

# Trauma and Recovery

## Judith Lewis Herman, M.D.

Basic Books, 1992

[To return to Psych 270's home page, click here.](#)

The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma

When the truth is fully recognized, survivors can begin their recovery. But far too often, secrecy prevails and the story of the traumatic event surfaces not as a verbal narrative but as a symptom.

Denial exists on a social as well as an individual level... We need to understand the past in order to reclaim the present and the future. An understanding of psychological trauma begins with rediscovery the past.

The fundamental stages of recovery are:

1. Establishing safety
2. Reconstructing the traumatic story
3. Restoring the connection between the survivor and his/her community.

It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim ask the bystander to share the burden of the pain. The victim demands action, engagement, and remembering. (A tendency to render the victim invisible; to look the other way.)

Freud's investigations led the furthest of all into the unrecognized reality of women's lives. His discovery of childhood sexual exploitation at the roots of hysteria crossed the outer limits of social credibility and brought him to a position of total ostracism within his profession. (He eventually repudiated his own findings.)

### Traumatic Neurosis of War

The soldier who developed a traumatic neurosis was at best a constitutionally inferior human being, at worst, a malingerer and a coward. They were described as moral invalids. Hysterical symptoms such as mutism, sensory loss, or motor paralysis were treated with electric shock; threatened with court martial. The goal of treatment was to return the soldier to combat.

In WWII, it was recognized that any man could break down under fire and that psychiatric casualties could be predicted in direct proportion to the severity of combat exposure.

There is no such thing as "getting used to combat." Each moment of combat imposes a strain so great that men will break down in direct relation to the intensity and duration of their exposure. Thus, psychiatric casualties are inevitable as gunshot and shrapnel wounds in warfare.

In their quest for a quick and effective method of treatment, military psychiatrists once again found the mediating role of altered states of consciousness in psychological trauma. They found that artificially induced altered states could be used to access traumatic memories.

As in earlier work on hysteria, the focus of the "talking cure" for combat neuroses was on the recovery and cathartic reliving of the traumatic memories with all their attendant emotions of terror, rage, and grief.

Combat leaves a lasting impression on men's minds, changing them as radically as any crucial experience through which they live. It points to the need for integration.

After Vietnam, the diagnosis "post traumatic stress disorder" included in the APA's DSM, giving it legitimacy.

Not until the women's liberation movement of the 1970s was it recognized that the most common PTSDs are those not of men in war, but of women in civilian life. The cherished value of privacy created a barrier to consciousness and rendered women's reality practically invisible.

Research of the '70s confirmed the reality of women's experience that Freud had dismissed as fantasies a century before. Sexual assaults against women and children were shown to be endemic and pervasive in our culture. The results: On women in four had been raped. One women in 3 had been sexually abused as a child.

Rape was the feminist movements's initial paradigm for violence against women in the sphere of personal life.

Women experienced rape as a life threatening event having feared mutilation and death during the assault. Rape victims complained of insomnia, nausea, startle responses, and nightmares as well as dissociative or numbing symptoms. The symptoms resemble that of combat neurosis.

Necessity for a political movement to support the continued exploration of trauma or its survival as a legitimate are of study is in jeopardy.

Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. Traumatic events overwhelm the ordinary symptoms of care that give people a sense of control, connection, and meaning.

Certain experiences increase the likelihood of harm.

1. Being taken by surprise
2. Being trapped
3. Being at the point of exhaustion
4. Being physically violated or injured
5. Being exposed to physical violence
6. Witnessing grotesque deaths

Trauma occurs when action is of no avail--when neither resistance nor escape is possible.

The traumatized individual may experience intense emotion but without clear memory of the event--or

may remember everything in detail but without emotion. Traumatic symptoms have a tendency to become disconnected from their source and to take on a life of their own. (Dissociation)

### The Main Categories of Post Traumatic Stress Disorder

1. Hyperarousal: Persistent expectation of danger
2. Intrusion: The indelible imprint of the traumatic even returning unbidden.
3. Constriction: The numbing response of surrender

#### **In Hyperarousal**

The system of self preservation goes into permanent alert as if the danger could return at any moment. (Symptoms: Startle easily, reacts irritably to small provocations, sleeps poorly). It is the constant arousal of the autonomic nervous system.

#### **In Intrusion**

Long after the danger is past, traumatized people relive the event as though it were continually recurring in the present. The trauma interrupts daily life. (Symptoms: Flashbacks during waking; nightmares during sleeping)

Traumatic memories lack verbal narrative and context; rather they are encoded in the form of vivid sensations and images. They resemble the memories of young children.

Traumatized people find themselves reenacting some aspect of the trauma scene in disguised form without realizing what they're doing (e.g., putting themselves in dangerous situations this time to make the end come out differently (a version of the repetition compulsion).

Seen as a possible attempt at integration--to relive and master the overwhelming feelings of the traumatic moment(s).

Attempts to avoid reliving the trauma too often result in a narrowing of consciousness or withdrawal from engagement with others and an impoverished life.

#### **In Constriction (numbing)**

The system of self esteem shuts down completely (a state of surrender). The helpless person escapes not by action, but by altering her/his state of consciousness.

Events continue to register in awareness but its as though these events have been disconnected from their ordinary meaning (similar to trance states).

Those who cannot dissociate may turn to drugs or alcohol for their numbing effects.

Adaptive during the trauma, numbing becomes maladaptive once the danger is past.

In an attempt to crease some sense of safety, traumatized people restrict their lives.

In avoiding any situation reminiscent of the past trauma or any initiative that might involve future planning and risk, traumatized people deprive themselves of those new opportunities for successful coping that might mitigate the effect of the traumatic experience.

Because post traumatic symptoms are so persistent and widespread, they may be mistaken for enduring characteristics of the victim's personality.

#### **Disconnection**

Traumatic events breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief system that gives meaning to human experience. They violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis. It is a shattering of "basic trust." A sense of alienation, disconnection pervades every relationship.

### **Damaged Self**

Trauma forces the survivor to relive all earlier struggles over autonomy, initiative, competence, identity, and intimacy.

The developing child's positive sense of self depends upon a caretaker's benign use of power.

Traumatic events violate the autonomy of the person at the level of basic bodily integrity (Body ego -> first sense of "I")

The belief in a meaningful world is formed in relation to others and begins earliest life. Basic trust, acquired in the primary intimate relationship is the foundation of faith. Trauma creates a crisis of faith.

Damage to the survivor's faith and sense of community is particularly severe when the event themselves involve the betrayal of important relationships.

Survivors oscillate between:

Uncontrollable outbursts of anger and intolerance of rage in any form.

Seeking intimacy desperately and totally withdrawing from it.

Self esteem is assaulted by experiences of humiliation, guilt, and helplessness.

### **Vulnerability and Resilience**

Individual personality characteristics count for little in the face of overwhelming events. With severe enough experience, no person is immune.

Individual differences play a part in determining the form PTSD will take. It is related to individual history, emotional conflicts, and adaptive style.

Highly resilient people are able to make use of any opportunity for purposeful action in concert with others, while ordinary people are more easily paralyzed or isolated by them.

Some features of highly resilient people:

1. Alert, active temperament
2. Unusual sociability
3. Good communicating skills
4. Strong internal locus of control

and

GOOD LUCK

Increased vulnerability is enhanced by:

1. Disempowerment (children, adolescents)
2. Disconnection from others
3. Lack of social supports
4. Poor or absent communication avenues

### The Effect of Social Support

The survivor's social world can influence the eventual outcome of trauma.

The emotional support that is sought takes many forms and changes during the course of resolution.

In the immediate aftermath, rebuilding of some minimal form of trust is the primary task. Assurances of safety and protection are of the greatest importance.

Then, the survivor needs assistance of others in rebuilding a positive sense of self. Others must show tolerance for the oscillating behaviors of the survivor. It is not blanket acceptance but the kind of respect for autonomy that fostered the original development of self esteem in the first year of life. (Movement toward self-regulation).

The survivor needs the assistance of others in her/his struggle to arrive at a fair assessment of her/his conduct. Harsh criticism or ignorance or blind acceptance greatly compounds the survivor's self blame and isolation. Realistic judgments include a recognition of the dire circumstances of the traumatic event and the normal range of the victim's reactions. They include the recognition of moral dilemmas in the face of severely limited choices. This, hopefully, leads to a fair attribution of responsibility.

Finally, the survivor needs help from others to mourn her/his losses. Failure to complete the normal process of grieving perpetuates the traumatic reaction.

### The Role of Community

Sharing the traumatic experience with others is a precondition for the restitution of a meaningful world.

Once it is publicly recognized that person has been harmed, the community must take action to assign responsibility for the harm and to repair the injury. Recognition and restitution are necessary to rebuild the survivor's sense of order and justice.

Repeated trauma in adult erodes the structure of personality already formed, but repeated trauma in childhood forms and deforms the personality.

Under conditions of chronic childhood abuse, fragmentation becomes the central principle of personality organization. Fragmentation in consciousness prevents the ordinary integration of knowledge, memory, emotional states, and bodily experiences. Fragmentation in the inner representations of the self prevent the integration of identity. Fragmentation of the inner representation of others prevents the development of a reliable sense of independence within connection.

### **On Idealizing**

By idealizing the person to whom she becomes attached, she attempts to keep at bay the constant fear of being either dominated or betrayed. Inevitably, however, the chosen person fails to live up to her

fantastic expectations. When disappointed, she may ferociously denigrate the same person whom she so recently adored. Ordinary interpersonal conflicts may provoke intense anxiety, depression, or rage. In the mind of the survivor, even minor slights evoke past experiences of deliberate cruelty. These distortions are not easily corrected by experience since the survivor tends to lack the verbal and social skills for resolving conflict. Thus, the survivor develops a pattern of intense, unstable relationships repeatedly enacting the drama of rescue, injustice, and betrayal.

### **Relationship problems**

1. Desperate longing for nurturance make it difficult to establish safe and appropriate boundaries.
2. Denigration of self and idealization of others.
3. Empathic attunement to the wishes of others and unconscious habits of obedience make her vulnerable to people in positions of authority.
4. Dissociative tendencies make it difficult to form conscious, accurate assessments of danger.
5. The wish to relive dangerous situations to make them come out differently leads to reenactments of abuse.

### **A New Diagnosis -- Complex Post Traumatic Stress Disorder**

A history of subjection to totalitarian control over a prolonged period (months or years). Examples include hostages, prisoners of war, concentration camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.

Alterations in affect regulation, including

Persistent dysphoria

Chronic suicidal preoccupation

Self injury

Explosive or extremely inhibited anger (may alternate)

Compulsive or extremely inhibited sexuality (may alternate)

Alterations in consciousness, including

Amnesia or hypermnesia for traumatic events

Transient dissociative states

Depersonalization/derealization

Reliving experiences either in the form of intrusive post traumatic stress disorder symptoms or in the form of ruminative preoccupations.

#### Alterations in self-perceptions, including

- Sense of helplessness or paralysis of initiative

- Shame, guilt, and self blame

- Sense of defilement or stigma

- Sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

#### Alterations in perception of perpetrator, including

- Preoccupation with relationship with perpetrator (includes preoccupation with revenge)

- Unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)

- Idealization or paradoxical gratitude

- Sense of special or supernatural relationship

- Acceptance of belief system or rationalizations of perpetrator

#### Alteration in relations to others, including

- Isolation or withdrawal

- Disruption of intimate relationships

- Repeated search for rescuer (may alternate with isolation and withdrawal)

- Persistent distrust

- Repeated failures of self protection

#### Alterations in systems of meaning

- Loss of sustaining faith

- Sense of hopelessness and despair

#### Survivors as Patients

They present a bewildering array of symptoms. They come for help because of their many symptoms or because of difficulty with relationships, problems in intimacy, excessive responsiveness to the needs of

others, and repeated victimizations.

Often receive the diagnosis of (1) Somatization Disorder; (2) Borderline Personality Disorder; or (3) Multiple Personality

### **Communalities in the above three diagnoses**

1. High levels of dissociation
2. Unstable relationships (oscillating between clinging and withdrawal; submissiveness and ferocious rebellion.
3. Disturbances in identity formation (fragmentation leading to good self/bad self identities)
4. Origins in chronic abuse

### **Stages of Recovery**

Recovery is based upon the empowerment of the survivor and the creation of new connections. It can take place only in the context of a relationship.

The survivor must be the author and arbiter of her own recovery.

The therapist abstains from using her/his power over the patient to gratify his/her needs and does not take sides in the patient's inner conflict or try to direct the patient's life decisions. The therapist is called upon to bear witness to a crime.

### **Traumatic Transference**

"It is as if the patient's life depends on keeping the therapist under control." -- Kernberg

Because the patient feels as though her life depends on the therapist, she cannot afford to be tolerant; there is no room for human error. There is likely to be a displacement of the rage from perpetrator to caregiver.

The patient feels a desperate need to rely on the integrity and competence of the therapist but cannot because her capacity to trust has been damaged by the traumatic experience.

The survivor also mistrusts the therapist who does not move away. She attributes the same motives as those of the perpetrator. The dynamics of dominance are reenacted in the therapy.

The patient scrutinizes the therapist's every word and gesture in an attempt to protect herself from the hostile reactions she expects. Because she has no confidence in the therapist's benign intentions, she persistently misinterprets the therapist's motives and intentions.

### **Traumatic Countertransference**

No therapist can work with trauma alone.

As a defense against the unbearable feelings of helplessness, the therapist may try to assume the role of rescuer.

There is also the danger of identifying with the perpetrator.

Witness guilt is also a danger. Guilt over having been spared the same plight.

The two most important guarantees of safety are the goals, rules, and boundaries of the therapy contract and the support system of the therapist.



### **The Therapy Contract**

A relationship of existential engagement in which both parties commit themselves to the task of recovery.

- Emphasis on truth telling and full disclosure
- Cooperative nature of the work
- Preparation for repeated testing, disruption, and the rebuilding of trust
- Careful attention to the boundaries
- Decision on limits based on whether they empower the patient and foster a good working relationship--not whether they patient should be frustrated or indulged. Negotiation

Because of the conflicting requirements for flexibility and boundaries, the therapist can expect repeatedly to feel put on the spot.

Recovery unfolds in three stages: (1) The establishment of safety; (2) Remembrance and mourning; and (3) Reconnection with ordinary life.

Therapist who believes that the patient is suffering from a traumatic syndrome should share the information fully. There is a name for what is going on.

Patients with Complex PTSD feel as if they have lost themselves. Patients with PTSD feel as if they have lost their minds.

A guiding principle of recovery is to restore power and control to the survivor. The first task is to establish the survivor's safety. Nothing can happen until this is accomplished.

Establishing safety begins by focusing on control of the body and gradually moves outward toward control of the environment.

With the survivor of chronic abuse, establishing safety can be an extremely complex and time consuming task. Self care is disrupted and self harm may take various forms (symbolic reenactments of the initial abuse) serving the function of regulating intolerable feeling states. Self soothing must be painstakingly constructed in later life. As she begins to exercise these capacities (e.g., initiating action, using her best judgment) she enhances her sense of competence, self esteem, and freedom.

To counter the compelling fantasy of a fast cathartic cure, the therapist may compare the recovery process to running a marathon. Recovery is a test of endurance, requiring long preparation and repetitive practice.

### **Completing the First Stage**

- The survivor no longer feels completely vulnerable although still less trusting
- Development of some confidence in the ability to protect her/himself
- Patient know how to control her most disturbing symptoms

- Patient knows t who to rely on for support

## Remembrance and Mourning

**Reconstruction:** (Telling the story in depth.) Transforms the traumatic memory so that it can be integrated into the survivor's life story. The choice to confront the horrors of the past rests with the survivor. The therapist is witness and ally.

As the survivor summons her memories, the need to preserve safety must be balanced against the need to face pain. (Negotiating a safe passage)

The patient's intrusive symptoms should be monitored carefully so that the recovering work remains within the realm of what is bearable.

A narrative that does not include the traumatic imagery and bodily sensations is barren and incomplete. The ultimate goal, however, is to put the story, including the imagery, into words. The patient must construct not only what happened but also what she/he felt.

The therapist must help the patient move back and forth in time, from the 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.

Why me? The arbitrary random quality of her fate defies the basic human faith in a just or even predictable world order. She is faced with the double task of rebuilding her own "shattered assumptions" about meaning, order, and justice in the world and also find a way to resolve her differences with those who beliefs she can no longer share.

The therapist's role is to affirm a position of moral solidarity with the survivor.

As the therapist listens, she/he must constantly remind him/herself to make no assumptions about either the facts or the meaning of the trauma to the patient.

The goal of recounting the trauma story is integration, not exorcism.

## Transforming Traumatic Memory

**Flooding:** A controlled reliving experience in which the patient learns how to manage anxiety. A script is prepared including (1) context; (2) fact; (3) emotion; (4) meaning. The patient chooses the sequence for presentation from easiest to most difficult memories and events.

**Testimony:** Similar to Flooding, it is used with survivors of political torture. The central point is to create a detailed, extensive record of the traumatic experience.

It appears that the action of telling the story in the safety of a protected relationship can actually produce a change in the abnormal processing of the traumatic memory.

The patient may be reluctant to give up symptoms such as nightmares and flashback because they have acquired important meanings. The symptom may be symbolic means for keeping faith with the lost person, a substitute for mourning, or an expression of unresolved guilt.

## Mourning Traumatic Loss

Trauma inevitably brings loss. The descent into mourning is at once the most necessary and the most dreaded task of this stage of recovery. It is an act of courage not humiliation.

Resistance to mourning:

The Revenge Fantasy: where victim and perpetrator roles are reversed. Based on the fantasy of getting even which is not possible. A goal is to transform anger into righteous indignation.

The Forgiveness Fantasy: transcending the rage through a willful, defiant act of love.

Healing depends on the discovery of restorative love in her own life--not on the contrition of the perpetrator.

The Compensation Fantasy: is a formidable impediment to mourning. Prolonged, fruitless struggle 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 fair compensation. The wish for compensation ties the survivor's fate to the perpetrator's and she is then held hostage.

In the course of therapy, the patient may focus her demands for compensation on the therapist. She may resent the limits; insist on some form of special dispensation. Underlying these demands is the fantasy that only the boundless love of the therapist can undo the damage of the trauma. Unfortunately, therapists sometimes collude with their patients fantasy of restitution. Boundary violations ultimately lead to exploitation of the patient even when they are initially undertaken in good faith.

The only way 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.

Survivors of chronic childhood abuse face the task of grieving not only what they lost but also for what was never theirs to lose. The childhood that was stolen from them is irreplaceable.

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 second stage of recovery has a timeless quality that is frightening.

The survivor may wonder how she can possibly give her due respect to the horror she has endured if she no longer devotes her life to remembrance and mourning. She will never forget. But the time comes when the trauma no longer commands the central place in her life.

The reconstruction of the trauma is never completed; new events at each stage of the life cycle will inevitably reawaken the trauma and bring some new aspects of the experience to light. The second stage is completed when the patient reclaims her own history and feels renewed hope and energy for engagement with life.

## **Reconnection**

The survivor faces the task of creating a future:

Developing a new self

Developing new relationships

Developing a sustaining faith

Empowerment and reconnection are the core experiences of recovery.

Taking power in life involves the conscious choice to face danger. Survivors have come to understand

their symptoms are a pathological response to danger. It is not the same as reenactment because the task (facing danger) is taken consciously, in a planned, methodical manner.

As survivors recognize their own socialized assumptions that rendered them vulnerable of exploitation in the past, they may also identify sources of continued, social pressure that kept them confined in a victim role in the present

### **Reconciling with Oneself**

"I know I have myself." Her task is to become the person she wants to be. She draws upon the aspects of herself she most values from the time before the trauma, from the experience of the trauma itself, and from the period of recovery. Integrating all these aspects, she creates a new self both ideally and in actuality.

Here, the work of therapy focuses on the development of desire and initiative.

As the survivor recognizes and "lets go" of those aspects of her/himself that were formed by the traumatic experiences, she/he also becomes more forgiving of him/herself.

### **Reconciling with Others**

The survivor has regained some capacity for appropriate trust. The therapeutic alliance feels less intense but more relaxed and secure.

As trauma receded, it no longer represents a barrier to intimacy.

### **Finding a Survivor Mission**

This may take the form of social action and a willingness to speak the unspeakable. It is also a form of pursuing justice.

The survivor who elects to engage in public battle cannot afford to delude herself about the inevitability of victor.

### **Resolving the Trauma**

The resolution is never complete, it is often sufficient for the survivor to turn her attention from the task of recovery to the tasks of ordinary life.

Dr. Mary Harvey's (colleague of Judith Herman) criteria for the resolution of trauma:

1. Symptoms are brought within manageable limits.
2. Survivor is able to bear the feelings associated with traumatic memories.
3. Survivor has authority over the memories.
4. Memory is a coherent narrative.
5. Self esteem has been restored.
6. Important relationships have been reestablished.
7. There has been a reconstruction of a coherent system of meaning and belief that encompasses the story of the trauma.

### **Commonality**

The restoration of social bonds begins with the discovery that one is not alone and that others have experienced similar events and can understand them. Participation in a group may provide a sense of

"universality."

[To return to Psych 270's homepage, click here.](#)