TRAUMA AND RECOVERY

The Aftermath of Violence— From Domestic Abuse to Political Terror

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seems possible to further paraphrase the relation of adult integrity and infantile trust by saying that healthy children will not fear life if their elders have integrity enough not to fear death."[54]

Integrity is the capacity to affirm the value of life in the face of death, to be reconciled with the finite limits of one's own life and the tragic limitations of the human condition, and to accept these realities without despair. Integrity is the foundation upon which trust in relationships is originally formed, and upon which shattered trust may be restored. The interlocking of integrity and trust in caretaking relationships completes the cycle of generations and regenerates the sense of human community which trauma destroys.

CHAPTER 8

Safety

RECOVERY UNFOLDS in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central task of the third stage is reconnection with ordinary life. Like any abstract concept, these stages of recovery are a convenient fiction, not to be taken too literally. They are an attempt to impose simplicity and order upon a process that is inherently turbulent and complex. But the same basic concept of recovery stages has emerged repeatedly, from Janet's classic work on hysteria to recent descriptions of work with combat trauma, dissociative disorders, and multiple personality disorder.[1] Not all observers divide their stages into three; some discern five, others as many as eight stages in the recovery process.[2] Nevertheless, there is a rough congruence in these formulations. A similar progression of recovery can be found across the spectrum of the traumatic syndromes (see table). No single course of recovery follows these stages through a straightforward linear sequence. Oscillating and dialectical in nature, the traumatic syndromes defy any attempt to impose such simpleminded order. In fact, patients and therapists alike frequently become discouraged when issues that have supposedly been put to rest stubbornly reappear. One therapist describes the progression through the stages of recovery as a spiral, in which earlier issues are continually revisited on a higher level of integration.[3] However, in the course of a successful recovery, it should be possible to recognize a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection.

The traumatic syndromes are complex disorders, requiring complex

Stages of Recovery

Syndrome	Stage One	Stage Two	Stage Three
Hysteria (Janet 1889)	Stabilization, symptom-oriented treatment	Exploration of traumatic memories	Personality reintegration, rehabilitation
Combat trauma (Scurfield 1985)	Trust, stress-management, education	Reexperiencing trauma	Integration of trauma
Complicated post-traumatic stress disorder (Brown & Fromm 1986)	Stabilization	Integration of memories	Development of self, drive integration
Multiple personality disorder (Putnam 1989)	Diagnosis, stabilization, communication, cooperation	Metabolism of trauma	Resolution, integration, development of postresolution coping skills
Traumatic disorders (Herman 1992)	Safety	Remembrance and mourning	Reconnection

treatment. Because trauma affects every aspect of human functioning, from the biological to the social, treatment must be comprehensive.[4] Because recovery occurs in stages, treatment must be appropriate at each stage. A form of therapy that may be useful for a patient at one stage may be of little use or even harmful to the same patient at another stage. Furthermore, even a well-timed therapy intervention may fail if the other necessary components of treatment appropriate to each stage are absent. At each stage of recovery, comprehensive treatment must address the characteristic biological, psychological, and social components of the disorder. There is no single, efficacious "magic bullet" for the traumatic syndromes.

NAMING THE PROBLEM

Traumatic syndromes cannot be properly treated if they are not diagnosed. The therapist's first task is to conduct a thorough and informed

diagnostic evaluation, with full awareness of the many disguises in which a traumatic disorder may appear. With patients who have suffered a recent acute trauma, the diagnosis is usually fairly straightforward. In these situations clear, detailed information regarding post-traumatic reactions is often invaluable to the patient and her family or friends. If the patient is prepared for the symptoms of hyperarousal, intrusion, and numbing, she will be far less frightened when they occur. If she and those closest to her are prepared for the disruptions in relationship that follow upon traumatic experience, they will be far more able to tolerate them and take them in stride. Furthermore, if the patient is offered advice on adaptive coping strategies and warned against common mistakes, her sense of competence and efficacy will be immediately enhanced. Working with survivors of a recent acute trauma offers therapists an excellent opportunity for effective preventive education.

With patients who have suffered prolonged, repeated trauma, the matter of diagnosis is not nearly so straightforward. Disguised presentations are common in complex post-traumatic stress disorder. Initially the patient may complain only of physical symptoms, or of chronic insomnia or anxiety, or of intractable depression, or of problematic relationships. Explicit questioning is often required to determine whether the patient is presently living in fear of someone's violence or has lived in fear at some time in the past. Traditionally these questions have not been asked. They should be a routine part of every diagnostic evaluation.

When the patient has been subjected to prolonged abuse in childhood, the task of diagnosis becomes even more complicated. The patient may not have full recall of the traumatic history and may initially deny such a history, even with careful, direct questioning. More commonly, the patient remembers at least some part of her traumatic history but does not make any connection between the abuse in the past and her psychological problems in the present. Arriving at a clear diagnosis is most difficult of all in cases of severe dissociative disorder. The average delay between the patient's first encounter with the mental health system and an accurate diagnosis of multiple personality disorder is six years.[5] Here both parties to the therapeutic relationship may conspire to avoid the diagnosis—the therapist through ignorance or denial, the patient through shame or fear. Though a small minority of patients with multiple personality disorder seem to enjoy and flaunt the dramatic features of their condition, the majority seek to conceal their symptoms. Even after the clinician has arrived at a presumptive diagnosis of multiple personality disorder, it is not at all unusual for the patient to reject the diagnosis.[6]

If the therapist believes the patient is suffering from a traumatic syndrome, she should share this information fully with the patient. Knowledge is power. The traumatized person is often relieved simply to learn the true name of her condition. By ascertaining her diagnosis, she begins the process of mastery. No longer imprisoned in the wordlessness of the trauma, she discovers that there is a language for her experience. She discovers that she is not alone; others have suffered in similar ways. She discovers further that she is not crazy; the traumatic syndromes are normal human responses to extreme circumstances. And she discovers, finally, that she is not doomed to suffer this condition indefinitely; she can expect to recover, as others have recovered.

The immense importance of sharing information in the immediate aftermath of the trauma is illustrated by the experience of a team of Norwegian psychologists who took part in a rescue effort after a disaster at sea. Survivors of a capsized offshore oil rig were briefly counseled by a mental health team after their rescue and given a one-page fact sheet on post-traumatic stress disorder. In addition to listing the most common symptoms, the fact sheet offered two practical recommendations. Survivors were advised, first, to talk with others about their experience in spite of a predictable temptation to withdraw, and second, to avoid using alcohol for control of their symptoms. One year after the disaster the survivors were contacted for follow-up interviews. Many of the men still carried in their wallets the fact sheet that they had been given on the day of their rescue, now tattered from many readings and rereadings.[7]

With survivors of prolonged, repeated trauma, it is particularly important to name the complex post-traumatic disorder and to explain the personality deformations that occur in captivity. While patients with simple post-traumatic stress disorder fear they may be losing their minds, patients with the complex disorder often feel they have lost themselves. The question of what is wrong with them has often become hopelessly muddled and ridden with moral judgment. A conceptual framework that relates the patient's problems with identity and relationships to the trauma history provides a useful basis for formation of a therapeutic alliance.[8] This framework both recognizes the harmful nature of the abuse and provides a reasonable explanation for the patient's persistent difficulties.

Though many patients are relieved to learn that their suffering has a name, some patients resist the diagnosis of a post-traumatic disorder. They may feel stigmatized by any psychiatric diagnosis or wish to deny their condition out of a sense of pride. Some people feel that acknowledging psychological harm grants a moral victory to the perpetrator, in a way

that acknowledging physical harm does not. Admitting the need for help may also compound the survivor's sense of defeat. The therapists Inger Agger and Soren Jensen, who work with political refugees, describe the case of K, a torture survivor with severe post-traumatic symptoms who adamantly insisted that he had no psychological problems: "K . . . did not understand why he was to talk with a therapist. His problems were medical: the reason why he did not sleep at night was due to the pain in his legs and feet. He was asked by the therapist . . . about his political background, and K told that he was a Marxist and that he had read about Freud and he did not believe in any of that stuff: how could his pain go away by talking to a therapist?"

This patient eventually agreed to tell his story to a therapist, not to help himself but to further his political cause. Though in the process he obtained considerable symptomatic relief, he never acknowledged either his diagnosis or his need for treatment: "K said that he wanted to give his testimony, but that he also wanted to know why the therapist was willing to help him do that. The therapist answered that she considered it an important part of her work to collect information about what was going on in the prisons in his country. She also explained that it was her experience that it helped people who had been tortured and had nightmares about the torture to tell others about what happened. K then took the attitude of: 'Well, if I can use the therapist for my own purposes, then ok—but it does not have anything to do with therapy.' "[9]

Often it is necessary for the therapist to reframe accepting help as an act of courage. Acknowledging the reality of one's condition and taking steps to change it become signs of strength, not weakness; initiative, not passivity. Taking action to foster recovery, far from granting victory to the abuser, empowers the survivor. The therapist may need to state this view explicitly and in detail, in order to address the feelings of shame and defeat that prevent the survivor from accepting the diagnosis and seeking treatment.

RESTORING CONTROL

Trauma robs the victim of a sense of power and control; the guiding principle of recovery is to restore power and control to the survivor. The first task of recovery is to establish the survivor's safety. This task takes precedence over all others, for no other therapeutic work can possibly succeed if safety has not been adequately secured. No other therapeutic

work should even be attempted until a reasonable degree of safety has been achieved. This initial stage may last days to weeks with acutely traumatized people or months to years with survivors of chronic abuse. The work of the first stage of recovery becomes increasingly complicated in proportion to the severity, duration, and early onset of abuse.

Survivors feel unsafe in their bodies. Their emotions and their thinking feel out of control. They also feel unsafe in relation to other people. The strategies of therapy must address the patient's safety concerns in all of these domains. The *physioneurosis* of post-traumatic stress disorder can be modified with physical strategies. These include the use of medication to reduce reactivity and hyperarousal and the use of behavioral techniques, such as relaxation or hard exercise, to manage stress. The confusion of the disorder can be addressed with cognitive and behavioral strategies. These include the recognition and naming of symptoms, the use of daily logs to chart symptoms and adaptive responses, the definition of manageable "homework" tasks, and the development of concrete safety plans. The destruction of attachments that occurs with the disorder must be addressed by interpersonal strategies. These include the gradual development of a trusting relationship in psychotherapy. Finally, the social alienation of the disorder must be addressed through social strategies. These include mobilizing the survivor's natural support systems, such as her family, lovers, and friends; introducing her to voluntary self-help organizations; and often, as a last resort, calling upon the formal institutions of mental health, social welfare, and justice.

Establishing safety begins by focusing on control of the body and gradually moves outward toward control of the environment. Issues of bodily integrity include attention to basic health needs, regulation of bodily functions such as sleep, eating, and exercise, management of post-traumatic symptoms, and control of self-destructive behaviors. Environmental issues include the establishment of a safe living situation, financial security, mobility, and a plan for self-protection that encompasses the full range of the patient's daily life. Because no one can establish a safe environment alone, the task of developing an adequate safety plan always includes a component of social support.

In cases of a single recent trauma, control of the body begins with medical attention to any injuries the survivor may have suffered. The principle of respecting the patient's autonomy is of great importance from the outset, even in the routine medical examination and treatment of injuries. An emergency-room physician describes the essentials of treating rape victims:

> The most important thing in medically examining someone who's been sexually assaulted is not to re-rape the victim. A cardinal rule of medicine is: Above all do no harm . . . rape victims often experience an intense feeling of helplessness and loss of control. If you just look schematically at what a doctor does to the victim very shortly after the assault with a minimal degree of very passive consent: A stranger makes a very quick intimate contact and inserts an instrument into the vagina with very little control or decision-making on the part of the victim; that is a symbolic setup of a psychological re-rape.
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> So when I do an examination I spend a lot of time preparing the victim; every step along the way I try to give back control to the victim. I might say, "We would like to do this and how we do it is your decision," and provide a large amount of information, much of which I'm sure is never processed; but it still comes across as concern on our part. I try to make the victim an active participant to the fullest extent possible.[10]

Once basic medical care has been provided, control of the body focuses on restoration of the biological rhythms of eating and sleep, and reduction of hyperarousal and intrusive symptoms. If the survivor is highly symptomatic, medication should be considered. While research in the pharmacological treatment of post-traumatic stress disorder is still in its infancy, several classes of medication have shown sufficient promise to warrant clinical use. In studies with combat veterans, a number of antidepressants have been moderately effective, not only for relief of depression but also for intrusive symptoms and hyperarousal. Newer categories of antidepressants that primarily affect the serotonin system of the brain also show considerable promise.[11] Some clinicians recommend medications that block the action of the sympathetic nervous system, such as propranolol, or medications that decrease emotional reactivity, such as lithium, in order to reduce arousal and irritability. Probably the most commonly prescribed medications for post-traumatic stress disorder, as well as for a host of other ills, are the minor tranquilizers, such as benzodiazepenes. These are effective for short-term use in the immediate aftermath of a traumatic event, although they carry some risk of habituation and addiction.[12]

The informed consent of the patient may have as much to do with the outcome as the particular medication prescribed. If the patient is simply ordered to take medication to suppress symptoms, she is once again disempowered. If, on the contrary, she is offered medication as a tool to be used according to her best judgment, it can greatly enhance her sense of efficacy and control. Offering medication in this spirit also builds a cooperative therapeutic alliance.

ESTABLISHING A SAFE ENVIRONMENT

From control of the body, the focus on safety progresses to control of the environment. The acutely traumatized person needs a safe refuge. Finding and securing that refuge is the immediate task of crisis intervention. In the first days or weeks following an acute trauma, the survivor may want to seclude herself in her home, or she may not be able to go home at all. If the perpetrator of the trauma is a family member, home may be the most unsafe place she can choose. Crisis intervention may require a literal flight to shelter. Once the traumatized person has established a refuge, she can gradually progress toward a widening sphere of engagement in the world. It may take weeks to feel safe in resuming such ordinary activities as driving, shopping, visiting friends, or going to work. Each new environment must be scanned and assessed with regard to its potential for security or danger.

The survivor's relationships with other people tend to oscillate between extremes as she attempts to establish a sense of safety. She may seek to surround herself with people at all times, or she may isolate herself completely. In general, she should be encouraged to turn to others for support, but considerable care must be taken to ensure that she chooses people whom she can trust. Family members, lovers, and close friends may be of immeasurable help; they may also interfere with recovery or may themselves be dangerous. An initial evaluation of the traumatized person includes a careful review of the important relationships in her life, assessing each as a potential source of protection, emotional support, or practical help, and also as a potential source of danger.

In cases of recent acute trauma, crisis intervention often includes meeting with supportive family members. The decision about whether to have such meetings, whom to invite, and what sort of information to share ultimately rests with the survivor. It should be clear that the purpose of the meetings is to foster the survivor's recovery, not to treat the family. A little bit of preventive education about post-traumatic disorders, however, may be helpful to all concerned. Family members not only gain a better understanding about how to support the survivor but also learn how to cope with their own vicarious traumatization.[13]

Relatives or close friends who take on the task of participating in the survivor's safety system must expect to have their lives disrupted for a time. They may be called upon to provide round-the-clock support for the basic tasks of daily living. The rape survivor Nancy Ziegenmayer relied upon her husband, Steve, for a sense of safety in the aftermath of the assault: "Just six weeks had passed since a man had forced his way into her car at a Des Moines parking lot and raped her. The man was in jail, but the image of his face was still in front of her each time she closed her eyes. She was jumpy all the time. She cringed when friends hugged or touched her. Only a few people knew about her ordeal. . . . Nights were the hardest. Sometimes she'd doze off, only to have Steve wake her from a nightmare that caused her to pound on him over and over. She was afraid to get up in the dark to use the bathroom, so she'd ask Steve to take her. He became her strength, her pillar."[14]

Underlying tensions in family relationships are frequently brought to light during this sort of crisis. While intervention must focus on helping the survivor and her family to deal with the immediate trauma, sometimes the crisis forces a family to deal with issues that have been previously denied or ignored. In the case of Dan, a 23-year-old gay man, the family equilibrium was altered in the aftermath of a traumatic event:

> Dan was severely beaten by a gang of men in a "gay-bashing" incident outside a bar. When he was hospitalized for his injuries, his parents flew to visit him at the bedside. Dan was terrified that they would discover his secret, which he had never disclosed. Initially he told them that he had been beaten in a robbery attempt. His mother was sympathetic; his father was outraged and wanted to go to the police. Both parents plied Dan with questions about the assault. Dan felt helpless and trapped; he found it more and more difficult to maintain his fictitious story. His symptoms worsened, he became increasingly anxious and agitated, and finally he became uncooperative with his doctors. At this point a mental health consultation was recommended.
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> The consulting therapist, recognizing Dan's dilemma, reviewed his reasons for secrecy. Dan feared his father's homophobic prejudices and violent temper. He was convinced that his father would disown him if he came out. A more careful review of the situation revealed that Dan's mother almost certainly knew and tacitly accepted the fact that he was gay. Dan feared, however, that in a confrontation she would defer to her husband, as she always had.
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> The therapist offered to mediate a meeting between mother and son. The meeting confirmed some of Dan's perceptions: his mother had long known that he was gay and welcomed his coming out to her. She acknowledged that Dan's father had difficulty accepting this reality. She also admitted a habit of humoring and placating her husband rather than confronting him with unwelcome facts. However, she told Dan that he seriously underestimated her if he believed she would ever break off their relationship or allow her husband to do so. Furthermore, she believed Dan had underestimated his father. He might be prejudiced, but he wasn't in the

same category as the criminals who had beaten Dan. She expressed the hope that the assault would bring them closer as a family and that, when the time was right, Dan would consider coming out to his father. Following this meeting, Dan's parents stopped questioning him about the circumstances of the assault and focused on helping him with the practical problems of his recovery.

Establishing a safe environment requires not only the mobilization of caring people but also the development of a plan for future protection. In the aftermath of the trauma, the survivor must assess the degree of continued threat and decide what sort of precautions are necessary. She must also decide what actions she wishes to take against her attacker. Since the best course of action is rarely obvious, decision-making in these matters may be particularly stressful for the survivor and those who care for her. She may feel confused and ambivalent herself and may find her ambivalence reflected in the contradictory opinions of friends, lovers, or family. This is an area where the cardinal principle of empowering the survivor is frequently violated as other people attempt to dictate the survivor's choices or take action without her consent. The case of Janet, a 15-year-old rape survivor, illustrates how a family's response aggravated the impact of the trauma:

Janet was gang-raped at an unsupervised party. The assailants were older boys at her high school. Following the rape, her family quarreled over whether to file criminal charges. Her parents adamantly opposed reporting the crime, because they feared public exposure would damage the family's standing in their small community. They pressured her to forget about the incident and get "back to normal" as soon as possible. Janet's older sister, however, who was married and lived in another town, felt strongly that the rapists ought to be "put away." She invited Janet to live with her, but only on condition that she agree to press charges. Caught in the middle of this conflict, Janet steadily constricted her life. She stopped socializing with friends, skipped school frequently, and spent more and more time in bed complaining of stomachaches. At night she frequently slept in her mother's bed. The family finally sought help for Janet after she took an overdose of aspirin in a suicide gesture.

The therapist first met with Janet. She ascertained that Janet dreaded going to school, where her reputation had been ruined and she had to face continued threats and ridicule from the rapists. She, too, longed to see the rapists punished, but she was too frightened and ashamed to tell her story to the police or testify at trial. The therapist then met with the family and explained the importance of restoring choice to the victim. The family agreed to allow Janet to move in with her sister, who in turn agreed not to pressure Janet to report the crime. Janet's symptoms gradually improved once she was allowed to retreat to an environment that felt safe.

In the matter of criminal reporting, as in all other matters, the choice must rest with the survivor. A decision to report ideally opens the door to social restitution. In reality, however, this decision engages the survivor with a legal system that may be indifferent or hostile to her. Even at best, the survivor has to expect a marked disparity between her own timetable of recovery and the timetable of the justice system. Her efforts to reestablish a sense of safety will most likely be undermined by the intrusions of legal proceedings; just as her life is stabilizing, a court date is likely to revive intrusive traumatic symptoms. The decision to seek redress from the justice system, therefore, cannot be made lightly. The survivor must make an informed choice with the full knowledge of risks as well as benefits; otherwise she will simply be retraumatized.

With survivors of a single acute trauma, a rudimentary sense of safety can generally be restored within a matter of weeks if adequate social support is available. By the end of three months, stabilization in symptoms can usually be expected.[15] Brief treatment that focuses on empowerment of the survivor can hasten the relief of symptoms.[16] The process of establishing safety may be hampered or stymied altogether, however, if the survivor encounters a hostile or unprotective environment. The process may also be disrupted by intrusions outside of the survivor's control, such as legal proceedings. It is nevertheless reasonable to expect that the therapeutic task of the first stage of recovery can be carried out within the general framework of crisis intervention or short-term psychotherapy.[17]

The standard treatment of acute trauma in combat veterans or rape survivors focuses almost entirely on crisis intervention. The military model of brief treatment and rapid return to normal functioning has dominated the therapeutic literature. One fairly typical military program is designed to return soldiers with combat stress reactions to active duty within 72 hours.[18] In these cases, recovery is often assumed to be complete once the patient's most obvious acute symptoms have subsided. Crisis intervention, however, accomplishes the work of only the first stage of recovery. The tasks of the later stages require a more prolonged course of time. Though the survivor may make a rapid and dramatic return to the appearance of normal functioning, this symptomatic stabilization should not be mistaken for full recovery, for the integration of the trauma has not been accomplished.[19]

With survivors of prolonged, repeated trauma, the initial stage of

recovery may be protracted and difficult because of the degree to which the traumatized person has become a danger to herself. The sources of danger may include active self-harm, passive failures of self-protection, and pathological dependency on the abuser. In order to take charge of her own self-care, the survivor must painstakingly rebuild the ego functions that are most severely damaged in captivity. She must regain the ability to take initiative, carry out plans, and exercise independent judgment. Crisis intervention or brief therapy is rarely sufficient to establish safety; a longer course of psychotherapy is generally required.

With survivors of chronic childhood abuse, establishing safety can become an extremely complex and time-consuming task. Self-care is almost always severely disrupted. Self-harming behavior may take numerous forms, including chronic suicidality, self-mutilation, eating disorders, substance abuse, impulsive risk-taking, and repetitive involvement in exploitative or dangerous relationships. Many self-destructive behaviors can be understood as symbolic or literal reenactments of the initial abuse. They serve the function of regulating intolerable feeling states, in the absence of more adaptive self-soothing strategies. The capacities for self-care and self-soothing, which could not develop in the abusive childhood environment, must be painstakingly constructed in later life.

Even the goal of establishing reliable self-care may initially be a point of contention between patient and therapist. The patient who is invested in a fantasy of rescue may resent having to do this work and may want the therapist to do it. The patient who is filled with self-loathing may not feel deserving of good treatment. In both instances, the therapist is often left with the feeling that she is more committed to ensuring the patient's safety than the patient herself. The psychiatrist John Gunderson, for example, describes the early phase of treatment with borderline patients as being focused on "issues of the patient's safety and whose responsibility that will be."[20] A long period of struggle over these issues can be expected.

As in the case of a single acute trauma, establishing safety begins with control of the body and moves outward toward self-protection and the organization of a safe environment. Even the first order of business, control of the body, may be a complicated task, because of the degree to which the survivor has come to view her body as belonging to others. In the case of Marilyn, a 27-year-old woman who had been sexually abused by her father, establishing safety required an initial focus on the patient's care of her body:

> Marilyn sought psychotherapy as a last resort to deal with her severe, chronic back pain. She thought that her pain might be related to stress, and she was willing to give psychotherapy a try. If she did not get quick relief, however, she planned to undergo extensive back surgery, which carried considerable risks of permanent disability. Two prior surgeries had been unsuccessful. Her father, a physician, prescribed her pain medication and participated in the planning of her care; the surgeon was her father's close colleague.
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> The therapy focused initially upon establishing Marilyn's sense of control over her body. The therapist strongly recommended that she postpone her final decision on surgery until she had fully explored all the options available to her. She also recommended that Marilyn keep a daily log of her activities, emotional states, and physical pain. It soon became apparent that her back pain was closely linked to emotional states. In fact, Marilyn discovered that she often engaged in activities that worsened the pain when she felt neglected or angry.
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> Over the course of six months, Marilyn learned behavioral techniques of pain management and gradually formed a trusting relationship in psychotherapy. By the end of a year, her physical complaints had subsided, she was no longer taking medication prescribed by her father, and the possibility of surgery was no longer under consideration. She observed, however, that her back pain recurred during her therapist's vacation and during visits to her family home.

In the process of establishing basic safety and self-care, the patient is called upon to plan and initiate action and to use her best judgment. As she begins to exercise these capacities, which have been systematically undermined by repeated abuse, she enhances her sense of competence, self-esteem, and freedom. Furthermore, she begins to develop some sense of trust in the therapist, based on the therapist's reliable commitment to the task of ensuring safety.

When the survivor is not reliable about her own self-care, the question of involving supportive family members in her treatment often arises. Meetings with family members, lovers, or close friends may be useful. In this, as in all other matters, however, the survivor must be in control of the decision-making process. If this principle is not scrupulously observed, the survivor may come to feel belittled, patronized, or demeaned. She may also begin to feel that the therapist is allied with members of her family rather than with her and that they, not she, are responsible for her recovery. In the case of Florence, a 48-year-old married mother of six children, recovery progressed after the patient identified and reversed a pattern of relinquishing control to her husband:

Florence had been in psychiatric treatment for ten years, carrying diagnoses of major depression, panic disorder, and borderline personality disorder. Her history of extensive childhood abuse was known but had never been addressed in psychotherapy. When Florence had flashbacks or panic episodes, her husband usually telephoned her psychiatrist, who would recommend a tranquilizer.

Upon entering a group for incest survivors, Florence stated that she regarded her husband and her psychiatrist as her "lifelines" and felt she could not manage without them. She accepted their decisions about her care, since she felt she was too "sick" to take an active part in her own treatment. Once she felt securely attached to the group, however, she began to express resentment against her husband for treating her "like a baby." Group members pointed out that if she was capable of taking care of six children, she was probably far more competent than she realized. A turning point was reached when, during an upsetting episode at home, Florence refused to allow her husband to call the psychiatrist, stating that she could decide when such calls were necessary.

The task of establishing safety is particularly complex when the patient is still involved in a relationship that has been abusive in the past. The potential for violence should always be considered, even if the patient initially insists that she is no longer afraid. It is common, for example, for a battered woman and her abuser to seek couple treatment shortly after a violent episode. Often the abuser has promised never to use force again and has agreed to seek counseling to prove his willingness to change. The abused woman is gratified by this promise and eager to enter treatment in order to save the relationship. For this reason, she often denies or minimizes the ongoing danger.

Though both partners may wish for reconciliation, their unspoken goals are often sharply in conflict. The abuser usually wishes to reestablish his pattern of coercive control, while the victim wishes to resist it. Though the abuser is often sincere in his promise to give up the use of force, his promise is hedged with implicit conditions; in return for his pledge of nonviolence, he expects his victim to give up her autonomy. As long as the abuser has not relinquished his wish for dominance, the threat of violence is still present. The victim cannot possibly speak freely in couple sessions, and conflictual issues in the relationship cannot possibly be discussed, without increasing the likelihood of a violent incident. For this reason, couple therapy is contraindicated until the violence has been brought under real control and the pattern of dominance and coercion has been broken.[21]

The guarantee of safety in a battering relationship can never be based upon a promise from the perpetrator, no matter how heartfelt. Rather, it must be based upon the self-protective capability of the victim. Until the victim has developed a detailed and realistic contingency plan and has demonstrated her ability to carry it out, she remains in danger of repeated abuse. Couples seeking help because of violence in their relationship should therefore be advised first to seek treatment separately. Wherever possible, the perpetrator should be referred to specialized programs for men who batter, so that not only the violence but also the underlying problem of coercive control will be addressed in treatment.[22]

The case of Vera, a 24-year-old single mother of three young children who was battered by her boyfriend, illustrates the gradual development of reliable self-protection during a year-long course of psychotherapy. Establishing safety required attention to Vera's care of her children as well as herself. The full range of therapeutic interventions was brought to bear in her treatment, including biological (medication), cognitive and behavioral (education on traumatic syndromes, journal-keeping, and homework tasks), interpersonal (building a therapeutic alliance), and social (family support and a protective court order):

Vera obtained a court order banning her boyfriend from her home after he had beaten her in front of the children. Since his departure, she could not eat or sleep and found it difficult to get out of bed during the day. Nightmares and intrusive memories of violence alternated with fond memories of the good times during their relationship. She had frequent crying spells and thoughts of suicide. She sought therapy in order to "get rid of him once and for all." On careful questioning, however, she acknowledged that she could not imagine life without him. In fact, she had already begun to see him again. She felt like a "love addict."

Though the therapist privately would have liked nothing better than to see Vera separate from her boyfriend, she did not agree to this as a therapeutic goal. She advised Vera not to set goals that seemed unattainable, since she had already had quite enough experiences of failure. Instead, she suggested that Vera postpone her final decision about the relationship until she felt strong enough to make a free choice and that in the meantime she focus on increasing her sense of safety and control of her life. It was agreed that during the initial phase of treatment, Vera would continue to see her boyfriend on occasion but would not allow him to move back into her home and would not leave the children alone with him. These were promises she felt she could keep.

At first Vera was erratic about keeping appointments. The therapist was not critical but pointed out the importance for her own self-respect of following through on plans she had made. Therapy settled into a fairly regular routine after it was agreed that Vera would only schedule appoint-

ments that she was sure she could keep. Each session focused on identifying some positive action, however small, that Vera felt sure she could take on her own behalf. Initially she would rummage through her purse to find scraps of paper on which to write down this weekly "homework." An important milestone was reached when she bought herself a notebook in which to record her weekly tasks and began to check off each accomplishment with a bright red felt-tip marker.

One of Vera's chief complaints was depression. The only times she felt good were during brief romantic interludes with her boyfriend. Occasionally he also supplied her with cocaine, which gave her a transient sense of power and well-being, followed by a "crash" that made her depression even worse. The therapist raised the possibility of a trial of medication for both depression and intrusive post-traumatic symptoms, but explained that she could not prescribe it unless Vera was willing to give up her recreational drug use. Vera chose to accept the medication and felt increased pride and self-confidence after refusing her boyfriend's offer of cocaine. She responded well to antidepressant medication.

As Vera's symptoms abated, the focus of treatment shifted to her children. Since the boyfriend's departure, the children, who used to be quiet and submissive, had gone completely out of control. She complained that they were clinging, demanding, and insolent. Overwhelmed and frustrated, she longed for her boyfriend to return so that he could "knock some sense into them." The therapist offered information about the effects of violence on children and encouraged Vera to seek treatment for her children as well as for herself. She also reviewed practical options for help with child care. The situation improved when Vera, who had been estranged from her family, invited a sister to visit for a few weeks. With her sister's help, she was able to reinstate predictable routines of child care and nonviolent discipline.

The work of the therapy continued to focus on concrete goal-setting. For example, one week Vera agreed to a goal of reading her children a bedtime story. This activity gradually developed into a soothing routine that both she and her children enjoyed, and she found that she no longer had to struggle to get her children to go to bed. Another milestone was reached when Vera's boyfriend called during one of these peaceful times and demanded to see her immediately. Vera refused to be interrupted. She told her boyfriend that she was tired of being available whenever he was in the mood to see her. In the future he would have to make a date with her in advance. In her next therapy session, she reported with astonishment and some sadness that she no longer needed him so desperately; in fact, she really felt capable of getting along without him.

Like battered women, adult survivors of chronic abuse in childhood are often still entangled in complicated relationships with their abusers. They may come into treatment because of ongoing conflict in these

relationships and may wish to involve their families in the initial stages of their treatment. These encounters, too, should be postponed until secure self-protection has been established. Often some degree of coercive control is still present in the relationship between the perpetrator and the adult survivor, and occasionally the abuse itself is still recurring intermittently. The therapist should never assume that safety has already been established but should carefully explore the particulars of the survivor's present family relationships. Patient and therapist together can then delineate problem areas in need of attention. Widening the survivor's sphere of autonomy and setting limits with the family of origin are the appropriate tasks during the initial stage of recovery. Disclosures to the family of origin and confrontations with the perpetrator are far more likely to be successful in the later stages.[23]

Securing a safe environment requires attention not only to the patient's psychological capacity to protect herself but also to the realities of power in her social situation. Even when reliable self-care is established, the patient may still lack a sufficiently safe environment to allow progression to the next stages of recovery, which involve in-depth exploration of the traumatic events. The case of Carmen, a 21-year-old college student, illustrates how a premature family disclosure compromised safety:

> Carmen caused an uproar in her family by accusing her father, a wealthy and prominent businessman, of sexually abusing her. Her parents threatened to take her out of school and commit her to a psychiatric facility. She initially sought treatment in order to prove she was not crazy and to avoid being literally imprisoned by her father. On evaluation, she was found to have many symptoms of a complex post-traumatic syndrome. However, she was not acutely suicidal, homicidal, or unable to care for herself, so there were no grounds for involuntary hospitalization.
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> The therapist initially made clear that he believed Carmen's story. However, he also advised Carmen to consider the realities of power in her situation and to avoid a battle that she was not in a position to win. A compromise was reached: Carmen retracted her accusation and agreed to enter outpatient psychiatric treatment, with a therapist of her choice. As soon as she recanted, her parents calmed down and agreed to allow her to continue school. Her father also agreed to pay for her treatment.
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> In therapy, Carmen recovered more memories and became more certain that incest had in fact occurred; however, she felt obliged to keep silent out of fear that her father would cut off payments for therapy or school. She was accustomed to her family's affluent life-style and felt incapable of supporting herself; thus, she felt entirely at her father's mercy. Finally she realized that she was at an impasse: she could not progress any further with her treatment as long as her father retained financial control of her life.

Therefore, after completing her junior year, she arranged a leave of absence from college, obtained a job and an apartment, and negotiated a reduced fee for therapy, based on her own income. This arrangement allowed her to progress in her recovery.

In this case, creating a safe environment required the patient to make major changes in her life. It entailed difficult choices and sacrifices. This patient discovered, as many others have done, that she could not recover until she took charge of the material circumstances of her life. Without freedom, there can be no safety and no recovery, but freedom is often achieved at great cost. In order to gain their freedom, survivors may have to give up almost everything else. Battered women may lose their homes, their friends, and their livelihood. Survivors of childhood abuse may lose their families. Political refugees may lose their homes and their homeland. Rarely are the dimensions of this sacrifice fully recognized.

COMPLETING THE FIRST STAGE

Because the tasks of the first stage of recovery are arduous and demanding, patient and therapist alike frequently try to bypass them. It is often tempting to overlook the requirements of safety and to rush headlong into the later stages of therapeutic work. Though the single most common therapeutic error is avoidance of the traumatic material, probably the second most common error is premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance.

Patients at times insist upon plunging into graphic, detailed descriptions of their traumatic experiences, in the belief that simply pouring out the story will solve all their problems. At the root of this belief is the fantasy of a violent cathartic cure which will get rid of the trauma once and for all. The patient may imagine a kind of sadomasochistic orgy, in which she will scream, cry, vomit, bleed, die, and be reborn cleansed of the trauma. The therapist's role in this reenactment comes uncomfortably close to that of the perpetrator, for she is invited to rescue the patient by inflicting pain. The patient's desire for this kind of quick and magical cure is fueled by images of early, cathartic treatments of traumatic syndromes which by now pervade popular culture, as well as by the much older religious metaphor of exorcism. The case of Kevin, a 35-year-old divorced man with a long history of alcoholism, illustrates the error of premature uncovering work:

Kevin stopped drinking after he nearly died from medical complications of his alcoholism. Newly sober, he began to be tormented by flashback memories of severe, early childhood abuse. He sought psychotherapy to "get to the bottom" of his problem. He felt that the traumatic memories were the cause of his drinking and that he would never crave alcohol again if he could just "get it all out of my system." He refused to participate in a formal alcoholism program and was not attending Alcoholics Anonymous. He saw these programs as a "crutch" for weak-willed, dependent people and felt that he had no need for such support.

The therapist agreed to focus on Kevin's childhood history. In the psychotherapy sessions Kevin poured out his memories in gruesome detail. His nightmares and flashbacks worsened, and he began to make more and more emergency phone calls between sessions. In the meantime, his attendance at regularly scheduled therapy sessions became erratic. During some of the phone calls Kevin sounded drunk, but he adamantly denied that he had resumed drinking. The therapist realized her error only when Kevin arrived at a session with alcohol on his breath.

In this case the therapist, who was unsophisticated in matters of substance abuse, paid insufficient attention to the task of establishing sobriety. She accepted the patient's argument that he had no need of social support, thus ignoring one of the basic components of safety. She also failed to recognize that exploring traumatic memories in depth was likely to stimulate more intrusive symptoms of post-traumatic stress disorder and therefore to jeopardize the patient's fragile sobriety.

Kevin's case illustrates the need for a thorough evaluation of the patient's current situation before agreement is reached on the focus of psychotherapy. This evaluation includes an assessment of the degree of structure necessary to ensure safety. Outpatient psychotherapy may be inadequate or completely inappropriate for a patient whose self-care or self-protection is badly compromised. The patient may initially need day treatment, a halfway house, or referral to an alcohol or drug treatment program. Hospitalization may be required for detoxification, control of an eating disorder, or containment of suicidality. Necessary social interventions may include reporting children at risk to protective services, obtaining civil protection orders, or facilitating the patient's flight to a shelter.

When the best course of action is unclear, the therapist is better off to err on the side of safety. By so doing, she puts the patient in a position

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.
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> 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.
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> 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.
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> 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 . . .
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> 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 10

Reconnection

HAVING COME TO TERMS with the traumatic past, the survivor faces the task of creating a future. She has mourned the old self that the trauma destroyed; now she must develop a new self. Her relationships have been tested and forever changed by the trauma; now she must develop new relationships. The old beliefs that gave meaning to her life have been challenged; now she must find anew a sustaining faith. These are the tasks of the third stage of recovery. In accomplishing this work, the survivor reclaims her world.

Survivors whose personality has been shaped in the traumatic environment often feel at this stage of recovery as though they are refugees entering a new country. For political exiles, this may be literally true; but for many others, such as battered women or survivors of childhood abuse, the psychological experience can only be compared to immigration. They must build a new life within a radically different culture from the one they have left behind. Emerging from an environment of total control, they feel simultaneously the wonder and uncertainty of freedom. They speak of losing and regaining the world. The psychiatrist Michael Stone, drawing on his work with incest survivors, describes the immensity of this adaptive task: "All victims of incest have, by definition, been taught that the strong can do as they please, without regard for convention. . . . *Re-education* is often indicated, pertaining to what is typical, average, wholesome, and 'normal' in the intimate life of ordinary people. Victims of incest tend to be woefully ignorant of these matters, owing to their skewed and secretive early environments. Although victims in their original homes, they are like strangers in a foreign country, once 'safely' outside."[1]

The issues of the first stage of recovery are often revisited during the third. Once again the survivor devotes energy to the care of her body, her immediate environment, her material needs, and her relationships with others. But while in the first stage the goal was simply to secure a defensive position of basic safety, by the third stage the survivor is ready to engage more actively in the world. From her newly created safe base she can now venture forth. She can establish an agenda. She can recover some of her aspirations from the time before the trauma, or perhaps for the first time she can discover her own ambitions.

Helplessness and isolation are the core experiences of psychological trauma. Empowerment and reconnection are the core experiences of recovery. In the third stage of recovery, the traumatized person recognizes that she has been a victim and understands the effects of her victimization. Now she is ready to incorporate the lessons of her traumatic experience into her life. She is ready to take concrete steps to increase her sense of power and control, to protect herself against future danger, and to deepen her alliances with those whom she has learned to trust. A survivor of childhood sexual abuse describes her arrival at this stage: "I decided, 'Okay, I've had enough of walking around like I'd like to brutalize everyone who looks at me wrong. I don't have to feel like that any more.' Then I thought, 'How would I like to feel.' I wanted to feel safe in the world. I wanted to feel powerful. And so I focused on what was working in my life, in the ways I was taking power in real-life situations."[2]

LEARNING TO FIGHT

Taking power in real-life situations often involves a conscious choice to face danger. By this stage of recovery, survivors understand that their post-traumatic symptoms represent a pathological exaggeration of the normal responses to danger. They are often keenly aware of their continued vulnerability to threats and reminders of the trauma. Rather than passively accepting these reliving experiences, survivors may choose actively to engage their fears. On one level, the choice to expose oneself to danger can be understood as yet another reenactment of trauma. Like reenactment, this choice is an attempt to master the traumatic experience; unlike reenactment, however, it is undertaken consciously, in a planned and methodical manner, and is therefore far more likely to succeed.

For those who have never learned the basics of physical self-defense,

this instruction can become a method of both psychological mastery and physiological reconditioning. For women, it is also a repudiation of the social demand for the submissive, placating stance of traditional feminity. Melissa Soalt, a therapist and instructor in self-defense for women, describes how her training program reconditions the response to threat through a graded series of exercises, in which instructors simulate increasingly aggressive attacks that the students learn to repel:

> Our goal is to have them taste fear but know that they can fight back anyway. By the end of the first class, the sense of power starts to outweigh the fear—or at least runs neck and neck. They're beginning to develop a sensation tolerance for the adrenaline. They get used to the feeling of their hearts pounding. We teach them how to breathe, how to settle under pressure. . . .
>
> The fourth class is often the most intense. . . . It includes a really long fight, where the model muggers keep going and keep going and keep going. People get to a point where they feel like they *can't* go on, but they *have to.* And so people discover that they have a reservoir deeper than they thought, even when they come out of that fight exhausted or crying and shaking like a leaf. That's a very important breakthrough.[3]

By choosing to "taste fear" in these self-defense exercises, survivors put themselves in a position to reconstruct the normal physiological responses to danger, to rebuild the "action system" that was shattered and fragmented by the trauma. As a result, they face their world more confidently: "Their heads are up, they're breathing easier, their eye contact is better, they're more grounded. . . . People will say when they're walking down the street, they're seeing people in the streets more, as opposed to looking down and cowering."[4]

Other forms of disciplined, controlled challenges to fear may be equally important for survivors at this stage of recovery. For example, some treatment programs or self-help organizations offer wilderness trips as a carefully planned encounter with danger. These chosen experiences offer an opportunity to restructure the survivor's maladaptive social responses as well as her physiological and psychological responses to fear. In the words of Jean Goodwin, who has participated as a therapist in wilderness trips with survivors of childhood abuse: "Magical or neurotic means of ensuring safety do not work in this setting. Being 'sweet,' not making demands, 'disappearing,' making excessive and narcissistic demands, waiting for a rescuer: none of these maneuvers puts breakfast on the table. On the other hand, victims are surprised and delighted at the

effectiveness of their realistic coping. In reality, they are able to learn to rappel down a cliff; their adult skills . . . outweigh the fears and low estimation of themselves that initially made them judge this impossible."[5]

In the wilderness situation, as in the self-defense training, the survivor places herself in a position to experience the "fight or flight" response to danger, knowing that she will elect to fight. In so doing, she establishes a degree of control over her own bodily and emotional responses that reaffirms a sense of power. Not all danger is overwhelming; not all fear is terror. By voluntary, direct exposure, the survivor relearns the gradations of fear. The goal is not to obliterate fear but to learn how to live with it, and even how to use it as a source of energy and enlightenment.

Beyond the confrontation with physical danger, survivors at this point often reevaluate their characteristic ways of coping with social situations that may not be overtly threatening but are nonetheless hostile or subtly coercive. They may begin to question previous assumptions that permitted them to acquiesce in socially condoned violence or exploitation. Women question their traditional acceptance of a subordinate role. Men question their traditional complicity in a hierarchy of dominance. Often these assumptions and behaviors have been so ingrained that they have operated outside of awareness. Mardi Horowitz, describing the third stage of psychotherapy with a rape survivor, shows how the patient came to realize that her stereotypically feminine attitudes and behavior put her at risk: "One unconscious attitude present before the stress event was that an erotic approach was the only way to get attention because she herself was so undeserving. . . . In work on the meaning of the rape, she became aware of this defective self-concept and related rescue fantasies. She was able to revise her attitudes, including her automatic and unrealistic expectations that dominant others would feel guilty about exploiting her and then be motivated by guilt to be concerned and tender."[6]

It bears repeating that the survivor is free to examine aspects of her own personality or behavior that rendered her vulnerable to exploitation only after it has been clearly established that the perpetrator alone is responsible for the crime. A frank exploration of the traumatized person's weaknesses and mistakes can be undertaken only in an environment that protects against shaming and harsh judgment. Otherwise, it becomes simply another exercise in blaming the victim. Robert J. Lifton, in his work with Vietnam veterans, makes a clear distinction between the destructive quality of the men's initial self-blame and the constructive, affirming self-examination that subsequently evolved in their "rap group":

> I was struck by the emphasis the men . . . placed upon responsibility and volition. While freely critical of military and political leaders, and of institutions promoting militarism and war, they invariably came back to the self-judgment that they had, themselves, entered willingly. . . . They stressed that they had done so . . . for the most foolish of reasons. But their implication was that they had chosen the military and the war, rather than the military and the war choosing them. Nor was that self-judgment totally attributable to residual guilt; rather, it was part of a struggle to deepen and stretch the reach of the self toward the far limits of autonomy.[7]

As survivors recognize their own socialized assumptions that rendered them vulnerable to exploitation in the past, they may also identify sources of continued social pressure that keep them confined in a victim role in the present. Just as they must overcome their own fears and inner conflicts, they must also overcome these external social pressures; otherwise, they will be continually subjected to symbolic repetitons of the trauma in everyday life. Whereas in the first stage of recovery survivors deal with social adversity mainly by retreating to a protected environment, in the third stage survivors may wish to take the initiative in confronting others. It is at this point that survivors are ready to reveal their secrets, to challenge the indifference or censure of bystanders, and to accuse those who have abused them.

Survivors who grew up in abusive families have often cooperated for years with a family rule of silence. In preserving the family secret, they carry the weight of a burden that does not belong to them. At this point in their recovery, survivors may choose to declare to their families that the rule of silence has been irrevocably broken. In so doing, they renounce the burden of shame, guilt, and responsibility, and place this burden on the perpetrator, where it properly belongs.

Family confrontations or disclosures can be highly empowering when they are properly timed and well planned. They should not be undertaken until the survivor feels ready to speak the truth as she knows it, without need for confirmation and without fear of consequences. The power of the disclosure rests in the act of telling the truth; how the family responds is immaterial. While validation from the family can be gratifying when it occurs, a disclosure session may be successful even if the family responds with unyielding denial or fury. In this circumstance the survivor has the opportunity to observe the family's behavior and to enlarge her understanding of the pressures she faced as a child.

In practice, family disclosures or confrontations require careful preparation and attention to detail. Because so many family interactions are

habitual and taken for granted, the dynamics of dominance and submission are frequently relived even in apparently trivial encounters. The survivor should be encouraged to take charge of the planning of the session and to establish explicit ground rules. For some survivors, it is a completely novel experience to be the maker of rules rather than the one who automatically obeys them.

The survivor should also be clear about her strategy for disclosure, planning in advance what information she wishes to reveal and to whom she wishes to reveal it. While some survivors wish to confront their perpetrators, many more wish to disclose the secret to nonoffending family members. The survivor should be encouraged to consider first approaching those family members who might be sympathetic, before proceeding to confront those who might be implacably hostile. Just like self-defense training, direct involvement in family conflicts often requires a series of graded exercises, in which the survivor masters one level of fear before choosing to proceed to higher levels of exposure.

Finally, the survivor should anticipate and plan for the various possible outcomes of her disclosure. While she may be clear about the desired outcome, she must be prepared to accept whatever the outcome may be. A successful disclosure is almost always followed by both exhilaration and disappointment. On the one hand, the survivor feels surprised at her own courage and daring. She no longer feels intimidated by her family or compelled to participate in destructive family relationships. She is no longer confined by secrecy; she has nothing more to hide. On the other hand, she gains a clearer sense of her family's limitations. An incest survivor describes her feelings after disclosing the secret to her family:

> Initially I felt a sense of success, completion, incredible relief! Then, I began to feel very sad, deep grief. It was extremely painful and I had no words for what I was feeling. I found myself crying and crying and not knowing exactly why. This hardly ever happens to me. I am usually able to have some kind of verbal description to explain my feelings. This was just raw feeling. Loss, grief, mourning, as if they had died. I felt no hope, no expectations from them . . . I knew there was nothing unspoken on my part. I didn't feel "Oh, if only I had said this or that." I had said everything I wanted to say in the way I wanted to say it. I felt very complete about it and was very grateful for the lengthy planning, rehearsals, strategizing, etc. . . .
>
> Since then I have felt free. . . . I feel HOPE! I feel like I have a future! I feel grounded, not like I'm manicky or high. When I'm sad, I'm sad; when I'm angry, I'm angry. I feel realistic about the bad times and the difficulties I will face, but I know I have myself. It's very different. And it's nothing

I ever could imagine, not at all. I always wanted this freedom and was always fighting to get it. Now it's no longer a battle—there's no one to fight—it's simply mine.[8]

RECONCILING WITH ONESELF

This simple statement—"I know I have myself"—could stand as the emblem of the third and final stage of recovery. The survivor no longer feels possessed by her traumatic past; she is in possession of herself. She has some understanding of the person she used to be and of the damage done to that person by the traumatic event. Her task now is to become the person she wants to be. In the process she draws upon those aspects of herself that she most values from the time before the trauma, from the experience of the trauma itself, and from the period of recovery. Integrating all of these elements, she creates a new self, both ideally and in actuality.

The re-creation of an ideal self involves the active exercise of imagination and fantasy, capacities that have now been liberated. In earlier stages, the survivor's fantasy life was dominated by repetitions of the trauma, and her imagination was limited by a sense of helplessness and futility. Now she has the capacity to revisit old hopes and dreams. The survivor may initially resist doing so, fearing the pain of disappointment. It takes courage to move out of the constricted stance of the victim. But just as the survivor must dare to confront her fears, she must also dare to define her wishes. A guidebook for formerly battered women who face the task of rebuilding their lives explains how to recover lost aspirations:

> Now is the time to rise above the sameness of your days and explore the risk of testing your abilities, the expansive feeling that comes from . . . growth. Perhaps you've been taught that while everyone of course wants all that, it's just adolescent nonsense to expect it. Maybe you believe mature people settle down to a dull life and make do with what they have. It may, indeed, be impractical to recapture and act upon your girlhood dreams. This may not be the time to go (with or without the children) off to Hollywood to become a star. But don't count it, or anything, out until you've come up with some good reasons. . . . If you really "always wanted to act," don't go to your grave saying that regretfully. Get out and join a little theater group.[9]

The work of therapy often focuses at this point on the development of desire and initiative. The therapeutic environment allows a protected space in which fantasy can be given free rein. It is also a testing ground for the translation of fantasy into concrete action. The self-discipline learned in the early stages of recovery can now be joined to the survivor's capacities for imagination and play. This is a period of trial and error, of learning to tolerate mistakes and to savor unexpected success.

Gaining possession of oneself often requires repudiating those aspects of the self that were imposed by the trauma. As the survivor sheds her victim identity, she may also choose to renounce parts of herself that have felt almost intrinsic to her being. Once again, this process challenges the survivor's capacities for both fantasy and discipline. An incest survivor describes how she embarked on a conscious program to change her ingrained sexual responses to scenarios of sadomasochism: "I came to the point where I really understood that they weren't *my* fantasies. They'd been imposed on me through the abuse. And gradually, I began to be able to have orgasms without thinking about the SM, without picturing my father doing something to me. Once I separated the fantasy from the feeling, I'd consciously impose other powerful images on that feeling—like seeing a waterfall. If they can put SM on you, you can put waterfalls there instead. I reprogrammed myself."[10]

While the survivor becomes more adventurous in the world during this period, her life at the same time becomes more ordinary. As she reconnects with herself, she feels calmer and better able to face her life with equanimity. At times, this peaceable day-to-day existence may feel strange, especially to survivors who have been raised in a traumatic environment and are experiencing normality for the first time. Whereas in the past survivors often imagined that ordinary life would be boring, now they are bored with the life of a victim and ready to find ordinary life interesting. A survivor of childhood sexual abuse testifies to this change: "I'm an intensity junkie. I feel a letdown whenever I come to the end of a particular cycle of intensity. What am I going to cry and throw scenes about now? . . . I see it as almost a chemical addiction. I became addicted to my own sense of drama and adrenaline. Letting go of the need for intensity has been a process of slowly weaning myself. I've gotten to a point where I've actually experienced bits of plain contentment."[11]

As survivors recognize and "let go" of those aspects of themselves that were formed by the traumatic environment, they also become more forgiving of themselves. They are more willing to acknowledge the damage done to their character when they no longer feel that such damage must be permanent. The more actively survivors are able to engage in rebuilding their lives, the more generous and accepting they

can be toward the memory of the traumatized self. Linda Lovelace reflects on the ordeal of being coerced into her career as a pornographic movie star: "I'm not so hard on myself these days. Maybe it's because I'm so busy taking care of a three-year-old son, a husband, a house, and two cats. I look back at Linda Lovelace and I understand her; I know why she did what she did. It was because she felt it was better to live than to die."[12]

At this point also the survivor can sometimes identify positive aspects of the self that were forged in the traumatic experience, even while recognizing that any gain was achieved at far too great a price. From a position of increased power in her present life, the survivor comes to a deeper recognition of her powerlessness in the traumatic situation and thus to a greater appreciation of her own adaptive resources. For example, a survivor who used dissociation to cope with terror and helplessness may begin to marvel at this extraordinary capacity of the mind. Though she developed this capacity as a prisoner and may have become imprisoned by it as well, once she is free, she may even learn to use her trance capability to enrich her present life rather than to escape from it.

Compassion and respect for the traumatized, victim self join with a celebration of the survivor self. As this stage of recovery is achieved, the survivor often feels a sense of renewed pride. This healthy admiration of the self differs from the grandiose feeling of specialness sometimes found in victimized people. The victim's specialness compensates for self-loathing and feelings of worthlessness. Always brittle, it admits of no imperfection. Moreover, the victim's specialness carries with it a feeling of difference and isolation from others. By contrast, the survivor remains fully aware of her ordinariness, her weaknesses, and her limitations, as well as her connection and indebtedness to others. This awareness provides a balance, even as she rejoices in her strengths. A woman who survived both childhood abuse and battering in adulthood expresses her appreciation to the staff at a women's shelter: "Now I can thank myself too because you can lead a horse to water but you can't make her drink. I was mighty damn thirsty and you showed me the way to the water . . . the wellspring of living water within as well as without . . . a resource I can draw on any time. And sisters, I drank and drank and I'm not through drinking yet. I feel so lucky. I've been given so much love and healing and I'm learning how to pass it on. . . . Hey take a look at me now. Ain't I something!"[13]

RECONNECTING WITH OTHERS

By the third stage of recovery, the survivor has regained some capacity for appropriate trust. She can once again feel trust in others when that trust is warranted, she can withhold her trust when it is not warranted, and she knows how to distinguish between the two situations. She has also regained the ability to feel autonomous while remaining connected to others; she can maintain her own point of view and her own boundaries while respecting those of others. She has begun to take more initiative in her life and is in the process of creating a new identity. With others, she is now ready to risk deepening her relationships. With peers, she can now seek mutual friendships that are not based on performance, image, or maintenance of a false self. With lovers and family, she is now ready for greater intimacy.

The deepening of connection is also apparent within the therapeutic relationship. The therapeutic alliance now feels less intense, but more relaxed and secure. There is room for more spontaneity and humor. Crises and disruptions are infrequent, with more continuity between sessions. The patient has a greater capacity for self-observation and a greater tolerance for inner conflict. With this changed appreciation of herself comes a changed appreciation of the therapist. The patient may idealize the therapist less but like her more; she is more forgiving of the therapist's limitations as well as her own. The work comes to feel more like ordinary psychotherapy.

Because the survivor is focusing on issues of identity and intimacy, she often feels at this stage as though she is in a second adolescence. The survivor who has grown up in an abusive environment has in fact been denied a first adolescence and often lacks the social skills that normally develop during this stage of life. The awkwardness and self-consciousness that make normal adolescence tumultuous and painful are often magnified in adult survivors, who may be exquisitely ashamed of their "backwardness" in skills that other adults take for granted. Adolescent styles of coping may also be prominent at this time. Just as adolescents giggle in order to ward off their embarrassment, adult survivors may find in laughter an antidote to their shame. Just as adolescents band together in tight friendships in order to risk exploring a wider world, survivors may find themselves developing intense new loyalties as they rebuild their lives. A mother of two children created such a bond in the renewal of an old friendship after she had escaped from her battering husband: "My girlfriend from Utah moved here. Hot mama one and two! . . . We're like

teenagers sometimes. Somebody said we're like primates picking out fleas, and we are. We give each other that kind of attention. She's the only one I'd do without for."[14]

As the trauma recedes into the past, it no longer represents a barrier to intimacy. At this point, the survivor may be ready to devote her energy more fully to a relationship with a partner. If she has not been involved in an intimate relationship, she may begin to consider the possibility without feeling either dread or desperate need. If she has been involved with a partner during the recovery process, she often becomes much more aware of the ways in which her partner suffered from her preoccupation with the trauma. At this point she can express her gratitude more freely and make amends when necessary.

Sexual intimacy presents a particular barrier for survivors of sexual trauma. The physiological processes of arousal and orgasm may be compromised by intrusive traumatic memories; sexual feelings and fantasies may be similarly invaded by reminders of the trauma. Reclaiming one's own capacity for sexual pleasure is a complicated matter; working it out with a partner is more complicated still. Treatment techniques for posttraumatic sexual dysfunction are all predicated upon enhancing the survivor's control over every aspect of her sexual life. This is most readily accomplished at first in sexual activities without a partner.[15] Including a partner requires a high degree of cooperation, commitment, and self-discipline from both parties. A self-help manual for survivors of childhood sexual abuse suggests "safe-sex guidelines" for exploring sexual intimacy, instructing partners to define, for themselves and for each other, activities that predictably trigger traumatic memories and those that do not, and only gradually to enlarge their exploration to areas that are "possibly safe."[16]

Finally, the deepening of intimacy brings the survivor into connection with the next generation. Concern for the next generation is always linked to the question of prevention. The survivor's overriding fear is a repetition of the trauma; her goal is to prevent a repetition at all costs. "Never again!" is the survivor's universal cry. In earlier stages of recovery the survivor often avoids the unbearable thought of repetition by shunning involvement with children. Or if the survivor is a parent, she may oscillate between withdrawal and overprotectiveness with her children, just as she oscillates between extremes in her other relationships.

In the third stage of recovery, as the survivor comes to terms with the meaning of the trauma in her own life, she may also become more open to new forms of engagement with children. If the survivor is a parent, she may come to recognize ways in which the trauma experience has indirectly affected her children, and she may take steps to rectify the situation. If she does not have children, she may begin to take a new and broader interest in young people. She may even wish for the first time to bring children into the world.

Also for the first time the survivor may consider how best to share the trauma story with children, in a manner that is neither secretive nor imposing, and how to draw lessons from this story that will protect children from future dangers. The trauma story is part of the survivor's legacy; only when it is fully integrated can the survivor pass it on, in confidence that it will prove a source of strength and inspiration rather than a blight on the next generation. Michael Norman captures the image of survivorship as a legacy in describing the baptism of his newborn son, with his Vietnam War combat buddy, Craig, serving as godfather: "Standing in a crowded room watching Craig cradle the baby in his arms, I suddenly realized that there was more to the moment than even I had intended, for what was truly taking place . . . went well beyond the offering of a holy sacrament or the consecration of a private pact. In the middle of the ritual, I was overcome with a sense . . . of winning! . . . Here, at last, was victory worth having—my son in the arms of my comrade."[17]

FINDING A SURVIVOR MISSION

Most survivors seek the resolution of their traumatic experience within the confines of their personal lives. But a significant minority, as a result of the trauma, feel called upon to engage in a wider world. These survivors recognize a political or religious dimension in their misfortune and discover that they can transform the meaning of their personal tragedy by making it the basis for social action. While there is no way to compensate for an atrocity, there is a way to transcend it, by making it a gift to others. The trauma is redeemed only when it becomes the source of a survivor mission.

Social action offers the survivor a source of power that draws upon her own initiative, energy, and resourcefulness but that magnifies these qualities far beyond her own capacities. It offers her an alliance with others based on cooperation and shared purpose. Participation in organized, demanding social efforts calls upon the survivor's most mature and adaptive coping strategies of patience, anticipation, altruism, and humor. It brings out the best in her; in return, the survivor gains the sense of

connection with the best in other people. In this sense of reciprocal connection, the survivor can transcend the boundaries of her particular time and place. At times the survivor may even attain a feeling of participation in an order of creation that transcends ordinary reality. Natan Sharansky, a prisoner of conscience, describes this spiritual dimension of his survivor mission:

> Back in Lefortovo [prison], Socrates and Don Quixote, Ulysses and Gargantua, Oedipus and Hamlet, had rushed to my aid. I felt a spiritual bond with these figures; their struggles reverberated with my own, their laughter with mine. They accompanied me through prisons and camps, through cells and transports. At some point I began to feel a curious reverse connection: not only was it important to me how these characters behaved in various circumstances, but it was also important to *them,* who had been created many centuries ago, to know how I was acting today. And just as they had influenced the conduct of individuals in many lands and over many centuries, so I, too, with my decisions and choices had the power to inspire or disenchant those who had existed in the past as well as those who would come in the future. This mystical feeling of the interconnection of human souls was forged in the gloomy prison-camp world when our zeks' solidarity was the one weapon we had to oppose the world of evil.[18]

Social action can take many forms, from concrete engagement with particular individuals to abstract intellectual pursuits. Survivors may focus their energies on helping others who have been similarly victimized, on educational, legal, or political efforts to prevent others from being victimized in the future, or on attempts to bring offenders to justice. Common to all these efforts is a dedication to raising public awareness. Survivors understand full well that the natural human response to horrible events is to put them out of mind. They may have done this themselves in the past. Survivors also understand that those who forget the past are condemned to repeat it. It is for this reason that public truth-telling is the common denominator of all social action.

Survivors undertake to speak about the unspeakable in public in the belief that this will help others. In so doing, they feel connected to a power larger than themselves. A graduate of an incest survivors' group describes how she felt after members of her group presented an educational program on sexual abuse for child protective workers: "That we could come to this point and do this at all is a miracle of major proportions. The power we all felt at reaching 40 people at once, each of whom will touch the lives of 40 children, was so exhilarating. It *almost* overcame

the fear."[19] Sarah Buel, once a battered woman and now a district attorney in charge of domestic violence prosecutions, describes the central importance of her own story as a gift to others: "I want women to have some sense of hope, because I can just remember how terrifying it was not to have any hope—the days I felt there was no way out. I feel very much like that's part of my mission, part of why God didn't allow me to die in that marriage, so that I could talk openly and publicly—and it's taken me so many years to be able to do it—about having been battered."[20]

Although giving to others is the essence of the survivor mission, those who practice it recognize that they do so for their own healing. In taking care of others, survivors feel recognized, loved, and cared for themselves. Ken Smith, a Vietnam veteran who is now the director of a model shelter and rehabilitation program for homeless veterans, describes the sense of "interconnection of human souls" that sustains and inspires his work:

> There are times when I am completely at odds with what I do here, because I am not by any shake of a stick any kind of a leader. Whenever the responsibility becomes heavy, I appeal to my brothers, and whatever the big heavy issue is at the moment, miraculously some form of solution is developed—most times not by me. If you follow it back, it's someone who has been touched by Vietnam. I pretty much count on it now. That is the commonality of the experience, that thousands, hundreds of thousands, even millions of people were touched by this. Whether you're a Vietnam vet or an antiwar protester, it doesn't matter. This is about being an American, this is about what you learn in a fourth-grade civics class, this is about taking care of our own, this is about my brother. This feels very personal to me. That feeling of isolation, it's gone. I'm so connected into it, it's therapeutic to me.[21]

The survivor mission may also take the form of pursuing justice. In the third stage of recovery, the survivor comes to understand the issues of principle that transcend her personal grievance against the perpetrator. She recognizes that the trauma cannot be undone and that her wishes for compensation or revenge can never be truly fulfilled. She also recognizes, however, that holding the perpetrator accountable for his crimes is important not only for her personal well-being but also for the health of the larger society. She rediscovers an abstract principle of social justice that connects the fate of others to her own. When a crime has been committed, in the words of Hannah Arendt, "The wrongdoer is brought to justice because his act has disturbed and gravely endangered the community as a whole. . . . It is the body politic itself that stands in need of being

repaired, and it is the general public order that has been thrown out of gear and must be restored. . . . It is, in other words, the law, not the plaintiff, that must prevail."[22]

Recognizing the impersonality of law, the survivor is to some degree relieved of the personal burden of battle. It is the law, not she, that must prevail. By making a public complaint or accusation, the survivor defies the perpetrator's attempt to silence and isolate her, and she opens the possibility of finding new allies. When others bear witness to the testimony of a crime, others share the responsibility for restoring justice. Furthermore, the survivor may come to understand her own legal battle as a contribution to a larger struggle, in which her actions may benefit others as well as herself. Sharon Simone, who with her three sisters filed suit for damages against her father for the crime of incest, describes the sense of connection with another child victim that spurred her to take action:

> I read about a case in the newspaper. A man had admitted he raped a little girl twice. The child was brought to the sentencing hearing because the therapist thought it would be good for her to see the man led away; she would see that crimes do get punished. Instead, the judge allowed a parade of character witnesses. He said there really are two victims in this courtroom. I thought I was going to go berserk with the injustice. . . . That was such a turning point. The rage and the sense of holding someone accountable. I saw that it was a necessary thing. It wasn't that I needed a confession. I needed to do the action of holding someone accountable. I wanted to break the denial and the pretense. So I said, I *will* join that lawsuit. I'll do it for that little girl. I'll do it for my brothers and sisters. And I think a little voice said, "You should also do it for you."[23]

The sense of participation in meaningful social action enables the survivor to engage in legal battle with the perpetrator from a position of strength. As in the case of private, family confrontations, the survivor draws power from her ability to stand up in public and speak the truth without fear of the consequences. She knows that truth is what the perpetrator most fears. The survivor also gains satisfaction from the public exercise of power in the service of herself and others. Buel describes her feeling of triumph in advocating for battered women: "I love court. There's some adrenaline rush about court. It feels so wonderful to have learned enough about the law and to care enough about this woman so I know the facts cold. It feels wonderful to walk into court and the judge has to listen to me. That's exactly what I've wanted to do for

fourteen years: to force the system to treat women respectfully. To make this system that victimized . . . so many women work for us, not being mean or corrupt about it, but playing by their rules and making it work: there's a sense of power."[24]

The survivor who undertakes public action also needs to come to terms with the fact that not every battle will be won. Her particular battle becomes part of a larger, ongoing struggle to impose the rule of law on the arbitrary tyranny of the strong. This sense of participation is sometimes all that she has to sustain her. The sense of alliance with others who support her and believe in her cause can console her even in defeat. A rape survivor reports on the benefit of standing up in court: "I was raped by a neighbor, who got into my house on the pretext of helping me out. I went to the police and pressed charges, and I went to court twice. I had a rape crisis counselor, and the district attorneys were really nice and helpful, and they all believed me. The first time there was a hung jury, and the second time he was acquitted. I was disappointed in the verdict, but I can't control that. It didn't ruin my life. Going through the court was a kind of catharsis. I did everything I could to protect myself and stand up for myself, so it didn't fester."[25]

The survivor who elects to engage in public battle cannot afford to delude herself about the inevitability of victory. She must be secure in the knowledge that simply in her willingness to confront the perpetrator she has overcome one of the most terrible consequences of the trauma. She has let him know he cannot rule her by fear, and she has exposed his crime to others. Her recovery is based not on the illusion that evil has been overcome, but rather on the knowledge that it has not entirely prevailed and on the hope that restorative love may still be found in the world.

RESOLVING THE TRAUMA

Resolution of the trauma is never final; recovery is never complete. The impact of a traumatic event continues to reverberate throughout the survivor's lifecycle. Issues that were sufficiently resolved at one stage of recovery may be reawakened as the survivor reaches new milestones in her development. Marriage or divorce, a birth or death in the family, illness or retirement, are frequent occasions for a resurgence of traumatic memories. For example, as the fighters and refugees of the Second World War encounter the losses of old age, they experience a revival of post-

traumatic symptoms.[26] A survivor of childhood abuse who has resolved her trauma sufficiently to work and love may suffer a return of symptoms when she marries, or when she has her first child, or when her child reaches the same age that she was when the abuse began. A survivor of severe childhood abuse, who returned to treatment several years after completing a successful course of psychotherapy, describes how her symptoms came back when her toddler son began to defy her, "Everything was going so well until the baby reached the 'terrible twos.' He had been such an easy baby; now all of a sudden he was giving me a hard time. I couldn't cope with his tantrums. I felt like beating him until he shut up. I had a vivid image of smothering him with a pillow till he stopped moving. I know now what my mother did to me. And I know what I could have done to my child if I hadn't gotten help."[27]

This patient was humiliated by her need to return to psychotherapy. She feared that the return of symptoms meant her earlier therapy had been a failure and proved she was "incurable." To avert such needless disappointment and humiliation, patients should be advised as they complete a course of treatment that post-traumatic symptoms are likely to recur under stress. As therapy nears its end, it is useful for patient and therapist together to review the basic principles of empowerment and affiliation that fostered recovery. These same principles can be applied to preventing relapses or to coping with whatever relapses may occur. The patient should not be led to expect that any treatment is absolute or final. When a course of treatment comes to its natural conclusion, the door should be left open for the possibility of a return at some point in the future.

Though resolution is never complete, it is often sufficient for the survivor to turn her attention from the tasks of recovery to the tasks of ordinary life. The best indices of resolution are the survivor's restored capacity to take pleasure in her life and to engage fully in relationships with others. She has become more interested in the present and the future than in the past, more apt to approach the world with praise and awe than with fear. Richard Rhodes, a survivor of severe childhood abuse, describes the feeling of resolution achieved after many decades: "It was time at last to write this book—to tell my orphan's story, as all orphans do; to introduce you to my child. There was a child went forth. He'd hidden in the basement all those years. The war's over and my child has come up from the basement to blink in the sunlight. To play. I'm amazed and grateful that he never forgot how to play."[28]

The psychologist Mary Harvey defines seven criteria for the resolution

of trauma. First, the physiological symptoms of post-traumatic stress disorder have been brought within manageable limits. Second, the person is able to bear the feelings associated with traumatic memories. Third, the person has authority over her memories: she can elect both to remember the trauma and to put memory aside. Fourth, the memory of the traumatic event is a coherent narrative, linked with feeling. Fifth, the person's damaged self-esteem has been restored. Sixth, the person's important relationships have been reestablished. Seventh and finally, the person has reconstructed a coherent system of meaning and belief that encompasses the story of the trauma.[29] In practice, all of these issues are interconnected, and all are addressed at every stage of recovery. The course of recovery does not follow a simple progression but often detours and doubles back, reviewing issues that have already been addressed many times in order to deepen and expand the survivor's integration of the meaning of her experience.

The survivor who has accomplished her recovery faces life with few illusions but often with gratitude. Her view of life may be tragic, but for that very reason she has learned to cherish laughter. She has a clear sense of what is important and what is not. Having encountered evil, she knows how to cling to what is good. Having encountered the fear of death, she knows how to celebrate life. Sylvia Fraser, after many years spent unearthing childhood memories of incest, reflects on her recovery:

> In retrospect, I feel about my life the way some people feel about war. If you survive, then it becomes a good war. Danger makes you active, it makes you alert, it forces you to experience and thus to learn. I know now the cost of my life, the real price that has been paid. Contact with inner pain has immunized me against most petty hurts. Hopes I still have in abundance, but very few needs. My pride of intellect has been shattered. If I didn't know about half my own life, what other knowledge can I trust? Yet even here I see a gift, for in place of my narrow, pragmatic world of cause and effect. . . . I have burst into an infinite world full of wonder.[30]