with ambiguity while exploring at a tolerable pace.

In order to resolve her own doubts or conflicting feelings, the patient may sometimes try to reach premature closure on the facts of the story. She may insist that the therapist validate a partial and incomplete version of events without further exploration, or she may push for more aggressive pursuit of additional memories before she has dealt with the emotional impact of the facts already known. The case of Paul, a 23-year-old man with a history of childhood abuse, illustrates one therapist's response to a patient's premature demand for certainty:

> After gradually disclosing his involvement in a pedophilic sex ring, Paul suddenly announced that he had fabricated the entire story. He threatened to quit therapy immediately unless the therapist professed to believe that he had been lying all along. Up until this moment, of course, he had wanted the therapist to believe he was telling the truth. The therapist admitted that she was puzzled by this turn of events. She added: "I wasn't there when you were a child, so I can't pretend to know what happened. I do know that it is important to understand your story fully, and we don't understand it yet. I think we should keep an open mind until we do." Paul grudgingly accepted this premise. In the course of the next year of therapy, it became clear that his recantation was a last-ditch attempt to maintain his loyalty to his abusers.

Therapists, too, sometimes fall prey to the desire for certainty. Zealous conviction can all too easily replace an open, inquiring attitude. In the past, this desire for certainty generally led therapists to discount or minimize their patients' traumatic experiences. Though this may still be the therapist's most frequent type of error, the recent rediscovery of psychological trauma has led to errors of the opposite kind. Therapists have been known to tell patients, merely on the basis of a suggestive history or "symptom profile," that they definitely have had a traumatic experience. Some therapists even seem to specialize in "diagnosing" a particular type of traumatic event, such as ritual abuse. Any expression of doubt can be dismissed as "denial." In some cases patients with only vague, nonspecific symptoms have been informed after a single consultation that they have undoubtedly been the victims of a Satanic cult. The therapist has to remember that she is not a fact-finder and that the reconstruction of the trauma story is not a criminal investigation. Her role is to be an open-minded, compassionate witness, not a detective.

Because the truth is so difficult to face, survivors often vacillate in reconstructing their stories. Denial of reality makes them feel crazy, but acceptance of the full reality seems beyond what any human being can bear. The survivor's ambivalence about truth-telling is also reflected in conflicting therapeutic approaches to the trauma story. Janet sometimes attempted in his work with hysterical patients to erase traumatic memories or even to alter their content with the aid of hypnosis.[11] Similarly, the early "abreactive" treatment of combat veterans attempted essentially to get rid of traumatic memories. This image of catharsis, or exorcism, is also an implicit fantasy in many traumatized people who seek treatment.

It is understandable for both patient and therapist to wish for a magic transformation, a purging of the evil of the trauma.[12] Psychotherapy, however, does not get rid of the trauma. The goal of recounting the trauma story is integration, not exorcism. In the process of reconstruction, the trauma story does undergo a transformation, but only in the sense of becoming more present and more real. The fundamental premise of the psychotherapeutic work is a belief in the restorative power of truth-telling.

In the telling, the trauma story becomes a testimony. Inger Agger and Soren Jensen, in their work with refugee survivors of political persecution, note the universality of testimony as a ritual of healing. Testimony has both a private dimension, which is confessional and spiritual, and a public aspect, which is political and judicial. The use of the word *testimony* links both meanings, giving a new and larger dimension to the patient's individual experience.[13] Richard Mollica describes the transformed trauma story as simply a "new story," which is "no longer about shame and humiliation" but rather "about dignity and virtue." Through their storytelling, his refugee patients "regain the world they have lost."[14]

TRANSFORMING TRAUMATIC MEMORY

Therapeutic techniques for transforming the trauma story have developed independently for many different populations of traumatized people. Two highly evolved techniques are the use of "direct exposure" or "flooding" in the treatment of combat veterans and the use of formalized "testimony" in the treatment of survivors of torture.

The flooding technique is part of an intensive program, developed within the Veterans' Administration, for treating post-traumatic stress disorder. It is a behavioral therapy designed to overcome the terror of the

traumatic event by exposing the patient to a controlled reliving experience. In preparation for the flooding sessions, the patient is taught how to manage anxiety by using relaxation techniques and by visualizing soothing imagery. The patient and therapist then carefully prepare a written "script," describing the traumatic event in detail. This script includes the four elements of context, fact, emotion, and meaning. If there were several traumatic events, a separate script is developed for each one. When the scripts are completed, the patient chooses the sequence for their presentation in the flooding sessions themselves, progressing from the easiest to the most difficult. In a flooding session, the patient narrates a script aloud to the therapist, in the present tense, while the therapist encourages him to express his feelings as fully as possible. This treatment is repeated weekly for an average of twelve to fourteen sessions. The majority of patients undergo treatment as outpatients, but some require hospitalization because of the severity of their symptoms during treatment.[15]

This technique shares many features with the testimony method for treating survivors of political torture. The testimony method was first reported by two Chilean psychologists, who published their findings under pseudonyms in order to protect their own security. The central project of the treatment is to create a detailed, extensive record of the patient's traumatic experiences. First, therapy sessions are recorded and a verbatim transcript of the patient's narrative is prepared. The patient and therapist then revise the document together. During revision, the patient is able to assemble the fragmented recollections into a coherent testimony. "Paradoxically," the psychologists observe, "the testimony is the very confession that had been sought by the torturers . . . but through testimony, confession becomes denunciation rather than betrayal."[16] In Denmark, Agger and Jensen further refined this technique. In their method, the final written testimony is read aloud, and the therapy is concluded with a formal "delivery ritual," during which the document is signed by the patient as plaintiff and by the therapist as witness. An average of 12–20 weekly sessions is needed to complete a testimony.[17]

The social and political components of the testimony method of treatment are far more explicit and developed than in the more narrowly behavioral flooding. This should not be surprising, since the testimony method developed within organizations committed to human rights activism, whereas the flooding method developed within an institution of the United States government. What is surprising is the degree of congruence in these techniques. Both models require an active collaboration of

patient and therapist to construct a fully detailed, written trauma narrative. Both treat this narrative with formality and solemnity. And both use the structure of the narrative to foster an intense reliving experience within the context of a safe relationship.

The therapeutic effects are also similar. Reporting on 39 treatment cases, the Chilean psychologists noted substantial relief of post-traumatic symptoms in the great majority of survivors of torture or mock execution. Their method was specifically effective for the aftereffects of terror. It did not offer much solace to patients, such as the relatives of missing or "disappeared" persons, who were suffering from unresolved grief but not from post-traumatic stress disorder.[18]

The outcome of the flooding treatment with combat veterans gives even clearer evidence for the effectiveness of this technique. Patients who completed the treatment reported dramatic reductions in the intrusive and hyperarousal symptoms of post-traumatic stress disorder. They suffered fewer nightmares and flashbacks, and they experienced a general improvement in anxiety, depression, concentration problems, and psychosomatic symptoms. Moreover, six months after completing the flooding treatment, patients reported lasting improvement in their intrusive and hyperarousal symptoms. The effects of the flooding treatment were specific for each traumatic event. Desensitizing one memory did not carry over to others; each had to be approached separately, and all had to be addressed in order to achieve the fullest relief of symptoms.[19]

It appears, then, that the "action of telling a story" in the safety of a protected relationship can actually produce a change in the abnormal processing of the traumatic memory. With this transformation of memory comes relief of many of the major symptoms of post-traumatic stress disorder. The *physioneurosis* induced by terror can apparently be reversed through the use of words.[20]

These intensive therapeutic techniques, however, have limitations. While intrusive and hyperarousal symptoms appear to improve after flooding, the constrictive symptoms of numbing and social withdrawal do not change, and marital, social, and work problems do not necessarily improve. By itself, reconstructing the trauma does not address the social or relational dimension of the traumatic experience. It is a necessary part of the recovery process, but it is not sufficient.

Unless the relational aspect of the trauma is also addressed, even the limited goal of relieving intrusive symptoms may remain out of reach. The patient may be reluctant to give up symptoms such as nightmares or flashbacks, because they have acquired important meaning. The symp-

toms may be a symbolic means of keeping faith with a lost person, a substitute for mourning, or an expression of unresolved guilt. In the absence of a socially meaningful form of testimony, many traumatized people choose to keep their symptoms. In the words of the war poet Wilfred Owen: "I confess I *bring on* what few war dreams I now have, entirely by *willingly* considering war of an evening. I have my duty to perform towards War."[21]

Piecing together the trauma story becomes a more complicated project with survivors of prolonged, repeated abuse. Techniques that are effective for approaching circumscribed traumatic events may not be adequate for chronic abuse, particularly for survivors who have major gaps in memory. The time required to reconstruct a complete story is usually far longer than 12–20 sessions. The patient may be tempted to resort to all sorts of powerful treatments, both conventional and unconventional, in order to hasten the process. Large-group marathons or inpatient "package" programs frequently attract survivors with the unrealistic promise that a "blitz" approach will effect a cure. Programs that promote the rapid uncovering of traumatic memories without providing an adequate context for integration are therapeutically irresponsible and potentially dangerous, for they leave the patient without the resources to cope with the memories uncovered.

Breaking through the barriers of amnesia is not in fact the difficult part of reconstruction, for any number of techniques will usually work. The hard part of this task is to come face-to-face with the horrors on the other side of the amnesiac barrier and to integrate these experiences into a fully developed life narrative. This slow, painstaking, often frustrating process resembles putting together a difficult picture puzzle. First the outlines are assembled, and then each new piece of information has to be examined from many different angles to see how it fits into the whole. A hundred years ago Freud used this same image of solving a puzzle to describe the uncovering of early sexual trauma.[22] The reward for patience is the occasional breakthrough moment when a number of pieces suddenly fall into place and a new part of the picture becomes clear.

The simplest technique for the recovery of new memories is the careful exploration of memories the patient already has. Most of the time this plain, workaday approach is sufficient. As the patient experiences the full emotional impact of facts she already knows, new recollections usually emerge spontaneously, as in the case of Denise, a 32-year-old incest survivor:

> Denise entered treatment tormented by doubt about whether she had been abused by her father. She had a strong "body feeling" that this was the case but claimed to have no clear memories. She thought hypnosis would be needed to recover memories. The therapist asked Denise to describe her current relationship with her father. In fact, Denise was dreading an upcoming family gathering, because she knew her father would get boisterously drunk, subject everyone at the party to lewd remarks, and fondle all the women. She felt she could not complain, since the family considered her father's behavior amusing and innocuous.
>
> At first Denise belittled the importance of this current information. She was looking for something much more dramatic, something that her family would take seriously. The therapist asked Denise what she felt when her father fondled her in public. Denise described feeling disgusted, humiliated, and helpless. This reminded her of the "body feeling" she had reported at the start of therapy. As she explored her feelings in the present, she began to recall many instances in childhood when she had sought protection from her father, only to have her complaints ridiculed and dismissed. Eventually she recovered memories of her father entering her bed at night.

The patient's present, daily experience is usually rich in clues to dissociated past memories. The observance of holidays and special occasions often affords an entry into past associations. In addition to following the ordinary clues of daily life, the patient may explore the past by viewing photographs, constructing a family tree, or visiting the site of childhood experiences. Post-traumatic symptoms such as flashbacks or nightmares are also valuable access routes to memory. Sharon Simone describes how a flashback triggered by sexual intercourse offered a clue to her forgotten childhood history of incest: "I was having sex with my husband, and I had come to a place in the middle of it where I felt like I was three years old. I was very sad, and he was doing the sex, and I remember looking around the room and thinking, 'Emily' (who's my therapist), "please come and get me out from under this man.' I knew 'this man' wasn't my husband, but I didn't yet say 'Dad.' "[23]

In the majority of cases, an adequate narrative can be constructed without resort to formal induction of altered states of consciousness. Occasionally, however, major amnesiac gaps in the story remain even after careful and painstaking exploration. At these times, the judicious use of powerful techniques such as hypnotherapy is warranted. The resolution of traumatic memories through hypnosis, however, requires a high degree of skill.[24] Each venture into uncovering work must be preceded by careful preparation and followed by an adequate period for integration.

The patient learns to use trance for soothing and relaxation first, moving on to uncovering work only after much anticipation, planning, and practice. Shirley Moore, a psychiatric nurse and hypnotherapist, describes her approach to hypnotic uncovering work with traumatized people:

> We might use an age regression technique like holding a ribbon or a rope that goes to the past. For some survivors you can't use ropes. There are a lot of standard techniques that you have to change the language for. Another technique that works well for a lot of people is imagining they are watching a portable TV. When we use this, they become accustomed to having a "safe" channel, and that's always where we tune in first. The working channel is a VCR channel. It has a tape that covers the traumatic experience, and we can use it in slow-motion, we can fast-forward it, we can reverse it. They also know how to use the volume control to modulate the intensity of their feelings. Some people like to just dream. They'll be in their protected place and have a dream about the trauma. These are all hypnotic projective techniques.
>
> Then I will suggest that the tape or the dream is going to tell us something about the trauma. I will count and then they will begin to report to me. I watch very closely for changes in facial expression, body movements. If a memory is going to come up, it comes at this time. We work with whatever comes up. Sometimes when it's an image of a very young child being abused, I will check whether it's all right to continue. People in trance can be clearly aware that they are split: there is the observing adult part and the experiencing child part. It's intense, no question about it, but the idea is to keep it bearable.
>
> People come out of trance with a lot of affect but also with some distance. A lot of the affect is sadness, and feeling appalled and stunned by the brutality. On coming out of trance they frequently will begin to make connections for themselves. There are suggestions to help them do that: they will remember only what they are ready to remember, they will have thoughts, images, feelings, and dreams that will help them understand it better over time, they will be able to talk about it in therapy. It's pretty incredible when you're sitting with it. There are those moments of having to reassure yourself that this really is helpful. But people do feel better after they've retrieved the memory.[25]

In addition to hypnosis, many other techniques can be used to produce an altered state of consciousness in which dissociated traumatic memories are more readily accessible. These range from social methods, such as intensive group therapy or psychodrama, to biological methods, such as the use of sodium amytal. In skilled hands, any of these methods can be effective. Whatever the technique, the same basic rules apply: the locus of control remains with the patient, and the timing, pacing, and design of the

sessions must be carefully planned so that the uncovering technique is integrated into the architecture of the psychotherapy.

This careful structuring applies even to the design of the uncovering session itself. Richard Kluft, who works with patients with multiple personality disorder, expresses this principle as the "rule of thirds." If "dirty work" is to be done, it should begin within the first third of the session; otherwise it should be postponed. Intense exploration is done in the second third of the session, while the last third is set aside to allow the patient to reorient and calm herself.[26]

For survivors of prolonged, repeated trauma, it is not practical to approach each memory as a separate entity. There are simply too many incidents, and often similar memories have blurred together. Usually, however, a few distinct and particularly meaningful incidents stand out. Reconstruction of the trauma narrative is often based heavily upon these paradigmatic incidents, with the understanding that one episode stands for many.

Letting one incident stand for many is an effective technique for creating new understanding and meaning. However, it probably does not work well for physiological desensitization. While behavioral techniques such as flooding have proved to be effective for alleviating the intense reactions to memories of single traumatic events, the same techniques are much less effective for prolonged, repeated, traumatic experiences. This contrast is apparent in a patient, reported on by the psychiatrist Arieh Shalev, who sought treatment after an automobile accident for the symptoms of simple post-traumatic stress disorder. She also had a history of repeated abuse in childhood. A standard behavioral treatment successfully resolved her symptoms related to the auto accident. However, the same approach did little to alleviate the patient's feelings about her childhood victimization, for which prolonged psychotherapy was required.[27]

The physiological changes suffered by chronically traumatized people are often extensive. People who have been subjected to repeated abuse in childhood may be prevented from developing normal sleep, eating, or endocrine cycles and may develop extensive somatic symptoms and abnormal pain perception. It is likely, therefore, that some chronically abused people will continue to suffer a degree of physiological disturbance even after full reconstruction of the trauma narrative. These survivors may need to devote separate attention to their physiological symptoms. Systematic reconditioning or long-term use of medication may sometimes be necessary. This area of treatment is still almost entirely experimental.[28]

MOURNING TRAUMATIC LOSS

Trauma inevitably brings loss. Even those who are lucky enough to escape physically unscathed still lose the internal psychological structures of a self securely attached to others. Those who are physically harmed lose in addition their sense of bodily integrity. And those who lose important people in their lives face a new void in their relationships with friends, family, or community. Traumatic losses rupture the ordinary sequence of generations and defy the ordinary social conventions of bereavement. The telling of the trauma story thus inevitably plunges the survivor into profound grief. Since so many of the losses are invisible or unrecognized, the customary rituals of mourning provide little consolation.[29]

The descent into mourning is at once the most necessary and the most dreaded task of this stage of recovery. Patients often fear that the task is insurmountable, that once they allow themselves to start grieving, they will never stop. Danieli quotes a 74-year-old widow who survived the Nazi Holocaust: "Even if it takes one year to mourn each loss, and even if I live to be 107 [and mourn all members of my family], what do I do about the rest of the six million?"[30]

The survivor frequently resists mourning, not only out of fear but also out of pride. She may consciously refuse to grieve as a way of denying victory to the perpetrator. In this case it is important to reframe the patient's mourning as an act of courage rather than humiliation. To the extent that the patient is unable to grieve, she is cut off from a part of herself and robbed of an important part of her healing. Reclaiming the ability to feel the full range of emotions, including grief, must be understood as an act of resistance rather than submission to the perpetrator's intent. Only through mourning everything that she has lost can the patient discover her indestructible inner life. A survivor of severe childhood abuse describes how she came to feel grief for the first time:

> By the time I was fifteen I had had it. I was a cold, flip little bitch. I had survived just fine without comfort or affection; it didn't bother me. No one could get me to cry. If my mother threw me out, I would just curl up and go to sleep in a trunk in the hallway. Even when that woman beat me, no way was she going to make me cry. I never cried when my husband beat me. He'd knock me down and I'd get up for more. It's a wonder I didn't get killed. I've cried more in therapy than in my whole life. I never trusted anyone enough to let them see me cry. Not even you, till the last couple of months. There, I've said it! That's the statement of the year![31]

Since mourning is so difficult, resistance to mourning is probably the most common cause of stagnation in the second stage of recovery. Resistance to mourning can take on numerous disguises. Most frequently it appears as a fantasy of magical resolution through revenge, forgiveness, or compensation.

The revenge fantasy is often a mirror image of the traumatic memory, in which the roles of perpetrator and victim are reversed. It often has the same grotesque, frozen, and wordless quality as the traumatic memory itself. The revenge fantasy is one form of the wish for catharsis. The victim imagines that she can get rid of the terror, shame, and pain of the trauma by retaliating against the perpetrator. The desire for revenge also arises out of the experience of complete helplessness. In her humiliated fury, the victim imagines that revenge is the only way to restore her own sense of power. She may also imagine that this is the only way to force the perpetrator to acknowledge the harm he has done her.

Though the traumatized person imagines that revenge will bring relief, repetitive revenge fantasies actually increase her torment. Violent, graphic revenge fantasies may be as arousing, frightening, and intrusive as images of the original trauma. They exacerbate the victim's feelings of horror and degrade her image of herself. They make her feel like a monster. They are also highly frustrating, since revenge can never change or compensate for the harm that was done. People who actually commit acts of revenge, such as combat veterans who commit atrocities, do not succeed in getting rid of their post-traumatic symptoms; rather, they seem to suffer the most severe and intractable disturbances.[32]

During the process of mourning, the survivor must come to terms with the impossibility of getting even. As she vents her rage in safety, her helpless fury gradually changes into a more powerful and satisfying form of anger: righteous indignation.[33] This transformation allows the survivor to free herself from the prison of the revenge fantasy, in which she is alone with the perpetrator. It offers her a way to regain a sense of power without becoming a criminal herself. Giving up the fantasy of revenge does not mean giving up the quest for justice; on the contrary, it begins the process of joining with others to hold the perpetrator accountable for his crimes.

Revolted by the fantasy of revenge, some survivors attempt to bypass their outrage altogether through a fantasy of forgiveness. This fantasy, like its polar opposite, is an attempt at empowerment. The survivor imagines that she can transcend her rage and erase the impact of the trauma through a willed, defiant act of love. But it is not possible to

exorcise the trauma, through either hatred or love. Like revenge, the fantasy of forgiveness often becomes a cruel torture, because it remains out of reach for most ordinary human beings. Folk wisdom recognizes that to forgive is divine. And even divine forgiveness, in most religious systems, is not unconditional. True forgiveness cannot be granted until the perpetrator has sought and earned it through confession, repentance, and restitution.

Genuine contrition in a perpetrator is a rare miracle. Fortunately, the survivor does not need to wait for it. Her healing depends on the discovery of restorative love in her own life; it does not require that this love be extended to the perpetrator. Once the survivor has mourned the traumatic event, she may be surprised to discover how uninteresting the perpetrator has become to her and how little concern she feels for his fate. She may even feel sorrow and compassion for him, but this disengaged feeling is not the same as forgiveness.

The fantasy of compensation, like the fantasies of revenge and forgiveness, often becomes a formidable impediment to mourning. Part of the problem is the very legitimacy of the desire for compensation. Because an injustice has been done to her, the survivor naturally feels entitled to some form of compensation. The quest for fair compensation is often an important part of recovery. However, it also presents a potential trap. Prolonged, fruitless struggles to wrest compensation from the perpetrator or from others may represent a defense against facing the full reality of what was lost. Mourning is the only way to give due honor to loss; there is no adequate compensation.

The fantasy of compensation is often fueled by the desire for a victory over the perpetrator that erases the humiliation of the trauma. When the compensation fantasy is explored in detail, it usually includes psychological components that mean more to the patient than any material gain. The compensation may represent an acknowledgment of harm, an apology, or a public humiliation of the perpetrator. Though the fantasy is about empowerment, in reality the struggle for compensation ties the patient's fate to that of the perpetrator and holds her recovery hostage to his whims. Paradoxically, the patient may liberate herself from the perpetrator when she renounces the hope of getting any compensation from him. As grieving progresses, the patient comes to envision a more social, general, and abstract process of restitution, which permits her to pursue her just claims without ceding any power over her present life to the perpetrator. The case of Lynn, a 28-year-old incest survivor, illustrates how a compensation fantasy stalled the progress of recovery:

Lynn entered psychotherapy with a history of numerous hospitalizations for suicide attempts, relentless self-mutilation, and anorexia. Her symptoms stabilized after a connection was made between her self-destructive behavior and a history of abuse in childhood. After two years of steady improvement, however, she seemed to get "stuck." She began calling in sick at work, canceling therapy appointments, withdrawing from friends, and staying in bed during the day.

Exploration of this impasse revealed that Lynn had essentially gone "on strike" against her father. Now that she no longer blamed herself for the incest, she deeply resented the fact that her father had never been held accountable. She saw her continued psychiatric disability as the one possible means of making her father pay for his crimes. She expressed the fantasy that if she were too disturbed to work, her father would have to take care of her and eventually feel sorry for what he had done.

The therapist asked Lynn how many years she was prepared to wait for this dream to come true. At this, Lynn burst into tears. She bewailed all the time she had already lost, waiting and hoping for acknowledgment from her father. As she grieved, she resolved not to lose any more precious time in a fruitless struggle and renewed her active engagement in her own therapy, work, and social life.

A variant of the compensation fantasy seeks redress not from the perpetrator but from real or symbolic bystanders. The demand for compensation may be placed upon society as a whole or upon one person in particular. The demand may appear to be entirely economic, such as a claim for disability, but inevitably it includes important psychological components as well.

In the course of psychotherapy, the patient may focus her demands for compensation on the therapist. She may come to resent the limits and responsibilities of the therapy contract, and she may insist upon some form of special dispensation. Underlying these demands is the fantasy that only the boundless love of the therapist, or some other magical personage, can undo the damage of the trauma. The case of Olivia, a 36-year-old survivor of severe childhood abuse, reveals how a fantasy of compensation took the form of a demand for physical contact:

During psychotherapy Olivia began to uncover horrible memories. She insisted that she could not endure her feelings unless she could sit on her therapist's lap and be cuddled like a child. When the therapist refused, on the grounds that touching would confuse the boundaries of their working relationship, Olivia became enraged. She accused the therapist of withholding the one thing that would make her well. At this impasse the therapist suggested a consultation.

The consultant affirmed Olivia's desire for hugs and cuddling but wondered why she thought her therapist was a suitable person to fulfill it, rather than a lover or friend. Olivia began to cry. She feared she was so damaged that she could never have a mutual relationship. She felt like a "bottomless pit" and feared that sooner or later she would exhaust everyone with her insatiable demands. She did not dare risk physical intimacy in a peer relationship, because she believed she was incapable of giving as well as receiving love. Only "reparenting" by an all-giving therapist could heal her.

The consultant suggested that therapy focus on mourning for the damage that had been done to the patient's capacity for love. As Olivia grieved the harm that was done to her, she discovered that she was not, after all, a "bottomless pit." She began to recognize the many ways in which her natural sociability had survived, and she began to feel more hopeful about the possibility of intimacy in her life. She found that she could both give and receive hugs with friends, and she no longer demanded them from her therapist.

Unfortunately, therapists sometimes collude with their patients' unrealistic fantasies of restitution. It is flattering to be invested with grandiose healing powers and only too tempting to seek a magical cure in the laying on of hands. Once this boundary is crossed, however, the therapist cannot maintain a disinterested therapeutic stance, and it is foolhardy to imagine that she can. Boundary violations ultimately lead to exploitation of the patient, even when they are initially undertaken in good faith.

The best way the therapist can fulfill her responsibility to the patient is by faithfully bearing witness to her story, not by infantilizing her or granting her special favors. Though the survivor is not responsible for the injury that was done to her, she is responsible for her recovery. Paradoxically, acceptance of this apparent injustice is the beginning of empowerment. The only way that the survivor can take full control of her recovery is to take responsibility for it. The only way she can discover her undestroyed strengths is to use them to their fullest.

Taking responsibility has an additional meaning for survivors who have themselves harmed others, either in the desperation of the moment or in the slow degradation of captivity. The combat veteran who has committed atrocities may feel he no longer belongs in a civilized community. The political prisoner who has betrayed others under duress or the battered woman who has failed to protect her children may feel she has committed a worse crime than the perpetrator. Although the survivor may come to understand that these violations of relationship were committed under extreme circumstances, this understanding by itself does not fully resolve the profound feelings of guilt and shame. The survivor needs to mourn

for the loss of her moral integrity and to find her own way to atone for what cannot be undone. This restitution in no way exonerates the perpetrator of his crimes; rather, it reaffirms the survivor's claim to moral choice in the present. The case of Renée illustrates how one survivor took action to repair the harm for which she felt responsible.

Renée, a 40-year-old divorced woman, sought therapy after escaping from a twenty-year marriage to a man who had repetitively beaten her in front of their children. In therapy she was able to grieve the loss of her marriage, but she became profoundly depressed when she recognized how the years of violence had affected her adolescent sons. The boys had themselves become aggressive and openly defied her. The patient was unable to set any limits with them because she felt that she deserved their contempt. In her own estimation she had failed in her role as a parent, and now it was too late to undo the damage.

The therapist acknowledged that Renée might well have reasons to feel guilty and ashamed. She argued, however, that allowing her sons to misbehave would make the harm even worse. If Renée really wanted to make amends to her sons, she had no right to give up on them or on herself. She would have to learn how to command their respect and enforce discipline without violence. Renée agreed to enroll in a parenting course as a way of making restitution to her sons.

In this case it was insufficient to point out to the patient that she herself was a victim and that her husband was entirely to blame for the battering. As long as she saw herself only as a victim, she felt helpless to take charge of the situation. Acknowledging her own responsibility toward her children opened the way to the assumption of power and control. The action of atonement allowed this woman to reassert the authority of her parental role.

Survivors of chronic childhood trauma face the task of grieving not only for what was lost but also for what was never theirs to lose. The childhood that was stolen from them is irreplaceable. They must mourn the loss of the foundation of basic trust, the belief in a good parent. As they come to recognize that they were not responsible for their fate, they confront the existential despair that they could not face in childhood. Leonard Shengold poses the central question at this stage of mourning: "Without the inner picture of caring parents, how can one survive? . . . Every soul-murder victim will be wracked by the question 'Is there life without father and mother?' "[34]

The confrontation with despair brings with it, at least transiently, an increased risk of suicide. In contrast to the impulsive self-destructiveness

of the first stage of recovery, the patient's suicidality during this second stage may evolve from a calm, flat, apparently rational decision to reject a world where such horrors are possible. Patients may engage in sterile philosophical discussions about their right to choose suicide. It is imperative to get beyond this intellectual defense and to engage the feelings and fantasies that fuel the patient's despair. Commonly the patient has the fantasy that she is already among the dead, because her capacity for love has been destroyed. What sustains the patient through this descent into despair is the smallest evidence of an ability to form loving connections.

Clues to the undestroyed capacity for love can often be found through the evocation of soothing imagery. Almost invariably it is possible to find some image of attachment that has been salvaged from the wreckage. One positive memory of a caring, comforting person may be a lifeline during the descent into mourning. The patient's own capacity to feel compassion for animals or children, even at a distance, may be the fragile beginning of compassion for herself. The reward of mourning is realized as the survivor sheds her evil, stigmatized identity and dares to hope for new relationships in which she no longer has anything to hide.

The restorative power of mourning and the extraordinary human capacity for renewal after even the most profound loss is evident in the treatment of Mrs. K, a survivor of the Nazi Holocaust:

> The turning point in Mrs. K's treatment came when she "confessed" that she had been married and had given birth to a baby in the ghetto whom she "gave to the Nazis." Her guilt, shame, and feeling "filthy" were exacerbated when she was warned after liberation by "well-meaning people" that if she told her new fiancé, he would never marry her. The baby, whom she bore and kept alive for two and a half years under the most horrendously inhuman conditions, was torn from her arms and murdered when his whimper alerted the Nazi officer that he was hidden under her coat. . . .
>
> The K family started sharing their history and communicating. It took about six months, however, of patient requests for her to repeat the above incident . . . until she was able to end her ghetto story with "and they took the child away from me." She then began to thaw her identificatory deadness and experience the missing . . . emotions of pain and grief. . . .
>
> Much of Mrs. K's healing process capitalized on sources of goodness and strength before and during the war, such as her spunk as a child, her ability to dream of her grandfather consoling her when she gave up in the camps, her warmth, intelligence, wonderful sense of humor, and reawakened sense of delight. . . . Her ability and longing to love were really resurrected. . . . No longer formally in therapy, Mrs. K says, "I have myself back, all over again. . . . I wasn't proud. Now I'm proud. There are some things I don't like, but I have hope."[35]

The second stage of recovery has a timeless quality that is frightening. The reconstruction of the trauma requires immersion in a past experience of frozen time; the descent into mourning feels like a surrender to tears that are endless. Patients often ask how long this painful process will last. There is no fixed answer to the question, only the assurance that the process cannot be bypassed or hurried. It will almost surely take longer than the patient wishes, but it will not go on forever.

After many repetitions, the moment comes when the telling of the trauma story no longer arouses quite such intense feeling. It has become a part of the survivor's experience, but only one part of it. The story is a memory like other memories, and it begins to fade as other memories do. Her grief, too, begins to lose its vividness. It occurs to the survivor that perhaps the trauma is not the most important, or even the most interesting, part of her life story.

At first these thoughts may seem almost heretical. The survivor may wonder how she can possibly give due respect to the horror she has endured if she no longer devotes her life to remembrance and mourning. And yet she finds her attention wandering back to ordinary life. She need not worry. She will never forget. She will think of the trauma every day as long as she lives. She will grieve every day. But the time comes when the trauma no longer commands the central place in her life. The rape survivor Sohaila Abdulali recalls a surprising moment in the midst of addressing a class on rape awareness: "Someone asked what's the worst thing about being raped. Suddenly I looked at them all and said, the thing I hate the most about it is that it's *boring.* And they all looked very shocked and I said, don't get me wrong. It was a terrible thing. I'm not saying it was boring that it happened, it's just that it's been years and I'm not interested in it any more. It's very interesting the first 50 times or the first 500 times when you have the same phobias and fears. Now I can't get so worked up any more."[36]

The reconstruction of the trauma is never entirely completed; new conflicts and challenges at each new stage of the lifecycle will inevitably reawaken the trauma and bring some new aspect of the experience to light. The major work of the second stage is accomplished, however, when the patient reclaims her own history and feels renewed hope and energy for engagement with life. Time starts to move again. When the "action of telling a story" has come to its conclusion, the traumatic experience truly belongs to the past. At this point, the survivor faces the tasks of rebuilding her life in the present and pursuing her aspirations for the future.

Chapter 2

1. Amencan Psyciatric Association, *Diagnostic and Statistical Manual of Psychiatric Disorders,* vol. 3 (DSM-III) (Washington, D.C.: American Psychiatric Association, 1980), 236.
2. N. C. Andreasen, "Posttraumatic Stress Disorder," in *Comprehensive Textbook of Psychiatry,* 4th ed., ed. H. I. Kaplan and B. J. Sadock (Baltimore: Williams & Wilkins, 1985), 918–24.
3. B. L. Green, J. D. Lindy, M. C. Grace et al., "Buffalo Creek Survivors in the Second Decade: Stability of Stress Symptoms," *American Journal of Orthopsychiatry* 60 (1990): 43–54.
4. B. Green, J. Lindy, and M. Grace, "Posttraumatic Stress Disorder: Toward DSM-IV," *Journal of Nervous and Mental Disease* 173 (1985): 406–11.
5. P. Janet, *L'Automatisme Psychologique* (Paris: Félix Alcan, 1889), 457. For a review and summary of Janet's work on psychological trauma see B. A. van der Kolk and O. van der Hart, "Pierre Janet and the Breakdown of Adaptation in Psychological Trauma," *American Journal of Psychiatry* 146 (1989): 1530–40.
6. A. Kardiner and H. Spiegel, *War, Stress, and Neurotic Illness* (rev. ed. *The Traumatic Neuroses of War*) (New York: Hoeber, 1947), 186.
7. R. Graves, *Goodbye to All That* [1929] (New York: Doubleday, 1957), 257.
8. Kardiner and Spiegel, *War, Stress,* 13.
9. R. Grinker and J. P. Spiegel, *Men Under Stress* (Philadelphia: Blakeston, 1945), 219–20.
10. L. C. Kolb, "A Neuropsychological Hypothesis Explaining Post-Traumatic Stress Disorders," *American Journal of Psychiatry* 144 (1987): 989–95.
11. R. Pitman, *Biological Findings in PTSD: Implications for DSM-IV Classification* (unpublished ms., Veterans Administration Center, Manchester, NH, 1990), 16.
12. M. E. McFall, M. M. Murburg, D. K. Roszell et al. "Psychophysiologic and Neuroendocrine Findings in Posttraumatic Stress Disorder: A Review of Theory and Research," *Journal of Anxiety Disorders* 3 (1989): 243–57.
13. A. Shalev, S. Orr, T. Peri et al. "Impaired Habituation of the Automatic Component of the Acoustic Startle Response in Post-Traumatic Stress Disorder" (Paper presented at the American Psychiatric Association Annual Meeting, New Orleans, LA, 1991).
14. L. C. Kolb and L. R. Multipassi, "The Conditioned Emotional Response: A Subclass of Chronic and Delayed Post-Traumatic Stress Disorder," *Psychiatric Annals* 12 (1982): 979–87. T. M. Keane, R. T. Zimering, and J. M. Caddell, "A Behavioral Formulation of Posttraumatic Stress Disorder in Vietnam Veterans," *The Behavior Therapist* 8 (1985): 9–12.
15. S. Freud, "Beyond the Pleasure Principle," [1922] in *Standard Edition,* vol. 18 (London: Hogarth Press 1955): 7–64, quote on 13.
16. Kardiner and Spiegel, *War, Stress,* 201.

17. P. Janet, *Psychological Healing,* [1919] vol. 1, trans. E. Paul and C. Paul (New York: Macmillan, 1925), 661–63.
18. D. Lessing, "My Father," in *A Small Personal Voice* (New York: Random House, 1975), 87.
19. E. A. Brett and R. Ostroff, "Imagery in Post-Traumatic Stress Disorder: An Overview," *American Journal of Psychiatry* 142 (1985): 417–24.
20. R. J. Lifton, "The Concept of the Survivor," in *Survivors, Victims, and Perpetrators: Essays on the Nazi Holocaust,* ed. J. E. Dimsdale (New York: Hemisphere, 1980), 113–26.
21. T. O'Brien, "How to Tell a True War Story," in *The Things They Carried* (Boston: Houghton Mifflin, 1990), 89.
22. B. A. van der Kolk, "The Trauma Spectrum: The Interaction of Biological and Social Events in the Genesis of the Trauma Response," *Journal of Traumatic Stress* 1 (1988): 273–90.
23. L. Terr, "What Happens to Early Memories of Trauma? A Study of Twenty Children Under Age Five at the Time of Documented Traumatic Events," *Journal of the American Academy of Child and Adolescent Psychiatry* 27 (1988): 96–104.
24. R. Pitman, "Post-Traumatic Stress Disorder, Hormones, and Memory," *Biological Psychiatry* 26 (1989): 221–23.
25. van der Kolk, "Trauma Spectrum."
26. B. A. van der Kolk, R. Blitz, W. Burr et al., "Nightmares and Trauma," *American Journal of Psychiatry* 141 (1984): 187–90; R. J. Ross, W. A. Ball, K. A. Sullivan et al., "Sleep Disturbance as the Hallmark of Post-Traumatic Stress Disorder," *American Journal of Psychiatry* 146 (1989): 697–707.
27. L. Terr, *Too Scared to Cry* (New York: HarperCollins 1990), 238, 239, 247.
28. Interview, S. Abdulali, 2 April 1991.
29. Interview, S. Simone, 7 May 1991.
30. Interview, K. Smith, 14 June 1991.
31. Freud; "Pleasure Principle."
32. Janet, *Psychological Healing,* 603.
33. M. Horowitz, *Stress Response Syndromes* (Northvale, NJ: Jason Aronson, 1986), 93–94.
34. P. Russell, "Trauma, Repetition and Affect" (Paper presented at Psychiatry Grand Rounds, Cambridge Hospital, Cambridge, MA, 5 September 1990).
35. New York Radical Feminist Speakout on Rape, 1971, as quoted in S. Brownmiller, *Against Our Will: Men, Women, and Rape* (New York: Simon & Schuster, 1975), 358.
36. Quoted in P. Bart and P. O'Brien, *Stopping Rape: Successful Survival Strategies* (New York: Pergamon, 1985), 47.
37. Quoted in R. Warshaw, *I Never Called it Rape* (New York: Harper & Row, 1988), 56.
38. Quoted in N. Frankel and L. Smith, *Patton's Best* (New York: Hawthorne Books, 1978), 89.

39. E. Hilgard, *Divided Consciousness: Multiple Controls in Human Thought and Action* (New York: John Wiley, 1977).
40. D. Spiegel, "Hypnosis, Dissociation, and Trauma," in *Repression and Dissociation: Implications for Personality Theory, Psychopathology, and Health*, ed. J. L. Singer (Chicago: University of Chicago Press, 1990), 121–42.
41. Hilgard, *Divided Consciousness.*
42. J. Hilgard, *Personality and Hypnosis: A Study of Imaginative Involvement* (Chicago: University of Chicago Press, 1970); R. K. Stutman and E. L. Bliss, "Post-Traumatic Stress Disorder, Hypnotizability, and Imagery," *American Journal of Psychiatry* 142 (1985): 741–43; D. Spiegel, T. Hunt, and H. Dondershine, "Dissociation and Hypnotizability in Post-Traumatic Stress Disorder," *American Journal of Psychiatry* 145 (1988): 301–5; J. L. Herman, J. C. Perry, and B. A. van der Kolk, "Childhood Trauma in Borderline Personality Disorder," *American Journal of Psychiatry* 146 (1989): 490–95.
43. D. Spiegel, E. J. Frischholz, H. Spiegel et al., "Dissociation, Hypnotizability, and Trauma" (Paper presented at the annual meeting of the American Psychiatric Association, San Francisco, May 1989), 2.
44. Hilgard, *Divided Consciousness,* 246.
45. R. K. Pitman, B. A. van der Kolk, S. P. Orr et al., "Naloxone-Reversible Analgesic Response to Combat-Related Stimuli in Post-Traumatic Stress Disorder: A Pilot Study," *Archives of General Psychiatry* 47 (1990): 541–47.
46. Grinker and Spiegel, *Men Under Stress.*
47. J. J. Card, *Lives After Vietnam: The Personal Impact of Military Service* (Lexington, MA: D. C. Heath, 1983).
48. H. Hendin and A. P. Haas, *Wounds of War: The Psychological Aftermath of Combat in Vietnam* (New York: Basic Books, 1984).
49. R. A. Kulka, W. E. Schlenger, J. A. Fairbank et al., *Trauma and the Vietnam War Generation* (New York: Brunner/Mazel, 1990).
50. Lifton, *Concept of the Survivor.*
51. P. Janet, *L'Etat mental des hystériques* (Paris: Félix Alcan, 1911).
52. Kardiner and Spiegel, *War, Stress,* 128, case 28 (my italics).
53. New York Radical Feminist Speakout, 1971, as quoted in *Rape: The First Sourcebook for Women,* ed. N. Connell and C. Wilson (New York: New American Library, 1974), 44.
54. Quoted in Warshaw, *I Never Called It Rape,* 33.
55. Interview, K. Smith, 1991.
56. Grinker and Spiegel, *Men Under Stress.*
57. L. C. Terr, "Chowchilla Revisited: The Effects of Psychic Trauma Four Years After a School-Bus Kidnapping," *American Journal of Psychiatry* 140 (1983): 1543–50.
58. Kardiner and Spiegel, *War, Stress;* Horowitz, *Stress Response Syndromes;* Brett & Ostroff, *Imagery.*
59. van der Kolk points out that the hyperarousal symptoms of PTSD are congruent with those of opiate withdrawal and postulates a disturbance in the normal balance between central adrenergic and opioid systems. See his "Inescapable Shock, Neurotransmitters, and Addiction to Trauma: Toward a Psychobiology of Post Traumatic Stress," *Biological Psychiatry* 20 (1985): 314–25.
60. D. G. Kilpatrick, L. J. Veronen, and P. A. Resick, "The Aftermath of Rape: Recent Empirical Findings," *American Journal of Orthospychiatry* 49 (1979): 658–69.
61. J. V. Becker, L. J. Skinner, G. G. Abel et al., "The Effects of Sexual Assault on Rape and Attempted Rape Victims," *Victimology* 7 (1982): 106–13.
62. C. C. Nadelson, M. T. Notman, H. Jackson et al., "A Follow-up Study of Rape Victims," *American Journal of Psychiatry* 139 (1982): 1266–70.
63. A. W. Burgess and L. L. Holmstrom, "Adaptive Strategies and Recovery from Rape," *American Journal of Psychiatry* 136 (1979): 1278–82.
64. H. M. van der Ploerd and W. C. Kleijn, "Being Held Hostage in the Netherlands: A Study of Long-Term Aftereffects," *Journal of Traumatic Stress* 2 (1989): 153–70.
65. Kardiner and Spiegel, *War, Stress,* case 40, 381–89.
66. C. Van Dyke, N. J. Zilberg, and J. A. McKinnon, "PTSD: A 30-year Delay in a WW II Combat Veteran," *American Journal of Psychiatry* 142 (1985): 1070–73.
67. S. Sutherland and D. J. Scherl, "Patterns of Response Among Victims of Rape," *American Journal of Orthopsychiatry* 40 (1970): 503–11; E. Hilberman, *The Rape Victim* (Washington, D.C.: American Psychiatric Press, 1976); D. Rose, " 'Worse than death': Psychodynamics of Rape Victims and the Need for Psychotherapy," *American Journal of Psychiatry* 143 (1986): 817–24.
68. V. Woolf, *Mrs. Dalloway* [1925] (New York: Harvest, 1975), 132–33.
69. Lessing, *Small Personal Voice,* 86.
70. D. G. Kilpatrick, C. L. Best, L. J. Veronen et al., "Mental Health Correlates of Criminal Victimization: A Random Community Survey," *Journal of Consulting and Clinical Psychology* 53 (1985): 866–73.
71. D. A. Pollock, M. S. Rhodes, C. A. Boyle et al., "Estimating the Number of Suicides Among Vietnam Veterans," *American Journal of Psychiatry* 147 (1990): 772–76.
72. H. Hendin and A. P. Haas, "Suicide and Guilt as Manifestations of PTSD in Vietnam Combat Veterans," *American Journal of Psychiatry* 148 (1991): 586–91.
73. Freud, "Pleasure Principle," 35.

Chapter 3

1. M. Horowitz, *Stress Response Syndromes* (Northvale, NJ: Jason Aronson, 1986).
2. R. Janoff-Bulman, "The Aftermath of Victimization: Rebuilding Shattered Assumptions," in *Trauma and Its Wake,* ed. C. Figley (New York: Brunner/Mazel, 1985), 15–35.

Scurfield, "Post-Trauma Stress Assessment and Treatment: Overview and Formulations," in C. R. Figley, *Trauma and Its Wake,* vol. 1 (New York: Brunner/Mazel, 1985), 219–56; F. Putnam, *Diagnosis and Treatment of Multiple Personality Disorder* (New York: Guilford Press, 1989).

2. D. P. Brown and E. Fromm, *Hypnotherapy and Hypnoanalysis* (Hillsdale, NJ: Lawrence Erlbaum, 1986); E. R. Parson, "Post-Traumatic Self Disorders: Theoretical and Practical Considerations in Psychotherapy of Vietnam War Veterans," in *Human Adaptation to Extreme Stress,* ed. J. P. Wilson, Z. Harel, and B. Kahana (New York: Plenum, 1988), 245–83; Putnam, *Multiple Personality Disorder.*
3. S. Sgroi, "Stages of Recovery for Adult Survivors of Child Sexual Abuse," in *Vulnerable Populations,* vol. 2, ed. S. Sgroi (Lexington, MA: D. C. Heath, 1989), 11–130.
4. L. S. Schwartz, "A Biopsychosocial Treatment Approach to PTSD," *Journal of Traumatic Stress* 3 (1990): 221–38.
5. Putnam, *Multiple Personality Disorder.*
6. R. P. Kluft, "The Natural History of Multiple Personality Disorder," in *Childhood Antecedents of Multiple Personality Disorder,* ed. R. P. Kluft (Washington, D.C.: American Psychiatric Press, 1984), 197–238.
7. A. Holen, *A Long-Term Outcome Study of Survivors from a Disaster* (Oslo, Norway: University of Oslo Press, 1990); idem, "Surviving a Man-Made Disaster: Five-Year Follow Up of an Oil-Rig Collapse" (Paper presented at Boston Area Trauma Study Group, March 1988).
8. See, for example, the discussion of initial formulation of the effects of incest in J. Herman, *Father-Daughter Incest* (Cambridge: Harvard University Press, 1981).
9. I. Agger and S. B. Jensen, "Testimony as Ritual and Evidence in Psychotherapy for Political Refugees," *Journal of Traumatic Stress* 3 (1990): 115–30, quote on 124.
10. Quoted in T. Beneke, *Men on Rape* (New York: St. Martin's Press, 1982), 137.
11. J. Davidson, S. Roth, and E. Newman, "Fluoxetine in PTSD," *Journal of Traumatic Stress* 4 (1991): 419–24; P. J. Markovitz, J. R. Calabrese, S. C. Schulze et al.: "Fluoxetine in the Treatment of Borderline and Schizotypal Personality Disorders," *American Journal of Psychiatry* 148 (1991): 1064–67; J. Shay, "Fluoxetine Reduces Explosiveness and Elevates Mood of Vietnam Combat Veterans with PTSD," *Journal of Traumatic Stress* 5 (1992), in press; B. A. van der Kolk, preliminary data, controlled study of fluoxetine in PTSD (Trauma Clinic, Massachusetts General Hospital, Boston, MA, 1991).
12. For a review of the psychopharmacology of PTSD see M. Friedman, "Biological Approaches to the Diagnosis and Treatment of PTSD," *Journal of Traumatic Stress* 4 (1991): 69–72; J. M. Silver, D. P. Sandberg, and R. E. Hales, "New Approaches in the Pharmacotherapy of Posttraumatic Stress Disorder," *Journal of Clinical Psychiatry* 51, supplement (1990): 33–38.
13. For exploration of the role of the family in response to traumatic events see C. Figley, ed., *Treating Stress in Families* (New York: Brunner/Mazel, 1990).

14. J. Schorer, *It Couldn't Happen to Me: One Woman's Story* (Des Moines, IA: *Des Moines Register* reprint 1990), 6.
15. D. G. Kilpatrick, L. J. Veronen, and P. A. Resick, "The Aftermath of Rape: Recent Empirical Findings," *American Journal of Orthopsychiatry* 49 (1979): 658–69.
16. L. Ledray, *The Impact of Rape and the Relative Efficacy of Guide-to-Goals and Supportive Counseling as Treatment Models for Rape Victims* (Ph.D. diss., University of Minnesota, Minneapolis, 1984).
17. M. P. Koss and M. R. Harvey, *The Rape Victim: Clinical and Community Interventions* (Beverly Hills, CA: Sage, 1991).
18. G. L. Belenky, S. Noy, and Z. Solomon, "Battle Factors, Morale, Leadership, Cohesion, Combat Effectiveness, and Psychiatric Casualties," in *Contemporary Studies in Combat Psychiatry,* ed. G. L. Belenky (Westport, CT: Greenwood Press, 1987).
19. D. Rose, " 'Worse than Death': Psychodynamics of Rape Victims and the Need for Psychotherapy," *American Journal of Psychiatry* 143 (1986): 817–24; Z. Solomon, *The Never-Ending Battle* (unpublished ms., Mental Health Department, Israeli Defense Forces, 1990).
20. J. Gunderson, *Borderline Personality Disorder* (Washington, D.C.: American Psychiatric Press, 1984), 54.
21. S. Schechter, *Guidelines for Mental Health Practitioners in Domestic Violence Cases* (Washington, D.C.: National Coalition Against Domestic Violence, 1987).
22. For a prototype of such programs see D. Adams, "Treatment Models of Men Who Batter," in K. Yllo and M. Bograd, *Feminist Perspectives on Wife Abuse* (Beverly Hills, CA: Sage, 1988), 176–99.
23. E. Schatzow and J. Herman, "Breaking Secrecy: Adult Survivors Disclose to Their Families," *Psychiatric Clinics of North America* 12 (1989): 337–49.

Chapter 9

1. R. Mollica, "The Trauma Story: The Psychiatric Care of Refugee Survivors of Violence and Torture," in *Post-Traumatic Therapy and Victims of Violence,* ed. F. Ochberg (New York: Brunner/Mazel, 1988), 295–314.
2. F. Snider, Presentation at Boston Area Trauma Study Group (1986).
3. S. Freud, "Remembering, Repeating, and Working-Through (Further Recommendations on the Technique of Psycho-Analysis, II," [1914]) in *Standard Edition,* vol. 12, trans. J. Strachey (London: Hogarth Press, 1958), 145–56. This paper also contains the first mention of the concept of a repetition-compulsion, which Freud later elaborated in "Beyond the Pleasure Principle."
4. Y. Danieli, "Treating Survivors and Children of Survivors of the Nazi Holocaust," in *Post-Traumatic Therapy,* ed. F. Ochberg, 278–94, quote on 286.
5. Interview, J. Wolfe and T. Keane, January 1991.

6. L. McCann and L. Pearlman, *Psychological Trauma and the Adult Survivor: Theory, Therapy, and Transformation* (New York: Brunner/Mazel, 1990).
7. Breuer and Freud, "Studies on Hysteria," [1893–95] in *Standard Edition*, vol. 2, trans. J. Strachey (London: Hogarth Press, 1955), 6.
8. This simultaneous present and past orientation is well described in V. Rozynko and H. E. Dondershine, "Trauma Focus Group Therapy for Vietnam Veterans with PTSD," *Psychotherapy* 28 (1991): 157–61.
9. The term is from R. Janoff-Bulman, "The Aftermath of Victimization: Rebuilding Shattered Assumptions," in *Trauma and Its Wake*, ed. C. Figley (New York: Brunner/Mazel, 1985), 135.
10. Interview, Karen, 1986.
11. O. van der Hart, P. Brown, and B. van der Kolk, "Pierre Janet's Treatment of Post-Traumatic Stress," *Journal of Traumatic Stress* 2 (1989): 379–96.
12. S. Hill and J. M. Goodwin, *Freud's Notes on a Seventeenth Century Case of Demonic Possession: Understanding the Uses of Exorcism* (unpublished ms., Department of Psychiatry, Medical College of Wisconsin, Milwaukee, 1991).
13. I. Agger and S. B. Jensen, "Testimony as Ritual and Evidence in Psychotherapy for Political Refugees," *Journal of Traumatic Stress* 3 (1990): 115–30.
14. Mollica, "The Trauma Story," quote on 312.
15. T. M. Keane, J. A. Fairbank, J. M. Caddell et al., "Implosive (Flooding) Therapy Reduces Symptoms of PTSD in Vietnam Combat Veterans," *Behavior Therapy* 20 (1989): 245–60.
16. A. J. Cienfuegos and C. Monelli, "The Testimony of Political Repression as a Therapeutic Instrument," *American Journal of Orthopsychiatry* 53 (1983): 43–51, quote on 50.
17. Agger and Jensen, "Testimony as Ritual."
18. Cienfuegos and Monelli, "Testimony of Political Repression."
19. T. Keane, presentation at Harvard Medical School Conference on Psychological Trauma, Boston, MA, June 1990.
20. Keane's work has recently been confirmed in a similar treatment program for combat veterans. See P. A. Boudeyns, L. Hyer, M. Woods et al., "PTSD Among Vietnam Veterans: An Early Look at Treatment Outcome Using Direct Therapeutic Exposure," *Journal of Traumatic Stress* 3 (1990): 359–68.
21. W. Owen, letter to his mother, February 1918, as quoted in P. Fussell, *The Great War and Modern Memory* (London: Oxford University Press, 1975), 327.
22. S. Freud, "The Aetiology of Hysteria," [1896] in *Standard Edition*, vol. 3, trans. J. Strachey (London: Hogarth Press, 1962), 191–221, quote on 205.
23. Interview, S. Simone, 1991.
24. D. Brown and E. Fromm, *Hypnotherapy and Hypnoanalysis* (Hillsdale NJ: Lawrence Erlbaum, 1986).
25. Interview, S. Moore, 16 November 1990.
26. R. Kluft, Course on Treatment of Multiple Personality Disorder, Annual Meeting of the American Psychiatric Association, San Francisco, CA, May 1989.

27. A. Shalev, T. Gali, S. Schreiber, and R. Halamish, *Levels of Trauma: A Multidimensional Approach to the Psychotherapy of PTSD* (unpublished ms., Center for Traumatic Stress, Hadassah Hospital, Jerusalem, Israel, 1991).
28. R. F. Mollica, G. Wyshak, J. Lavelle et al., "Assessing Symptom Change in Southeast Asian Refugee Survivors of Mass Violence and Torture," *American Journal of Psychiatry* 147 (1990): 83–88.
29. For discussion of the dynamics of mourning see B. Raphael, *The Anatomy of Bereavement* (New York: Basic Books, 1984); C. M. Parkes, *Bereavement: Studies of Grief in Adult Life* (London: Tavistock, 1986).
30. Danieli, "Treating Survivors," 282.
31. Interview, Claudia, 1972.
32. R. S. Laufer, E. Brett, and M. S. Gallops, "Symptom Patterns Associated with Post-Traumatic Stress Disorder Among Vietnam Veterans Exposed to War Trauma," *American Journal of Psychiatry* 142 (1985): 1304–11.
33. I owe this formulation of the transformation of helpless rage to righteous indignation to my mother. See H. B. Lewis, *Shame and Guilt in Neurosis* (New York: International Universities Press, 1971); H. B. Lewis, "Shame: The 'Sleeper' in Psychopathology," in H. B. Lewis, *The Role of Shame in Symptom Formation* (Hillsdale, NJ: Lawrence Erlbaum, 1987), 1–28.
34. L. Shengold, *Soul Murder: The Effects of Childhood Abuse and Deprivation* (New Haven: Yale University Press, 1989), 315.
35. Danieli, "Treating Survivors," 287.
36. Interview, S. Abdulali, 1991. Terence Keane also cites boredom with the trauma story as a sign of completion (interview, 1991).

Chapter 10

1. M. H. Stone, "Individual Psychotherapy with Victims of Incest," *Psychiatric Clinics of North America* 12 (1989): 237–56, quote on 251–52.
2. Quoted in E. Bass and L. Davis, *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse* (New York: Harper & Row, 1988), 163.
3. Interview, M. Soalt, Model Mugging of Boston, 7 December 1990.
4. Interview, M. Soalt, 1990.
5. J. Goodwin, "Group Psychotherapy for Victims of Incest," *Psychiatric Clinics of North America* 12 (1989): 279–93, quote on 289.
6. M. Horowitz, *Stress Response Syndromes* (Northvale, NJ: Jason Aronson, 1986), 136.
7. R. J. Lifton, *Home from the War: Vietnam Veterans: Neither Victims nor Executioners* (New York: Simon & Schuster, 1973), 287.
8. Quoted in E. Schatzow and J. Herman, "Breaking Secrecy: Adult Survivors Disclose to Their Families," *Psychiatric Clinics of North America* 12 (1989): 337–49, quote on 348.
9. G. NiCarthy, *Getting Free: A Handbook for Women in Abusive Relationships* (Seattle, WA: Seal Press, 1982), 238.