

TRAUMA
AND
RECOVERY

The Aftermath of Violence—
From Domestic Abuse
to Political Terror

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With a New Epilogue by the Author

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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."⁵ 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."⁶

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

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 As the patient explores her feelings, she may become either agitated or withdrawn.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

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

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

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

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

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

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

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

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

When Stephanie first told her story, her therapist was horrified by the sheer brutality of the rape, which had gone on for over two hours. To Stephanie, however, the worst part of the ordeal had occurred after the assault was over, when the rapists pressured her to say that it was the "best sex she ever had." Numbly and automatically, she had obeyed. She then felt ashamed and disgusted with herself.

The therapist named this a mind rape. She explained the numbing response to terror and asked whether Stephanie had been aware of feeling afraid. Stephanie then remembered more of the story: the rapists had threatened that they "just might have to give it to her again" if she did not say that she was "completely satisfied." With this additional information, she came to understand her compliance as a strategy that hastened her escape rather than simply as a form of self-abasement.

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

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

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

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

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

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

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

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

TRANSFORMING TRAUMATIC MEMORY

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

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

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

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

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

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

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

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

It appears, then, that the "action of telling a story" in the safety of a protected relationship can actually produce a change in the abnormal processing of the traumatic memory. With this transformation of memory comes relief of many of the major symptoms of post-traumatic stress disorder. The *physiogenesis* 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 impatient "package" programs frequently attract survivors with the unrealistic promise that a "blitz" approach will effect a cure. Programs that promote the rapid uncovering of traumatic memories without providing an adequate context for integration are therapeutically irresponsible and potentially dangerous, for they leave the patient without the resources to cope with the memories uncovered.

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

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

Denise entered treatment tormented by doubt about whether she had been abused by her father. She had a strong "body feeling" that this was the case but claimed to have no clear memories. She thought hypnosis would be needed to recover memories. The therapist asked Denise to describe her current relationship with her father. In fact, Denise was dreading an upcoming family gathering, because she knew her father would get boisterously drunk, subject everyone at the party to lewd remarks, and fondle all the women. She felt she could not complain, since the family considered her father's behavior amusing and innocuous.

At first Denise belittled the importance of this current information. She was looking for something much more dramatic, something that her family would take seriously. The therapist asked Denise what she felt when her father fondled her in public. Denise described feeling disgusted, humiliated, and helpless. This reminded her of the "body feeling" she had reported at the start of therapy. As she explored her feelings in the present, she began to recall many instances in childhood when she had sought protection from her father, only to have her complaints ridiculed and dismissed. Eventually she recovered memories of her father entering her bed at night.

The patient's present, daily experience is usually rich in clues to dissipated 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 Kluff, 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 Shaley, who sought treatment after an automobile accident for the symptoms of simple post-traumatic stress disorder. She also had a history of repeated abuse in childhood. A standard behavioral treatment successfully resolved her symptoms related to the auto accident. However, the same approach did little to alleviate the patient's feelings about her childhood victimization, for which prolonged psychotherapy was required.²⁷

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

MOURNING TRAUMATIC LOSS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The K family started sharing their history and communicating. It took about six months, however, of patient requests for her to repeat the above incident . . . until she was able to end her ghetto story with "and they took the child away from me." She then began to thaw her identificatory deadness and experience the missing . . . emotions of pain and grief. . . .

Much of Mrs. K's healing process capitalized on sources of goodness and strength before and during the war, such as her spunk as a child, her ability to dream of her grandfather consoling her when she gave up in the camps, her warmth, intelligence, wonderful sense of humor, and reawakened sense of delight. . . . Her ability and longing to love were really resurrected. . . . No longer formally in therapy, Mrs. K says, "I have myself back, all over again. . . . I wasn't proud. Now I'm proud. There are some things I don't like, but I have hope."⁵⁵

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 Sohala Abdulai 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."⁵⁶

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.