

Understanding
trauma and
emotion

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Understanding trauma and emotion

**Dealing with trauma using an
emotion-focused approach**

Colin Wastell

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*This book is dedicated to all survivors of trauma,
individuals, families, friends, communities and beyond.*

*My hope is that in some small way these words
may assist you and those who help you, as you
live your life after the terrible events
that you have survived.*

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INTRODUCTION

P psychological trauma is a subject of great professional and public interest. From media reports to personal testimonies, we are confronted daily by the terrible effects of accidents, war and mistreatment. These stories are not new. For centuries, it has been common knowledge that survivors of horrific events may suffer ongoing distress. There are descriptions of this sort from Homer's *Iliad* to Samuel Pepys' commentary on the Black Death and Great Fire of London in 1665–6 that clearly show the effects of these events as marking survivors with deep, disturbing and debilitating psychological scars (see Trimble 1985, pp. 6–7). However, over the last 150 years, there has been a growing acceptance by the public of the impact of traumatic events and accompanying changes, and this has been reflected in social and legislative responses to the ongoing effects of trauma on survivors.

The initial impetus for the modern study of trauma came from two separate sources in the West during the latter part of the nineteenth century. The first was the large number of surviving casualties of war, while the second came in the form of new compensation laws in Europe, which resulted in relatively large sums of money being paid to the survivors of accidents.

The initial focus was a medical model of trauma. Bodily trauma was viewed as essentially a wound or injury affecting body tissues or structures, with a resulting loss of function of the tissue or organ. The emphasis was on finding out what was no longer working, and either biochemically or surgically repairing it.

Definitions of psychological trauma have been heavily influenced by medical models of physical trauma. An older definition

of psychological trauma is exemplified by Drever (1952). Trauma is 'an emotional shock, producing a disturbance, more or less enduring of mental functions' (1952, p. 298). The concept of 'shock' is central to this definition of trauma. Again quoting Drever, shock is 'sudden depression of the nervous system or nervous exhaustion produced by violent emotion, accident, surgical operation, etc.' (1952, p. 265). Such an approach leads to theorising that is biased toward viewing psychological trauma primarily as a physical injury to the nervous system. This was the view taken in the latter part of the nineteenth century and the first decades of the twentieth century. Following on from these 'physicist' views came the early psychological theories. For example, Freud's initial work with women suffering from hysteria led him to postulate that it was actual seduction that was traumatising these women. He then abandoned this view in favour of his Oedipus theory, which persisted for many decades and was only seriously challenged in the early 1970s, when clinicians such as Herman (1992a, 1992b) and others began to confront society with the reality of the existence of incest and domestic violence. The Vietnam War brought the horror of conflict into the homes of many people in a way that was traumatising in itself. From the 1980s onward, there has been a groundswell of support for the recognition of trauma and the provision of assistance to those affected by it.

It is important to recognise from the outset that the experience of going through a traumatic event is one that can, in essence, only be truly understood by survivors. The theories which guide and inform professionals are central to responding to the needs of those who have been traumatised. One of the most influential approaches to trauma—and, indeed, to many psychological problems—is the rationalist based cognitive behavioural model, which focuses on the rational mind. Survivors are encouraged to address the residual effects of trauma using techniques that essentially subsume emotion beneath rational thinking. The focus is on getting the survivor's thoughts back into perspective through a combination of talking and activity (see Rothbaum et al. 2000). The cognitivist approach is challenged in this book, however. The fundamental proposition of this present work is that, at its core, psychological trauma is an emotional process. The theory and treatment of psychological trauma must be guided by approaches that acknowledge this and enable survivors to integrate the

emotional aspects as primary rather than secondary elements of their experience.

In order to fully present an emotion-focused model of psychological trauma, we first chart the history of trauma through the last 100 or so years, and examine recent theoretical and treatment studies. This provides a reframing of psychological trauma. The perspective presented in this book is designed to be far more 'experience near' to the survivor than rationalist cognitive models, which fail to adequately capture the experience of survivors. Comments of survivors are utilised to illustrate this perspective.

The study of the emotional core of psychological trauma necessitates the use of many methods. By the very nature of trauma, it is entirely unethical to do research on experimentally 'traumatised' subjects. Epidemiological, survey, outcome and intensive case studies are the most common methods of obtaining the necessary information. All of these approaches are, however, simply data-collection methods. They do not support any one model of psychological trauma. Much trauma theorising has been dominated by the rationalist Western mind, which has been extolled as supreme all the way from Plato to Descartes. I assert that, in psychological trauma, primitive, biologically programmed and innate processes of survival take control to the point of subsuming the rational narrative that is the overlay of much of our experience in Western society. Trauma is about life and death, and it is in these instances that our primitive instincts take over. When there is no time to 'think', people react. It is the residuals of these life-preserving processes that cry out for integration. This book presents an integrative model of trauma that takes into account emotion and cognitive aspects as well as the bodily presentation of the aftermath of trauma so as to facilitate the recovery of survivors.

In one way the approach taken in this book is not new at all. Yet as Monson et al. (2004) observe, 'deficits in emotional functioning have been described as among the least understood and studied features of Post Traumatic Stress Disorder'. Many therapists have long recognised that emotional reactions are a central feature of trauma. The resolution and integration of these emotional states is one of the most important components of recovery from exposure to a traumatic event. The investigation of emotion, and the construction of theories to account for its

function and purpose, have undergone considerable development over the last few decades. This upsurge of interest in emotion and the emergence of trauma as a field in its own right has brought into focus several important questions. Firstly, what is the purpose of the strong emotions generated by traumatic experiences? Secondly, what psychological mechanisms enable traumatised individuals to continue to function in spite of the sometimes overwhelming emotional reactions that accompany traumatising? And thirdly, how can therapists enable individuals to recover from trauma so as to eliminate or minimise recurring emotional disturbance? This book answers these questions.

One influential approach to emotion's role within general human psychological functioning was developed by Plutchik (1980a, 1980b), and is termed the psychoevolutionary model of emotion. This approach asserts that emotion is crucial to the activation of survival behaviours. Emotion enables individuals to preserve their life by activating survival behaviours. This is the answer to our first question. This assertion accords well with the stage of outcry experienced by trauma victims. However, ongoing emotion that is not controlled or modulated produces negative effects on an individual, which can lead to the alternate stage of denial or numbing, as too much emotion will be counterproductive for survival behaviours. The mechanisms that modulate the emotion flow are termed 'control processes' by Horowitz (1997). Horowitz's general model of trauma is used as the main theoretical basis for the position taken in this book. His model incorporates concepts such as schemas and scripts for the modulation of emotion. I will present a new theoretical model that incorporates an information processing paradigm with the concepts of Plutchik's psychoevolutionary model of emotion. This theoretical model is designed to provide a specific answer to the second of the three questions—that is, what psychological mechanisms enable traumatised individuals to continue to function in spite of often overwhelming emotional reactions. The integrated model developed here is used to set out and guide principles for treatment, the answer to our third question.

The model developed here has been tested with members of the emergency services and medical professions. Dyregrov and Mitchell (1992) have identified the impact of working with victims of disasters, and noted that emergency services personnel (ESP) are under constant pressure from the need to perform their

duties in emotionally demanding circumstances. The emotional cost of assisting survivors of trauma is often unacknowledged. It can, and does, result in the development of trauma-like symptoms that require intervention (McCann and Pearlman 1990b). This process is often termed vicarious traumatisation. Emergency services personnel and therapists exhibit the same symptoms as if they had been subjected to direct traumatisation. Consistent with the framework of this book, this process is seen as an instance of emotion contagion. It is the emotional reactions of the ESP that create the symptoms. The work of ESP is vital to the survival of trauma victims, and the cost to ESP must be acknowledged. Their work is only the beginning of the recovery process. The work of therapists and supporters of survivors is integral and cannot be over-estimated. The model and guidelines provided in this book are of assistance not only to survivors, but also to their supporters and therapists.

The best way to understand the modern view of trauma is to examine the relatively recent history of the study of trauma. No such history would be complete without mention of Freud's early theories. These theories are no longer regarded as appropriate, but were in their day important breakthroughs in the recognition of trauma as a psychological process. This book uses a modernised version of psychodynamic theory. As the twentieth century developed, the ravages of World War I, World War II, Korea and Vietnam gave rise to the work on trauma of pioneers such as Abram Kardiner. His and other researchers' and clinicians' work enabled the development of the most widespread model of trauma, that proposed and formalised by Horowitz (1997). Many of these models are somewhat experience distant. That is, they fail to reflect the actual experience of survivors by reducing the emotional elements to mere cognitive distortions. This results in a failure to give due weight to emotional processes, a deficiency that this book aims to correct. An exposition of emotion theory is necessary to fully comprehend the role of emotion in trauma. I present a number of theories and concentrate on the psycho-evolutionary model proposed by Plutchik (1980a). His model and others have provided a better understanding of the important role of the various brain structures that are central to human responses to traumatic events. The role of the limbic system is of particular importance. The model I have developed incorporates both the cognitive information perspective and the



emotion body theories, both of which are equally important to an understanding of trauma. I examine several case study presentations of the most common traumatic events. In examining these case studies, I show how an emotion approach significantly enhances both theory and treatment of trauma. Working as a trauma therapist or health worker—if done correctly and empathically—is an emotionally demanding job. Two important concepts—namely, vicarious traumatization and trauma countertransference—are essentially emotion-based issues. I show that these issues can be understood from an emotion perspective. Bringing the emotion perspective to trauma appropriately raises the important issue of traumatic dissociation. Traumatic dissociation illustrates the role of emotion processes in a focused and far-reaching way. Dissociation is not pathology in and of itself; it is adaptive. But, like all such processes, it is not adaptive when used out of its environment. An examination of dissociation from an emotion perspective shows how this process is focused on survival of the self.

This book is about trauma and how, by taking an emotion-based approach, therapists and others can better assist and treat survivors. This book shows, from both the theoretical and treatment perspectives, that the emotion approach is not simply an optional extra, but must be incorporated as a central feature of trauma treatment.

1 | TRAUMA

This chapter begins with an outline of the impetus for the modern study of trauma. It then goes on to examine the contribution of two famous French traumatologists, Charcot and Janet. Of course, no discussion of the origin of modern trauma study would be adequate without a review of the work of Freud. The great conflicts of the twentieth century produced a tremendous amount of suffering and trauma, and a consequent focus on treatment and theory. The work of Abram Kardiner is described and the central importance of his work commented upon. The societal revolutions of the latter half of the twentieth century led in the West to the examination of sexual and domestic violence and trauma. We focus on these discussions by examining both the diagnosis of PTSD and a proposal for an integrated model of trauma.

A brief introduction to the study of trauma

The study of trauma (a term used here and throughout this book to refer to *psychological* trauma) is relatively new, though the phenomena has existed since humans began to be aware of their existence. The study is also the product of a complex interplay between human needs and social expectations. The formal study of trauma has a history of only about 150 years. It emerged due to changes in social structures, medical advances and philosophical outlooks. The material that follows is designed to provide an overview of the contexts of the models of trauma and their consequences for the way survivors of trauma have been viewed and treated.

Financial compensation and the modern study of psychological trauma

The Industrial Revolution in Europe and North America was a period of great change, particularly in terms of transport. The rise of railways across the globe meant that, for the first time, great numbers of people could travel at unprecedented speeds. Along with this great mobility came the potential for terrible accidents. At this time, the West was experiencing a period of great wealth creation, and also the expansion of middle-class political power. Railway accidents thus led to legal action for compensation, a problem which became the focus of political concern. The British government brought in the *Campbell Act* of 1846, which was revised in 1864. This act authorised compensation payments to victims of accidents. The 1864 amendment authorised payment to survivors of railway accidents. There were similar Acts in France which authorised monetary gain as a result of the reporting of injuries from accidents. In the case of trauma unaccompanied by physical injury, the suspicion emerged that the claimant may not actually be affected, but rather attempting to gain compensation by fraud. Erichsen (1883) contemptuously labelled the condition ‘railway spine’. The rise of interest in this condition was the beginning of the funded study of trauma. It is interesting, in this regard, that renowned French psychologist Charcot was requested to look into the phenomena of ‘railway spine’ by an insurance company. As the symptoms of ‘railway spine’ were studied, it became clear to some that they were very similar to ‘hysteria’—which was believed only to occur in women. The association of trauma with monetary compensation and with a ‘disorder’ associated with women resulted in a large degree of suspicion being directed towards those who claimed to be afflicted with trauma. Indeed, it is consistent with later literature that, from the point of view of the legal profession, if a person displayed the symptoms associated with trauma, they were either malingering or constitutionally weak (remember that women at this time were considered the weaker sex). This was not the whole picture, however. Some researchers and clinicians who were studying those afflicted with trauma were more focused on the condition than its financial or political contexts. For example, Briquet (1859, quoted in Mai and Merskey 1980) had examined women suffering from hysteria and noted that there was a high incidence of childhood trauma involved.

The Third Republic of France and French traumatologists

The political situation in France in the latter half of the nineteenth century led the period to be termed the ‘Third Republic’. One aspect of this political situation was that the secular governments of the time were staunchly anti-clerical. One of the deep desires of the Third Republic was to extol the virtues of science in opposition to superstition—by which was largely meant religion. The Roman Catholic Church had great influence in France, particularly among French women. If the Third Republic was to wrest more and more power away from the church, then it had to show that science was able to describe and understand people—especially women. The nature of women in this society was taken to be an important question for study. The focus of such study was not a form of early enlightenment about women’s rights; rather, it was part of the struggle between state and church. It is in this context that two great traumatologists made their very important contributions to the study of trauma: Jean Charcot and Pierre Janet.

Charcot

In addition to his early work on trauma, Charcot’s general psychological work was very significant for a number of reasons which are beyond the scope of this book. Using hypnotic suggestion, he studied women with a range of disorders. He connected suggestibility to hysteria, and was able to implant physical behaviours into patients under hypnotic trances. This had the result that the physical features of hysteria could be simulated in hypnosis. The famous demonstrations he conducted became legendary throughout Europe. Figure 1.1 shows the famous painting by Brouillet depicting one of these demonstrations. The painting also clearly illustrates the French attitude to the study of women with hysteria. The room is full of men in the pose of experts, scientifically studying the swooning woman. However, Charcot’s work was significant in that he asserted that symptoms of ‘real’, as opposed to induced, hysterics were the result of the women’s traumatic experiences. His reputation and standing meant that the scientific community was forced to consider the assertion that psychological events could produce physical symptoms that were not under the volitional control of the individual. However, by his demonstration



'A Clinical lecture at the Salpêtrière.' Brouillet's painting shows Charcot at the height of his fame, demonstrating a case of 'grand hystérie' to an elite audience of physicians and writers; behind him is his favourite disciple, Babinski. The painter has involuntarily shown Charcot's fatal error: his verbal explanations and the picture on the wall suggest to the patient the crisis which she is beginning to enact; two nurses are ready to sustain her when she falls on the stretcher, where she will display her full-fledged crisis.

Figure 1.1 Brouillet's painting of a Charcot demonstration of hysteria and accompanying caption (Ellenberger 1970, p. 330)

that symptoms could also be implanted into subjects who were not traumatised, Charcot raised the possibility that some sufferers were in fact malingering or simulating their symptoms. The concept of simulation was taken up by his followers, with discussion concerning the exertion of the will. This led to a view that becoming traumatised was a matter of the sufferer having a weak will. In essence, the survivor of trauma became responsible for their own symptoms, since they were perceived as weak willed.

Janet

The work of Janet in the period 1890–1910 was very significant for the development of the psychological view of trauma. His

work was not studied extensively until the last decade and a half (van der Kolk and van der Hart 1989). It was Janet who noted the impact of ‘vehement emotions’ in the experience of trauma. By ‘vehement emotions’, he meant terror and fear. This insight is important, since it points to the critical role of emotion processes in trauma. Janet suggested that the result of these emotional reactions was to give rise to a kind of split existence. He maintained that the painful memories became locked into a kind of unrecited memory which simply replayed and replayed but was never integrated. He asserted that, because the memories were so painful, they could not be recited as part of one’s personal narrative. He further claimed that the agitation produced was of no adaptive value, and thus became an insurmountable obstacle in the life of the traumatised person. It was Janet who asserted that dissociation was the core of the pathological process involved in trauma. The work done on the dissociative process led him to develop the concept of *simultaneous consciousness*—that is, the idea that consciousness is not one-dimensional. The clear implication of this is that there are layers to the processing of human experience, and that what is seen in sufferers of traumatic neurosis is the result of an unsuccessful attempt to process the vehement emotions. Janet, like Charcot, also asserted that hysteria was the product of real trauma.

Sigmund Freud and trauma

No introduction to the study of trauma could be undertaken without an examination of the work of Sigmund Freud. Freud studied under Charcot and knew of the work of Janet, although Freud always denied that any of his theory was taken from Janet. There are similarities but these may simply be the product of a common mentor—Charcot. Freud discussed (Jones 1953, p. 226) the case of hysteria, of Anna O, with Breuer in the early 1880s before he went to see Charcot. Freud did not treat this case, but it shows that he was aware of the condition before actually seeing Charcot. Freud was very much in awe of Charcot. Freud refers to Charcot as the ‘greatest of physicians’ (Jones 1953, p. 185). He spent about five months with Charcot—although he notes that he was initially one among

many. Freud responded to a request by Charcot for someone to translate his works into German, and produced a translation of some of Charcot's work as early as 1886, which allowed Freud into Charcot's inner circle.

Charcot's assertion that symptoms of 'real' hysterics resulted from traumatic experiences, and that hysteria occurred in men as well as women, was a very confronting concept at the time. Freud's theory that hysterical paralysis was the result of 'popular conceptions' rather than of anatomical facts was also revolutionary. Freud demonstrated that certain physical symptoms of hysterics were not consistent with the anatomical structures of the human nervous system.

The famous case of glove anaesthesia is a very good example of this. A woman reported having no feeling in her hand. The pattern of this anaesthesia was consistent with the area covered by a women's glove (see Figure 1.2). When Freud pricked the hand with a pin, the woman showed no sign of pain in the afflicted area. However, the region suffering this condition was not consistent with the pattern of nerves servicing the human

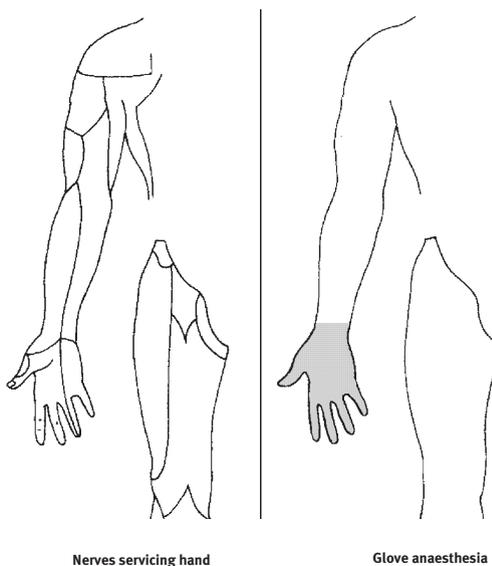


Figure 1.2 Glove anaesthesia (Erdelyi 1985, p. 3)

hand. What had produced this induced state of anaesthesia? Was the human mind capable of producing physical effects that were able to control the conscious registration of nerve impulses? Freud was very keen to spread the views of Charcot once he returned to Vienna, and presented a paper on male hysteria not long after returning from Paris in 1896. The discussion that followed within the profession was an example of professional resistance to the concept of trauma. Many rejected the connection between trauma and hysteria, and Freud was confronted with the establishment's views on male hysteria and trauma.

Between 1892 and 1896, Freud published and lectured on his work with women who suffered from hysteria and other maladies. Freud, like Janet, viewed dissociation as the core of the problem of hysteria. As a result of several famous cases involving Breuer and also Freud, there arose a theory of hysteria that was a shock to Freud himself. Freud and Breuer asserted that the women were suffering from hysteria as a result of their actual experiences of sexualised contact as children. From his work with patients, Freud determined that the process of traumatisation had two main aspects: first, the events were so terrible that they left an emotion-charged residue in the psyche; and second, this produced altered states of consciousness in which the trauma was encased. The basic process of the development of neurotic symptoms is shown in Figure 1.3.

This is the process for all 'traumatic' events. The process involves the generation of very powerful emotions that threaten to overwhelm the ego's ability to function. This is the context of Freud's often-quoted statement that people with hysteria 'suffer from reminiscences' (Breuer and Freud 1893–95). Memories are charged with strong emotion, or are highly stylised and emotionless. Freud cited clinical examples of 'intact' memories of traumatic events and noted the strong emotions that were expressed by patients. The alarming implication of this finding for Freud was that the traumatising events were being perpetrated in the home by family members. Here was the first instance of the study of trauma pointing to some very disturbing aspects of Western family life, structure and character. Freud published his findings concerning the link between hysteria and sexual abuse in 1896. This model is referred to as the *seduction theory*.

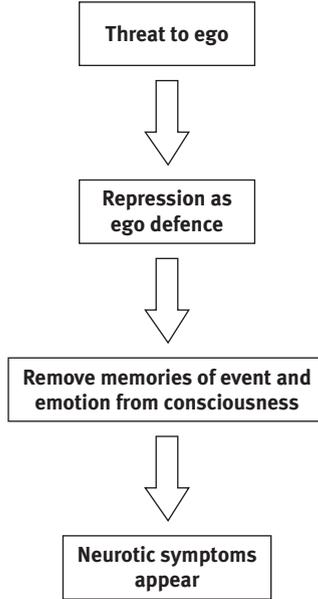


Figure 1.3 Freud's model of the development of neurotic symptoms

Society's reaction to the seduction hypothesis and its consequences

Society's reaction to Freud's seduction theory was one of mixed fascination and outrage. Typical of the reaction was that of C.H. Hughes, in the journal *Alienist and Neurologist* (1896), who described the assertions in Freud's seduction theory as 'grave' and went on 'to condemn the absurdity of such wildly conjectural, unproved and unprovable conclusions' (quoted in Kiell 1988, pp. 35–6). The impact of this type of reaction on Freud was considerable. By 1896, he had abandoned the seduction hypothesis in favour of his well-known Oedipus prototype. The impact of the public scorn on Freud is clearly shown in a letter to Wilhelm Fleiss, where Freud states that he feels 'as isolated as you could wish . . . abandon(ed)' (see Masson 1984, p. 10). It is important to remember that Freud's seduction hypothesis was confronting even to him, going against his conservative Jewish background. Freud was convinced that, if he maintained the seduction hypo-

thesis, he would have to reject the Oedipus complex and thereby the structure of psychoanalysis would be undermined (see Masson 1984, p. 113). The criticism, and Freud's interest in the psyche, combined to lead him in another direction. He became wedded to the idea that the inner world exerts immense power in determining behaviour and ideation. This belief in the power of the imagination led him to postulate that psychic reality is *the* reality, and it does not matter whether the events actually happened or not. By 1896, Freud had begun to focus on psychoneurosis, which has its origin in the powerful urges that result from the id instincts. This led to a shift in technique. Abreaction was the method espoused by Breuer and followed initially by Freud. Adoption of the tripartite model of the psyche (id, ego, superego) also meant that treatment was now focused on the ego gaining control of the instincts. Freud changed his approach from catharsis to free association, discarding the cathartic expression of emotion. Essentially, the consequence for the study of psychological trauma was that the focus was removed from the external origins of trauma and placed on to the internal psyche of the victim. With this emphasis came a period of societal amnesia regarding the real context of a great deal of personal trauma. We will return to Freud's approach later, with reference to the treatment of World War I survivors.

World War I

The horror of World War I can only be truly understood by those who were there—both military and civilian. The battlefields of Europe and the Middle East bear witness to great slaughter and terrible events, and the experience of battle left its mark on the vast majority of those who served. Witnessing such horror, let alone being personally threatened by it, would leave a psychological mark on any healthy person. Such was the psychological impact on civilian and military personnel involved that, for the first time, there was recognition that many 'casualties'—while not physically injured—were nevertheless incapacitated. The British army, for example, had treated over 80 000 cases of what was termed 'war neurosis' by the end of hostilities (Young 1995). After the war, there were 200 000 war-related 'nerves' pensions granted in Britain (Young 1995). These numbers should be

considered for a moment. Many tens of thousands of individuals were deeply distressed and physically afflicted, yet were not necessarily physically wounded. Two famous poets who served during World War I expressed the horror of that great conflict. Both met and were treated by W.H. Rivers, whose work is discussed later in this chapter. Wilfred Owen served on the Western Front and was killed just a few days before the war ended. In his poem 'Strange Meeting' (Owen 2004), he describes the fearful state of men as they attempted to survive the war:

Yet also there encumbered sleepers groaned,
Too fast in thought or death to be bestirred.
Then, as I probed them, one sprang up, and stared
With piteous recognition in fixed eyes,
Lifting distressful hands as if to bless.
And by his smile, I knew that sullen hall;
By his dead smile I knew we stood in Hell.

Owen had been hospitalised for war neurosis and, while in Craiglockhart Hospital, he met Siegfried Sassoon, who also had served on the Western Front and was also hospitalised as a result of the horrors of the war. Sassoon wrote in 'Does it Matter' (Sassoon 2004), in a similar vein to Owen:

Do they matter?—those dreams from the pit? . . .
You drink and forget and be glad,
And people won't say that you're mad

These men were typical of many thousands who were showing the signs of the terrible situation that had developed in the trench warfare of World War I.

To the British establishment, many thousands of soldiers were acting like hysterical women. During the war, as these cases came to light, there was great concern about the fighting ability and morale of the British army. This was looking like large-scale cowardice, and so the matter had to be dealt with quickly. With the dominance of medical approaches—remember, psychology was in its very early stages as a science—the approach adopted was to locate a physical cause for these cases of war nerves. In 1915, Myers (1940) asserted that war neurosis was the result of being in close proximity to exploding shells—or 'shell shock'.

There was a concussion of the blood vessels in the brain. This approach meant that war neurosis was not cowardice, but a direct consequence of battle experience.

Gradually, however, symptoms of war neurosis were found in soldiers who were not exposed to exploding shells. Another explanation had to be found. If the cause was not physical, then what was the origin of this problem? Studies of groups that did not exhibit a significant proportion of war neurosis cases were very revealing, yet at the same time problematic. There was very little war neurosis in three groups. They were:

- prisoners of war;
- soldiers with very serious wounds; and
- officers.

At first glance, the first two of these three groups would seem to be prime candidates for developing war neurosis. They were clearly exposed to battle and, in the case of the wounded, were severely injured. So why didn't they show appropriate levels of war neurosis? The inability of the medical establishment to find a physical cause was one of the reasons for the gradual acceptance of the psychological aetiology of war neurosis. The acceptance of such psychological origins, however, meant that some mechanism to account for the pattern of symptoms in war neurosis must be found.

The third group was used as evidence of the view that those who developed war neurosis were constitutionally weak. Officers, it was assumed in class-dominated Europe, would be constitutionally stronger since they mostly came from the upper classes of society. This was the view taken by one of Charcot's students, Babinski (1918). He based this on the notion that hysteria could be simulated by the use of suggestion in hypnotic states. The argument went that those who developed war neurosis were weak-willed, unable to control their fear, so they developed this woman-like condition. Treatments that followed this analysis tended to be somewhat brutal by modern standards. The use of electric shocks to severely traumatised individuals was common, along with shouted commands, restricted diets and isolation. The patient was told that he could relieve himself of this treatment by abandoning his symptoms (see Young 1995, p. 68). The disciplinary approach, as it has been termed, focused on the

strengthening of the perceived weak will. Another approach, though, was adopted and is best represented by the work of William Rivers.

Rivers and the humane treatment of war neurosis

William Rivers was an ethnographer and a psychiatrist. He served in the Royal Army Medical Corps (RAMC), and is credited with a very humane and insightful analysis of war neurosis. In essence, he asserted that soldiers who developed war neurosis were overcome by the fear of death (Rivers 1918). They were confronted by the horror of the slaughter of the Western Front (or elsewhere), so their symptoms were an effort to preserve their individual lives. Rivers asserted that war neurosis was not the result of moral weakness of the will, but rather the response of an individual faced with a degree of fear he could not suppress. It was this fear of death that made the soldiers ripe for the therapeutic process of suggestion. Rivers used this to reorientate the sufferer towards the group so that he could return to battle. He noted that the high incidence of war neurosis was the result of the large number of conscripts, who were not as heavily socialised into the repression necessary for military service as regular soldiers. He also accounted for the low incidence of war neurosis in prisoners of war and the seriously injured by noting that they were now safe from the threat of being killed in battle. The third group, officers, presented a problem. Research both then and after World War II noted that the expectations placed on the officers were so strong that breaking down was psychologically much more constrained. One can only wonder about the life-time impact of such powerful denial in the light of our modern knowledge of trauma.

Freud and war neurosis

World War I provided Freud with an opportunity to study the effects of unambiguously externally generated traumatic events. At the beginning of the war, psychoneurosis was seen as the result of intrapsychic conflicts that resulted from unresolved psychosexual issues. The war, however, confronted Freud with the results of a number of clinical investigations, conducted by his followers, that required a restatement of the nature of trauma. Freud asserted that:

- traumatic events lead to traumatic neurosis;
- traumatic neuroses are not the same as ‘spontaneous’ neuroses—that is, hysterical neuroses;
- key features are:
 - intrusive imagery;
 - hyper-alertness and reactivity; and
 - active reliving of the event.

His construction of the double consciousness was the result of the evidence of the carnage of World War I. The soldier was faced with a warlike ego that propelled him into battle. This was counterbalanced by the ego that promotes life. The soldier lives in a split state of consciousness. Freud rejected the organic view (e.g. shell shock). The concept of the stimulus barrier was central to his explanation. The nature of overwhelming fear, with its absence of signal anxiety, made the individual unprepared for the externally traumatising events, so the ego did not have time to prepare defence formations. The primary defence was repression, across both types of neurosis. In 1920, Freud was called to give evidence in the case of the conduct of Wagner-Juraegg (Freud 1919–20/1955). In this case Freud asserted that:

- Every neurosis has an intrapsychic purpose.
- Neurosis constitutes a flight into illness—in other words, it involves subconscious intentions.
- With the end of the hostilities, ‘war neurosis’ would disappear.

It is worth noting that Freud was wrong on all three counts!

In 1920, Freud wrote ‘Beyond the Pleasure Principle’, in which he sets out his view of the concept of the traumatic neurosis as having four features:

- the stressor overwhelms the ego;
- the stressor causes disequilibrium;
- a reduced coping capacity; and
- an effort to master the stressor.

These models reflect the development occurring in Freud’s thinking, and also an attempt to incorporate new clinical material. This trend toward an internal focus compared with a recognition of the external origins of trauma has implications

both for theory and for the treatment that was followed after World War I. It is worth comparing Freud and Rivers on the nature of war neurosis in order to better understand the dual development of the concept of trauma up to this time (see Table 1.1).

Table 1.1 Conceptualisation of trauma: Comparison of Freud and Rivers

Issue	Rivers	Freud before 1914	Freud after 1920
Location of war neurosis	Consciousness—i.e. attempts to put memories and emotions out of awareness	Unconscious mental process	Conflict in the ego sphere Peaceful vs warlike ego elements Double consciousness
Cause of war neurosis	Disturbance to the instinct of self-preservation	Disturbance of sexual function	Combination of 'fright' and conflict With fright there is no signal anxiety Fright overwhelms the stimulus barrier Fear of internal enemy—i.e. warlike ego
Dreams	Perpetuation of high levels of anxiety—i.e. energising the instinct of self-preservation	Wish fulfilments—i.e. gratification of desires	Evidence of compulsion to repeat and so continue anxiety—anticipate the trauma retrospectively

Evaluation

As a result of his work with women suffering from hysteria, Freud discovered first-hand some of the horrors that were being committed within the family. He attempted to bring this knowledge to public and professional attention. Judith Herman (1992a, p. 18) points out that Freud's abandonment of the seduction theory was only to be expected. There was no widespread social movement to support such a contentious assertion. World War I confronted Freud and the West with the terrible psychological consequences that occur as a result of horrific events. With Freud's shift to the Oedipus complex and the primacy of the inner

life, he placed the processes of fantasy and psychic structure to the foreground and real-life events were lost sight of. This perspective dominated psychology and psychiatry for many decades. The understanding of trauma that had been gained during the war drifted from view. With Freud's emphasis on fantasy, the shift was made to the study of premorbid conditions in sufferers of traumatic neurosis. This was appealing to both the general public and to insurance companies.

Other members of the psychoanalytic community had not forgotten the plight of children abused by adults, however. Sandor Ferenczi's 1932 paper, 'Confusion of Tongues between Adults and the Child (The Language of Tenderness and the Language of Passion)' was delivered in 1932 but was not published until the 1950s—many years after both his death and Freud's. Other clinicians who conducted therapy with war veterans gradually became aware that the internal world was not in fact the origin of trauma.

Abram Kardiner

Kardiner trained as a psychoanalyst in Vienna and returned to the United States in 1922–23 to set up practice as a psychoanalyst. He had been analysed by Freud and followed Freudian treatment principles. Among his patients were US war veterans. He tried to account for war neurosis using standard psychoanalytic principles, but found this impossible. In 1939 he wrote a book which stimulated his thinking about his war neurosis patients, although it was not directly related to trauma. From this re-evaluation, he established the structure and outline of trauma that provided the forerunner for modern lists of symptoms of post-traumatic stress disorder (PTSD). Kardiner (1941) asserted that anyone could break down under the fear of death in war. He noted that war neurosis was a form of hysteria, which consisted of:

- extreme physiological arousal that produced a lowered threshold to stimulation;
- a readiness for fright reactions;
- a sense of futility about life; and
- acting as though the past traumatic situation was reality in the here and now.

Kardiner's work recognised the primacy of the external event in generating the conditions for trauma. He placed great store in his clinical experience as he witnessed the re-experienced terror of his patients. But his most important contribution is the link he drew between the psychological and the physiological. It is this rejoining of the mind and the body that is so important for understanding the process and purpose of traumatic stress responses.

Military and civilian survivors of traumatic events

The period since 1939 has been littered with wars and disasters, including World War II, the Korean War, the Vietnam War, several wars in the Middle East and numerous others in various parts of the world. Several authors have written about the experiences of US military personnel. Kardiner and Spiegel (1947) asserted that both resistance to and recovery from war neurosis was predicated on the relatedness of the individual to the unit and to confidence in the leadership of the unit. Grinker and Spiegel (1945), in similar vein, noted that recovery from trauma was predicated on unit morale and leadership. The resultant treatment followed the principle of reintegration of the traumatic memories into consciousness. The focus was on undoing the split in conscious experience.

Krystal (1968, 1978, 1988) studied civilian survivors of conflict, including the dropping of the atomic bombs in Japan. He noted that these survivors:

- showed hyper-alert anxiety;
- experienced progressive blocking of emotions;
- exhibited behavioural inhibition; and
- suffered de-differentiation of emotion (alexithymia).

Krystal's work was typical of a growing body of research that began to look at the emotion processes associated with trauma. While emotions had always been part of various models of trauma, they were now being regarded not just as dysfunctional, but as having an important role in their own right in the recovery process. Krystal's work is developed in Chapter 2, in the context of a fuller exposition of the role of emotion in trauma.

The Vietnam War occupies an important place in the study and understanding of trauma. It was not innovative in terms of treat-

ment, as the principles developed for World War II were also used during the Vietnam conflict. Vietnam was associated with a major shift in social attitudes. This conflict saw the emergence of a disillusionment with war, and the political power of the returning veterans and their families was responsible for significant changes to both diagnosis and treatment of trauma. It is no accident that the diagnosis of Post Traumatic Stress Disorder (PTSD) first entered the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1980—just five years after the end of the Vietnam War. Social pressure after Vietnam, especially in the United States, helped to establish trauma as an important subject of study. This in turn resulted in the establishment of national bodies and the provision of unprecedented research and treatment funds.

Traumatic neurosis of the sex war

Women's questioning of their role in society coincided with the 1960s notions of freedom of expression and issues concerning the privacy of the family. The women's movement confronted Western society with a number of disturbing issues but, as Herman (1992a) points out, this was only possible due to a new political will to engage in this questioning. One of the prominent issues at this time was rape. Treatment centres were set up and research was conducted which explored the experience of this survivor group and validated the viewpoint of its members. Old Freudian notions of Oedipus and Electra complexes were seen as examples of male oppression. The survivor of rape was not dysfunctional—it was society which created the problem by privileging the dominance of men.

Research established that sexual assault was endemic in Western society—a truth that is still difficult for certain sectors of society to acknowledge. Early figures from the 1980s (see Walker 1991) state that 25 per cent of women were raped and 33 per cent of female children were sexually abused. More recent figures indicate a lifetime prevalence of sexual assault against adults of approximately 27 per cent for women aged between 20 and 59 (Thumbi et al. 2000). Researchers and clinicians began to identify a 'rape trauma' syndrome and a 'domestic violence' syndrome. A picture of a war of the sexes emerged and has been part of the

social context under which the investigation of trauma has proceeded over the last twenty or so years. This movement has also exerted a political influence over laws and services. Society is now being confronted with much of what Freud asserted in 1896. Children are being molested; women are being terribly mistreated inside the family. There have been strong reactions against both these assertions; however, I would say that the evidence is both widespread and convincing for both of them.

Trauma: Episodic study and periodic amnesia

The study of psychological trauma has been an episodic process. There have been periods of great effort when significant advances have been made. The work of Charcot, Janet, the early Freud, Rivers, Kardiner and others have brought forward an initial understanding of the phenomena of trauma to the point where there is now a fairly well-accepted description of the symptoms which were codified in the DSM by 1980 (see Figure 1.4 for the main stages). Research over the past two decades (see Brewin 2003) has further refined our understanding of the experience and treatment of trauma.

One point needs to be stated very strongly: the horror of trauma is very confronting for people. Periodic amnesia, as Herman

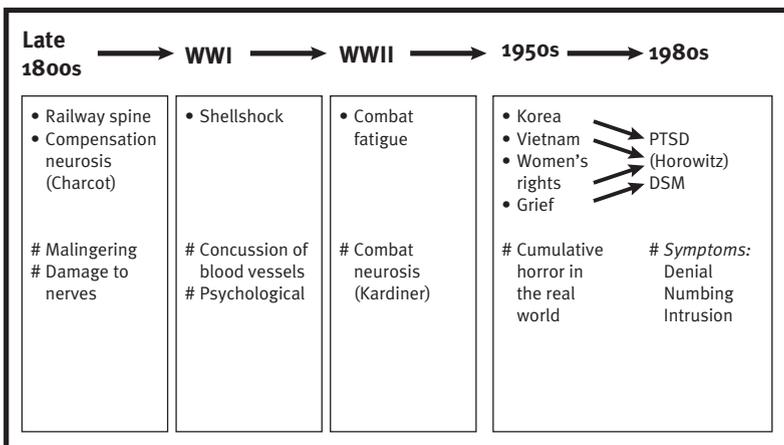


Figure 1.4 Major stages in the development of the concept of trauma

(1992a, p. 7) describes it, is therefore very understandable. The temptation always exists to turn away from the knowledge of the terrible things done by human beings to each other both in war and elsewhere. It is also hard to accept that the planet we inhabit can be deadly and dangerous. Floods, earthquakes and other natural disasters cause a great deal of traumatic suffering. As we move into the twenty-first century, are we entering a period of amnesia or awareness? In one sense, that is up to each individual to answer; however, it is also about having the political will not to turn away from the survivors of trauma in order for the non-traumatised to live more comfortable lives. Societies everywhere need to engage in a process of understanding trauma and to commit to the well-being of those who have survived traumatic events.

Diagnosis of trauma: Post Traumatic Stress Disorder

The diagnosis of PTSD appeared in the 3rd edition of the official manual of the American Psychiatric Association in (DSM III) 1980 (APA 1980). The symptoms had been known and studied for approximately 100 years prior to this official publication. A number of controversies were associated with this diagnostic label. The purpose of this section is to describe the accepted diagnostic criteria as they stand at the time of writing (i.e. DSM IV TR, 2000/APA). In essence, the symptoms outlined by Rivers, Kardiner and especially Horowitz are codified under the diagnostic label 'PTSD'. The purpose of these criteria is to assist with the differentiation of this cluster of symptoms from other similar disorders. The most common of these are the other anxiety disorders such as Generalised Anxiety Disorder. PTSD is classified as an anxiety disorder due to the focus of the symptoms. There are, however, critical divergences between PTSD and the anxiety disorders. The most important of these is the recognition of an event or situation that triggers the symptoms. In the words of the DSM IIIR (APA 1987 p. 250): 'The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone.' The disorder of PTSD is said to be applicable to almost everyone. This is one of the controversial aspects of the diagnosis: if it can happen to anyone, how can it be a disorder? The DSM IV TR (APA 1994, pp. 424–9) replaced this statement with two criteria

which specify event types (e.g. threatened death) and the response to the event (e.g. horror). The key point is that the symptoms persist and cause disturbance to the individual's life. The criteria which follow in DSM IV TR (APA 2000) represent, to varying degrees, the symptom lists of Kardiner, Krystal, Horowitz and others. Symptoms include re-experiencing, avoidance and heightened arousal including hypervigilance and startle reactions. The symptoms are said to be problematic if they persist for longer than three months. (Appendix A and B present the DSM IIR and DSM IV TR criteria respectively.) This period of time since the identified event is important from our perspective. These reactions are normal in the early stages following a traumatic event. They only qualify for the term 'disorder' once they persist and lower the survivor's level of functioning. The period of time required is also debated, and has become the focus of research into the acute stress disorder concept (Bryant and Harvey 2000). The relevant point is that the symptoms arise as a normal reaction to coping with traumatic events. Their pattern and period need to be assessed, but the reactions are not pathological in and of themselves. Other controversies exist in the field of trauma, and some of these will be explored later in this book. A unified theory of the process of trauma at a conceptual level is still under development, and considerable divergence exists. The following section will present the essential elements of the theoretical framework that guides the approach presented in this book.

Developing an integrated model of trauma

The purpose of this section is not to fully describe and evaluate all the theories of trauma that currently exist. Rather, it is to examine two approaches which are relevant to the theoretical underpinning of the model utilised in this book. These approaches to conceptualising trauma have been, to varying degrees, incorporated into the integrated model proposed in the current work. They are van der Kolk's biochemical model, and Horowitz's information processing model.

Biochemical models of trauma

Work by Kolb (1985) and Kolb and Mutalipassi (1982), as well as by van der Kolk (van der Kolk et al. 1984), has emphasised the

overload created on the neurones in the brain by traumatic events. The brain of an individual experiencing a traumatic event is processing a tremendous amount of activity. Van der Kolk uses the concept of receptor hypersensitivity to explain this. This model is based heavily on experimental work with animals in the 'inescapable shock situation' developed by Maier and Seligman (1976) and termed 'learned helplessness'. According to this theory, during trauma the brain is stimulated rapidly beyond usual limits. Van der Kolk et al. (1984) assert that certain neurotransmitters (e.g. norepinephrine and dopamine) are depleted, which results in both the loss of escape (flight) behaviours and of the ability to initiate action. The result of this over-stimulation is that the receptor sites become hypersensitive, and eventually an addiction to the trauma can develop. Van der Kolk et al. (1984) note the tendency for victims of trauma to seek out stimuli not unlike the original experience. They note that traumatic exposure leads to a 'CNS opioid response' (Peterson et al. 1991, p. 93). The result of the endogenous opioid production is that, when the trauma ceases, the symptoms of Post Traumatic Stress Response—which are similar to opioid withdrawal—occur. Re-exposure to traumatic situations leads to opioid production and an experience of control that results from the psychoactive properties of endogenous opioids. This model is not without its critics: 'Peterson and Seligman (1983) . . . warn against over-generalisation . . . (of) . . . findings from controlled laboratory experiments to natural settings.' (quoted in McCann and Pearlman 1990a, p. 54). The main point is that trauma sets in motion biological processes that are not within the volitional control of the survivor. These processes occur in both the brain and other parts of the body, such as the central nervous system and associated muscle groups—something van der Kolk (1987) has described as the body keeping score of the traumatic experience. This has led to a recognition that trauma is not only a psychological condition, but there are also bodily consequences. The biochemical components of trauma are therefore clearly very important in terms of pharmacological treatments. These theories provide little in the way of explanation of the manifest psychological symptoms that are the hallmark of trauma reactions. The role of broader physiological processes cannot be ignored—and indeed, an integrated view of the biological and psychological processes is necessary for comprehensive treatment.

Information processing models

One of the most influential models of trauma is that of Mardi Horowitz. Peterson et al. (1991) state that, with regard to Post Traumatic Stress Disorder, ‘this model formed the cornerstone for the diagnostic criteria for inclusion in DSM III’ (1991, p. 70). Horowitz’s work of more than 30 years has culminated in a comprehensive theory of trauma and an approach to treatment that is applied to a wide variety of trauma experiences, from bereavement to combat. He utilises a combination of psychodynamic and modern cognitive science concepts. His model of trauma is based on the premise that, as a person experiences extreme stress or trauma, they are flooded with information, some of which is stored in active memory. This information is then compared with current self-schemas. Information that is consistent with current schemas or within an acceptable range of characteristics is easily assimilated into those schemas. The material that is unacceptable or simply overwhelming stays in active memory until, through a process Horowitz calls ‘dosing’, it is assimilated into a revised self-schema. Active memory can be thought of as material that, due to its emotive content, agitates for processing. Figure 1.5 presents Horowitz’s depiction of the pathological and non-pathological reaction processes.

In Horowitz’s model, the potential for being overwhelmed is assessed preconsciously, which may lead to a period of denial so characteristic of trauma experience. The recurring flashbacks, nightmares and avoidances are indications that the traumatic material has not been fully integrated. Horowitz has specified a series of five phases that follow a traumatic event—that is, one with the potential to overwhelm.

Horowitz gives prominence in the recovery process to the phases of denial and intrusion. He says that episodes ‘of intrusion and of denial or avoidance do not occur in any prescribed pattern, but appear to oscillate in ways particular to each person’ (1979, p. 236). It is these two phases which are crucial to an understanding of his model.

Denial phase

This phase is characterised by emotional numbness, selective inattention, complete or partial amnesia and constriction of associational thinking. This phase typically follows the initial

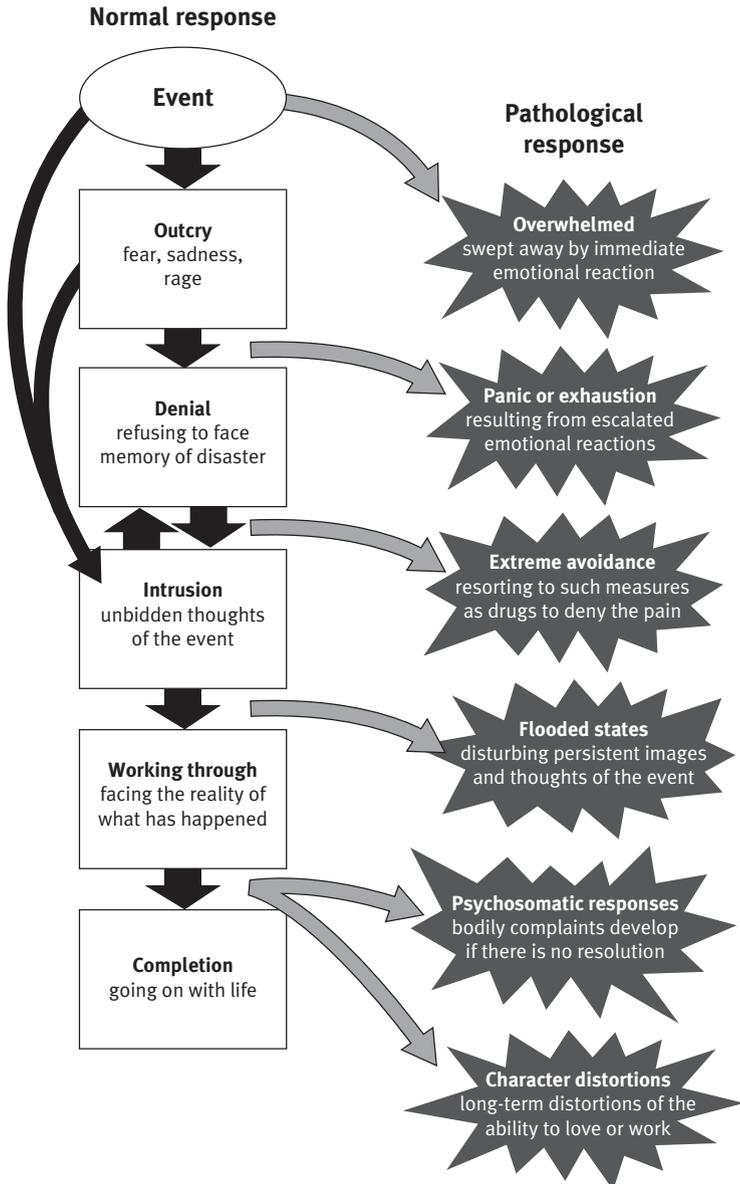


Figure 1.5 The normal and pathological phases of the post-stress response (Horowitz 2001, p.41)

outcry and is seen by Horowitz as a control process to ward off the total fragmentation of the personality that is threatened if the emotions generated by the trauma are left unchecked. The observable behaviours that accompany this phase are frantic over-activity often followed by withdrawal, or general withdrawal and inactivity.

Intrusion phase

Signs of the intrusion phase include hyper-vigilance, sleep disturbance, intrusive thoughts, repetitive thoughts, confusion, physiological arousal and emotion pangs. The observable behaviours include searching for lost persons and compulsive repetitions. The generation of the intrusive material is the result of a combination of influences: firstly, the traumatic material stored in active memory presses for resolution; and secondly, the innate cognitive processing tendency to complete integration draws the material into consciousness.

Normal is not always pathological

Horowitz does not see these reactions as pathological in themselves. They are the normal means by which individuals resolve trauma. It is only because 'some people's predisposition and situational circumstances . . . produce the characteristic symptom pattern of overwhelming intrusion and maladaptive denial' (Horowitz 1986, p. 32) that pathological reactions to trauma develop. It is the blocked processing of trauma experiences that causes problems for survivors. The symptoms associated with intrusion include hyper-alertness, survivor guilt and re-experiencing of trauma event(s) and associated emotions. These are pathological when they result in maladaptive interpersonal patterns and constrictions to life that include the 'inability to work, create, to feel emotion or positive states of mind' (Horowitz 1991, p. 17).

Schemas and information processing

Trauma in Horowitz's model involves disruptions to self-schemas. He defines self-schemas as 'a view of self whose conscious representation is not necessarily available but persists unconsciously to organise inner mental processes' (Horowitz 1988, p. 29). Horowitz divides cognitive structures into two categories: person schemas (self and 'other') and role relationship models. He states that: 'Person schemas summarise past interpersonal experience

into integrated, generalised, and modular forms against which incoming information is measured and reorganised for a “goodness-of-fit” (Horowitz 1991, p. 13). He further distinguishes two stages of person schemas: ‘Enduring schemas are intrapsychically retained meaning structures. They maintain generalised formats of knowledge and can be activated by other mental activities related to that knowledge.’ Working models are ‘transitory combinations of internal and external sources of information’ (1991, p. 15). Working models integrate externally generated information (e.g. social transactions) and internal information such as role relationship models and enduring self-schemas. Horowitz (1991) states that: ‘Role-relationship models (RRMs) are combinations of a schema for self, a schema for at least one other person, and a script of transaction between them’ (1991, p. 22). In Horowitz’s view, role relationship models also contain the potential for experienced emotion. That is, once the script is followed, the emotion that is included in the model is activated. The process of schema modification is thus an ongoing interaction between the external world and the internal schemas mediated by scripts. This process of schema formation also includes the development of what Horowitz describes as ‘supra-ordinate self-schemas’, which ‘give a sense of more continuity of identity and overall cohesion of self-organisation. The absence of such forms can lead to conscious imagery of chaos, emptiness, fragmentation, identity diffusion, depersonalisation or multiplicity’ (1991, p. 26).

In commenting on the impact of trauma on self-schemas, Horowitz says: ‘It is a general principle that a stressful event presents a person with stimuli that drastically conflict with inner schemas. Continued confrontation with the new situation requires a change in schemas’ (1988, p. 75). The continued confrontation results from the action of active memory in which ‘information stored in this manner has a tendency to repeated representation and if important will continue to be coded for more than a short time . . . Emotional activation is one sign or marker of such importance’ (1988, p. 175). Horowitz also states that, in general, ‘when there is not an immediate good fit between the new information and existing schemata, further information processing is instigated’ (1986, p. 96). Thus, once an event is stored in active memory, it presses for incorporation into self-schemas. Emotions are markers of important information and,

with regard to traumatic events, he says that the 'discrepancy between the new ideas and the (existing) schemata evokes emotion . . . threatening emotional states of such power that controls are activated to prevent their occurrence or continuation' (1986, p. 100).

The 'controls' Horowitz mentions are more usually termed 'defences'. Their purpose is to 'modulate emotional reactions to serious life events' (Horowitz 1986, p. 102). These are pivotal in preventing the complete overwhelming of the person who undergoes a traumatic experience.

The relationship between the processing of information and its accessibility is a key feature of Horowitz's model. He states that: 'Roughly speaking, the more conscious the thought is the greater will be the probability of solving problems, but the slower will be the thought processes' (1986, p. 98). Thus, when a traumatic event is kept out of consciousness, the material that would be incorporated into a revised self-schema cannot be accessed. However, the material continues to press for incorporation and the result is an ever-activated defensive process which attempts to prevent the overwhelming of the personality. In pathological trauma reactions, the anxiety levels are maintained by the continual antagonism between active memory and the defences. Horowitz prefers the term 'control' to 'defence' since it focuses on the 'ways in which incipient topics, schemas, and thoughts and feelings might be inhibited or facilitated' (Horowitz et al. 1990, p. 65). He views defences as either adaptive or maladaptive if they are regulatory, or as having failed if they result in complete breakdown. This view of defences is therefore based on a cognitive information processing model, since it asserts that defences prevent trauma from overwhelming the system. They are not seen, in the context of the classical psychoanalytic model, as the result of internal conflicts. Horowitz's model is one of the most comprehensive and widely accepted in this field.

Summary

Neither Horowitz's model nor those which emphasise the biochemical aspects of trauma explicitly identify or develop a role for emotion processes in trauma. This is a major omission: to assume that emotions will look after themselves if the cognition

and schemas are 'corrected' is to fail to acknowledge the place of emotion processes in human functioning generally, and in trauma in particular. It is the experience of strong emotions which often dominates the recall and processing of a traumatic event by survivors. The next chapter addresses important developments in emotion theory and research as they apply to the study and treatment of trauma.

2 | EMOTION PROCESSES AND TRAUMA

This chapter introduces and develops theories of emotion. A special position is assigned to the psycho-evolutionary theory of emotion. The contributions of traumatologists Robert Lifton and Henry Krystal will be examined to highlight the important role of emotion specifically in trauma. From an evolutionary perspective, an examination of the role of biological structures and processes—particularly the limbic system—will be undertaken with particular reference to trauma. Following on from the discussion in Chapter 1, I propose an integrated model of trauma that combines experiential aspects with emotion and cognitive theories of human functioning during and after traumatic events.

Emotion and its role in human functioning

This chapter provides an introduction to the role of emotion in general human functioning, and especially in trauma. For our purposes here, the terms ‘emotion’, ‘affect’ and ‘feeling’ will be treated as equivalents. In many cultures, and especially in the West, displays of emotion are not encouraged as they are associated with weakness. A number of researchers have taken a different view, and regard emotion as both adaptive and central to normal human functioning. Its role in trauma is life-preserving, through the activation of responses such as flight and fight. If the physical and psychological mechanisms associated with emotion’s role in trauma remain activated, then problems will arise. The emphasis placed on the positive and constructive role of emotion in this

book is the result of several influences. As with the previous chapter on trauma theories, the review of emotion theories which follows is selective and focuses on the proposed model of trauma.

Modern cognitive theories of emotion

The predominant theories of emotion have been ‘rationalist’ in approach—that is, they have emphasised the role of evaluative cognitive processes. The widely used approach of cognitive behavioural therapies to mood disorders illustrates the dominant position of reasoning over emotion. In essence, this approach asserts that if one’s cognitions are rational, the appropriate emotions will automatically follow. The work of a number of cognitivist theorists will now be discussed.

Schachter and Mandler: Cognitive arousal

The concept of bodily registration leading to feeling states was used by Schachter (1966, 1971; Schachter and Singer 1962), but from within a cognitive-contextual framework. In this theory, the physiological arousal that accompanies an emotion experience is recognised, but the label attached to the arousal is determined by the context. That is, the arousal states are not specific to the feelings but the feeling labels are the result of the environmental context in which the arousal occurs.

Mandler (1980) took a similar approach to feeling states. He was interested in the cognitions that led to certain feeling states. Greenberg and Safran (1987) state, regarding this approach, that ‘there is no affect without evaluation’ (1987, p. 111). However, this theory cannot account for the impact of non-autonomic nervous system effects on emotion. The recently established finding that evaluation is not neutral, but a predetermined process that biases the selection of information, also limits the usefulness of this approach.

Arnold and Lazarus: Cognitive appraisal

Arnold (1960) proposed that there were essentially two orientations within the human species: attraction and aversion. The experience of these two orientations results in emotions. Over

time, memories of attractive and aversive experiences—termed ‘affective memories’—are accumulated and retrieved in certain circumstances. Arnold asserts that the process of perception–appraisal–emotion is a rapid one, so knowledge of an experience is never simply objective, but always coloured by one’s intuitive appraisal. In her view, emotions are multiply determined by both the initial appraisal and later reappraisal cognitions. Behaviours that follow are a result of the cognitive processes triggered, rather than the emotions generated.

Richard Lazarus (1966, 1968, 1982, 1984, 1991; Lazarus et al. 1970) starts from the premise that people are evaluators. Thus emotions are the consequence of particular evaluative cognitions. This ‘commonsense’ view of the generation of emotion has been very influential in both clinical and experimental psychology. Lazarus’s model is comparatively simple and linear (see Figure 2.1).

In 1982, Lazarus attempted to correct the assumption that emotion and cognition were somehow independent realities. He asserted that they were ‘fused’; however, for him cognition was still primary. In a more recent article, Lazarus (1991) has stated that: ‘The proposition that appraisal is a necessary condition of emotion is, in my view, the most parsimonious, non-reductive, and internally consistent conception of how things work’ (1991, p. 298). He remains committed to the position that the ‘appraiser system’ is central in the generation of emotion.

Recognising the importance of emotion

The dominance of the rationalist models of emotion began to decline noticeably in the 1980s, especially through the work of Richard Zajonc. The theories which gained prominence during

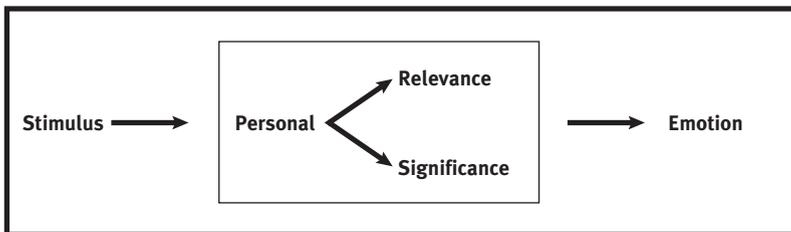


Figure 2.1 Lazarus' model of emotion

this period had been developing before, but now began to gain in both visibility and acceptance. The characteristic Western view of emotions as subservient to thinking was shown to be inadequate by a number of researchers and clinicians. This process of change was reflected in the debate that took place between Zajonc and Lazarus in the early 1980s. The emergence of evolutionary psychology, coupled with the rediscovery of Darwin's (1872) work on emotion, was the foundation for a reconsideration of the role of emotion in human functioning.

Charles Darwin

The impact of the theory of evolution on many areas of Western thought is also evident in emotion theory. In 1872, Darwin published 'The Expression of Emotion in Man and Animal'. This work contended that emotion was primarily an instinctive mechanism that was adaptive in its functioning. Its expression was centred in the muscles of the face. The evolutionary purpose of these reactions was self-preservative and their survival value was the reason for their continued existence. Darwin's theory was largely ignored until well into the twentieth century.

Zajonc's view of the primacy of emotion

Zajonc's position on the place of emotion in human functioning was a direct challenge to the parsimony of the position of Lazarus and others. Zajonc (1980) asserted that affective and cognitive processes were under the control of separate and partially independent systems. He appealed to common experiences such as the resistance of emotional judgments, difficulty in verbalising feelings and the separation of affective memory components from the content of the experiences. Zajonc also cited a number of research findings to support his position regarding the primacy of affect. He included studies on 'exposure effect of stimuli' and emotional memory, and cited work on the hemispheric specialisation concerning the processing of emotional information. Zajonc speculated that coding for emotional material may be different and on separate systems. Greenberg and Safran (1987) comment that, whether 'in the final analysis, Zajonc's argument about the precognitive nature of affect is judged valid or not, we do believe that his work has served a vitally important function.

It has challenged the prevailing assumption in experimental psychology that cognition is in some sense more fundamental than emotion' (1987, p. 123).

Lazarus (1982) replied to Zajonc and rebuffed him for confusing the debate by not providing a comprehensive definition of cognition. Lazarus stated that: 'Information processing as an exclusive model of cognition is insufficiently concerned with the person as a source of meaning' (1982, p. 1020). However, Zajonc (1984) replied that to broaden the definition of cognition was to obscure concepts such as perception. The debate between these two men culminated in emotion being seen as a concept worthy of study in its own right. No longer is emotion seen as the servant of cognition but, as Lazarus has said: 'Emotion, of course, is not merely cognition, and I don't believe any cognitivists have ever really suggested this' (1991, p. 295). Lazarus has asserted that the makeup of emotion 'includes . . . hot components [highly emotion charged], especially when there is mobilisation to deal with harms and benefits,' (1991, p. 295). This assertion brings us to the next group of emotion theorists to be examined: the 'evolutionary-expressive' theorists, as Greenberg and Safran (1987) designate them.

Tomkins' theory

Silvan Tomkins (1962, 1965, 1979, 1980, 1981, 1987) is a pioneering figure in the modern study of emotion. He undertook emotion research when the topic was not a prominent part of mainstream psychology, and his investigation of the facial expression of emotion was a direct result of the influence of Charles Darwin's work (1872). For Tomkins, emotion was primarily evident in the human face. Awareness or consciousness of a particular emotion was the result of feedback from the facial musculature, with each emotion characterised by a specific facial expression. Tomkins posited eight basic emotions pairs. They were surprise–startle, interest–excitement, enjoyment–joy, distress–anguish, contempt–disgust, anger–rage, fear–terror and shame–humiliation. Later he expanded this list to nine by separating contempt and disgust (Tomkins 1980, p. 142). These basic emotions have adaptive value: each emotion enables the individual to function within their environment by motivating certain behaviours.

Tomkins viewed affects 'as the innate biological motivating mechanism, more urgent than drive deprivation and pleasure and

more urgent than physical pain . . . it lends its power to memory, to perception, to thought and to action no less than to the drives' (1980, pp. 146–7). Affects do not amplify other systems' action, but act separately to increase urgency in behaviour. In another development, Tomkins moved from the musculature to the skin as the site of affective stimulation.

Izard's differential emotions theory

Izard (1977, 1978, 1979; Izard and Buechler 1980) was a student of Tomkins and extended her mentor's work concerning emotion. Izard asserted that there are three components of emotion:

- neural activity;
- facial-postural expression (expressive motor behaviour or EMB) and feedback to the brain; and
- subjective experience.

In Izard's theory, the following sequence is postulated (see Figure 2.2).

She asserted that:

- There is specific expressive motor behaviour (EMB) for each emotion; and
- Initially the response is innate but is gradually conditioned to some degree.

Izard (1977) also expanded Tomkins' list of fundamental emotions to ten: interest, joy, surprise, distress, anger, disgust, contempt, fear, shame and guilt. She asserted that emotional

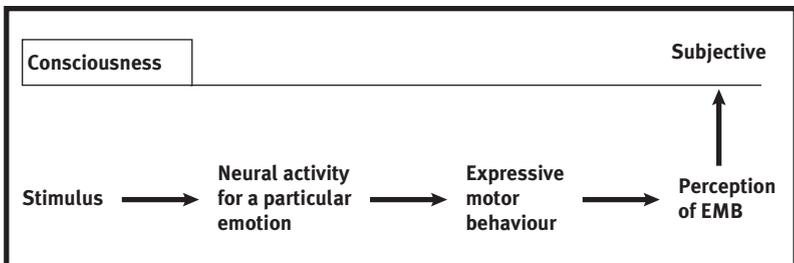


Figure 2.2 Izard's model of emotion

expression operates somewhat independently of, and yet is influenced by, cognitive processes. She stated that: ‘Differential emotions theory stresses that it is the emotions that determine the range of input in consciousness, by controlling the processes of awareness.’ (1980, pp. 167–8). Emotions play a crucial role in conscious processing of information, and hence are important in cognitive processes. Izard stressed the ‘functional role’ of emotions with respect to the motivation of behaviour. They function to give urgency to behaviours, as well as to facilitate cognitive processes that enable the selection of appropriate behaviour. Izard stated that emotion can be ‘conceived as motivation for cognition and behaviour’ and ‘invariance of emotion feelings over the life span provides a sense of continuity and contributes to the development of the self-image or concept of self’ (1984, p. 34). This points to the global function of emotion as essential to self-stability and continuity. Izard (1978) also stated that, developmentally, emotions are important aspects of socialisation that predate formal cognitive evaluations and rule governance.

Plutchik’s psychoevolutionary theory

Plutchik (1962, 1980a, 1980b) saw emotions as a vital biologically adaptive mechanism. They help a person to organise and deal with key survival issues. In one of his more radical postulates, Plutchik (1977) asserted that cognition evolved later in the service of emotions since it facilitated evaluation and prediction of emotional events.

Cognition’s role, as shown in Figure 2.3, is to evaluate events so that the appropriate emotion may be selected. The system can breakdown at any point through either faulty perception or evaluation. He recognised influences such as defences and environmental barriers to behaviour.

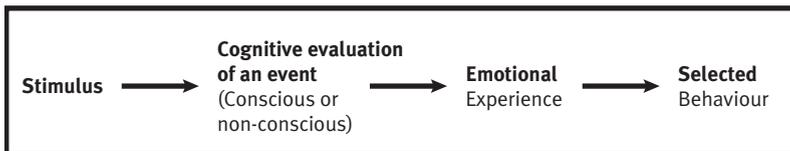


Figure 2.3 Plutchik’s model of emotion

Comparison of evolutionary emotion theories

Tomkins, Izard and Plutchik are all emotion theorists who adopt an evolutionary view. In their various writings and theories, the emphasis is on the adaptive role of emotion processes. They differ in the detail, but all assert that the emotion system is a long-established mechanism in human beings that enables people to respond rapidly to danger, and that in most cases this response is adaptive. Emotions are regarded as being 'hard wired' into the human body and as being most evident in the muscles of the face (see Ekman 1982). Table 2.1 compares the lists of fundamental emotions proposed by Tomkins, Izard and Plutchik.

Tomkins, Izard and Plutchik agreed on five basic emotions from their respective lists (shown in bold in each list). Each of the nominated fundamental emotions is part of the adaptive development of the individual. Emotion also plays a critical role in the social life of individuals. Research on emotion theory and attachment (see Mikulincer and Florian 1998) provides further insight into the significance of emotions for human functioning and existence.

Evolutionary emotion theory and trauma

The evolutionary perspective on emotion processes is pivotal to the model of trauma and trauma treatment presented in this book. The strong emotions experienced by trauma survivors are life-preserving at their foundations. These emotions are adaptive to the

Table 2.1 Comparative lists of fundamental emotions

Tomkins	Izard	Plutchik
Surprise–startle	Surprise	Surprise
Interest–excitement	Interest	Expectation
Enjoyment–joy	Joy	Joy
Distress–anguish	Sadness	Sadness
Contempt–disgust	Disgust	Disgust
Anger–rage	Anger	Anger
Fear–terror	Fear	Fear
Shame–humiliation	Shame/shyness	Acceptance
	Guilt	
	Contempt	

situation of the traumatic experience. They become problematic only when they are experienced in non-traumatic situations.

Emotion as a coherent lawful system

Emotions are sometimes regarded as ‘illogical’, or difficult to understand, which implies that the study of emotions could be problematic. During the decades leading up to the 1980s, research on emotion produced a great deal of insight into both the adaptive purpose of emotion and its functioning. Frijda (1986, 1988) proposed a set of laws that describe the functioning of emotion. Such a proposal is a recognition that the study of emotion has made considerable advances, and that sufficient material has been gathered to enable the formulation of such laws. Frijda stated that he was ‘discussing what are primarily empirical regularities’ (1988, p. 349). The laws he proposed are summarised in Table 2.2.

Frijda’s list of laws has been challenged by Smedslund (1992) on the grounds of their ‘empirical’ status, but not on the grounds that they are unobservable. Since emotions display ‘empirical regularities’ according to Frijda it is appropriate that a model of trauma should incorporate these as significant concepts rather than as transient phenomena. Several of these ‘laws’ will be addressed in the model proposed later in this chapter.

Emotion system and alexithymia

If emotions are central to healthy human functioning, what happens to people who have difficulty utilising emotion signals? The concept of alexithymia arose within the clinical literature to explore just such a problem. Alexithymia literally means an absence of words for emotion. The term has a relatively short history, as it was first coined by Sifneos in 1973. The concept was originally developed in relation to a psychotherapy patient group which experienced a noticeable difficulty in expressing emotion. The problem of a group with emotion expression issues goes back to the mid-twentieth century. In 1948 Ruesch noted that there were a group of psychosomatic patients who had ‘a disturbance of verbal and symbolic expression’ (quoted in Taylor 1984, p. 725). In 1963, the French psychoanalysts Marty and de M’Uzan

Table 2.2 Frijda's laws of emotion

Law	Name	Description
1	Situational meaning	Emotions arise due to specific meaning structures
2	Concern	Emotions arise in response to events that are important to the individual's goals
3	Apparent reality	Emotions are elicited by events appraised as real
4	Change	Emotions are elicited by actual or expected changes in favourable conditions
5	Habituation	Emotions lose their impetus from repeated experience
6	Comparative feeling	Intensity of emotion is related to frame of reference
7	Hedonic asymmetry	Pleasure will diminish but pain may persist
8	Conservation of emotional momentum	Emotional events retain their power to elicit emotions unless counteracted (e.g. by repetition)
9	Closure	Emotions tend to be closed to judgments of relativity
10	Care for consequence	Emotional impulses elicit secondary impulses that modify the original impulse
11	Lightest load	Situations are viewed in order to minimise negative emotional load
12	Greatest gain	Situations are viewed in order to maximise emotional gain

described this disturbance as being characterised by operational thinking and a lifestyle that was devoid of emotion. The three main features of persons with alexithymia are:

- reduced or absent symbolic thinking;
- focus on utility and external events; and
- lack of dreams or fantasy—or, if reported, the dreams are bland.

Taylor (1984) noted that alexithymic 'individuals show a striking difficulty in recognising and describing their own feelings, and they have difficulty discriminating between emotional states and bodily states' (1984, p. 726). The features of alexithymia are present in many individuals to varying degrees. As Taylor states: 'Alexithymia is not an all or none phenomenon,

and all people seem to have the capacity to shift at times to a communicative style that is less symbolic' (1984, p. 726).

Krystal (1979) has observed that alexithymic individuals have a reduced empathic ability which is likely to result from their inability to recognise their own emotions. If empathy is an example of the interface between emotion and cognition, and alexithymia is an inability to 'process emotions cognitively' (Taylor et al. 1990, p. 154), then alexithymia and empathy may be closely related. Both concepts stress the importance of emotional awareness in the realm of interpersonal functioning. Taylor et al. (1990) have conducted research into alexithymia that has a direct bearing on the area of stress and trauma. They state that 'normal individuals . . . with high alexithymic levels manifest a dissociation of the physiological and subjective responses to stress' and 'the alexithymic individual's vulnerability to illness is caused primarily not by conflicts, but by deficits in the cognitive processing of emotions, independent of their source' (1990, pp. 156–7).

The modern view of emotion

In summary, the modern view of emotion which has gained considerable momentum over the last three decades asserts that emotion is an important part of the overall well-being of people. Such a view is well accepted among counsellors and psychotherapists, but has been left largely uninvestigated in the academic community. The work of Bower (1981) on the effects of mood on memory, the challenge of Zajonc (1980, 1984), and the work on constructs such as alexithymia, discussed above, have brought emotion to a prominent place in the investigation of human functioning—both psychologically and physically. Emotion's role in cognitive processes is not fully understood at the present time. Investigators are, however, realising that 'hot cognitions' are processed differently to 'cold cognitions' (see Lazarus 1991). Figure 2.4 presents the main conceptual steps in the development of the theory of emotion utilised in this book. Emotion is a separate, though closely linked, system from cognition. One of its primary roles is to motivate the individual to action that assists survival. It also plays both a facilitative and an inhibiting role in the cognitive processing of events. Emotion's role in trauma reactions is paradoxical, since it is both obscure and obvious. The

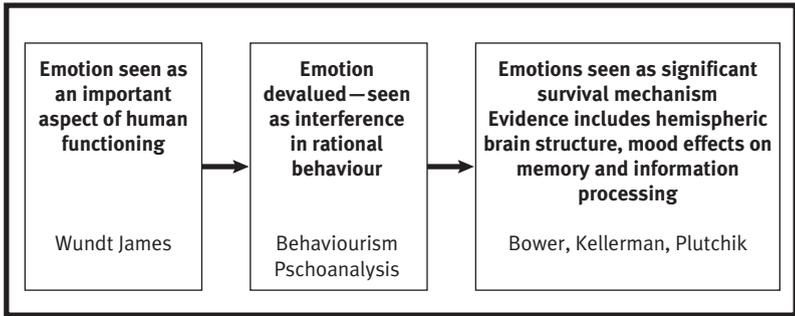


Figure. 2.4 Summary of the conceptualisation of emotion

overwhelming nature of emotional experience in trauma leads to the denial of emotion in order to ‘get back to normal’. The integration of emotion is central to recovery from trauma.

Setting the scene: Two examples of the role of emotion in traumatic situations

Before proceeding to a fuller exploration of the nature of emotion’s role in trauma, let’s look at two examples that illustrate the diversity of the experience of emotion in trauma. These examples come from Wastell (2003).

Example 1: Kamikaze attacks

During World War II in the Pacific Theatre, Allied ships came under terrible attack by Japanese *kamikaze* planes. Alan Walker describes the effect five straight days of these suicide attacks had on the crew of *HMAS Australia*:

There was a fearful atmosphere of uncertainty. The men felt that their ship was singled out for a special attack . . . After these assaults many exhaustion states were seen: men lost their grip, and cried out that they could stand no more (quoted in Wastell 2003, p. 285).

In this example, we see emotion processes as they are very commonly experienced. After prolonged exposure to the threat

and consequences of attack, these men showed the signs of emotional exhaustion. Their bodies and psyches were unable to bear the burden of the continual state of emotional priming and adrenalin that accompanies such a fight for survival.

Example 2: Self-sacrifice

The second example also comes from World War II and provides a contrast to the first. The example concerns the actions of one Ordinary Seaman Edward Sheean. During the early years of the war in the Pacific, as the Japanese were in control of much of Southeast Asia, *HMAS Armidale* was involved in resupplying troops on the island of Timor. During this activity, she was attacked by aircraft and fatally damaged. As she sank and her crew abandoned ship, the attacking aircraft began strafing the crew in the water, killing several men. Edward Sheean, who had begun to abandon ship, saw the harm to his shipmates, turned around and returned to his gun, and began firing at the attacking aircraft. He shot down one and damaged others. Eyewitnesses assert that he continued to fire at the aircraft as the ship sank and he disappeared below the water (see Wastell 2003, pp. 302–3).

This act of sheer self-sacrifice is another manifestation of the role of emotion in traumatic situations. Faced with death, Edward Sheean acted to protect and preserve the lives of his shipmates. Emotion processes also act to preserve the life of the broader group, and this is consistent with emotion's role in such psychological processes as attachment and bonding.

Modern emotion theory and trauma

The study of the role of emotion in trauma has partly been a response to the horrors of the twentieth century. Studies of military and civilian survivors, and of emergency services personnel, have brought to light a clearer picture of emotion's role in trauma. The work of two researchers in this field is important here.

Lifton's 'symbolisation theory'

Lifton's work with trauma survivors from a number of different populations—Hiroshima (Lifton 1968), natural disasters (Lifton

and Olson 1976) and Vietnam (Lifton 1973)—led him to conclude that trauma disrupts primary life symbols. This disruption manifests itself in the following steps:

- 1 The survivor has a death imprint on their life. That is, the traumatic experience has brought the reality of death clearly into the victim's conception of life in general as well as their own life in particular.
- 2 The experience of survivor guilt is focused on what Lifton describes as 'failed enactment'. There is often a sense that 'if I had done . . . then the other person(s) would not have died'.
- 3 The numbing that takes place serves two purposes. Initially the numbing prevents the person being overwhelmed by the emotions generated by the event. In the long term, however, numbing functions to block the emotions generated by the ongoing death anxiety.
- 4 As a result of the numbing and death imprint, the survivor experiences difficulty in the area of interpersonal relationships.
- 5 In time, the survivor reanimates their life symbols—that is, the aspects of the survivor's belief system which enable them to function normally.

Lifton's work with survivor populations shows how the imprint of death calls forth an emotion-suppressing process. The fear expressed by survivors was often that they would be overwhelmed by the strong emotions they had either sensed or experienced as a result of the horrific events they had survived. Referring back to Frijda's laws of emotion, we see that several of Lifton's findings are consistent with emotion processes. Law 1 is about emotion's relationship to meaning structures. Lifton observed that the issue of meaning was particularly salient to survivors and their confrontation with death. Another of Lifton's observations had to do with survivors' difficulties in the sphere of interpersonal relationships. The role of emotions in this context is central to the concept of facial expression of emotion. While Lifton did not emphasise the role of emotion *per se*, his findings are consistent with the modern view of the role of emotion in trauma. Henry Krystal, however, did make emotion processes central to his view of trauma.

Krystal's analysis of trauma and emotion

Krystal (1968, 1978; Krystal and Niederland 1968) has worked extensively with survivors of the Nazi Holocaust. From these and other studies, he has subdivided the concept of trauma into two categories:

- near-trauma, where there is threat to the person but this is not sufficient to result in the overwhelming of the personality; and
- catastrophic trauma, where the trauma overwhelms the personality.

The key distinction is the individual's ability to tolerate strong emotion. For Krystal, there is a gradual maturation of the emotions. In infancy, emotions are undifferentiated, experienced primarily in bodily sensations and therefore non-verbal in quality. Maturity is marked by differentiation of emotions, desomatization of affect and an ability to express emotions using verbal labels. An individual undergoing near-trauma is able to tolerate, to a large extent, the emotional reaction generated. In the case of an individual undergoing catastrophic trauma, there will occur a regression to less mature forms of emotional experience and expression. This may result in a fragmentation of the personality that leads to a greater degree of impairment following the event.

Krystal also identifies the concept of a 'survivor syndrome'. The syndrome consists of 'survivor guilt at having lived while others died or having lived at the expense of others; chronic anxiety as reflected in traumatic nightmares; psychological changes; psychosomatic symptoms; and disturbances in cognitions' (Ulman and Brothers 1988, p. 56). Krystal also notes the ongoing occurrence of 'memory fragments' that invoke intense emotions. These affect storms cause a fear of being overwhelmed and, in extreme cases, a fear of undergoing psychogenic death.

Developmental stage and trauma

Krystal focuses on affective states and the defences necessary to control them. He also highlights the stage of cognitive development as an important variable in determining the meaning attached to a traumatic experience. Krystal proposes that trauma is experienced differently by adults than by children: 'Krystal postulated a surrender pattern in adults, which may include behavioural paralysis, emotional blocking, and progressive cognitive constriction' (McCann et al. 1990a, p. 47).

Alexithymia and trauma

Krystal has utilised the concept of alexithymia in his theory of trauma to further examine the place of affect in recovery from trauma. As mentioned previously, alexithymia literally means ‘without words for emotions’. The concept first came into the literature in the early 1970s in an article by Sifneos (1973), but the identification of the patient group went back to Marty and de M’Uzan (1963). These theorists described a set of behaviours in relation to psychosomatic patients that centred on the inability to describe or access emotional states as well as a kind of flattened cognitive processing. Krystal points out that there is an unusually high incidence of psychosomatic diseases among survivors of the Holocaust. The high incidence positively correlates with the age of the victim being lower at the time of the persecution. He stated that ‘whereas the *overall* [emphasis added] incidence of psychosomatic disease was 30%, among survivors who were under 20 years during the persecutions that rate rose to 70%’ (Krystal 1988, p. 160). The general incident rate reported is very high, but it certainly becomes endemic for those who were aged under 20 at the time of persecution. Krystal points out that alexithymic characteristics are consistent with trauma reactions, and states that the psychosomatic aspects of trauma reactions are ‘well documented’ (Krystal 1988, p. 160).

Although Krystal does not make the point at length, he does postulate that alexithymia acts as a defence by directing the focus on to ‘things’ rather than people—that is, ‘operative thinking’. In describing ‘catastrophic trauma’, he states that in ‘the traumatic process, there is a constriction of cognition in which memory, fantasy, problem solving, and all other functions become gradually blocked’ (1988, p. 273). This type of cognitive processing is ‘a form of “primal repression”’ (1988, p. 274). Work by Pedinielli (1985–86) has developed this connection between alexithymia and defence: he describes alexithymia as a defence against feeling.

Emotion studies of trauma

Study of the emotion aspects of trauma has rightly highlighted the importance of understanding the biology of trauma. The findings of Krystal and others point to the strong relationship between bodily

dysfunction (especially psychosomatic disorders) and emotion suppression as a result of trauma. It is fair to say that, by focusing on the emotion aspects of trauma theory and treatment, we are brought face to face with the bodily phenomena associated with trauma. The next section will address these bodily aspects of trauma.

The relationship of biology to emotion and trauma

The results of studies of the emotion system are in agreement with what is known about the biological aspects of extreme stress reactions (e.g. the biological basis of startle reactions). Under conditions of extreme stress, an individual's survival mechanisms are activated. These operate via the emotion system, which is designed to be fast-acting. As a result, the emotion centres of the brain around the limbic system activate the adrenal system, which in turn activates large muscle groups in the body to fight, take flight or freeze. Which of these actions is chosen is dependent on the situation and the person. The main point is that these protective actions leave a biological residue that becomes associated with the fragmentary memory trace which is common in trauma survivors. Plutchik (1980a) has written extensively about the adaptive and life-preserving role of emotion processes in human functioning. Trauma is where these processes come to the fore.

The limbic system

The central role of the limbic system is to unconsciously guide the emotions that stimulate self-preservative behaviour (see Figure 2.5). The amygdala assigns emotional significance to incoming stimuli. It attaches emotional valance to neutral stimuli. These emotional responses include felt senses of significance, truth and meaning. The neocortex elaborates these emotions. Most human information processing is done out of awareness; unless the amygdala assigns feelings of threat, reward or novelty, incoming information is not registered consciously.

For information to be stored in long-term memory the Hippocampus must be engaged at the time of learning. The hippocampus is the main connection between the amygdala and the neocortex. High-level stimulation of the amygdala inhibits the operation of the hippocampus. Affect storms thus inhibit the categorisation and

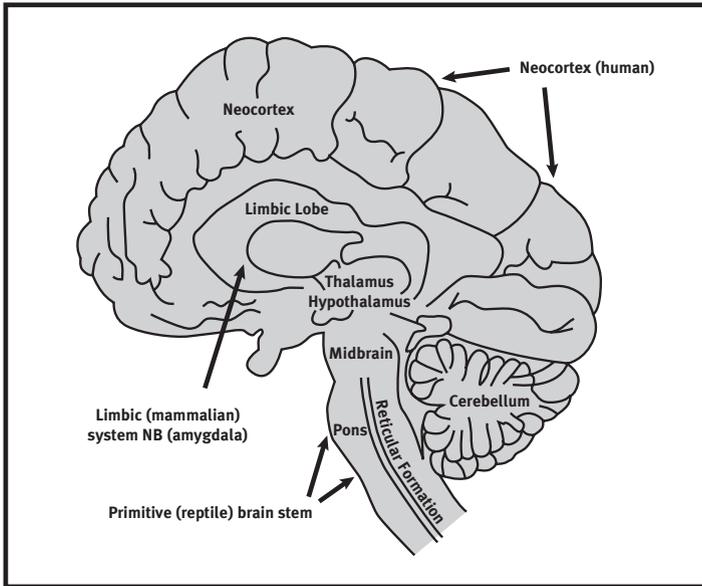


Figure 2.5 Structure of the brain showing the three fundamental regions (from Wastell 2003, p. 294)

evaluation of stimuli. Thus the stimuli associated with trauma are not integrated with previous information and schemas.

Emotion, the body and trauma

An apprehended traumatic event initially involves the activation of emotionally based survival action(s). The activation is especially evident in the amygdala. This in turn activates the endocrine system, most notably the adrenal gland. As the activation takes effect, larger muscle groups and critical systems (e.g. the heart and circulation) become activated. This means the body is now energised to flight, fight or freeze (see Figure 2.6).

Numbing and intrusion in the body's response to trauma

The basic post-trauma response pattern involves alternating phases of intrusion and numbing. Emotions post-traumatisation lose their function as signals. Survivors thus go straight from

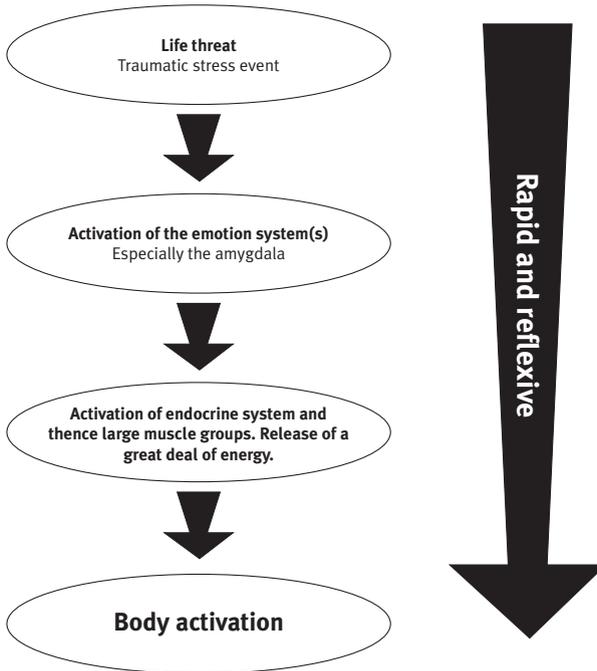


Figure 2.6 Automated traumatic stress response (from Wastell 2003, p. 295)

stimulus to response without assessment of the meaning or context of the stimulus. This results in excessive responses for minor stimuli. Kardiner (1941) pointed out that people are better able to block out conditioned stimuli from the mind than from the body. As a result, while the mind might deny certain stimuli, the body is reacting to them as though it were threatened with harm. The mental numbing process interferes with such functions as the capacity to fantasise and symbolise—both of which are necessary to create new meaning from experience.

Emotion, memory and the body

Memory is often conceptualised as a storage and categorisation system for incoming stimuli. The creation of memory schemas results in the integration of information. Human beings look for patterns, not merely isolated bits of information. The role of the

central nervous system (CNS) in memory is pivotal for the recall of events. When the CNS is activated in alarm, the memories associated with that alarm mode are recalled in similar states of alarm. This is also the case when memories are accessed from non-traumatic situations—for example, by smell or image. The memory evokes the traumatically associated emotions, and the survivor re-experiences the trauma as though it were occurring in the present! The extreme emotions generated interfere with coherency of experience and memory storage. As long ago as Janet, it was proposed that traumatic emotions cause a splitting of consciousness (see Chapter 7 for a fuller discussion). This results in fragmentation of the memory of the trauma, which is stored not as linguistic memory but as visual images or bodily sensations. The bodily processes are thus also re-experienced. The intrusion of traumatic memories and the experience of severe bodily agitation are particularly disturbing to survivors. Van der Kolk (1993, p. 232) captures the essence of the experience and the focus of treatment when he observes that the ‘task of therapy with people who have stored terrifying information on a visceral level is to help them remember the fragments stored in the taxon system and recategorize them in the ways that ordinary memories are stored, by attaching context and meaning’.

The emotion–cognition–experiential model

The model presented in Figure 2.7 incorporates Horowitz’s (1988, 1997) information-processing concepts and a recognition of the importance of emotion as an essential component of a comprehensive model of traumatic experiences. The model brings to the foreground the role of emotion in both the traumatic experience itself and in the process of recovery and rebuilding. Understanding the role of emotion in trauma reactions is crucial to the effective treatment of survivors.

In order to comprehend the role of emotion, the model presented in Figure 2.7 is designed to place emotion into the response pattern to trauma as a:

- system input that causes the entire psychological response to proceed in a heightened state of arousal. This is consistent with researchers such as Janet, Kardiner, Krystal and van der Kolk; and

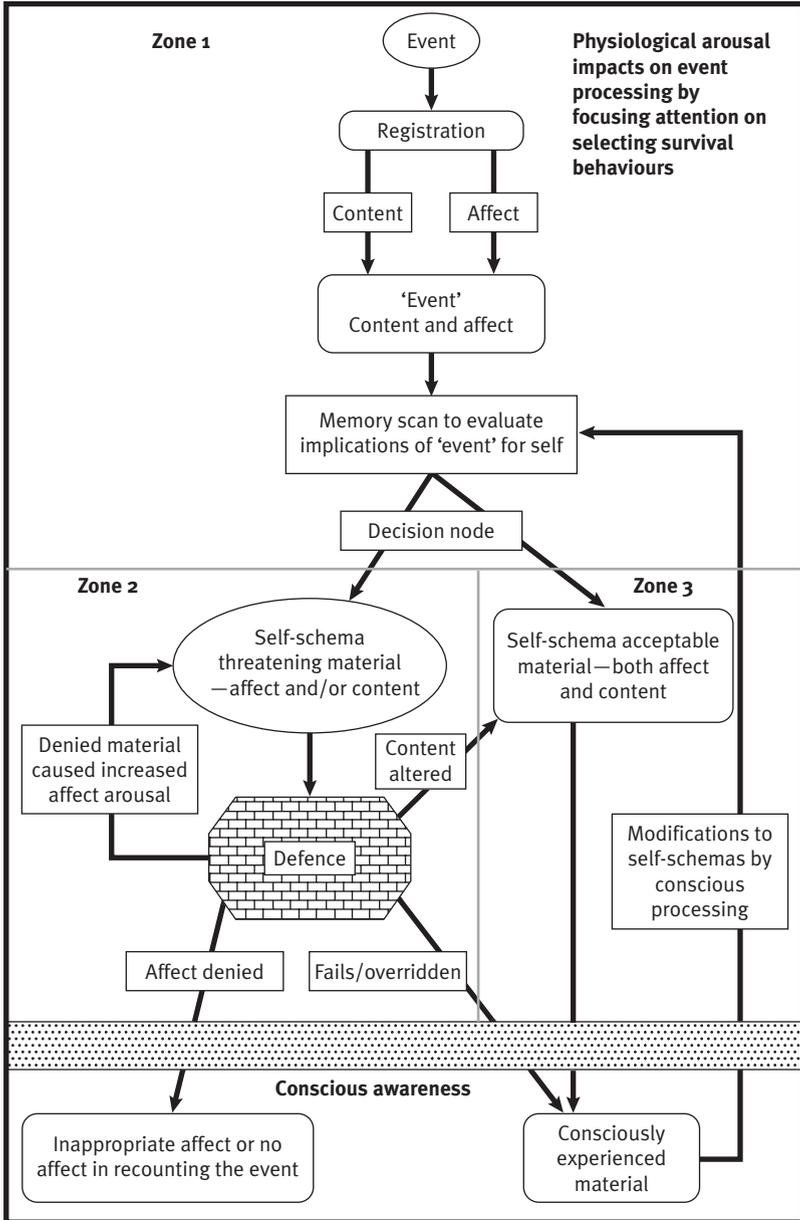


Figure 2.7 Emotion–cognition–experiential model of trauma

- component of the schemas activated as a result of the trauma event.

An event is experienced as traumatic when the emotions generated trigger a set of processes that eventually lead to mental and physical activity. The initial processes activated while responding to the actual traumatic event are designed to control the potentially overwhelming emotions that are useful in enabling adaptive fight, flight or freeze responses to be rapidly mobilised. After the event, however, the same processes persist, and lead to disrupted functioning. The model in Figure 2.7 focuses on the mental processes after the threat has ceased. It is divided into three zones of non-conscious processing of incoming information:

- *Zone 1.* This zone is concerned with the registration of the event after perception and involves the heightened states or physiological arousal so important in immediate reflexive responses to life-threatening events. The material enters the mind as both content of the event and a registration of the affective state of physical arousal (e.g. rapid breathing, quickened pulse rate). This material is compared with currently held schemas, which may be consistent long-standing schemas or recently constructed ones. The degree to which the elements of these schemas are available to conscious awareness varies considerably. The decision node located at the bottom of Zone 1 ‘gates’ material, based on the degree of threat. Material that is within acceptable threat limits is passed directly on to Zone 3, where it is ultimately accessible to conscious processing. Material that is unacceptable—either because it is too threatening or because it is potentially overwhelming and would thus prevent appropriate functioning—is passed on to Zone 2.
- *Zone 2.* The purpose of Zone 2 is to contain and alter threatening material so it will not disrupt the functioning of the individual. It is here that various defences are located. The defences fall into three classes in this model. The first class alters the content so that the nature of the event is sanitised. This would include such defences as distortion and fantasy. The second class removes the registration of the disturbing emotions and includes rationalisation and isolation. The third class denies the entire event and so causes memory gaps—it is therefore an example of a dissociative process. The outcomes

of these three classes of defence are shown in Figure 2.7 as 'Content denied' or 'Affect denied'. When the entire event is denied, including both affect and content, the denied material recirculates through the pool of threatening material back into the defensive process. One of the consequences of the defensive process is to maintain a raised physiological set point for the activation of future defensive processes. The denied affect or content results in ineffective processing and integration of the event, meaning that future responses to related events will be distorted and often incomplete. The denied affect in particular may hypersensitise the system in such a way as to produce the excessive reactions typical of trauma survivor startle reactions.

- *Zone 3.* Once material is passed on to this zone, it is available to conscious processing. It is here that long-held schemas may be altered through such processes as rehearsal or other learning methods. This zone allows the information processing system to operate and avoid shutdown. The material that passes through Zone 3 is consciously processed. Horowitz (1991) has asserted that material that becomes conscious is available to the individual for the revision of schemas. This accords well with clinical principles that encourage the recall of trauma to facilitate the resolution of the experience.

Conscious awareness

There are two important types of conscious experience. One is characterised by full information of experiences—that is, both content and affect. Sometimes the affect is inaccurate or distorted, but at other times the affect is accurate. The section in Figure 2.7 located below the label 'conscious awareness' shows that sometimes material from the defensive regions of the psyche can leak or flood into consciousness when defences fail or are overridden. This typically manifests as flashbacks or severe nightmares in the case of trauma survivors. The other region of consciousness is the emotionless recounting of events. This region is important because it highlights the aspect of defensive processes focused on affect. The clearest example of this defence in trauma survivors is the numbing phase that Horowitz (1997) has described. Since affect is one of the chief sources of motivation towards change (Lichtenberg 1989), information in this region of consciousness

is of little value for the revision of schemas because it gives no indication as to the need for change.

The model tested

The model shown in Figure 2.7 has been subjected to rigorous testing on a number of diverse populations. For a treatment of the testing of the model readers are referred to Wastell (2002).

The experience of trauma from an emotion perspective

Someone who survives a trauma has undergone a rapid and terrible set of life-changing events and experiences. The model proposed in this book is an attempt to better understand the survivor's experience by being close to the phenomena. The role of terrifying emotions, long known to ordinary people and suggested by Janet, Kardiner and others, is central to the experience of trauma. This has implications of the highest order for treatment. Systems of treatment that concentrate on the purely cognitive-rational elements of trauma miss the point that trauma is a bodily registered, emotion-based process which requires an emotion-framed, body integrating response.

Summary

The emphasis of this chapter has been on the role of emotion in trauma. The theories and facts examined from Lifton's and Krystal's work through to the psycho-evolutionary theory of Plutchik all emphasise the important role of emotion in life preservation and general human functioning. The model presented in this chapter incorporates both an information processing perspective and an emotion-focused perspective. This model is more representative of the experience of trauma from both the survivor and helper viewpoints. It is what I term 'experience near' as opposed to 'experience distant'. This model is applied and its advantages are explored in the following chapters.

3 | EMOTION AND TRAUMA TREATMENT

The emotion-focused model of the last chapter is not currently the dominant one in the field of trauma theory and treatment. That place is held by cognitive behavioural therapy. In this chapter, I examine how an emotion-focused approach adds a critical dimension to the treatment of trauma survivors. I demonstrate through two case studies how emotion-focused theory can make treatment both more acceptable to survivors and ultimately more coherent for practitioners.

The purpose of this chapter is to place before the reader a review and analysis of one of the dominant approaches to the treatment of trauma survivors, and to illustrate from published case material the lack of emphasis on emotion in this approach. The goal is to enable readers to clearly identify the important contribution of emphasising emotion in treatment of trauma survivors.

The purpose of this chapter is not to denigrate or disparage the effective treatment that is offered by the dominant approach. The published studies are veridical. The vast majority of them have been carried out by dedicated researchers and clinicians, and they are concerned to improve the desperate conditions that many trauma survivors experience. I must emphasise that I have great respect and confidence in the clinicians who employ this approach. Second, I wish to explore the model from the viewpoint of adding to its effectiveness—not replacing its contribution. I believe the complexity that is trauma requires a multi-modal approach incorporating a selected and tailored set of theories which coherently inform

treatment. I do not wish to add to the already legion number of treatments for psychological conditions, as this would be counter-productive in the long term by creating further fragmentation in the field.

Searching for the most effective treatment

Research and tribalism

Finding the most effective and efficient treatment for any psychological condition is the hope of any good therapist. We all want to assist our clients so that they can lead their lives to the best possible outcome. This desire has translated, over the last 50 years or so in the West, into a concerted research effort. We now have a veritable mountain of outcome studies across a plethora of conditions (see Bergin and Garfield 1994). Interestingly, this vast research effort has contributed to the formation of a degree of tribalism in the treatment community. The various ‘schools’, represented by their journals and conferences of choice, seem to be saying: ‘If you want to join our tribe then you must adhere to this theory and this method of treatment’. The rationale is either the weight of ‘empirical studies’ or the accumulated ‘clinical wisdom/experience’—or, in some cases, both.

I do not see such tribalism as helpful. The end result is often that survivors come for assistance and receive the ‘mandated’ treatment, whether or not it is the most appropriate for them. I will leave the reader to explore this area further if they are interested. Lynn Seiser and I have written about the issue in Chapter 8 of our book on interventions and techniques in therapy (Seiser and Wastell 2002).

Cost-efficiency

The search for the most effective treatment has also been coupled with the search for the most cost-efficient treatment. The funding of treatment for any psychological condition is dependent on the total available finance either of the individual or from a service provider. The eternal cry is that there is not enough money to do everything. The question of efficiency is therefore about maximising the number of people who can be assisted. The history of

trauma is replete with instances of political struggle to secure funds for treatment provision. Two situations that deserve mention are the establishment of rape crisis and assistance centres and the provision of treatment of Vietnam War veterans. Both these situations were examples of resistance of government and general society attitudes to the recognition of a need for, and provision of, publicly funded treatment. This, as I have pointed out earlier, is an example of the periodic amnesia concerning trauma that occurs in our society.

The need to find cost-efficient treatment is therefore very important. Therapists, faced with the great number of people in need, want to meet as much of that need as possible. Trauma therapists are no different. It is therefore very understandable that therapists and their management look for the most cost-efficient treatments.

Societal denial and numbing

There is another aspect to the question of what constitutes the most effective treatment. Trauma is generated in fearful and horrific circumstances. This is especially true for the survivor, but it is also true in many ways for the broader society. The periodic amnesia I mentioned earlier is at its heart a form of social denial and numbing. The events that lead to a person suffering from trauma symptoms as defined in the DSM IV TR (APA 1994) would lead to such reactions in almost anyone. Part of the social denial is a tendency to want the survivors to get well quickly. This desire is also experienced by survivors—anyone would want to put the horrors that generate trauma reactions behind them.

The upshot of all this is that society, family, colleagues and the survivor join together to call for swift treatments. This is partially why we have to contend with the phenomenon of the delayed recall of victims of both combat and interpersonal trauma. Trauma isolates survivors from their affiliations. Only those who have been through it can understand, so why wouldn't a survivor want a treatment process that enabled them to put away the symptoms as quickly as possible? This is one of the major contributors to the re-emergence of trauma symptoms many months and even years after the traumatic event(s). However, the considered incorporation of emotion processes into therapy can help address this problem of collusion and denial.

Emergency services personnel and short-term treatment

The critical contribution of emergency services personnel (ESP) to the rescue and initial treatment of trauma victims and survivors cannot be under-estimated or minimised. These men and women are often confronted by very gruesome scenes indeed. Yet they continue to carry out their life-saving work. As discussed previously, the impact of this work on them became the focus of study in the 1980s. From this evolved such processes as debriefing (Mitchell 1984) and defusing. These processes were designed to enable ESP to deal with their work experiences and to remain productive. The concern of management was twofold: firstly, the impact of their work on ESP themselves was seen as potentially very damaging; and secondly, there was a clear financial cost associated with the likely decrease in performance and an even bigger cost in the potential loss of the employee in terms of retraining and necessary on-the-job learning by new recruits.

Debriefing and defusing, as their names imply, are meant to be short-duration, close-proximity activities designed to prevent the loss of performance and personnel. The emphasis of these forms of intervention is seen in the employee assistance programs (EAP) used by many organisations. These state clear and regulated limits on such components as the number of sessions and topics to be covered. EAP are designed to minimise the impact of trauma on survivors by 'immediate' short-term intervention. While the actual effectiveness of these programs is questioned by some (see Raphael et al. 1995), they remain part of the push for short-term cost-efficient treatments.

Life must go on

The push for a quick and effective form of on-the-job treatment is a manifestation of the general principle that life must go on and that staying focused on trauma is not the way to move forward. In a very real sense, this is accurate. But the problem is that this view reinforces the denial process: that is exactly what the survivor wants to do—get on with life and get away from the reminders and memories of the trauma. As Horowitz (1997) and others (including van der Kolk 1996) have commented, this is very difficult—the physiology and psychology of traumatic memory make such a process very energy-demanding if the

trauma is not integrated into a new set of schema of oneself and the world.

The evidence-based approach

Therapeutic approaches to trauma treatment

Foa et al. (2000) acknowledge that trauma treatment is in its early stages and that there is both scientific and clinical wisdom attesting to a range of approaches that are considered effective for trauma conditions and symptoms. They observe that:

The treatment for trauma-related disturbances has been discussed extensively in the literature for over 100 years. The rich literature has provided us with much clinical wisdom. In the last two decades, several treatments for PTSD have been studied using experimental and statistical methods. Thus, at the present time, we have both clinical and scientific knowledge about what treatment modalities help patients with post-trauma problems (Foa et al. 2000, p. 547).

This book, together with others such as Foa et al. (2000), advocates that trauma is ‘effectively’ treated by a number of approaches. There are many paths to recovery from trauma—a concept which applies to many forms of psychological problems. The forms of therapy that are prominent in the literature and clinical practice include psychodynamic-based treatments, cognitive behavioural and behavioural (i.e. with a minimal emphasis on cognitions) treatments. The term ‘psychodynamic’ covers a very diverse group of approaches to trauma. Horowitz’s (1997) information processing schema treatment approach is underpinned by psychodynamic concepts. There are also older approaches within the psychodynamic group which use the tripartite models of unconscious processes. The important feature to keep in mind with all the psychodynamic treatments is that they recognise important roles for unconscious processes such as defences, and they accept the adaptive role of compromise solutions to the containment of the impact of the traumatic event. Older models incorporating such notions as an Oedipus complex, penis envy and other highly derogatory concepts, especially with

respect to women, may still be practised, but are largely discredited in the broader trauma therapist community.

The search goes on

However, there is in many quarters a push for a cost-effective solution that often centres on the cost of treatment versus number of sessions. Within this discourse, and the more philosophical issue about models of scientific excellence, there are now lists of treatments sorted by problem area and then ranked according to particular criteria. The criterion often most emphasised is the quality of the evidence that is used to argue for the effectiveness of a particular treatment. The concept of a well-controlled study is central to the debate on comparing treatments. Foa et al. (2000, pp. 548–9) use seven criteria to evaluate ‘well-controlled studies’:

- clearly defined target symptoms;
- reliable and valid measures;
- use of blind evaluators;
- assessor training;
- manualised, replicable, specific treatment programs;
- unbiased assignment to treatment; and
- treatment adherence.

These criteria could be applied to any rigorous study of treatment effectiveness. They are used by Foa et al. (2000) to examine the various approaches to trauma treatment.

CBT and the gold standard

The criteria above are often described as the ‘gold standard’ for ranking treatment studies. Rothbaum et al. (2000, p. 558) assert that ‘many . . . CBT studies fare particularly well on this classification (the gold standard)’; by implication, therapists can have confidence in the treatment recommendations based on these studies. The findings and recommendations of Rothbaum et al. (2000) lead to the conclusion that CBT and behavioural treatments—especially exposure therapy—are the best treatments available. Others are not so convinced, however—especially about exposure therapy.

Chambless (1998, p. 12) classes CBT among the ‘probably efficacious treatments’ as far as the evidence stood at the time of writing. She also includes exposure and other behavioural approaches to the treatment of PTSD, as well as eye movement desensitisation and reprocessing (EMDR) (Shapiro 1995) as probably efficacious. This is interesting: while EMDR is not currently well understood in terms of its underlying mechanisms, it still shows good evidence of effectiveness in some populations of survivors.

Fundamentals of cognitive and behavioural therapy

An outline of the basic methods of CBT is provided in Seiser and Wastell (2002). For the present discussion, the following are its main principles. Mahoney (1991, pp. 205–6, 256–7) outlines the following assumptions as central to cognitive (C) and behavioural (B) therapies:

- 1 *The self*: a meaningless concept (B); a domain of ‘self-talk’ (C);
- 2 *Human nature*: neutral to negative (B); neutral to positive (C);
- 3 *Adaptation*: conformity to the environmental constraints (B), (C);
- 4 *Change process*: conditioning (B); rational restructuring (C); and
- 5 *Emotions*: often produce disorganising effects on individuals (B), (C).

The purpose of this approach to therapy is to enable survivors to bring their lives under rational and behavioural control. This is done by assisting the restructuring of cognitive schemas and enacting activities that control or eliminate problematic behaviours. The view of emotions as basically interferences in rational living underpins therapeutic interventions. The basic orientation of CBT is that:

affect, feelings and behaviour are largely determined by the way a person constructs or thinks about the world. The important cognitions are views of self, the future and the world . . . It is therefore thoughts, beliefs and attitudes, and the questioning of assumptions, that are the primary units of this form of therapy (Seiser and Wastell 2002, p. 65).

The appeal of CBT

The use of time-limited CBT and behavioural forms of treatment for trauma offers the substantial appeals of scientific credibility and economic restraint. Criticisms that are levelled at longer term therapies cannot be assigned to CBT. There are often a specified number of sessions with specific symptom-reduction targets. These models are the focus of the next section of this chapter, which looks at two published case presentations and examines how emotion processes could be incorporated into these treatments.

Examples emphasising emotion in CBT approaches

Example 3.1: CBT of a rape survivor

David Barlow (1993) has edited one of the most respected collections of CBT treatment outlines to appear in the last decade or so. Barlow notes that the criterion for the inclusion of a treatment approach is the description of ‘actual treatment protocols’ (1993, p. vii). The focus is on how to carry out the treatments outlined in the book. Chapter 2 is on PTSD and is written by Calhoun and Resick (1993). Patricia Resick is a noted authority on the CBT treatment of PTSD and was one of the co-authors of the *Journal of Traumatic Stress* review of treatments of 2000.

General observations of the treatment process

The following general observations about conceptual or general methodological aspects of the processes as outlined by Calhoun and Resick (1993) are presented in the same sequence as in the original chapter.

- 1 Calhoun and Resick, in agreement with Litz (1992), note that emotional numbing is a ‘complex, multiply determined problem that is best characterised as a selective emotion-processing deficit’ (Calhoun and Resick 1993, p. 49). I strongly agree with this observation. I would also assert that, from such a perspective, it would seem highly desirable to address in the treatment of survivors their ability to actually process emotions. Older models of the relationship between emotion and cognition do not put sufficient weight on the role of emotion in its own right. These models (see Chapter 2) assume that, if the cognitions are changed and reconstructed, then the emotions will follow. I do not view this as an acceptable model of emotion processing.

- 2 Calhoun and Resick (1993, p. 53) refer to the emotion theory of Lang (1979). This model tends to emphasise semantic aspects of emotion, but it also points to the issue of meaning and emotion. This is very important for trauma survivors. The creation of meaning is more than a rational logico-deductive process. There is the aspect of the role of emotion in the generation and consolidation of specific meaning structures, especially in the structure of the survivor's concept of the self. The deliberate and prominent role of emotion in the generation of meaning needs to be part of the therapy process.
- 3 The concept of confrontation is canvassed by Calhoun and Resick (1993, p. 59). A great deal of folk psychology and so-called common sense asserts that trauma survivors need to confront their fears. The reference to confrontation occurs in the context of eliciting memories and maladaptive beliefs. I agree that the reconstruction of beliefs is an important element of trauma recovery, but I would caution that the central variable of such a process is the modulation of the emotion processes that accompany such confrontation. The authors indicate elsewhere in the chapter that they are aware of this issue, but an integrated view of beliefs and emotion, and the roles they play in adaptive survival following a traumatic event, would be helpful for a clearer treatment process.

Comments on case material presented

Calhoun and Resick (1993) present the case of 'Cindy'. She is 26 years old at the time of treatment, and she was raped over a period of several weeks by a friend of the family when she was about 15 years old.

Background

The case presentation of Cindy has a number of aspects that require comment from an emotion perspective.

Cindy's most prominent memory during the assault is of 'feeling detached and numb' (1993, p. 63). This is consistent with the emotion system shutting down. The process of dissociation is now regarded as common for rape and other traumatic events. It is essentially an emotion process and is the third of the typical responses to extreme life threat: fight, flight and freeze.

Cindy is reported to have smoked marijuana (1993, p. 63). Such self-medication is also common. The physiological effects of marijuana are essentially to calm the person down. In a sense, this emotion control process is part of the adaptive response following the trauma. The cessation of smoking marijuana would need to be considered alongside

measures that deal with emotion processes rather than only as a health or legal issue.

Cindy describes her experience as fearing ‘the storm (emotions and memories)’ (1993, p. 63). This indicates that, for survivors, the memories and emotions are not necessarily sequential nor interrelated. Cindy is aware of both types of experience. This is consistent with the experiential phenomenology of an emotion perspective on trauma. Cindy will benefit from a cognitive process, but I would caution against the view that this means the emotion aspect will automatically be dealt with.

Survivor-therapist comments

- 1 The therapist tells Cindy that they are going to label feelings (1993, p. 65). This is an important process for many trauma survivors. However, labelling alone is not sufficient to integrate the emotions experienced during trauma. There is a need to explain, from an adaptive-survival perspective, the role of emotions in the whole process of trauma so that the survivor no longer experiences their emotions as foreign to them.
- 2 Cindy comments that recall of the feelings associated with the trauma ‘scares the hell’ out of her (1993, p. 65). This tells us that there is a secondary emotion process which acts as an anticipatory protective device. Cindy ‘knows’ through her emotion system that a storm will be unleashed if she recalls the rape unassisted. This is healthy, as unbounded rumination is very harmful—particularly when it leads to thoughts of suicide.
- 3 The therapist asserts that emotions must ‘run their course (extinguish)’ (1993, p. 65). Such a view does not take full account of the role of emotions in trauma. They do not extinguish. The emotion system should do the same thing next time a traumatic event confronts Cindy. The emotions are purposeful indicators, not aberrations.
- 4 The theme of distrusting society is explored in Calhoun and Resick (1993, pp. 66–7). Cindy points out that she has been angry and has turned this anger inward. The study of the role of anger in self-protection has a long history, including Freud’s concept of depression as anger turned inward. The positive contribution of this anger for Cindy is not explored; rather, it is viewed as a dysfunctional aspect of her coping. I would argue that the emotion of anger is actually protective. While it is certainly antisocial in many forms of expression, that should not blind us to its positive contribution to a post-trauma process.
- 5 Cindy states that her feelings scare her (1993, p. 67). This is a common

experience of trauma survivors. The strength of the emotions is quite powerful when they are activated. The therapist advises Cindy to do something with the feelings that is not aggressive. This is good advice, but in addition I would want to give the client some understanding of the importance of the power of emotions in assisting her to survive the ordeal and the subsequent long period following the rape.

- 6 The therapist asks the very common question of Cindy: 'What is the evidence that you let it happen?' (1993, p. 75) This question is central to the rational underpinnings of CBT. On face value, the question is very plausible. In some senses, it is important to ask and explore the answer as the attribution of blame and responsibility is part of the reconstruction of schemas (see Horowitz 1997). However, an emotion-informed approach to therapy would recognise that Cindy's sense of responsibility is possibly more about an attempt to take control and channel her emotion resources toward future prevention. This is an aspect of the therapy which would need to be explored, as it is not necessarily functional. The point I am making is that the surface rationalisations need to be examined for the underlying emotions so that the emotions can be integrated appropriately into her post-trauma view of herself and the world.
- 7 The term 'emotional reasoning' is used by the writers (1993, p. 79) to indicate a type of faulty thinking. This raises an important point about the privileging of rationalistic thinking over other forms of thinking. One of the consequences of this is that the processes that are used to survive a traumatic event are all bundled up as though they are dysfunctional. The thinking that survivors use in most trauma situations is often emotion based. This system of thinking has enabled the person to survive. The positive role of emotion in human rationality and learning has been demonstrated by a number of authors (see Damasio 1994, 1999).
- 8 Lest the reader get the impression that Calhoun and Resick (1993) have a totally negative view of emotion, I would draw attention to the section where the therapist acknowledges the positive role of emotions in human experience (1993, p. 93). I argue that the model of therapy presented in their chapter does not explicitly incorporate a role for emotion processes into the pragmatics of the therapeutic process.

Example 3.2: CBT of a combat survivor

The second example of CBT is taken from the crisis intervention arena. The practice of therapy in crisis situations is very demanding. It is

also, however, a place where trauma survivors often present for treatment. The experiences of flashbacks and other intrusive phenomena can very easily precipitate the need for emergency psychological assistance. The work of James and Gilliland (2001) is comprehensive and well developed. They present an attempt at a coherent and practicable model for emergency treatment. Their crisis assessment model explicitly acknowledges a contribution for emotion processes by the use of an ‘affective severity scale’ (2001, p. 39). Their work concentrates on negative affects such as anger, fear and sadness. This is perfectly understandable, given their focus on crisis interventions.

General observations of the treatment process

James and Gilliland’s (2001) general approach to the treatment of trauma survivors is based heavily on CBT. They state that ‘a multimodal approach is used with heavy reliance on various combinations of behavioral and cognitive-behavioral therapy’ (2001, p. 153). It would, however, be inaccurate to leave the reader with the impression that they do not acknowledge the importance and contribution of other approaches. They further state that ‘because of the idiosyncratic nature of the course of PTSD, various other techniques that employ psychodynamic . . . humanistic approaches . . . may be appropriate’ (2001, p. 153). I would commend the general wisdom and thoroughness of their work. My aim is to illustrate the contribution that a greater focus on emotion processes would make to their general approach.

Background

The survivor’s name is given as Billie Mac. At the time of therapy he is aged in his forties, and it is about twenty years since his experiences in the Vietnam War. Billie was eighteen years old when he went to Vietnam. He served in a front-line unit doing patrols and other missions, as was typical for such an infantry soldier. Billie reports many of the horrors of any war. He finds that, after initial reluctance, he fights to stay alive. This includes killing women and children (2001, p. 139), learning to move undetected and becoming robot-like in his manner.

Billie presents for therapy after a range of frightening events back at home, including nearly killing a boss and setting up to shoot at a truck on a local road—he had imagined it was part of the communist supply lines he had been attacking while in Vietnam but now he was twenty years away from the war and in his own country.

Survivor-therapist comments

- 1 In several comments, Billie notes the ongoing bodily and emotion registration of the experiences of Vietnam. For example, he talks about the smell of Vietnam returning when he tries to go fishing (2001, p. 141). The olfactory bulb in the brain is located very close to the limbic system, which accounts for the powerful nature of many 'smell' memories in trauma survivors. The emotion process is central to the power of this memory. Billie indicates that he still has trouble listening to the sound of a 'chopper' (2001, p. 142). The physical registration and its feedback to the emotion system cause Billie to react, and in the situation described he falls and breaks his arm. The activation of a self-preservative action has been enabled by the rapid emotion system coupling with the learned indicators from Vietnam. The decoupling will involve still being able to recognise the value of the emotion system, but reorienting Billie to the new circumstances.
- 2 James and Gilliland (2001, p. 154) note the physical responses as being a major problem in the initial stages of treatment. I would agree with this, but also observe that physical activations will occur when survivors are exploring new material or detect issues that they sense are frightening. The physical responses are integral to the emotion system's bodily activation. Whenever emotions are accessed, I would expect significant bodily manifestation that requires appropriate management. James and Gilliland recommend the use of relaxation training to assist with managing physical activation (2001, p. 155). I agree, but would recommend that the method of physical 'therapy' be flexible and in some cases that it be supervised by other paramedical professionals.
- 3 James and Gilliland make an interesting comment on their general view of emotions in trauma survivors when they talk about 'submerged feelings are uncovered and ultimately expunged' (2001, p. 155). The concept of expunging emotions is common to much folk psychology, and is consistent with the limited and pejorative view that is held concerning emotion in Western society. I would seek to instil in survivors an understanding of the essential role of the emotions in their survival and point out that, without the emotions, their chances of dying—particularly in combat—are increased. Therefore there is nothing to be expunged. To be fair, James and Gilliland recognise and incorporate emotion processes much more than many writers in the field but the 'expunging' view is very powerful and has a long history in mental health discourse.
- 4 When Billie talks about the 'all of a sudden' action to assist his buddy

- (2001, p. 156), he is witnessing the translation of emotion system activity into the rapid activation of large muscle groups (e.g. his legs). This is not a process that needs to be expunged. It certainly needs to be interpreted and made meaningful for Billie, however.
- 5 Billie describes the attempt to rescue his buddy (2001, p. 157) and describes himself as a 'puke-faced coward'. The heightened emotion process that activated his attempt to help is now coupled with the horror of his failure—that is, his confrontation with the spectre of death, both for his buddy and himself. The powerful emotions need to be understood and decoupled. In the case of running to help his friend, the emotion of fear is pro-social and outward looking, whereas when fear is coupled with death, it is self-focused—hence Billie's self-description. The emotions are amoral, they simply act to preserve life. The moral interpretation is a social construction, and Billie needs to be clear both about his emotion processes and his moral situation.
 - 6 James and Gilliland (2001, p. 158) observe that therapists may offer interpretations, but the acceptance of these by the survivor is a more difficult process. I would assert that the acceptance of the interpretations is dependent on the emotional acceptance by the survivor. This requires that the emotion experienced at the time of the trauma, and subsequently, be understood and made meaningful in terms of survival and the survivor's personal situation.
 - 7 In the same paragraph as the previous point, James and Gilliland note that the negative reaction to the therapist is typical. It is worth also noting that expressed emotions by survivors in treatment are important barometers as to the experience of the survivor regarding the pace and intrusiveness of the therapeutic process. Therapists would do well to use the expressed emotion as a way of modulating the pace of the therapy rather than merely seeing it as short-circuited affect.
 - 8 Billie is presented as participating in a gestalt two chair activity where Billie will alternate roles, speaking first as himself and then as his dead buddy (2001, p. 161). During this exchange, Billie declares with great remorse that he 'froze'. The reaction of freezing is a common one in relation to traumatic events, and one that is seen to be unacceptable within many societies. Billie expresses this when he says: 'I shouldn't have done that'. The freezing process is not intentional failure but is, from an emotion viewpoint, an indicator that the emotion system activation was at such a high level that the physical system was simply unable to act—and hence the freezing. This is not a moral question in many instances, but a system limitation issue. As I pointed out in the first example, there are three reactions in the automatic response

system of most animals: flight, fight and freeze. Each is useful in certain contexts, but not adaptive in others. Helping survivors to understand this is part of the process of bringing meaning to the survivor about their reactions during traumatic events.

The benefit of emphasising emotion in trauma treatment

The two examples of the use of CBT-based approaches to the treatment of PTSD were chosen because they are good approaches. I did not wish to choose treatments that were of questionable quality, as this would have obscured the purpose of this chapter. The purpose of this book is to call the attention of readers—be they researchers and therapists, survivors or others—to the important contribution of emotion process to the genesis and subsequent course of survivors' experience of trauma. It is also to encourage therapists and researchers to have the role of emotion at the forefront of their thinking as they do their important work.

The comments that I have made about the approaches of both Calhoun and Resick (1993) and James and Gilliland (2001) are designed to bring out the important contribution that a focus on emotion processes can make to the success and effectiveness of therapy for survivors. The remainder of this book will spell out how this can be achieved in more detail. I will outline general principles for treatment and make specific observations on the contribution of emotion process as appropriate.

Summary

Why would a therapist try to incorporate an emotion focused approach into their well-tried CBT practice? This chapter has demonstrated that the reasons to do so are manifold. The key role of emotion processes in the experience of trauma means that, for truly effective treatment, the therapist must acknowledge and incorporate such processes into their approach. Paivio and Neuwenhuis (2001) have reported on the effectiveness of such treatment for adult survivors of child abuse. In addition, the process of treatment involves the reconstruction of a world view. Any attempt to do this after a traumatic event must involve a

search for a meaningful existence. This can only be done by actively seeking out those beliefs that one can emotionally identify with. An emotion-focused approach offers therapists a model that gathers together those aspects which have been regarded as incompatible. The emotion-focused approach thus offers a coherent theoretical foundation for a full-spectrum approach to treatment. Chapter 4 will take up the emotion-focused approach and apply it to the form of trauma variously described, and to single-event or circumscribed trauma.

4 | TREATMENT OF CIRCUMSCRIBED TRAUMA

This chapter outlines two very well-founded models of trauma treatment. The first comes from Mardi Horowitz, one of the most significant trauma theorists since World War II. The other model was proposed by Frank Ochberg, whose approach to treatment is consistent with the modern concerns over therapeutic relationships and broader issues of survivor treatment as a holistic process. I comment on assessment issues and the importance of phase-appropriate treatment interventions as these apply to emotion-focused interventions. I then explore three case presentations from an emotion-focused perspective. The emphasis of the case presentation is to clearly illustrate the value and contribution of adopting an emotion-focused approach to treatment.

Chapters 5 and 6 present guidelines and illustrations concerning the treatment of survivors of trauma. This chapter concentrates on what Terr (1991) designates Type 1 trauma, which I refer to as circumscribed trauma. This type of trauma is characterised by a circumscribed event as the origin of the traumatic reactions. Events such as automobile accidents, single assaults or the death of a friend are typical of this category. Some authors, such as Horowitz (1997), include the death of a parent or spouse in this category, and to a large extent I would agree with such a view; however, some features of these events may be better dealt with by using models of treatment developed for chronically traumatised survivors.

Before presenting material directly related to treatment, let's revisit the underlying model of the trauma process outlined previously, in particular the role of emotion processes in the experience of traumatisation.

Models of treatment

Horowitz's model of trauma

Horowitz (1997) has specified a series of five phases through which a person typically progresses after a traumatic event. These phases are described as 'typical', so should not be viewed as prescriptive. Survivors must not be burdened with an expectation that they 'should' experience any particular phase in any particular order. However, it is accurate to say that these phases are very commonly experienced by survivors and are indicative of the process of post-trauma psychological efforts to deal with the traumatic experience. Table 4.1 also includes what Horowitz designates as pathological reactions to trauma. These reactions occur in many survivors, but it is their persistence and chronicity that indicate they have become pathological rather than being mere occurrences. The pathological behaviours would be more typical if the survivor had entered into catastrophic trauma, as described by Krystal (1988).

Traumatic experience is stored in what Horowitz calls active memory. Information that is consistent with pre-existing schemas, or within an acceptable range of characteristics of pre-existing schemas, is easily assimilated. Material that is unacceptable or simply overwhelming stays in active memory until, through a process Horowitz (1979) calls 'dosing', it is assimilated into a revised self-schema. Flashbacks, nightmares and avoidances are indications that the traumatic memory material has not yet been fully integrated.

Table 4.1 Horowitz's phases of trauma reactions

Phase	Typical (non-pathological) behaviours	Pathological behaviours
1 Outcry	Fear, sadness, rage	Panic/exhaustion
2 Denial	Refusing to face memory of trauma	Extreme avoidance
3 Intrusion	Unbidden thoughts of the event/ person	Flooded states
4 Working through	Facing the reality of what has happened	Psychosomatic responses
5 Completion	Getting on with life	

Phases in trauma response

Horowitz (1979) has developed the concept of phases in order to describe mental states that occur after traumatic events. He gives prominence to the phases of denial and intrusion. He says that states 'of intrusion and of denial or avoidance do not occur in any prescribed pattern, but appear to oscillate in ways particular to each person' (1979, p. 236). These two phases are crucial both to an understanding of his model and to the process of treatment.

- Denial phase. This phase is characterised by emotional numbness, selective inattention, complete or partial amnesia and constriction of associational thinking. It follows the initial outcry phase and is seen by Horowitz as a control process to ward off the total fragmentation of the personality that is threatened if the emotions generated by the trauma are left unchecked. The observable behaviours that accompany this phase are frantic over-activity which is often followed by withdrawal, or simply withdrawal and inactivity.
- Intrusion phase. Signs of the intrusion phase include hyper-vigilance, sleep disturbance, intrusive repetitive thoughts, confusion, physiological arousal and emotional attacks or pangs. The observable behaviours include searching for lost persons and compulsive repetitions. The generation of the intrusive material is the result of a combination of influences. Firstly, the traumatic material stored in active memory presses for resolution; and secondly, the innate cognitive processing tendency to complete integration draws the material into consciousness. Horowitz does not see these reactions as pathological in themselves. They are the normal method of resolving trauma. It is only because 'some people's predisposition and situational circumstances . . . produce the characteristic symptom pattern of overwhelming intrusion and maladaptive denial' (Horowitz 1986, p. 32) that pathological reactions to trauma develop.

It is the blocked processing of trauma experiences that causes problems for victims. Symptoms such as hyper-alertness, survivor guilt and the re-experiencing of trauma-associated emotions become pathological when they result in maladaptive interpersonal patterns and constricted lifestyles that include the 'inability to work, create, to feel emotion or positive states of mind' (Horowitz 1991, p. 17). For the majority of survivors, it is the intensity of re-experienced emotion that is most disturbing.

Schemas, information processing, and treatment

The process of schema formation includes the development of what Horowitz (1991) describes as 'supraordinate self-schemas' that 'give a sense of more continuity of identity and overall cohesion of self-organisation. The absence of such forms can lead to conscious imagery of chaos, emptiness, fragmentation, identity diffusion, depersonalisation or multiplicity' (1991, p. 26). Commenting on the impact of trauma on self-schemas, Horowitz (1988) says: 'It is a general principle that a stressful event presents a person with stimuli that drastically conflict with inner schemas. Continued confrontation with the new situation requires a change in schemas' (1988, p. 75). The continued confrontation results from the action of active memory in which 'information stored in this manner has a tendency to repeated representation and if important will continue to be coded for more than a short time . . . Emotional activation is one sign or marker of such importance' (1988, p. 175).

Horowitz also states that, in general, 'when there is not an immediate good fit between the new information and existing schemata, further information processing is instigated' (1986, p. 96). Thus, once an event is stored in active memory, it presses for incorporation into self-schemas. Emotions are markers of important information and, in regard to traumatic events, he says that the 'discrepancy between the new ideas and the (existing) schemata evokes emotion . . . threatening emotional states of such power that controls are activated to prevent their occurrence or continuation' (1986, p. 100). Horowitz's model thus recognises that the subject's experience of emotions will impact on the resolution or incorporation of information into self-schemas. The 'controls' Horowitz mentions are more classically designated 'defences', the purpose of which is to 'modulate emotional reactions to serious life events' (1986, p. 102); these are pivotal in terms of preventing the complete overwhelming of the person who undergoes a traumatic experience.

General principles of trauma treatment

The two models of trauma treatment that lend themselves to the incorporation of emotion processes are those of Horowitz (1986, 1997, 2001) and Ochberg (1995). This is because they both recognise the role of emotions and the body in their conceptualisations of trauma. These approaches are presented below with comments

regarding the contribution of emotion processes to the treatment of survivors. The work of Greenberg and his associates is very extensive in the area of emotion-focused therapy (see Greenberg and Paivio 1997; Greenberg 2002; Elliott et al. 2003). The use of a specific emotion-focused approach to therapy is not covered in the present book, as the focus is much more on a background for, and approach to, trauma using emotion theory. Specific training and supervision in emotion focused therapy can then be applied to trauma survivor clients as individual therapists see fit.

Horowitz's general principles

Normality not pathology

Trauma reactions are normal, and indicate that the survivor has experienced a horrific situation that would impact on anyone. This is recognised in the DSM III-R criterion statement (which was altered in DSM IV): 'such an event is markedly distressful to almost anyone who experienced it' (APA 1987, p. 250).

The case of prolonged trauma (e.g. childhood abuse, captivity) where significant self-fragmentation occurs will not lend itself to brief treatment, but may require either longer treatment or a series of shorter treatments as appropriate to each survivor. The treatment of chronic traumatisation will be addressed in the next chapter.

Principle 1: Treatment is started on the premise of it being brief until proven otherwise.

Treatment will have elements of crisis intervention

In line with the nature of the precipitating event (that is, horrific and disorganising), initial interventions must be in accord with crisis intervention approaches, including:

- supporting the client's coping;
- assisting to resolve specific cognitive impasses in their coping;
- providing respite where needed;
- keeping attention focused on the trauma situation and not allowing it to be diffused; and
- reducing the likelihood of further harm due to inattention, fatigue or demoralisation.

Client defences are stretched, and therefore the client may be more cooperative to exploratory psychotherapy than otherwise would be the case. However, there is a danger of retraumatising the survivor if the therapist moves into full treatment prematurely, based on the misunderstanding of the cooperativeness of the survivor. Crisis intervention assists the survivor to contain their disturbing thoughts, images and emotions in order to minimise the sensitisation or fragmentation. The survivor needs to rest and regain some degree of control, and not be re-exposed to the full impact of the traumatic events in therapy too quickly.

Principle 2: Treatment is designed to restore coping as the initial focus.

Treatment must align with the client's experience post-trauma

Horowitz's model asserts that the client will experience several phases in their post-trauma recovery. The phases of intrusion and denial are primary, and form an oscillating couplet in the life of most survivors. Since the main function of these phases is to assert some degree of control in the post-trauma period, it is absolutely essential that treatment be appropriate to the phase the survivor is experiencing. Therapists must synchronise and sensitise their pattern of treatment to the survivor's presenting dominant phase, and not attempt to take control from the client by phase-inappropriate interventions and treatment activities.

Principle 3: Treatment is designed to be in accord with the phasic condition of the client.

The physical is central

The response to trauma is most profoundly a bodily one. The fight/flight/freeze activation produces heightened heart rates, autonomic arousal and other physical changes (such as injuries). These are ongoing reminders of the trauma and lead to exhaustion, fatigue and lack of self-care—especially nutrition.

The client must be seen as an integrated whole and not as a disembodied psyche. Treatment may include medication for

respite from symptoms (e.g. nightmares), as well as bodily care (e.g. nutrition, exercise). It is in the body that survivors experience their emotional reactions and memories. Therapists trained in the ‘talking therapies’ traditions must develop either an appropriate referral network or seek training in the necessary skills to address the physical aspects of the survivor’s experience of their trauma. The referral network could include such experts as massage therapists, meditation trainers and physiotherapists.

Principle 4: Treatment is holistic.

Treatment goals

Treatment has a restorative focus. This is achieved by:

- restoring equilibrium;
- enabling the client to re-engage in adaptive activities;
- facilitating a ‘non-magical’ approach to decision-making; and
- enabling the client to regain a sense of competence.

Principle 5: Treatment is restorative.

Summary: Principles of treatment

- Principle 1: Treatment is started on the premise of it being brief until proven otherwise.
- Principle 2: Treatment is designed to restore coping as the initial focus.
- Principle 3: Treatment is designed to be in accord with the phasic condition of the client.
- Principle 4: Treatment is holistic.
- Principle 5: Treatment is restorative.

Ochberg’s domains of treatment

Ochberg (1995) has described four domains of treatment which are complementary concepts to Horowitz’s (1997) principles.

Educational

The disorientation that follows trauma must be addressed in order for the client to participate in treatment. Ochberg recommends the use of the DSM diagnostic criteria as an educational tool with survivors. Obtaining or designing a pamphlet that describes the main features of trauma is an excellent way of assisting survivors to start to make sense of their experience. Many specialist counselling services produce information pamphlets aimed at their particular survivor population (rape, war), their families and colleagues.

As trauma activates large muscle groups, and this physiological activation stays long after the event(s), survivors need to be assured that their 'sense' that something is not right has its origins in their adaptive biology and they are not 'falling apart'. The role of physiological/emotional processes must be explained in simple and direct terms.

Holistic health

The body is one of the primary concerns in survivors of trauma. The reduction of appetite and the general emotional shutdown typical of a major loss must be addressed. Early in therapy, a thorough medical examination is important with a view to enabling the person to undertake appropriate physical exercise. Some trusted referral sources are an important resource here. It is also important to address issues such as healthy eating and avoiding 'legal' intoxications (caffeine, nicotine and alcohol). Questions such as 'why me?' concerning the moral nature of the universe are often raised in the context of religious/spiritual issues. These need to be addressed, rather than being rejected because they are not seen as part of therapy. For many survivors of trauma, the whole of existence is brought into question and this doubt needs to be faced.

Social support and integration

The role of social support is central to any recovery from trauma. This may mean educating family members about their role in recovery. This will be complicated in the case of such traumas as incest, domestic violence and ritual abuse. Part of the assessment process should include an assessment of the functioning of the family, and in particular the ability of its members to assist with the process of treatment. Social integration involves informal and

formal groups of people. Friends play a key role in the processing of the experience, as traumatic memories often intrude when the client is relaxed with friends and family. Self-help groups—whether peer or professionally led—can also help. Many survivors find they can initially talk only to therapists and other survivors of the same trauma. Incest is not the same as a car accident!

Psychotherapy

The therapist has three central roles to play in treatment:

- as educator of the process of trauma and its aftermath;
- to witness the telling of the story; and
- as a fellow traveller who, by joining with the survivor, empowers them.

Therapy of trauma survivors has three important constraints. They are:

- The timing of the telling of the story is a key element. The therapist must be a partner in the pain, so mutual trust is critical. The therapist should modulate the telling of the story in synchrony with the development of trust.
- Symptom suppression is often needed to provide respite or rest. This may necessitate the use of medication in order for the client to build up enough strength to face the reworking of the traumatic material.
- The presence of pre-existing and coexisting problems prior to trauma should be clarified. In the case of domestic violence, there may have been incest or family of origin abuse. Safety is the first goal, then comes treatment for the trauma. Some disorders—such as borderline personality and dissociative identity disorders—coexist with trauma. These must be the primary focus of treatment, as the methods used in trauma treatment are not effective without dealing with these underlying problems.

Models of the stages of trauma treatment

The process of treatment must be designed to meet the needs and circumstances of the individual survivor. However, there are

outlines of trauma treatment which can help guide the process. Horowitz's model (Horowitz 1997; Horowitz et al. 1984) is influential, well researched and has been used in a wide range of therapeutic settings. Horowitz's treatment framework is presented below, supplemented by both Ochberg's approach and input from an emotion perspective.

Horowitz's stages of treatment

Horowitz's treatment model is designed to address many types of single event or circumscribed trauma. The emphasis is on the survivor being enabled to deal with their arousal and specific emotions while reviewing and modifying self-, other and world schemas. This is facilitated by the client firstly being able to construct a coherent narrative of what happened, and subsequently being able to reflect on the implications of the event for the nature and structure of the self.

The outline presented in Table 4.2 focuses on the three major components of treatment: therapeutic alliance; patient/client activity; and therapist activity. The timeframe is relatively brief, with therapy being kept to twelve sessions, each of approximately 50 minutes' duration. This is deliberate, for two reasons. Horowitz's research indicates that, for most circumscribed trauma that is non-pathological, twelve sessions should be an effective length of treatment. Secondly, the length of treatment is seen by clients as an indicator of the dysfunction that they are experiencing. To suggest an interminable length of therapy is to imply a degree of damage that is not necessarily the case. This is in line with the assumption that trauma therapists should assume therapy will be brief until proven otherwise. A client can only be informed about the likely length of therapy *after* a thorough assessment has been completed.

Ochberg's stages of psychotherapy

The model of treatment proposed by Horowitz et al. (1984) provides a solid framework for treatment. However, in order to capture the ethos of a respectful and sensitive approach to treatment, comments based on Ochberg's (1995) work are added to emphasise the findings of clinical and phenomenological studies with trauma survivors. In essence, these comments are designed

Table 4-2 Stages of treatment adapted from Horowitz's approach (Horowitz 1986, p. 131)

Stage name sequence [session number]	Therapeutic alliance	Patient activity	Therapist activity
1 State stabilisation [1]	<ul style="list-style-type: none"> Initial hope because expert help is available. Then the traumatic event related to life context of the survivor at the time it occurred, and current problems to what now can happen. 	<ul style="list-style-type: none"> Survivor tells story of traumatic event and current symptoms and problems. Describes goals. 	<ul style="list-style-type: none"> Takes psychiatric history. Makes diagnosis and early formulations. Acts to stabilise states if indicated. Establishes preliminary focus as relation of traumatic event to the 'self'.
2 Safety [2-4]	<ul style="list-style-type: none"> Survivor tests therapy situation to see if precipitation into dreaded emotional states might occur, with a sense that they will not. Therapeutic alliance is deepened. 	<ul style="list-style-type: none"> Survivor adds associations, expanding meaning to self of the trauma and its sequelae. 	<ul style="list-style-type: none"> Realignment of focus to more specific issues. If denial or distortions are excessive, interprets both defences and warded-off contents. Links warded-off emotions and ideas to traumatic event.
3 Work on meanings and identity [5-6]	<ul style="list-style-type: none"> Resentments, sorrows or worries that magical reparations will not occur may threaten the therapeutic alliance. 	<ul style="list-style-type: none"> Works on what has been avoided because it seemed too overwhelming before therapy. 	<ul style="list-style-type: none"> Linking of current reactions to personal appraisals of the meaning of traumatic event(s) in relation to pre-existing beliefs about self, others and how the world works.
4 Improving coping and resilience [7-10]	<ul style="list-style-type: none"> Irrational expectations of treatment may be clarified and alternate views of the future suggested. 	<ul style="list-style-type: none"> Makes plans for improving future coping. 	<ul style="list-style-type: none"> Time of termination is discussed. Work yet to do is clarified.

Table 4.2 Stages of treatment adapted from Horowitz's approach (Horowitz 1986, p. 131) (continued)

Stage name sequence [session number]	Therapeutic alliance	Patient activity	Therapist activity
5 Reviewing and revising [11]	<ul style="list-style-type: none"> • Meaning of termination as active rather than passive to counteract view that a traumatic abandonment is about to happen. 	<ul style="list-style-type: none"> • Working through central conflicts and issues of termination as related to topics about the trauma. • Giving up the therapist as restorer of what was lost. • Bolstering plans for realistic and assertive future actions. 	<ul style="list-style-type: none"> • Clarification of conflicts and how these relate to past personality, traumatic events and the pending termination. • Clarification of unfinished issues for future contemplations.
6 Ending [12]	<ul style="list-style-type: none"> • Saying goodbye without resentment. 	<ul style="list-style-type: none"> • Realisation and clarification of work to be continued on own in future. 	<ul style="list-style-type: none"> • Acknowledgment of real gains and real future work. • Additional recommendations. • Set up for booster sessions if indicated.

to alert the therapist to the experience of therapy from the perspective of the survivor. The three comments below are designed to assist therapists to have a set of over-arching goals that span individual therapy sessions and stages as outlined by Horowitz.

Telling the story

Controlled shared recollection of the terrifying event(s) builds mastery and integration of the fragments. One of the reasons survivors give for not telling their story is that it will frighten their spouses, family and friends. They are concerned that telling about such horrible events will have devastating effects on the people they tell. While this may partly be an excuse, it is nevertheless a real issue. The stories that survivors tell have a significant impact on therapists, as discussed in Chapter 6. Survivors are right to be concerned about the impact their experience will have on those who hear their story. The therapist is therefore an important bridge in the process of the survivor recounting and integrating their experience into their life narrative. The fragmentary nature of traumatic memory means that the story will need to be retold a number of times in order to build up a picture of the event which is sufficiently coherent for the survivor to be able to integrate the event into their life narrative. This means that the survivor needs to know that their therapist understands the process of the retelling, and is able to cope with the repeated exposure to the recounting of the horrible events.

Construction of meaning

The psychological impact of trauma is seen at its most pervasive in the shattering of assumptions about the world and the self. Janoff-Bulman (1992) asserts that people hold assumptions about the nature of the world and the 'rules' that control it, and has noted that trauma survivors have had three key assumptions destroyed:

- personal invulnerability;
- the world is a meaningful place (i.e. predictable); and
- a positive view of the self.

The destruction of these assumptions results in uncertainty and an ever-present raised level of anxiety or hyper-vigilance. The aim

of therapy is to assist survivors to integrate the traumatic event and to re-establish an acceptable set of meaningful assumptions about the world they live in. The construction of a life meaning that is sufficient for the survivor to move on is a very important aspect of the therapeutic process. These issues will tend to emerge in later stages of therapy, but may arise at any point in the process. Some of the CBT interventions and techniques (see Seiser and Wastell 2002) are particularly helpful in this process.

Conclusion/termination

The termination phase of therapy must address the change of self-perception from victim to survivor. The term 'survivor' has been preferred in this book since it emphasises the future as opposed to the past. However, termination can be felt as another loss for the survivor. Since, by its very nature, trauma involves loss, termination of treatment is even more important than usual, and must be handled in an empowering manner. This means that the victim's ability to see themselves as a survivor is taken to indicate that they have survived the terrible event and therefore the event is past and not one that continues to influence their life now and in the future. Some survivors and their colleagues, family and friends hope that the traumatic event and its consequences will be forgotten. This view is unhelpful and counter-productive. Trauma leaves its mark on the survivor, but it doesn't have to be a debilitating and incapacitating mark. For survivors, the process of therapy needs to deal with the termination phase in a constructive manner to show that termination is a sign of the limited nature of the impact of the traumatic event and that the survivor is ready and able to move on with their life.

Psychological assessment

The assessment aspect of any form of psychological therapy is an indispensable preliminary to the effective planning and conduct of therapy. There are many texts (e.g. Beutler and Berren 1995; Beutler and Clarkin 1990) that describe assessment for therapy, and I will not repeat that work here. I do, however, think it is important to point out several special aspects of the assessment process that need to be carried out in the case of someone who has experienced a circumscribed trauma.

General trauma assessment

There are a number of assessment instruments available for trauma survivors. I believe that it is both ethical and professionally responsible to carry out a thorough assessment irrespective of the survivor's legal situation. Assessment is designed to identify special characteristics of the survivor's psychological make-up—both strengths and weaknesses—that will facilitate the benefit of the therapy to the survivor. The role of professional psychological assessment will involve the use of licensed and copyrighted instruments. Appropriately qualified persons should be engaged to conduct and score such instruments. Therapists who are not appropriately qualified, apart from acting illegally, run the very real risk of misusing the tests via inaccurate conclusions or misinterpretation of the scores and profiles produced. Appropriate training is very important for the correct use of these instruments, as is ongoing supervision and professional development in assessment of PTSD. Some of the common general assessment instruments include the following.

Structured interviews

The use of structured interviews is recommended to avoid therapist bias in their diagnostic interviewing. This is especially true for therapists new to hearing the horror stories often central to traumatisation. The need to address a large number of domains is paramount for survivors of trauma, as traumatic events have such wide-ranging effects on the survivor's life. Examples include:

- structured clinical interview for DSM-III or SCID (Spitzer and Williams 1986);
- clinician-administered PTSD interview or CAPS (Blake et al. 1990); and
- structured interview for PTSD or SI-PTSD (Davidson et al. 1989).

Standardised instruments

The range of standardised assessment instruments relevant to PTSD is wide. There are instruments for specific populations (e.g. combat veterans), and instruments based on previous well-established psychological tests (e.g. MMPI). The use of these instruments also needs to be carried out under the appropriate requirements for administration and scoring. Examples include:

- MMPI subscale to assess PTSD (Keane et al. 1984);
- Mississippi Scale for Combat Related PTSD (Keane et al. 1988); and
- Penn Inventory for PTSD (Hammarberg 1992).

Assessment for phase identification

The general assessment described above does not address the requirement of the Horowitz model for the identification of the dominant phase in which the survivor presents at the start of therapy. This is very important, because phase-appropriate interventions at the start of therapy are necessary to minimise the chance of retraumatising the survivor. Retraumatising survivors is very easily done if a therapist does not accurately assess the dominant phase the survivor is in. As therapy progresses, a therapist will ascertain the phase by the content of the presenting material; however, initially this may not be easily identified. The following instruments can be used to assess the phase at the start of therapy:

- IES-R (Weiss and Marmar 1996). This instrument is an extension of the earlier IES which was developed by Horowitz et al. (1979) based on the two prominent phases of Horowitz's model, denial and intrusion. Weiss et al. added a scale for hyper-vigilance to better represent the criteria from DSM IV. The scale is scored for the three subscales and has norms available from Horowitz (1997) so that therapists can assess the dominant phase the survivor is presently experiencing.
- The Acute Stress Disorder Scale (ASDS) was developed by Bryant and Harvey (2000) as a result of their extensive work in the area of the immediate aftermath of the traumatic event. They have developed this instrument to better determine the features of a syndrome they describe as acute (i.e. transient-like) stress response, which can, but does not necessarily, develop into full-blown PTSD.

Assessment for likelihood of the development of pathology

My assertion that post-trauma therapy starts by assuming that the survivor's reactions are non-pathological until proven otherwise does not absolve a therapist from assessing for the indicators

that pathology may develop. There is a wealth of material that indicates that post-trauma survivors move through periods of suicidal ideation, or that nascent personality disorders or other severe psychological disorders may emerge. Therapists must therefore assess the potential for problems at the start of therapy. The level of stress experienced by most survivors of traumatic events during therapy is considerable, and this stress alone may be sufficient to trigger other psychological problems. These must be borne in mind as therapy proceeds. The following are some of the indicators that may help a therapist to be on the alert for problems arising during the processes of therapy:

- Beck inventories, especially hopelessness and suicide (Beck and Steer 1988, 1991);
- a history of loss;
- support system—that is, family, partners and friends;
- family psychopathology; and
- presence of dissociation defence during trauma.

Phase-appropriate interventions

The process of therapy for survivors of circumscribed trauma is best facilitated by matching interventions to the phase that the survivor is presently experiencing. This somewhat self-evident statement needs to be carefully considered, as it requires the therapist to constantly monitor the survivor's experience of therapy with a view to staying close to the survivor's traumatic material. There is increased potential for the therapist to be more stressed by the therapy than may normally be the case. The matching of interventions to phase experience is always a moment-by-moment process, as a survivor may move between trauma phases during, as well as between, sessions. The following material is therefore a general guide that must be applied thoughtfully and with a degree of reflective skill.

Outcry

During the periods of time dominated by the initial outcry phase, the following interventions are central to responding to a survivor of trauma:

- Social support is critical in this phase. The outcry phase is often marked by social rejection—that is, the survivor may withdraw, anticipating this rejection due to their experience of what most people find incomprehensible. Ensuring social contact is therefore very important at this point. The main proviso is that the level of social support must be acceptable and manageable to the survivor. Trauma isolates, since it is experienced as a tearing apart from one's social fabric. Therapy needs to focus on the availability of social support and whatever will engage the support network.
- The timeframe is the here and now. During this phase, survivors will not be able to make long-term plans. Therapists therefore need to resist assisting survivors to make long-term plans as the survivor may simply accept a plan offered by others rather than assess it from within their own context and ability to implement it. Therapists do well to encourage step-by-step planning. CBT approaches are very helpful here (see Seiser and Wastell 2002).
- Interventions must be designed to counter emotional flooding and hopelessness. The outcry phase is often followed by the denial phase, though this is not always the case. A survivor in the outcry phase may be flooded by the emotions of fear and rage. Therapists must be alert to this possibility, and conduct therapy so as not to prematurely propel the survivor into intrusive experiences before they are able to cope with the stress this generates.
- The overall therapy goal in the outcry phase is to empower the survivor to regain some control little by little, through achievable actions/decisions (e.g. have a bedside light on while going to sleep).

Denial

The denial phase may be thought of predominantly as a resting phase. Survivors in this phase are in both physical and psychological states where they are capable of regaining some strength. The physiology of adrenalin released during a trauma means that the high-energy activation will be followed by tiredness and exhaustion. The survivor needs time to recover. Denial is functional in an appropriate timeframe. If it goes on for 'too long', the therapist needs to examine the survivor's perception of the therapy process. The over-arching principle of therapy in this

phase is not to jolt or push the survivor out of the phase. Such action would be very detrimental, and possibly worse than the original trauma itself. During periods of time dominated by denial, the following interventions are important:

- Establish a level of equilibrium in the survivor's life;
- Select topics that move the client toward the emotional aspects of the trauma *slowly*!;
- Attention to concrete specific memories is important; and
- The focus should be on the immediate implications of the trauma for self-organisation, goals and beliefs.

Intrusion

During periods of time dominated by intrusions, the following interventions are recommended:

- Initially, the memories will be experienced as intrusive fragments, accompanied by bodily sensations. This can be very disturbing. Here the therapist will perform the important function of assisting the survivor with containment and management of the experience by carefully modulating recall and the amount of time spent on the memory fragment;
- It is important to explain the process of trauma as a way of addressing the anxiety, and to do some planning on ways to deal with the anxiety through relaxation techniques (Seiser and Wastell 2002);
- The survivor needs to construct a coherent and meaningful account of the event(s) and their experience of the trauma. The therapist supplies a structure for the scattered fragments. This is not to say that the therapist fills in missing details or attempts to direct the survivor towards any particular conclusion or narrative. It is in this area that major problems arise in the treatment of trauma survivors. Therapists must not suggest scenarios of the trauma event or point the survivor towards conclusions, as by doing this the therapist would be exercising control over the survivor and this is potentially extremely retraumatising. This type of iatrogenic effect is one of the real dangers in treating survivors who report recovered memories of trauma.
- A coherent timeframe is very important for creating a narrative. If the sequence is important for the survivor, then it will

be worth exploring; however, don't delve into it if it is not necessary; and

- Interpretations are designed to integrate conflicted self-schemas and to reconcile contradictory elements.

Working through

The overall aim in this phase is to generate a coherent account of the event(s) and its implications for the survivor's self-structure. This phase is marked by increasing ability to recall and describe the traumatic event and its implications for the survivor's life and self-structure. Toward the end of therapy, certain themes need to be addressed, including:

- fear of repetition;
- shame over vulnerability or incompetence;
- anger at the source/perpetrator;
- anger at those exempted or caretakers;
- survivor guilt; and
- mourning over loss.

Summary

The use of phase-appropriate intervention is meant to signify the pace of therapy and the role of the therapists in assisting the survivor to cope with the recalled material. Some techniques will be used across phases, but will be framed with the general guidelines of the phase. For example, a therapist may teach relaxation techniques in the outcry and denial phases. In the outcry phase, relaxation will be used to encourage the development of skills that are enabling the survivor to take more control of their life. In the denial phase, relaxation is part of the preparation for the intrusive material, as well as a means to deal with the bodily agitation that many survivors experience in this phase.

Case presentations: Introduction

The therapy cases presented in this section are fictitious. They are an amalgamation of survivor reports from the media, the therapeutic literature and the clinical experience of the author. Each

illustration will have three broad sections. Firstly, the situation leading up to the trauma will be outlined, as well as the incident in which the traumatic event took place. Secondly, material will be presented from the survivor's point of view about both the trauma experience and the process of therapy. Where possible, these comments will be as close to quotes from survivors as possible without breaching confidentiality. This material will be commented upon from the perspective of both general treatment principles and emotion aspects. Finally, a summation of and general comment on the important points that the case illustrates relating to the model presented in this book will be provided.

Case study 4.1: Single incident trauma—Jim

This case of Jim is a typical one. His traumatic experience is very much in line with the traditional understanding of a traumatic event which has resulted in psychological aftermath that persists after any physical injuries have healed. I would describe the situation of Jim as a contained trauma to emphasise the time-limited nature of the traumatic stressor. This is similar to Terr's (1991) Type 1 trauma, where the survivor's fundamental psychological makeup has not been developed in or substantially modified by the experience of ongoing traumatic events (e.g. war or domestic violence). This case enables us to see the critical elements of the traditional treatment that will then be used to highlight the contribution of an emotion-focused, informed approach to the treatment of trauma.

Life context

Jim is a 35-year-old factory worker. He is married with two children. He works in the heavy industrial sector in an aluminium rolling mill and smelter. He is a good employee and has no medical problems of either a physical or psychological nature.

The incident

Jim was working on the late afternoon shift on the factory floor. A new work associate was operating a forklift truck and moving a quantity of 50 kilogram ingots that were stacked in lots of ten. He was stacking the ingots near Jim's workstation for later use. Jim heard the forklift stop near

him and the driver alighted to reposition some materials so that he could deposit the ingots in the new position. The load on the forks dislodged and crashed down on to Jim's workstation and on to his work associate. Jim had turned around in time to see the load begin to fall. Jim cried out to try and warn his associate but was knocked unconscious. He awoke a very short time later to see the body of his associate crushed under the ingots.

Jim was not pinned under any of the ingots and was seen to quickly by first aid attendants. He was subsequently transported to a local hospital and found to have some bruising and slight concussion. He was kept overnight in hospital for observation. Early the next day, at his insistence, Jim was discharged from hospital.

Post-trauma reactions

Jim returned to work after a few days' rest. He appeared to be unaffected by the incident. He had not known the dead work associate very well. The accident investigation team had concluded that the accident was the result of the new worker not adhering to safe operating procedures, even though he had recently been certified to operate a forklift truck.

Jim's performance at work remained at its usual high standard for a week or so. Thereafter he began to become forgetful and irritated by seemingly trivial incidents involving both himself and his work associates. Jim's manager became concerned and requested that Jim see the employee assistance program providers.

Treatment and recovery

Jim was initially reluctant to talk about the incident, but after he began to develop a level of trust in the therapist, he did reveal that he had been suffering from anxiety attacks—though he described them as feeling very tense and starting to think he was going to die. He had been drinking more heavily than usual, and was short-tempered with both his wife and his children. He also indicated that he had not felt like socialising with his friends from work or his social acquaintances since the accident. Jim reported that he had been having nightmares about the death of the work associate, and that recently he had been having flashbacks of the incident including visions of the dead body that he saw when he woke up. Jim tried to be logical by explaining to himself that the incident was not his fault and that he was not injured, so there was nothing to worry about.

Analysis

The traumatisation of Jim is typical of many contained traumas. The following analysis presents key features of Jim's experience, places them into a theory context and highlights the relevant emotion processes (see Table 4.3).

Table 4.3 Analysis of Jim's trauma

Behaviour	Trauma phase	Emotion processes
Jim started to cry out	Outcry	Emotion system activated when confronted with life-threatening situation. Jim's body would already be releasing adrenalin and his large muscle groups becoming activated.
Knocked unconscious	NA	The activation of the large muscle groups was interrupted and not able to carry out their function (e.g. flight). This will leave a body memory that is not easily 'explained' away.
Return to work	Denial	Denial comes at the price of suppressing the emotion experiences, but with the benefit of a period of comparative rest.
Images of the body	Intrusion	The experience of these images will almost certainly be accompanied by heightened physiological arousal. These intrusive memories may be the result of heightened arousal produced by other experiences such as relaxation activities.
Increased alcohol intake	Denial	The use of legal drugs to contain the physical and psychological agitation is common, but also leads to the experiencing of flooding of emotion-charged memories which can be very distressing.
Logical by explaining the incident	Denial	The attempt to explain the incident can be seen as a denial activity in that the emotional impact of the incident is denied and the survivor attempts to rationalise away both the confrontation with death and the accompanying experience of the activation of emotion survival processes.

Recommendation

Jim is a suitable candidate for the treatment outlined by Horowitz (1997). He has a stable family context and no prior history of psychological problems. He will need to have his physical symptoms addressed by whatever is appropriate for him. He may find physical activities such as bushwalking or weight lifting useful for releasing the memory of his large muscle groups. His reactions are normal and should not be pathologised. With appropriate treatment and support, including support for his family and co-workers, Jim should be able to work through this trauma. It should be noted that the memory of the trauma and its impact on him will not be erased. It will be incorporated into a revised self-schema and that is the goal of treatment.

Case study 4.2: Death of a parent—Joan

The death of a parent is a highly likely event for the vast majority of adults in any society. The ‘natural’ order is that children bury their parents. I will consider the common situation here and in a later example look at the situation of the notification of the death of a child. Though the death of a parent is an extremely common event, it is still traumatic because the survivor is confronted with the death at very close quarters of someone who is psychologically very significant to the survivor.

Life context

Joan is the only daughter of Bill and Mary. Joan is 40 years old and is married with three teenage children. She is a professional and holds a senior position in an accounting firm. Joan’s family life, both as a child and now as a wife and parent, has been uncomplicated. She describes herself as close to both her parents and in frequent contact with them. She is physically and psychologically well-adjusted. Her parents were in generally good health until her father suddenly died of a heart attack.

The incident

Joan was at work when she received a phone call from her mother that her father had suddenly had a heart attack at home and was dead. Joan went into autopilot, as she later described it. She drove to the hospital where she comforted her mother. She was told that her father’s heart attack had occurred while he was moving some boxes around in the

garage to find some old photographs. Joan's mother had called the paramedics, who had attended very quickly; however, when they got her father to the hospital, he was pronounced dead on arrival. The suddenness of the death resulted in an autopsy which confirmed that the heart attack was massive and Joan's father had died instantly. The funeral was held soon after the autopsy.

Post-trauma reactions

After the funeral, Joan had gone back to work and had seemed to be coping fairly well. Colleagues were sympathetic and discussion of her father's age had been along the lines of, as a 77-year-old, he'd had a good long life. Joan tried to console herself with these and other thoughts, but somehow they did not seem to work. Joan was becoming distracted both at work and at home. Her children had been very supportive, as had her husband. After a few weeks, aspects of work that had not usually bothered Joan began to become very irritating. She got very annoyed with a junior staff member who was less than efficient. Joan usually did not have such a strict requirement of juniors. She became aware that her relationships with her husband and children had changed. She was more protective of her children and began to call her husband to see if he was okay, though he had no medical history that would cause concern. Joan decided to seek professional help and contacted a grief counsellor.

Treatment and recovery

In her initial meetings with the grief counsellor, Joan described her disbelief when she was told that her father was dead. She described how she just went into automatic mode, drove to the hospital and was able to comfort her mother. She now sees this as strange. Joan talked about these actions as if they had been carried out by someone else. She says she felt detached during this early stage. After the funeral, the numbness began to decrease and she became aware that she was angry at her father for moving the boxes. 'He should have asked for help,' was her assertion. She recognised that her anger was unreasonable but it is how she felt. She had been having dreams about her father, including ones of her early childhood. These dreams tended to end badly in that there was either a death or some other sad finish to the dream. Her husband reported that her sleep was restless and she was aware of being woken up by her thrashing about in bed. Joan is finding that she is listless both at home and at work.

Analysis

The analysis offered for Joan will concentrate on the emotion aspects (see Table 4.4). There are a number of texts (e.g. Worden 2001) which deal extensively with grief counselling, and in particular the issue of meaning and the symptoms of grief (e.g. reactive depression). Joan's reactions to the death of her father are very common and illustrate the fact that the death of a close relative is traumatic, even though such an event is not unexpected at a more advanced age.

Table 4.4 Analysis of Joan's trauma

Behaviour	Trauma phase	Emotion processes
Autopilot	Numbing	The role of emotions in human functioning is partly to focus attention on primary goals. In the case of such a traumatic event, Joan's emotion system enabled her to contain the potential disorganising effects of the news of her father's death and to act in a supportive manner towards her mother. This reaction is far from callous: it is very pro-social as it brings members of the family group to the aid of each other in times of crisis.
Dreams from childhood	Intrusion	From Horowitz's perspective, the role relationship models that direct our lives are challenged by traumatic events. The intrusive material in Joan's case has the content shaped by the schemas concerning her relationship with her father. Her loss directly relates to her concept of herself. The emotion activation that presses for acknowledgment brings with it content relevant to the self-schemas that need revision.
Short with colleagues and family	Denial	The heightened emotion processes activated by the traumatic event are demanding on Joan's ability to contain them. The necessary capacity to tolerate the shortcomings of others is strained by the need to contain the emotions associated with grief. The lack of tolerance is better considered as denial, as it is the result of holding back the emotions rather than a release of the emotions associated with the trauma.

Table 4.4 Analysis of Joan's trauma (continued)

Behaviour	Trauma phase	Emotion processes
Actions carried out by someone else	Numbing	This type of dissociated behaviour is relatively common amongst trauma survivors (Petridis 2002). Joan has experienced the ability to contain strong emotions to the extent that a split is created in the awareness of her felt experience. This process is adaptive and functional in the context of needing to take action in difficult times; however, it should be viewed as temporary and needs to be addressed in therapy should it become chronic.
Listless and inactive	Numbing	The process of reactive depression occurring to trauma survivors is common. The lack of energy after the danger has passed is typical of the post-adrenaline release. The body has acted to preserve what it can but, once the danger has passed, the body needs rest and the chemical balance needs to be restored. Emotion and physiological processes do require the restoration of balance, and exhaustion is a common sign of that need.

Recommendation

Joan is a good candidate for survivor-orientated grief therapy. In fact, Horowitz's early research was done with widows, and that is the context within which his model of treatment was initially developed. Again the physical needs of the survivor must be proactively addressed. Joan will need to be encouraged to take more rest and yet also needs to be willing to engage in social activities that will reconnect her to her family and social world. Nutrition is also important for the grieving person, and is not something that should be assumed to be fine.

Case study 4.3: Reported death of a child—John

The diagnostic manuals (DSMIV, ICD10) recognise that hearing about the death of, or serious injury to, a close relative or friend can produce traumatic reactions in an individual. The spectre of death that confronts

the person (Wastell 2003) is experienced as fully real, so they display reactions as if the traumatic event had actually happened. The disconfirmation of the death later does not eliminate the experience, as the emotion processes activated when the individual was informed (wrongly) that there had been a death of a close relative or friend have already left both a psychological and physical residue on the person.

Life context

John's family life is average in all respects. He has been married for eleven years to Mary and they have three children. The conceptions and births of the children were all normal, as was the medical history of all the family members. The first-born child, Zac, is just ten years old.

The incident

During a school excursion, there was an incident in which the bus the children were travelling in collided with a large truck. Several children were injured and one was killed. The accident resulted in the children's belongings being mixed up. The dead child was taken to the nearest hospital with what was thought to be his school bag. The bag was in fact Zac's. The hospital, through the police, notified John at work that his son had been killed in the accident. When he came to identify the body, to his great shock he was confronted with the dead body of another child that he did not know. He did, however, identify the bag as Zac's. Zac was in fact at another hospital being treated for minor cuts. Zac told the medical staff he had lost his school bag, but he did know his mother's mobile telephone number and she was called and came to pick him up. The discussion below will concentrate on John's reactions. John's wife Mary would also have had a similar—but I would suggest not as severe—set of reactions to the situation of Zac's involvement in the bus accident.

Post-trauma reactions

John's situation left him initially feeling very relieved. In talking over the incident with his wife, John expressed the range of reactions he went through and in particular the mental preparation for seeing Zac's body at the hospital. He was relieved and felt very tired.

The following few days and then weeks were a little stressful for John. He was very protective of Zac and his siblings. John took them to places where in the past he may have let Mary or other parents drive

them. John was also aware of the need for safety on the roads. John started to have nightmares about automobile accidents. He found himself more tense than normal, and Mary told him that he was being short with the children. John worked for a company that employed a firm to provide assistance to its employees, so he went along to ‘just talk things over’.

Treatment and recovery

The discussion with the psychologist began by describing the incident and John’s reactions to the fact that Zac was not dead. The psychologist indicated that John’s reactions were consistent with a traumatic stress reaction. As John explored his experience with the psychologist, he became aware of the depth of horror that filled him as he went to the hospital. John was also aware that he felt physically agitated more than normal, including disturbed sleep patterns. The psychologist was able to name the experience as a trauma and from that point started to help John work through his reactions.

Analysis

John’s situation could easily be seen as making a mountain out of a molehill (see Table 4.5). From an emotion processes point of view, this would be a mistake. The news of Zac’s death was accepted by John as real. His son was dead. All the grief and trauma reactions would have been mobilised. This would have created a body registration as well as commenced the cognitive processes to deal with such an event. Though the event did not actually happen, it did as far as John’s emotion system was concerned!

Recommendation

John’s openness to discussing the incident with a psychologist is a good indicator that he will be a short-term client. He will need somewhere to talk over his reactions and be able to use these discussions to modify his schemas about life, and in particular his understanding of the importance of his children to him and Mary. The theme that is most prominent to a ‘survivor’ like John is the existential one of the unpredictability of death and the vulnerability of life. The physical reactions will most likely be able to be dealt with through psycho-education, but would need to be monitored lest John is unable to deal with them himself.

Table 4.5 Analysis of John's trauma

Behaviour	Trauma phase	Emotion processes
Relieved and tired	Outcry	John's body would have released adrenalin and prepared itself to deal with the shock and horror. The tiredness is a common indicator of the level of activation that has preceded it. The outcry phase is when the system is activated.
Mental preparation	Denial	John's emotions enable him to focus on what must be done—that is, go and identify Zac's body at the hospital.
Very protective	NA	This is an indicator of the hyper-vigilance that accompanies trauma. John's raised awareness is a focus of the emotion residue, so he will take his alertness and apply it to the situation that generated the traumatic event.
Nightmares	Intrusion	The material stored in active memory has a high emotion valence. This material presses for acknowledgment in disturbing dreams. Though the incident did not happen, the emotion system valence is not dealt with by such cognitive evaluations.
Short with the children	Intrusions	Though John is not showing a marked degree of dysfunction, there are indicators that he has suffered a psychological impact from the incident. He is trying to deal with heightened arousal but cannot easily place it in the context of his recent experience. This is another reason for John to undergo some psycho-education about trauma reactions.

Summary

The case illustrations provided in this chapter centre around a circumscribed trauma. This term is chosen to incorporate all those traumas that fall short of chronic or complex trauma. Essentially, when dealing with circumscribed trauma from an emotion-focused perspective, a therapist is required to address the confrontation with the spectre of death and what that means for the survivor's long-term psychological adjustment. The emotion

processes are critical to developing and owning a coherent and meaningful life view. Survivors are faced with their reactions, which can be quite confronting in themselves. They need to understand that their emotion-based responses were there to protect their life and to enable them to survive. Attempts to subsume the emotions are fraught with important consequences. Self-preserving emotions are not under volitional control; they must be recognised and incorporated. This is what an emotion-focused approach emphasises. The next chapter will apply an emotion-focused approach to complex trauma.

5 TREATMENT OF COMPLEX TRAUMATISATION

Complex trauma involves such a level of chronicity that survivors may define their inner core self in terms of their traumatic treatment and experience. Before applying an emotion-focused approach, the chapter outlines the views of Bessel van der Kolk and Judith Herman, both of whom deserve special recognition for their contribution in this area. The chapter endorses the warning of van der Kolk and others concerning the current early stage of our knowledge of treatment of complex trauma; as a result of this, we are well advised to be tentative in applying simplistic models in our work with survivors of complex trauma. An emotion-focused approach alerts therapists to the need to recognise the fact that complex trauma is not amenable to quick, short-duration treatments. The case illustrations presented highlight the role of emotion in treatment and emphasise that treatment recommendations must incorporate both psychological and physical forms of treatment.

What is complex trauma?

Complex trauma is similar to Terr's (1991) concept of Type 2 trauma. Herman (1992b, p. 87) applies the term 'complex trauma' to situations that involve captivity. She asserts that the standard PTSD criteria are applicable to death, assaults and other singular terrible events. Trauma generated from within the context of captivity—including prison, domestic violence and cult membership—is characterised by coercive control. Whilst this is certainly true, prolonged traumatic events without personal

control are also characterised by the survivor experiencing a state of powerlessness akin to being under the control of the circumstances they find themselves in. I would add prolonged combat to Herman's list.

One of the central elements of complex trauma is the way the core self is defined by the experience. The loss of a separate identity for survivors of child abuse, domestic violence, cults and the like results in survivors' self-understanding being defined by the perpetrator or circumstance. Through a personality development process known as 'reflected appraisals' (Hergovich et al. 2002), the self-concept takes on a sinister form. The resultant self-structure is malformed in the likeness of the traumatic circumstance.

Van der Kolk's model of treatment

Trauma treatment is still in its infancy. The Koach project (Solomon et al. 1992) demonstrated problems with treatment in terms of objective outcome measure results. Treated veterans actually deteriorated in such areas as emotional distress and psychiatric symptomatology. I would strongly encourage readers to follow up the *Journal of Traumatic Stress*, vol. 5, no. 2 (1992) if they are interested in the findings of the Koach study. What is clear from such studies is that various aspects of trauma require different approaches—for example, physiological, family and social/employment.

Fundamental goals of treatment for survivors of complex trauma

- Establish a sense of relative safety. This is in direct contrast to the survivor's general experience of the world as an unsafe place.
- Aim to help clients move from being haunted by the past to being fully engaged with the present. This will involve emotions as signals, not only as alarms.
- Clients must regain control of their emotional responses.
- Place the trauma within the larger perspective of their life course.
- Relaxation of the massive defences which were essential for survival is crucial. This is especially the case for the defence of dissociation.

- The deconditioning of anxiety allows for the process of constructing an alternative view of the self, involving:
 - a sense of personal control;
 - the establishment of mutually satisfying interpersonal relationships—for example, via group psychotherapy, or with family members.
- The therapeutic relationship will be the site for replaying, exploring and treating such issues as:
 - mistrust/betrayal;
 - dependency; and
 - love/hate.

Diagnosis

A thorough history is necessary and would include:

- the nature of the stressor;
- the patient's role (potentially very painful if the survivor was complicit in acts of abuse);
- the patient's thoughts and feeling about their actions/non-actions;
- the effects of the trauma on the survivor's perceptions of self and others;
- habitual coping styles and personal strengths;
- all prior psychiatric history;
- medical, social, family and occupational history; and
- information about cultural and religious beliefs.

Intrusive re-experiencing

This process is central to treatment, and is best conceptualised from the perspective of a gradual self-revelation which proceeds through a series of stages/phases but *not* in a strictly linear fashion:

- not knowing;
- fugue states;
- retention of traumatic material as compartmentalised, undigested fragments of perceptions which break into consciousness with *no* conscious meaning to oneself;

- transference phenomena wherein the traumatic legacy is lived out as one's inevitable fate;
- partial, hesitant expression of the experience as an overpowering narrative;
- the expression of compelling, identity-defining and pervasive life themes—both conscious and unconscious; and
- organisation of the experience as a witnessed narrative.

Intense emotional reactions can occur for what appear to be minor reasons. This can disturb sleep due both to the level of arousal and to the fear of going to sleep and experiencing nightmares.

Autonomic arousal

In normal life, this alerts the person to potential danger. In traumatised people, it loses this function. Any arousing situation *may* trigger long-ago memories of the trauma. This process can occur more often as the survivor begins to trust the therapist.

Numbness

Numbness may be expressed/experienced as depression, anhedonia or lack of emotion. There is also the chance of dissociative symptoms being masked by what may appear as numbness. Emotional numbness can become a significant barrier for survivors in terms of them having any hope of a future and can hence be an impediment to treatment.

Memory disturbance

The development of Dissociative Identity Disorder is one end of the spectrum of memory disturbance. The fragmentation of memory is the result of the affective intensity that accompanies trauma. The stored material is often bodily in character or, in the case of childhood traumatisation, pre-verbal or pre-self-narrative, so the memory is *felt* and difficult to articulate. Amnesia may develop to a range of post-trauma experiences, and this may include work done in therapy.

Psychosomatic symptoms

Krystal (1988) has noted the role of alexithymia in trauma survivors. He demonstrates that those trauma survivors who display alexithymic traits tend to re-experience their trauma as bodily dysfunction via psychosomatic symptoms. This non-psychological focus may make treatment a slow process.

Phase-orientated treatment of trauma

Stabilisation: Overcoming the fear of trauma-related emotions

The aim of this phase is to enable the survivor to control overwhelming emotions and pathological defences. Medication may play a central role in supporting the survivor's ability to control the emotions and defences. Goals will include:

- the development of a cognitive frame that helps survivors to understand the intrusion/numbing pattern of their life. This also helps to place some emotional distance between the experience and their ongoing life; and
- a detailed behavioural analysis of triggers to memories and the consequent cognitive, autonomic and behavioural responses which will assist the survivor with stabilisation.

Identification of feelings by verbalising somatic states

Emotional signals for trauma survivors are experienced as bodily agitation. They do not signal significance as they normally would. A critical element of trauma treatment is assisting the survivor to find words for their somatic experiences which connect the experience to emotional modulation. Naming feelings brings mastery and a sense of meaning. The naming of feeling can start to put the experiences into a timeframe that enables the survivor to again connect with their life course.

Deconditioning traumatic memories/responses

Once stability has been achieved to some degree, the treatment can be terminated. If, however, the trauma is simply being re-experienced and stability has not been sufficiently established to

minimise the intrusion feedback cycle, then deconditioning may be appropriate. If the traumatic material is fragmented and non-verbal, then treatment consists of staying with the patient through the distressing emergence of the fragments and then assisting the patient with verbalising the material. This is the process of transforming traumatic fragments into narrative memory.

Memory and dissociation

Material stored as somatic fragments is disconnected from the processes of self-defining memory and narrative which enables a sense of mastery. The role of autobiographical memory is an extensive and important aspect of trauma treatment.

Controlled exposure and memory reactivation

This process must be conducted very carefully, in full consideration of the patient's ability to handle the distress which will be experienced. When the traumatic fragment is activated, some new information must be introduced which is incompatible with the traumatic memory. Trauma-related affect must be activated for the traumatic structure to be modified. Secure attachment to the therapist is essential for emotional regulation and for the patient to experience the return of the traumatic material less destructively than was feared.

Restructuring of trauma-related cognitive schemes: Overcoming the fear of life itself

Psychotherapy of trauma requires the therapist to deal with the experience of the trauma in relation to the patient's whole life. Issues such as trauma and the patient's self-efficacy, capacity for trust and intimacy, ability to negotiate their personal needs and ability to feel empathic toward others are part of the process of rejoining their social world.

Case study 5.1: Complex trauma as a result of exposure to combat—Matt

It could be argued that the modern study of trauma was given a crucial impetus as a result of the catastrophic wars that engulfed the world during the twentieth century. The study of trauma had to become

politically acceptable in the West at least to enable it to be officially recognised (e.g. APA, 1980). Recognition of the disorder resulted in it becoming a matter of financial concern for a nation's health care system.

The case of Matt is presented from within the context of the Vietnam War. This context has several advantages. Firstly, it is relatively recent—which means that therapists will still be seeing clients who are survivors of this conflict. Survivors of other major conflicts such as World War II and the Korean War are also potential clients, but they are of such an age as to make it more likely that there will be comorbid complications produced by the ageing process. I have written about the experience of trauma in war (see Wastell 2003) using examples from World War II, and the interested reader is encouraged to refer to this work for more details. Matt's case is also very indicative of survivors of recent conflicts such as the Persian Gulf Wars and various UN operations where violent conflict has occurred.

Life context

Matt was a young man of 20 when he first experienced combat. He was an infantry soldier who was keen to do the right thing and to protect innocent lives, as well as not let down his 'buddies'. His experience of combat was for a period of twelve months in Vietnam in the late 1960s. He took part in the whole range of military operations, from search and destroy through to humanitarian aid provision and was even involved in some construction work. He carried out his duties effectively and was commended by his company commander on several occasions. Matt was a very successful soldier, well respected by his peers and superiors. At the end of his tour, he was glad to get home to his family. He went back to the trade he had been learning and tried to get on with his life. Though he knew of the troubles others had had, he was treated well by his local community. He was bitter about the disparaging attitude of the general population (including World War II returned servicemen) towards returning Vietnam veterans. Matt married Anne, and together they had three children who grew up and at present are living away from home in various relationships and employment contexts.

The incident

For more than two decades, Matt's life was pretty normal—if somewhat subdued. He enjoyed his job and had a number of close workmates. He was described by them as quiet and a little withdrawn. Matt had been at

work one day when a boiler had exploded. No one had been hurt and the factory was closed down so the incident could be investigated and the boiler replaced. Matt went home.

Post-trauma reactions

While at home, he found himself feeling very uneasy and agitated. He had not been anywhere near the boiler when it exploded. He had heard only the muffled sound of the explosion. He could not figure out why he was feeling so uneasy. That night he did not sleep well. He tossed and turned and woke up his wife Anne several times. She became worried, because Matt was calling out in his sleep as though there was some imminent threat to him and others. In the morning, Anne talked about this with Matt, who was both perplexed and a little frightened. He said he felt strange in a sort of familiar way. Matt tried to return to work and get back to normal. He found he was not able to concentrate and he was having more disturbed nights. He eventually spoke to his supervisor, and they agreed to get Matt an appointment with the employee assistance program (EAP) provider to discuss Matt's reaction to the boiler explosion.

The meeting with the EAP counsellor began to accumulate evidence that the boiler incident had triggered in Matt bodily memories of his experiences in Vietnam. As the sessions progressed, Matt began to get in touch with the fear he had experienced in Vietnam and his efforts over the ensuing years to suppress the memories—for example, he did not go to reunions of his former army buddies, he found watching war movies distressing and he generally avoided becoming 'too emotional', as he described it.

Treatment and recovery

The delayed onset of Matt's symptoms and memories is typical of survivors of complex traumatic experiences. Matt had been leading a relatively normal and well-functioning life. Anne reported no marital problems nor violence towards herself or the children. Matt, if anything, was a bit reserved. Matt's adaptation to his postwar experience did not produce social or family problems. It did, however, result in a truncated lifestyle. Treatment in his case would need to focus on the mourning for the loss of aspects of his life that were put aside in order to adapt to the situation of surviving in the jungles of Vietnam. He may now experience the flashbacks, hyper-vigilance and intrusive memories that had been

suppressed for many years. The necessary support and normalisation would be provided through treatment for himself, Anne and his children, as well as appropriate psycho-education about the meaning of the reactivated traumatic memories.

There are several aspects of this case that are complex. There is the distortion of the structure of the self that occurred for Matt as a result of the effort to suppress the emotions and memories from combat. For many young men, the experience of combat changes their self-definition dramatically. The terrible things that they do to survive on the battlefield often confront them with a side of their personality that both horrifies and disgusts them. The rebuilding of the self and acceptance of the new self will be major parts of therapy. Often it is about accepting the actions as a demand characteristic of the situation rather than as purely emanating from their personality. Treatment will be episodic in character. Each episode will explore and deal with some subset of symptoms, memories and reactions so that the gradual rebuilding of a coherent self is attained. Complex trauma is not solved in one set of sessions. It often requires a long-term, multi-program approach. One of the keys is to recognise that the self is going to be resistant to restructuring, as the old self had been successful for such a long time—and indeed had initially preserved the survivor's life in situations of real and terrible danger.

Analysis

The emotion processes in combat-generated complex trauma are often powerful for both the survivor and the therapist. In Matt's case, the emotion processes are in some sense seen in reverse (see Table 5.1). His pattern of emotion suppression had controlled his system to a high degree.

Recommendation

Matt is going to require a long-term approach to treatment that is spread over a number of clusters of treatment. The process of working through the trauma of combat will entail acceptance of the loss of innocence and the exposure to horror that cannot help but leave some residue on the psyche of the survivor. In addition, the issues surrounding the treatment of returning veterans of the Vietnam War may surface, and will require both psychological and possibly social activity for Matt to move on constructively.

Table 5.1 Analysis of Matt's trauma

Behaviour	Trauma phase	Emotion processes
Withdrawn	Numbing	The process of emotional withdrawal is typical of survivors of complex trauma. This may be related to a dissociative process that is initially adaptive in the immediate circumstances, but becomes embedded in the character of the survivor. Emotions lose their signal function. To avoid potential agitation, the survivor tries to turn off the system by minimising the exposure to triggers.
Feeling so uneasy	Intrusion	The beginning of an awareness of intrusion for many survivors of complex chronic trauma is a sense of bodily unease. This is where the suppression has begun to fail, for whatever reason. The bodily registrations make their presence literally 'felt'.
Calling out	Intrusion	The flashbacks, nightmares and other signs of intrusion can cascade so that the survivor can be re-traumatised by the re-experiencing, due to its vividness and degree of disturbance. Here the emotion process of self-preservation is enacted, though not in the situation that generated it.
A little frightened	Intrusion	The realisation of fear is very significant. This fear experience may be an amalgam of the fear in combat and the fear associated with the boiler exploding. The bodily registration—however minor—of the fear of the boiler explosion associates and draws forward the memories of the fear in combat.
Difficulty concentrating	Denial	The distraction caused by the remembered fear may result in the survivor attempting to regain control. The ability to concentrate is often impaired by the effort to reassert control over the emotions by being alert to indicators of potential emotion eruptions.

Case study 5.2: Adult survivor of child sexual assault—Mary

The sexual or physical abuse of children is one of the most vile crimes imaginable. The expectation by societies all around the globe is that children are to be nurtured, protected and safeguarded. The betrayal of this trust and expectation has been a source of a great deal of political and social upheaval, especially in the West, for many decades now. The treatment of an adult survivor of child sexual assault (CSA) is at the heart of the modern investigation of trauma. It was just such cases that Freud examined that led to his rejected seduction hypothesis. The phenomena of CSA is often accompanied by society-wide disbelief. Many say the figures of abuse are ‘unbelievably high’. One of the consequences of this disbelief has been that the reporting of such cases has been subjected to questioning by both the general public and the research communities (see Loftus and Pickrell 1995). Adult survivors of CSA are thus often confronted with a doubting public, sometimes as well as a rejecting family. These contexts must be held clearly in mind when treating adult survivors of CSA. Adult-recovered memories of CSA are in my judgment possible and therefore potentially factual. This is the premise that treatment of such clients should start from until proven otherwise.

Life context

Mary is 32 years old. She is a successful career woman who has a long-term, stable and mutually beneficial relationship with Adam. They married when Mary was 28. Her career is going well, so recently she and Adam began to discuss the possibility of having children. The discussions went well with such matters as child care arrangements and shared child-rearing responsibility being clarified and mutually satisfactory. Both Mary and Adam have jobs where these issues are relatively easy to organise.

The incident

Mary began to think more and more about children and how she wanted to parent them. This began her thinking about her own childhood. She began to collect material on child rearing. In this material there were discussions of child protection and the incidence of CSA. Mary noticed that she found these references very disturbing. She began to have nightmares in which she was being chased or trapped, and she awoke very frightened in a cold sweat. Mary had not spoken very much to her

mother over the last few years, as her parents had moved to the other side of the country some years back. So she went and discussed her reactions with a work colleague who had done some child protection work in her earlier career as a school teacher. As they spoke, Mary began to wonder whether she had been abused in some way as a child. Her friend was very careful not to impose a scenario nor fill in details when Mary was unable to complete aspects of her retelling of her childhood. Mary became very depressed during this discussion. She seemed to go quiet and withdraw. Fortunately, her friend knew a therapist who was able to see Mary for a brief session. Mary's friend (with Mary's permission) telephoned Adam, who picked her up from the brief therapy session and was made aware of Mary's reaction and the need to be attentive to her over the next few days until the next session.

Post-trauma reactions

Mary began to have very disturbing dreams. In addition, she began to have very mixed feelings towards Adam—sometimes fearful of him and at other times feeling strong anger towards him. She said both types of feeling were unjustified, as Adam had been a wonderful partner. The therapy sessions that followed were interspersed with the recall of incidents of sexual abuse as a child and young adolescent. In brief, Mary was abused by a step-uncle from the age of seven until she was sixteen. The abuse involved digital manipulation, intercourse and later performing oral sex on her step-uncle. Mary had had an unspecified history of unease when she started dating. In her late adolescence, she had been a disturbed young woman who had been treated for several different disorders. Her behaviour had settled down when her parents and step-uncle had moved interstate. It was soon after this that she met Adam.

Treatment and recovery

The treatment of this type of complex trauma is itself a complex process. Mary's experience has at its heart one of the most destructive betrayals of trust possible. Mary had been betrayed from within her own family. There was therefore nowhere that was safe. The construction of the self that is facilitated by the reflected appraisals early in her life were infused with her being used as an object for the sexual gratification of her step-uncle. Her understanding of herself was very distorted. Many such survivors feel they must please others, or

alternatively they are highly reactive and untrusting. This oscillation is often very problematic in adolescence. Mary's situation is also common in that survivors of CSA are often misdiagnosed by the helping professions (medical and psychological), and may have experienced a long list of treatments for essentially non-existent disorders (see Wastell 1996). The current labile presentation is also part of the recovery process. Once the situation starts to become clear, the reactions of the survivor to the CSA are often those of rage directed at the people close to them. Mary's anger towards Adam fits this pattern. It is likely that Mary will experience anger at her mother and rage at her step-uncle during the process of treatment. The keys to Mary's treatment are the creation of a healing relationship, the experience of a safe environment (both generally and in therapy) and the generation of as complete a story as is possible given the timeframe of the incidents and any other structural limitations.

Recovery is a complex individual process for each survivor. Mary now has to connect with Adam in a revised way. Therapy will enable Mary to mourn what she has lost and to reconstruct her self-structure so that she both understands and accepts herself. The role of future relationships is very important for survivors of CSA, as it is here that they truly experience that connectedness that is the clearest evidence that the abuser could not ultimately destroy them; this is proof that they have overcome the sense of worthlessness and self-deprecation so common to survivors of CSA.

Analysis

Mary's recall in therapy and her early warning signs when the subject of children moved beyond the settling of arrangements are important indicators of the role of emotion processes as signals (see Table 5.2). This is one of the major problems for complex abuse cases. Emotions often lose their signal quality.

Recommendation

Mary's treatment through the stages appropriate to a survivor of CSA will be similar to Matt's, except that there may be more of a need to involve group survivor therapy to facilitate integration back into society. CSA is a very isolating form of trauma in that the betrayal robs the survivor of the sanctuary of the home and family. There is thus a strong need to supplement treatment with some form of therapeutic family.

Table 5.2 Analysis of Mary's trauma

Behaviour	Trauma phase	Emotion processes
Very disturbing references	Outcry	The initial response by Mary to the information she gathered is very similar to a muffled outcry. She is aware at a non-conscious level that there is danger present, but she is not clear what that is. Mary is different to Matt, as her initial disturbance is not the result of a clearly threatening incident but of the accessing of past experience by an indirect route that is in itself of a positive nature.
Nightmares of being chased	Intrusion	The occurrence of nightmares is very common and is evidence that the psyche is dealing with a heightened arousal level. Mary's psyche is either trying to account for the arousal with a plausible explanation, or the arousal accesses actual experiences. Either is possible and will be a matter for exploration in therapy.
Cold sweat	Intrusion	Clearly there is a great deal of physiological arousal. This indicates how much the system is now activated. This may be a reflection of her experience during the CSA or a product of her experience of remembering the CSA now. Again, this would be a matter for exploration during the therapy.
Anger towards Adam	Working through	The expression of anger towards Adam is important from the point of view of working through. The process of revising self and other schemas requires the accessing of the emotions so that they can be assigned to the appropriate schema and therefore dealt with in an empowering manner. Whilst it may seem unfair on Adam, it is nevertheless a common part of therapy.

Case study 5.3: A case of marital captivity with physical violence—Madge

The rise of awareness of the violence that occurs within the family is one of the most contentious areas in trauma theory and treatment. Women and

children are the majority of survivors of this blight on the social fabric of our society. Others affected include the elderly and, to a very small extent, men. Herman (1992) and others have identified this problem as a form of trauma involving coercion and control. Herman describes this form of complex trauma as 'domestic captivity' (1992a, p. 74). The context for these survivors is one of social amnesia, blindness and ostracism. The role of the therapist is often one of witnessing the horror that has occurred. There is also often, for these survivors, a sense of guilt where they have assisted the perpetrator to carry out actions that have harmed other family members.

Life context

Madge has been married to Ralf for about twelve years. Their early courtship was intense, with Ralf being attentive and complimentary. He often stated how very much in love he was with Madge. They have two children, a boy aged eight and a girl aged ten. Ralf works as a highly paid professional who is seen as a pillar of society. Madge does not work and has no friends outside the immediate family.

The incident

The police were called to the family home by Madge's ten-year-old daughter, who was scared by her father's violent outburst against her mother. When the police arrived, they found Madge with severe bruising about her head and a cut above her left eye. She was dazed and unable to speak coherently. Ralf was standing holding on to the children as the police entered. The police separated Ralf from the children. One officer took the children into another room away from Ralf, who was left with the other officer. The police had been told that it was a young girl who had called in. The police called for paramedics to treat and transport Madge to hospital. From records at the local hospital, it was ascertained that Madge had been admitted on several occasions for various injuries over the years. All of them had been attributed to clumsiness or accident. The police charged Ralf with assault. Madge was seen by a social worker, and she and the children moved out of the family home into a shelter. Madge began treatment at the shelter.

Post-trauma reactions

The experience of Madge is one of captivity and control. She had been isolated from her family of origin and prevented from forming any

meaningful social relationships outside the family. During therapy, Madge revealed that her relationship with Ralf had started out very well but that early on he had resorted to aggressive behaviour to get his way. Her initial reaction was numbed disbelief. Her family and her commitment to stay in the marriage had influenced her to stay. Once the children were born, the situation became worse. Ralf would criticise and belittle her. Eventually he would hit her, and over the last year or so the violence was getting to the stage where she needed hospital treatment. She reported that her reaction during the beatings was one of detachment. She described herself as being outside her body, watching it happen to ‘someone’ else. She had got to the stage where she feared for her life. In fact, her daughter had called the police this time after hearing Madge call out ‘don’t, please don’t kill me’. Her fear for her own life was reinforced as Ralf began to hurt the children. Madge was now concerned that Ralf might harm the children, or even accidentally kill them. The story of her experience was littered with self-loathing, confusion and self-blame. Madge will experience bouts of fear as she attempts to extricate herself and the children from this dysfunctional and threatening relationship.

Treatment and recovery

Madge’s treatment will be long and similar to that for other complex trauma. The need for safety—both psychological and physical—will be paramount in the beginning. Such cases as Madge’s are often cyclical, with returns to the family home and the perpetrator a frequent occurrence. The main focus of treatment is to unshackle the survivor from psychological domination by the perpetrator. The effects of domestic captivity are wide-ranging, but in essence the survivor sees themselves as under the control of the perpetrator. Returns to the family home are part of the survivor’s inability to see themselves as separate and capable of surviving apart from their relationship with the perpetrator. Madge seems to have come to a very important realisation about the threat the perpetrator poses to the lives of both herself and the children. The support needed to break away from the relationship may have to take precedence over the broader therapy aims of survivor recovery and the working through necessary to allow her to move on to self-acceptance or new relationships, as the case may be.

Analysis

One of the most important features of Madge’s case is the reactions she displayed to the violence (see Table 5.3). Clearly an assault outside of

Table 5.3 Analysis of Madge's trauma

Behaviour	Trauma phase	Emotion processes
Unable to speak coherently	Outcry	The effects of the physical beating on the emotion system would be to overload it. Provided there had been no neurological damage, the incoherent speech is consistent with the over-activation of the limbic system, which means that Madge's memory of the assault will be fragmentary and hence easier to dismiss.
Detachment	Denial	The process of dissociation in captivity trauma is critical for the person to survive. Madge's reactions enable her to psychologically survive, but at the price of further vulnerability to attack.
Feared for her life	Outcry	The emotion system in survivors of captivity violence still functions. In cases such as Madge's, she can still recognise the threat the violence poses, especially when it is directed towards her children.
Self-loathing	Denial	This form of emotion process is not strictly about the life-preserving aspects of the emotion system. However, it does illustrate that Madge could still attach emotional valence to her cognitive evaluations.
Bouts of fear	Working through	The emotion processes will be essential for Madge to really be psychologically free of Ralf. His control over her is, in a very real sense, a result of being able to shut down Madge's self-preservative emotion responses. The reactivation of this system will from time to time mean that Madge will find herself confronted by strong fear and rage as she explores the trauma. These are important reactions which need to be integrated for Madge's therapy to be effective.

marriage is very much a circumscribed trauma. The processes outlined by Horowitz's model (1997) would be highly likely. The emotion processes would take place as described in Chapter 4. However, Madge—like the majority of people in such cases of violent captivity—utilises dissociation as a mechanism to survive the repeated attacks. This is essentially an

emotion-suppression technique, which renders the horror of the attacks as though it was an illusion. As such, it can be dismissed and in many cases the survivors report that, to them, memories of the violence were outweighed by the memories of the 'good times'.

Recommendation

Madge's treatment will be cyclical and progressive. She has come to realise the threat Ralf poses. This, along with social and family of origin support, will enable her to work through the issues resulting from this traumatic experience.

Summary

The role of emotion in self-preservation is a central theme for all the survivors of complex trauma. It is seen more clearly in survivors of combat, but is present in survivors of domestic violence and child sexual assault. The emotions assist the individual to split off some aspect of their self so that there remains some part that is protected. This splitting process is discussed further in Chapter 7, which looks at dissociation. The case of Madge is a good illustration of the role of emotion. Madge's emotional connection to her children ultimately led her to seek help, once she perceived that Ralf was a threat to them. This role of emotion in terms of broader social connection is often overlooked in other approaches. The theme of all three case illustrations is the long-term nature of treatment. A self which is defined under traumatic conditions must be essentially rebuilt so that both the world view and emotion modulation can be reset to make life in less traumatic circumstances more appropriate. The problems associated with hyper-vigilance are often more to do with their setting than their absolute existence. In the jungle, it is entirely adaptive to be responsive to every cracking twig, but it is not adaptive in the backyard playing with one's children. The emotional consequences of trauma treatment for the survivors are considerable. The caveat concerning phase-appropriate interventions applies to all trauma treatment. The emotional impact of conducting trauma treatment on therapists, emergency services and medial professionals is also considerable and is the topic of the next chapter.

6 | THE TRAUMA THERAPIST AND THEIR EMOTIONS

Working with trauma survivors is an emotionally draining enterprise. Therapists, emergency services and medical professionals have long known this, but relatively little systematic attention was paid to the issue until the early 1990s. A central and significant issue for therapists is that of sustaining an empathic connection to survivors. Two concepts are covered in this chapter. The first is vicarious traumatisation. This term is used in the sense of focusing on the trauma-like symptoms that can develop in trauma therapists as a result of hearing the terrible stories of their client's traumatisation. The second is counter-transference. While the term has its origins in psychoanalytic theory, it is used in a broader sense here to refer to the expectations the therapist has of the survivor that meet the needs or self-perceptions of the therapist and are not evident in the actual therapeutic relationship. I comment on both these situations from the emotion focused approach, including an examination of how useful such reactions are in providing an insight into the emotions of both the therapist and the survivor.

The impact of witnessing trauma has a long and at times controversial history. The concepts discussed in this chapter have had periods of acceptance and rejection in their relatively short history. The recognition that a person could be traumatised by hearing about harm to a loved one (from DSM III—[APA 1980] onwards) has been accepted as a legitimate traumatic incident. The role of emergency services personnel (ESP) in both the rescue and triage phases of disaster and accident response has been recognised as exposing these personnel to potentially traumatising experiences.

However, the contribution and effectiveness of debriefing and defusing for both ESP and survivors of trauma has come under scrutiny and question in recent times (Raphael et al. 1995). Whatever the actual nature of the role of debriefing, exposure to the trauma experienced by those whom one assists following the event cannot help but have an impact. To hear and ultimately to witness the horrifying experiences recounted by survivors leaves its mark on those who attempt to care, either through their physical activities (e.g. rescue personnel) or their therapeutic endeavours (e.g. therapists and medical practitioners). This chapter will explore these issues from an emotion theory perspective.

Therapist self-care

Capacity for sustained empathy

An essential element of therapy is the capacity for sustained empathy. While certain approaches to therapy would try to deny the term 'empathy', the concept of a close working or therapeutic alliance is accepted by all major approaches to psychological treatment (Safran and Muran 1998). The concept of a therapeutic alliance has at its very foundation the ability of the therapist to understand the client as an individual, who is clearly separate from the therapist. As treatment unfolds, empathic strain occurs which makes it difficult to stay closely attuned to the dynamics of the client. The literature of therapeutic alliances points out that such strain is normal, and provides an opportunity to deepen the alliance by examining the strain and clarifying the problems that led to it. However, left unaddressed, loss of an empathic stance may result in severe disruptions and possibly lead to a complete breakdown in therapeutic effectiveness.

Disruptions to the therapeutic relationship

Some of the common problems that occur in the case of disruptions to the therapeutic relationship are:

- cessation of treatment;
- fixation within a phase of recovery;
- intensification of problem-specific transference;
- regression; and
- acting out behaviours.

Trauma and therapist self-care

The retelling of horrific events by survivors is a powerful experience for any therapist. Staying empathically attuned can be extremely difficult. Therapists may invoke (voluntarily or not) defences in order to contain and bind their own distress. The crucial issue for therapist self-care is to recognise the problems with empathic attunement and respond to the need for self-protection in a manner that does not result in a complete disruption to the therapeutic alliance.

Factors in therapist responses to survivor material

The personal and situational factors that affect any particular therapist vary greatly. The following represent a selection of the most common:

- types of affect experienced by the therapist;
- defences used by the survivor;
- coping modes of the survivor;
- management of role boundaries; and
- theoretical rationalisation.

The theoretical orientation of the therapist can play a very important role in the recognition of empathic strain and other therapeutic relationship disruptions. From an emotion perspective, theoretical differences are irrelevant, as the emotion system should not be treated as subservient to rationalisation processes. Trauma therapists will be impacted upon by the very nature of the work they do. This means that all such therapists need to pay close attention to the bodily processes associated with emotion reactions so that they can recognise and utilise these signs if and when they occur.

The remainder of this chapter will examine two common trauma therapist experiences: vicarious traumatisation; and counter-transference reactions.

Vicarious traumatisation (VT)

The term 'vicarious traumatisation' was first used in 1990 by McCann and Pearlman (1990b; see also Pearlman and Saakvitne

1995) to describe the development of a syndrome in therapists of incest survivors. The concept has been expanded to all those who work at one degree of separation from the traumatic incident. Thus ESP may be either directly traumatised by witnessing the horror scene itself, or they may suffer VT by hearing about the traumatic event from the survivor while undertaking their duties (e.g. a paramedic transporting a distressed child and mother). The early work in this area focused on the traumatisation of therapists that resulted from listening to stories of abuse and witnessing the horror of these survivors. However, VT is now seen to potentially occur to any ‘helper’ who hears stories of traumatic events.

It is important to emphasise that VT is different from:

- burnout, which is general lack of reward;
- counter-transference, which relates to therapists’ own psychological issues—either concerning family of origin or intrapsychic; and
- compassion fatigue, the emotional exhaustion of working in a demanding environment.

These aspects of therapist development and workplace constraints affect all therapists, and thus are more general. The specific context which gives rise to VT is an intense environment where stories of traumatisation constitute the majority of the work encountered.

Therapist VT

While VT can occur to any member of the helping community exposed to stories of traumatisation, the effects on therapists of hearing the recounting of sexual and physical abuse of children requires special mention. The attitude that the vast majority of helping professionals hold toward the protection of children is very strongly one of care and nurturance. The stories recounted by adult survivors of child sexual and physical abuse cannot be described as anything less than mind-shatteringly horrific. To hear of sexual abuse where the child is so objectified that they become used to the point of physical damage is potentially soul-destroying. This is compounded by the lies and deceit of the perpetrator to keep the abuse from being revealed. Such actions as threatening the child with harm or warning that great harm

will befall loved ones of the child if they tell are examples of the great power and essential evil of such actions.

The effect on therapists of such a process is potentially the development of a kind of traumatisation. It is important to emphasise that the occurrence of VT can take place in therapists who have never personally been abused as either children or adults. This is an important distinction. In many therapeutic services for survivors of childhood abuse, fellow survivors often take up the role of therapists—both trained and certified, and on a voluntary basis. This group of therapists is, in my judgment, in a different category with respect to VT than non-abused therapists. More will be said about this group when discussing countertransference.

Within the therapeutic community, a realisation gradually dawned that many therapists were showing signs of trauma symptoms. These therapists were observed to:

- have nightmares;
- become hyper-vigilant;
- experience flashbacks;
- avoid emotion both in themselves and in others;
- become aggressive and display anger more generally; and
- develop increasing cynicism.

Those who supervise trauma therapists who work in child-focused agencies and those who work in agencies that deal with adult survivors are aware that their therapists can grow more negatively reactive to their clients' situations, and so become more adversarial in their actions and therapy. This often seems to run parallel to their clients' experiences (see Neumann and Gamble 1995). Their news of difference value can decline.

The pattern of the development of VT seemed to follow a sequence related to increased exposure to both the number and the level of horror in the survivors' stories. It is now recognised that VT is a cumulative process. In novice trauma therapists, VT appears in the form of intrusions (Neumann and Gamble 1995). The less experienced and often younger therapists display symptoms of nightmares, flashbacks and a heightened level of physiological arousal. More seasoned trauma therapists tend to show VT in distorted beliefs about others, emotional distance and other numbing type processes. The overall effect within an agency

is to diminish the effectiveness of the therapists, due to the level of effort required to deal with their own reactions. This may take the form of therapists treating their clients as they themselves need to be treated. These therapists will constrain the therapeutic encounter so that they are able to maintain their own equilibrium. This is not a deliberate manipulation of their clients, but comes about from the need to contain their reactions and to prevent themselves being overwhelmed by their trauma reactions.

In my view, VT can be conceptualised as an osmotic form of Terr's Type 2 trauma or the DSM IV (APA 1994) as an instance of DESNOS symptomatology. The cumulative impact of hearing these horrific stories erodes and reshapes the world view of the therapist. Over time, therapists lose hope. It is important to remember that many therapists enter this work with a positive view of people and a very strong desire to help. This is based on the belief that it is possible to help—that they can make a difference. Working with children is especially infused with these beliefs and hopes. The recounting by survivors of their stories exposes these therapists to the very dark side of human beings. The effect is to gradually alter the therapist's self-schema and their schema of the goodness of the world. Janoff-Bulman (1985, 1992) describes the concept of world assumptions. This theory (Janoff-Bulman 1985) is representative of a group of approaches to trauma that emphasises the centrality of survivor's understanding of their world. Essentially, it asserts that people hold assumptions about the nature of the world and the 'rules' that control it. Janoff-Bulman (1985) notes that survivors of trauma have had three important assumptions destroyed. These are:

- personal invulnerability;
- the world is a meaningful place (i.e. predictable); and
- the self is viewed positively.

The destruction of these assumptions results in uncertainty and an ever-present raised level of anxiety or hyper-vigilance. These symptoms are characteristic of trauma survivors. However, as has been noted, they are also evident in therapists who have developed VT. The self is not viewed positively and the world that the therapist thought they could control—that is, make a difference in—seems to be unstoppable and overwhelmingly destructive. This may also be reinforced by survivors whose recovery is either

much slower than expected or fails to take place, thus confronting the therapists with their own limitations. The basis of VT is the fact that, once a therapist hears of the horror in the world, they can't go back. The stories of horror, once heard, are never forgotten. The growth of therapists beyond this realisation is one of the most important goals of supervision.

Trauma therapists need to continually ask themselves two questions in the light of their experience with survivors:

- What attracted them initially to working with trauma survivors?
- What keeps them in this work?

These questions may have different answers. The second one requires the therapist to examine their level of functioning as well as the clarity of their focus on the needs of survivors. Therapists who are suffering from VT are like anyone else: they are trying to survive a traumatic context, one that is continual and reinforced by each client. The ability to respond appropriately to survivors' needs is critical both for the treatment of the survivor and for the health and well-being of the therapist. Realising that one is harming survivors is a terrible revelation for any therapist, let alone those who treat some of the most wronged individuals in our society.

Vicarious traumatisation: Signs and symptoms

The following checklists cover the most common signs of VT as it is currently covered in the literature. As with all such lists, it is important to recognise the individualistic nature of such situations. Therapists may not display these signs, but may nevertheless have a form of VT. The key element is the impact the survivor's stories are having on the therapist and the resultant psychological pattern.

Individual signs and symptoms

- *Intrusive imagery, nightmares.* Therapists may not be aware of this and their partners, if they have one, need to be listened to for indications of their occurrence.
- *Shift towards a negative world view.* Discussions around the staff lounge area are important opportunities to detect this sign.

- *Disrupted beliefs and relationships.* The occurrence of relationship problems is potentially the result of emotional withdrawal which can be a result of VT. Therapists' work is stressful to be sure, but relationship breakups need to be explored lest the VT origin of the problems goes undetected.
- *Trouble managing emotions.* The emphasis of this book is on emotions, and this area in VT is a good example of the emotion system's role in response to trauma. Emotions are alerts. Therapists suffering from VT will have heightened emotions and no clear object to be alerted about. The focus of their heightened state is diffuse. The emotion 'spillages' are important indicators that this system is possibly more activated than necessary; and
- *Difficulty making decisions.* The inability to make decisions is one of the hallmarks of a person who is cognitively impaired in the sense that they are either distracted or their emotion system—so important in making decisions—is focused somewhere other than the decisions of the moment (see Damasio 1994, 1999).

Systemic indicators

The workplace behaviour of VT-affected therapists will ultimately be less effective than otherwise. Management of this problem requires the early detection of staff performance problems within a supportive framework of response. It is important to remember that it is not the fault of a weak therapist that they develop VT. The very nature of the work itself impacts on decent, caring human beings. To be impervious to the horror is to be robot-like—such a person would hardly be a good candidate for conducting empathic therapy. The performance indicators for an organisation include:

- widespread cynicism;
- increased illness;
- ethical/boundary violations;
- lowered motivation/productivity; and
- higher staff turnover.

Contributing factors

The context in which treatment of trauma survivors takes place is more than the organised setting. The list below divides the

contributing factors into three groups. The first two have already been touched on. The third—that is, the wider context—is also a major contributing factor.

- nature of the clientele/work;
- nature of the therapist; and
- nature of the cultural/political context.

The history of society's response to trauma survivors, at least in the West, has been less than exemplary. The periodic amnesia that Herman (1992) refers to has been most evident in the areas of trauma such as child abuse, domestic violence and war veterans. Therapists can't help but be affected by the dominant social perspective to the trauma field in which they work. Working with trauma survivors is difficult, but to work in an area where the general view is one of doubt or derision is to make the situation more difficult and therefore more demanding on the therapist.

Redressing the effects of VT

The responsibility for detecting and dealing with the impact of VT on therapists lies mostly with organisational management, or with the supervision group and its leader for lone therapists. Therapists themselves can only be expected to deal with their personal psychological experience to some degree. It is management's responsibility to ensure the highest quality of service delivery. Survivors of trauma must not be left in a situation where management bickers about who is responsible for monitoring the quality of service provided. It is, of course, appropriate for therapists to take responsibility for their response once problems like VT have been identified, but that does not mean management should avoid its primary responsibility to the survivors. The concept that clients are somehow the property of the therapist is one that I reject. Real commitment to client welfare means that a therapist must place themselves under the scrutiny of their supervisors, a supervision group or management.

In order to carry out this responsibility, management, supervisors and therapists need to commit to a monitoring and intervention program that focuses on detecting and addressing problems like VT early and with full commitment. The following represents an outline of such a policy.

Periodically utilise self-assessment tools

Assessment instruments are often greeted with scepticism and their use viewed as anathema by many therapists. I would assert that the use of these instruments—particularly those developed by therapists who work in the area of trauma survivor treatment—is concrete evidence that the most important consideration of the therapist and the organisation they work for is the welfare of the survivors. Such use shows that therapists are not willing to leave the detection of VT to chance within the organisation.

Preventing VT

The therapist's responsibility for preventing VT comes down to being committed to a self-care program that includes a high degree of self-monitoring. The breadth of outside activity and involvements is a good indicator that a therapist sees themselves as more than just a trauma therapist. Life must be broader than the job. Remember that one of the major problems for trauma survivors is withdrawal from social life. This is also a real problem for the VT-affected therapist. In summary, to help reduce the occurrence of VT, a therapist needs:

- awareness of their own needs, limits, emotions and resources;
- balance among life activities; and
- a connection to themselves, others and something larger.

Addressing VT

Once VT is detected, the therapist must undertake to act to restore their connection with themselves, family and friends, work colleagues and the wider community. The actual program of activity will be tailored to meet the individual's situation and needs, but the ingredients will include many of the following:

- self-care via:
 - reconnecting with their body through such things as exercise or massage;
 - setting limits, particularly on being helpful;
 - practising healthy habits, especially sleep and nutrition;
 - making connection to something/someone beyond themselves a priority;
- self-nurturance through:
 - seeking gentleness;

- focusing on pleasure;
- relaxation, play, love; and
- escape by:
 - getting away from work, especially mentally;
 - engaging in fantasy and positive imagination;
 - maximising opportunities for pleasant feelings.

Transforming VT

VT can easily return, due to the cumulative nature of its occurrence. Therapists in general, and especially those who have experienced VT directly, must be active in the prevention of VT. The beliefs and assumptions that a therapist lives by must be actively engaged so that the horror the therapist encounters in the workplace does not become the dominant focus of their whole life. Connection with self and others is something trauma therapists must actively pursue. The following are some important ways to transform VT:

- Challenge negative beliefs;
- Participate in community-building activities;
- Infuse current activity with meaning; and
- Follow a passion.

Specific recommendations

These recommendations are designed to enable a therapist who has some concern about the possibility of VT in their therapeutic practice to undertake pre-emptive action to avoid such problems. Therapists need to be on guard constantly regarding VT. The route for the impact of VT is substantially through the non-verbal pathways of the emotion system and the assimilation of gradual change in therapists' assumptive worlds. Therapists will rarely be confronted with noticeable instances where they are aware that a VT process has taken place. The following are also applicable for any therapist who wants to be better enabled to perform their therapeutic task:

- Give/receive supervision for oneself and for others.
- Exert control over client load. This is often difficult in over-worked, under-staffed agencies.
- Establish a variety of tasks and clients.
- Participate in professional development. This an ongoing lifetime pursuit as a professional therapist.

- Seek collegial support. Do not just wait for it to happen—seek it out.
- Find/create forums to address VT. Raising the issue for staff discussion is one way to bring VT to the forefront of people's thinking.
- Ask for appropriate resources and do not accept responsibility for making up for poor resourcing. The under-resourced organisation can end up abrogating its responsibility if therapists try to take on a workload that is self-harmful. This is part of the therapist's self-myth of having to care for everyone.
- Personal space and rewarding relationships are paramount, not optional. The form of these relationships is certainly a matter for personal orientations, but it is part and parcel of staying connected with the wider social world in a focused and committed way. Generally, for relationships to be rewarding, they must involve reciprocal valuing and caring.

Case study 6.1: Vicarious traumatisation of a rape crisis counsellor—Betty

The role of rape crisis counsellor is one of the most demanding in human services work. Often the survivor is still in the throes of rage and can exhibit strong anger at many around them. Other survivors are in a state of numbed shock. These people are often very quiet to mute, which makes helping them very difficult. The attacks that constitute sexual assault can, and often are, very violent, degrading and physically damaging. The question of disease in these cases is also very prominent. The experience of a rape crisis counsellor can thus be very demanding and emotionally exhausting. This can also be exacerbated by the shift work context, depending on the employment requirements for the crisis service. The exposure to the stories of brutal treatment and psychological harm is the context for the development of vicarious traumatisation in this case.

Life context

Betty works in a rape crisis team attached to a major suburban hospital. She is required to work one Saturday night a month, as this is the night of the week when a substantial number of incidents always take place. Betty is 28 years old and is a registered social worker. She has been a

counsellor for six years and has worked on the rape team for three and a half years. Betty is not married, nor is she cohabiting, but she has a caring and loving family of origin.

The incident

One Saturday night, a young woman aged in her early twenties was brought into the hospital by the police, who indicated that she had been raped by at least two men and possibly more. She had been physically assaulted, with multiple bruises and possibly a fractured skull. The men were believed to be involved in illicit drug activity in the area. Betty was on call and attended the hospital as required. After the young woman had been medically examined and treated for her bruises, Betty had a brief conversation with her about the service and what to expect in terms of possible reactions after the assault. Betty was struck by the similarities between herself and the young woman in terms of age, family background and even taste in clothes. The young woman was admitted to the hospital for observation due to a suspected fractured skull.

On the way home, Betty started to shake. She found herself in a rush to get to her home. Once there, she quickly went inside. She was highly sensitive to the slightest noise. That night she found herself unable to sleep for any length of time. When she did sleep, she had dreams of being chased by some unspecified threat. She had a similar restless night on Sunday. Betty went to work the following Monday tired from her restless nights.

Her manager noticed that Betty had been called out to the hospital and observed her less than rested look. She asked Betty to come into her office.

Vicarious trauma reactions

In her manager's office, Betty began to recount the call-out to the young woman at the hospital. As she did so, she began to shake slightly. Betty tried to control this, but her manager noticed it and fed back the observation. Betty felt tears welling up and went silent. Her manager talked about the impact of working in a rape crisis team and the problems associated with hearing the terrible stories. Betty said she remembered the seminars on vicarious traumatisation but didn't think it could happen to her. Betty's manager said it could happen to any therapist. Betty then recounted her restless nights and what she could of the nightmares.

Treatment

Betty's manager had assisted other members of her staff to deal with such reactions, and decided to take a mentor and facilitator role for Betty. If Betty's reactions deteriorated, she would recommend some therapy for Betty. The manager and Betty met regularly over the next few months to talk about Betty's reactions. During these meetings, it became clear that Betty had been having trauma-like reactions for the past year or so, though at very low intensity. Her trust in people generally, and of males in particular, had diminished, along with her confidence that she was making a difference.

Analysis

Betty shows the signs of VT as they tend to manifest in a relatively new trauma therapist (see Table 6.1). She has intrusive reactions that are finally brought to her awareness with the young woman in the hospital. Though in Betty's case there are several similarities between her and the young woman rape survivor, it is not always the case that such similarities will be involved in the surfacing of the trauma-like reactions in a therapist.

Recommendation

Betty's manager is a good example of a proactive supervisor who knows about the problems associated with VT. The manager acts to intervene and to support her colleague. The manager also realises that monitoring alone is not enough. She meets regularly with Betty to discuss VT and also realises that if Betty does not improve then there may be a need to recommend therapy.

Counter-transference

The concept of transference is mostly associated with the work of psychodynamically orientated therapists. The concept brings to the fore the phenomenon of the client acting toward their therapist in a manner inconsistent with the actual relationship that has developed. It is not necessary to subscribe to the theory of psychoanalysis to be able to recognise and benefit from the insights available from the observations that have been developed under the concept of transference. In therapy with trauma survivors, the

Table 6.1 Analysis of Betty's VT

Behaviour	Trauma phase	Emotion processes
Struck by similarities	Outcry	The recognition of the similarities between Betty and the young woman has an impact on Betty. The impact is in some ways equivalent to the trauma event. Betty's emotion system registers the connection to the woman and hence to her trauma. This is Betty's conscious registration of a trauma awareness.
Began to shake	Intrusion	The trauma realisation brings with it the activation of the emotion system. The shaking is typical of the post-exertion stages of adrenalin release.
Sensitive to the slightest noise	Hyper-vigilance	The heightened physiological arousal is consistent with the effects of intrusions. Survivors' alarm/protection processes stay active.
Nightmares	Intrusion	The dream consists of an image of being chased. The content of such dreams varies quite considerably, but the theme is generally of a threat to safety and/or existence.
Restless nights	Intrusion	The inability to sleep is both problematic and beneficial. Therapists who are aware that such a disturbance is potentially indicative of VT are in a much better position to use the information to seek assistance, though of course this is not always the response.

transference of the client toward the therapist may generate in the therapist their own transference reaction to the client. This is generally known as counter-transference (CT).

In the case of trauma therapy, transference can involve the therapist being treated as though they were the perpetrator of the trauma. In the case of trauma that has resulted from the direct malicious acts of other human beings (e.g. sexual abuse, domestic violence or physical assault), the survivor may impute powers of control or harmful intentions that were originally attributed to the actual perpetrator on to the therapist. This can be a very disturbing experience for any therapist, but especially for new therapists. Such an imputation can strike at the very heart of the

therapist's self-concept as someone who cares and wishes to empower all survivors. Yet, in some senses, there is a possibility that therapists do want to exercise control over others—even if it is the perpetrators of traumatic acts. Thus counter-transference can be a powerful experience that may touch deep-seated personal issues for the therapist. In addition, the transference reactions of survivors may draw the therapist into a role that is part of their 'hidden' self-concept (e.g. fellow survivor). Counter-transference reactions (CTR) are thus often very powerful insights into aspects of the therapist's psyche that need to be treated seriously. CTR must not be dismissed as inaccurate distortions of the therapeutic relationship. The above discussion assumes that there is an entirely appropriate therapeutic relationship in existence between the survivor and the therapist. If this is not the case, then the situation is compounded by malpractice and is therefore more complicated again.

Inevitability of counter-transference reactions

One of the most clinically wise writers of the twentieth century, Donald Winnicott (1949, 1960, 1972), asserts that counter-transference reactions are inevitable in psychotherapy generally. I would add that they are also inevitable in the treatment of survivors of trauma. The powerful emotions that are central to trauma will lead to an emotion-charged form of therapy. Any therapist dealing with the events that surround trauma will have strong emotions, even if they are not aware of them. Survivors will feel vulnerable with their therapists and so their transference on to the therapists will contain elements of strong reactions to their fear of harm and death. These strong transferences cannot help but bring up strong CTR in therapists.

There are three elements of CTR. They are the constituents of CTR, the role enactments in CTR and the appearance of the various elements within the course of treatment for trauma.

Constituent elements of CTR

The three constituent elements of CTR are:

- *Affect reactions.* The emotions that are part of CTR are often very strong. They are in part a reflection of the strong emotions

of the survivor's own experience. They are also part of the reaction of the therapist to hearing the material, as well as having to contain the strong emotions for both the survivor and the therapist themselves. The actual emotions experienced will be highly variable, but a common one is guilt;

- *Cognitive elements.* As with other processes in therapy, the ability to imagine scenarios is part of the CTR. In this case, the ideas that are imagined can lead to a variety of reactions and processes. Therapists may find themselves fantasising about the survivor, the perpetrator and themselves. The cognitive distortions are very powerfully influenced by the strong emotions, both for associative connections with the fantasy narratives that are generated and for the process of therapy in general; and
- *Action dispositions.* One of the crucial elements of CTR when treating trauma survivors is the theme of the therapist taking action—for example, taking on the role of rescuer. This can have very serious consequences for the conduct of the therapy.

Role enactments

Role enactments are a key element of CTRs. The therapist is impelled to do/be something. These roles are a product of the context of the survivor and the therapist, both at a phenomenal level and at a fantasy level. There are two orientations in these role enactments, positive and negative.

Positive role enactments

Positive role enactments are those roles that both the survivor and the therapist would identify as being of benefit to the survivor. The benefit could either be psychological or physical—or indeed both. A common one is the role of being a fellow sufferer. This role addresses a range of survivor experience. The therapist is thus imagined as being better able to understand the survivor because they truly know what it's like to go through this.

Negative role enactments

Negative role enactments bring to the fore a part of the survivor's situation that is both threatening and painful. This role may be empowering to the therapist. If this occurs, then the therapy is in real danger of being an experience of further traumatisation for the survivor. For example, if the therapist takes on the role of

hostile judge—albeit unconsciously—then the survivor may be treated as someone who is guilty, and therefore as somehow deserving of their experience of trauma.

Occurrence of CTR within the therapeutic process

The occurrence of CTRs tends to follow a parallel pattern with the focus and tone of the transference. For this reason, positive CTRs tend to appear early in therapy while the transference material is also positive. As the therapy progresses, negative CTRs are more likely to occur. This is due to the depth of material treated and the lessening defensive posture of the survivor. This is a general pattern and is not meant to be prescriptive. It is important to realise that the connection to the material of the transference is the important feature. If negative transference material occurs early, then so may negative CTR.

Types of CTRs

There are several ways to describe CTRs. The approach of Wilson and Lindy (1994) is one that recognises the importance of two broad dimensions. The first is the degree to which the therapist either over-identifies or the therapist avoids identification with their client. This identification dimension is central to the process of CTRs. The second dimension is the degree to which the CTR is either generalised as normative or personalised to the therapist. The therapist who adopts an avoidance posture is said to be experiencing a Type I CTR. The therapist who adopts an over-identification posture is said to be experiencing a Type II CTR.

Vantage point approach

Another way to approach CTR is from the perspective of a particular vantage point. This means that the CTR represents the view of a particular person or aspect of the intrapsychic element of the survivor within the survivor's social and psychological context. The focus is the vantage point for the search for, and creation of meaning out of, the traumatic situation. These positions can be identified with particular persons or viewpoints—either real or imagined. This falls into two broad categories:

- *Concordant CTR*. The therapist identifies with element(s) of the client’s situation. Therapists identify with some aspect of the survivor’s plight (Wilson and Lindy 1994, p. 11);
- *Complementary CTR*. The therapist’s vantage point is that of some other person (e.g. a parent). The plight of the survivor is viewed from a vantage point that is separate from the survivor’s.

The combination of the two dimensions produces a pattern of therapist CTRs that helps to identify the reactions from the behaviours of the therapists rather than from theoretical grounds or an analysis of case notes (see Figure 6.1). The advantage of this is that management and therapists themselves can more readily identify their CTRs, and so lessen their impact on therapy.

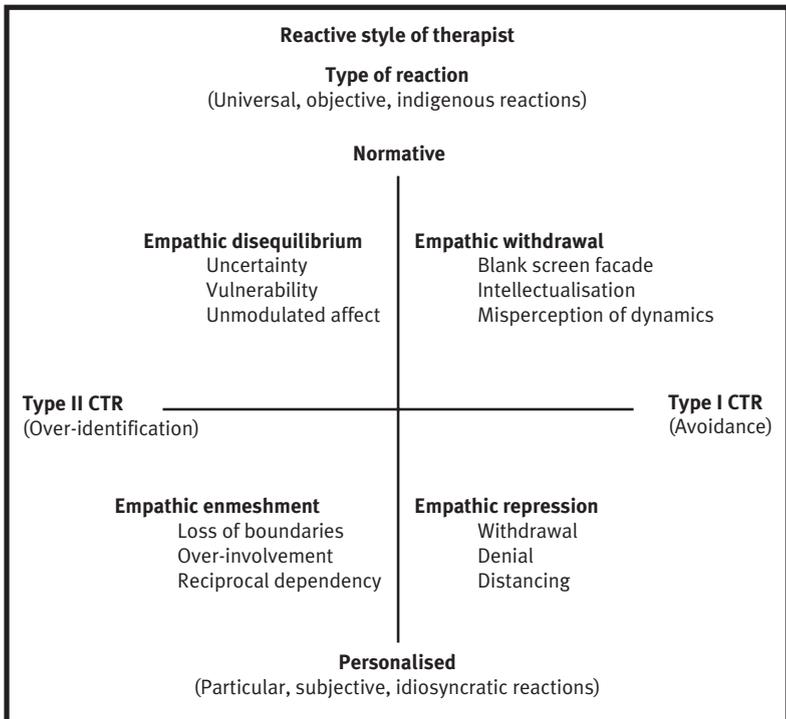


Figure 6.1 Modes of empathic strain in counter-transference reactions (CTRs) (Wilson and Lindy 1994, p. 15)

Case study 6.2: Therapist counter-transference reactions—Byron

The occurrence of counter-transference is inevitable, if we are to agree with Winnicott (1949, 1960, 1972). Survivors do have an inevitable impact on therapists, and much of this impact will be in the form of counter-transference reactions.

Life context

Byron is a 40-year-old therapist who has worked with a range of clients including those who have been traumatised. He has treated many clients with a range of clinical disorders, and utilises a psychodynamically informed approach, although he would not call himself a classical psychoanalyst. Byron is happily married and is in a stable work and social context.

The incident

Byron has been treating a female survivor for about three months with weekly sessions. The client, Belinda, has had a history of childhood sexual and physical abuse. She is presently in a stable relationship with a man ten years older than herself. She does not have any children of her own or living in her care. Recently she has requested a change to her arrangements for the therapy. She requested that the time be changed so that they could meet much earlier in the day, at about 7.30 a.m. This was much earlier than Byron was used to, but he agreed. After another few weeks, Belinda requested that the therapy fee be changed as she was having difficulty meeting the cost. Again Byron agreed reluctantly. The final feature for our consideration was the reporting in therapy of sexual feelings towards Byron by Belinda. By itself, this is not an unusual occurrence.

CTR reactions

The therapeutic relationship in this case was showing signs of a strong CTR component. Byron was experiencing strong dysphoric emotions toward his client. He was having to manage these emotions and try to meet the client's requests. He did not want to appear to be repeating the pattern of abuse from Belinda's childhood. His ability to be empathic was diminished, as he was aware in sessions of feelings of his anger rather

than concentrating on Belinda's material. Overall, Belinda's demands had created the situation in therapy that paralleled her experience in her family of origin.

Treatment

During supervision, Byron reported that he was feeling somewhat aggressive toward Belinda—not sexualised, but more of a punitive quality. Byron was also feeling angry toward Belinda. This was disturbing him more than the punitive thoughts.

Analysis

Byron, in his attempt not to repeat the family of origin situation in therapy for Belinda, had resulted in his emotional reactions being closer to a punishing parent than he had realised (see Table 6.2). The role of supervision in such an intense form of therapy is very important for detecting such problems as CTR before they do significant harm. Supervision is thus designed to positively seek to explore potential CTRs.

Table 6.2 Analysis of Byron's CTR

Behaviour	CTR element	Emotion processes
But he agreed	Positive role enactment	The role of emotions as signals is seen here in Byron's reaction. There is a sense of this being not quite right, yet Byron agrees to the changes. The emotion system is a good rapid detector of changes that may be harmful.
Feeling aggressive	Negative role enactment	The emergence and recognition of a clearly identified feeling state—that is, aggression—is important. From a CTR perspective, this emotion is an indicator of the feeling that is located somewhere in the therapeutic process—either as a parallel with the abuser or with the client as a form of repressed reaction to the therapy process. Either way, the emotion needs to be examined.
Punitive quality	Negative role enactment	The fact that Byron's feeling has this quality would lead me to investigate the extent to which he was now experiencing the role of possible abuser in the therapy.

Table 6.2 Analysis of Byron's CTR (continued)

Behaviour	CTR element	Emotion processes
Not sexualised	Empathic withdrawal via intellectualisation	<p>He had been pressured and was now wanting to punish Belinda. The emotion is thus again a good indicator of the therapeutic process.</p> <p>This denial of sexual content may be accurate, but for Byron to initiate such an assertion may indicate that there is an issue with sexual transference and his CTR to it. This absence of an emotion illustrates the need to pay attention to the possible gestalt of the emotions, not merely to those that are present.</p>

Recommendation

Byron has chosen to discuss this situation in supervision, and so presented himself for collegial and professional scrutiny. This is critical for quality assurance in long-term depth-orientated therapy. Byron's situation illustrates the need for a therapist to constantly monitor their reaction to their clients. CTRs can and do develop slowly, and may not be detectable by the therapist until they have done considerable damage. Byron is aiming to use his professional commitment to gain insights into the therapy from the CTR, which is both healthy and appropriate.

Emotions and identifying CTR issues

The relationship of emotion to CTR is complex, and at the same time very important for an accurate understanding of the use of CTR in therapy. Wilson and Lindy (1994, p. 71) have outlined (see Figure 6.2) a relationship between emotion and CTR that indicates that, as therapists move beyond the shame associated with the experience of CTR, it is the emotions that point to the most likely type of problems that will develop in the therapy.

Issues associated with a loss of professional boundary, loss of empathic function and symptom formation can be traced back to the emotion that is experienced by the therapist. This taxonomy of Wilson and Lindy (1994) is very useful for therapists and their

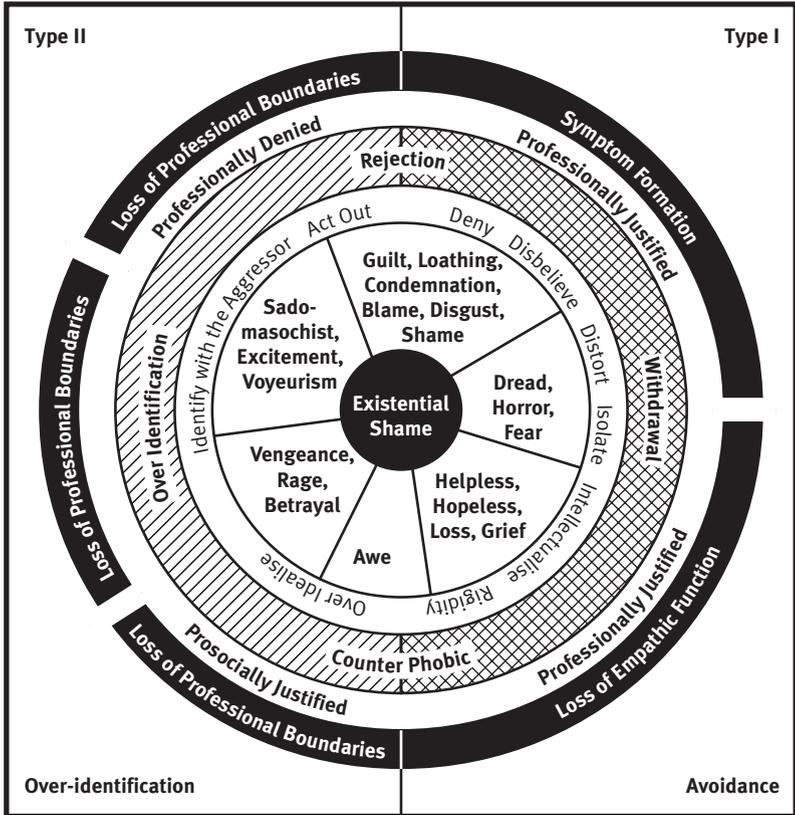


Figure 6.2 Layering of elements in CTR (Wilson and Lindy 1994, p. 71)

supervisors. The rationalisations and confusions that often accompany CTR can be addressed using a knowledge of the emotion experienced. Clear identification of the emotion can facilitate appropriate responses to CTR.

Summary

At first glance, the topics covered in this chapter may appear somewhat disconnected. However, they are very important aspects of the therapeutic context: the emotion processes that occur between therapist and survivor. The impact of survivor emotions on the therapists is considerable, and it is all too

often overlooked. This impact can result in therapists forming reactions that are potentially disruptive to treatment. The development of trauma-like symptoms is obviously problematic. A therapist who has not been traumatised yet has hyper-vigilance reactions is going to be weary and unresponsive to their survivor-client's needs. Therapists who are reacting out of their counter-transferential mindset will likewise be less than optimally responsive to their clients. Both of these situations are, however, potentially very potent aids for effective therapy. This potency can only be realised if the emotion signals that the therapist experiences are recognised and incorporated into the therapy. This requires therapists to adopt an emotion-focused approach to both themselves and therapy. The recognition and utilisation of coherent self-focused emotions is the theme of the next chapter, which deals with dissociative phenomena.

7 | TRAUMATIC DISSOCIATION

The focus of this chapter is the role of emotion in self-definition and healthy human functioning. Through examining the nature of self and self-defining memories, the role of emotion in these two processes is highlighted. The phenomenon of dissociation is then explored, and an emotion-focused perspective developed. The history of the study of dissociation and the study of trauma are linked both at the beginning of the modern period in such exponents as Janet and in the most recent writings of van der Kolk and others. The positive role of dissociation and the negative adaptive aspects of its overuse as a result of trauma are outlined. I also comment on the role of dissociation in such conditions as Dissociative Identity Disorder and Borderline Personality Disorder. In essence, this chapter focuses on the role of emotion in constructing a coherent self- and life-narrative and looks at how this is disrupted when dissociation is used as a psychological defence in trauma.

The nature of the relationship between trauma and emotion is such that there are several topics which at first glance may appear unrelated, but in fact are closely intertwined. These topics are the self, dissociation and the role of dissociation in modulating the experiences of trauma. Each of these topics is examined in terms of the emotion processes associated with it, and then described in terms of the important connection between dissociation, the self and trauma.

The self

Defining the self

There are many theories that chart the emergence of a self-concept in humans (Baumeister 1998; Kohut 1977; Epstein 1991, 1994). Definitions of the self abound and are much debated. I would agree with Baumeister (1998, pp. 680–1) that there are three central elements to defining the self as a psychological concept. They are:

- reflexive consciousness—humans are aware of their existence;
- interpersonal connectivity—humans are essentially social creatures who seek out and connect to others; and
- executive function and agency—humans are the source of action, appropriate to their cultural heritage.

Each of these elements is critical to the functioning of a person in terms of the psychological actions and processes that are observed, and indeed expected, of adults in Western society. These elements also apply to other cultures, but are defined in terms of the beliefs and behaviours that are sanctioned in those particular cultures (Nisbett 2003).

Mahoney (1991, p. 236) notes that in Western psychology the concept of a ‘self system is now being recognised as a powerful moderator of all aspects of learning and development’. This role is important from early in a child’s life. Mahoney also sees a critical role for the self in organising the coherency of experience. This is brought about by the ‘lifelong self (“organizing”) processes, which are fundamentally embodied and experiential. From the constructivist perspective, intense emotions are powerful allies in and expressions of the individual’s past and unfolding development’ (Mahoney 1991, p. 240). This observation is an important one: the organising role of the self is facilitated by emotion; any disruption to the emotion processes will thus have effects on the coherency of the self-formation.

Nearly all theories of the self assert that a person’s self-concept is a crucial aspect of healthy development and functioning. Most children develop a relatively healthy sense of self. But if the formation of a self is severely disrupted, then one of the possible outcomes is the development of a personality disorder. One of the

best known is Borderline Personality Disorder (BPD) (Wastell 1992, 1993b). One of the hallmarks of BPD is the difficulty of modulating emotions and the subsequent lability of emotions, especially as experienced in relationships. Indeed, in many societies—both East and West—the ability to modulate one’s emotions is seen as central to being a well-adjusted person. The ability to modulate emotions is a critical aspect of self-protection and social interactions for, as Mahoney (1991, p. 246) comments, at ‘the psychological level, the lifelong becoming of a human self is complexly interpersonal and intrapersonal’.

Emergence of the self

The concept of a differentiated self plays a pivotal role in theories of self-development. Questions such as when a separate sense of self emerges and how this can be observed are of great importance to developmental psychologists. A great deal of research has been done on this topic. One of the most influential models is that proposed by Daniel Stern (1985). Stern’s model of self-development alerts us to a critical period around eighteen to 36 months when the verbal and then narrative ‘selves’ emerge. This personalised sense of self is able to be differentiated from others and from the environment. One of my favourite illustrations of this is the dot on the nose observation. Place a small child in front of a mirror with a red dot on her nose and see what she does. Under about 24 months, the child will try to pull the red dot off the ‘baby in the mirror’. After this period, the child automatically picks the red dot off her own nose. The interpretation of this behaviour is that the child after about 24 months ‘knows’ it is herself that she is seeing with the red dot on her nose.

The self that emerges over time is dependent on a number of factors such as temperament, physical limitations, medical conditions and the activity of significant adults (e.g. grandparents). Figure 7.1 outlines the sequence of ‘selves’ that Stern (1985) postulates are developed over the first three years of life. I do not intend to debate the merits of all aspects of the model; I simply wish to emphasise that it postulates a sequence of the emergence of different elements of the total self. These ‘selves’ that Stern (1985) postulates are a symbolic of the emergence of a functioning person. From the intertwined and incorporated state of the

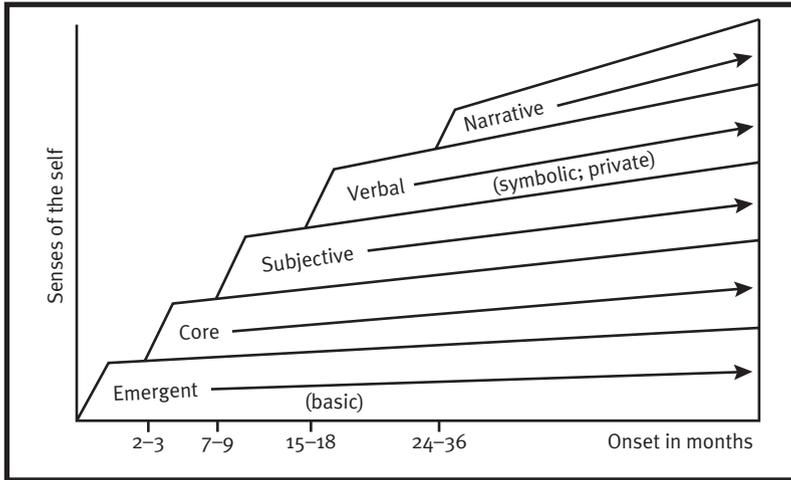


Figure 7.1 Development of the sense of self (Basch 1992, p. 36)

newborn there emerges a separate person who can articulate their experience of life as they ‘know’ it.

The role of emotion in self-structure consolidation

Modern studies (e.g. Magai and McFadden 1995) have established emotion processes as being fundamental to motivation. One of emotion’s primary roles is to direct attention and to prioritise action, especially in the area of survival and social situations. The development of emotion awareness, and hence refinement of the ability to direct one’s attention, requires the differentiation of generalised emotion or affect responses into more fine-grained emotion evaluations. This process of differentiation emerges over the first few years of life.

Figure 7.2 illustrates the timeframe for the differentiation of emotions from a general hedonic quality of positive/pleasant or negative/aversive evaluation through to the ability, by two or three years of age, to be able to distinguish shame from anger and surprise from love. These differentiations are extremely important for the development of appropriate human relationships. This progress presupposes a healthy and nurturing environment.

The models of self-emergence and emotion development

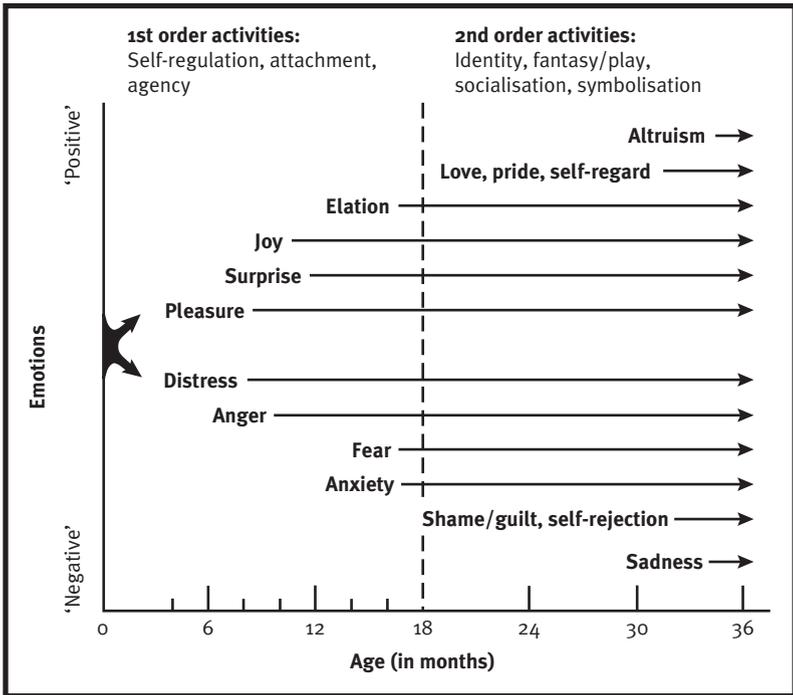


Figure 7.2 Emotion differentiation by age (Mahoney 1991, p. 165)

presented by Stern (1985) and Mahoney (1991) can together be used to outline the conjunction of emotion and self-development in the early years. Two observations stand out:

- The emergence of the 'subjective self' (nine to fifteen months) occurs in the same period as the emergence of identified negative (e.g. anger) and positive (e.g. surprise) emotions. The sense of self as subject is closely associated with emotion differentiation and the ability to sense difference in the emotion experience, with particular reference to self or 'internal' experience.
- The development of a 'narrative self' (24–36 months) occurs in the same period as the development of emotions associated with explicit connection to others. Shame is about rejection by others, while love and pride are about positive connection to others. The narrative self is active at the time when interactions with others at an emotional level are developing in many

diverse ways with a broadening range of emotions as part of the experience. The narrative that is generated can therefore be populated with more fine-grained and differentiated emotions.

The interrelationship of emotion and self-development is an important issue for the material covered in this chapter.

Time and self-identity

Once a sense of a separate self has developed, a 'narrative self' begins to emerge. This self has the ability to tell a life story, and so there arises the issue of the coherency of the story over time. Singer and Salovey (1993, p. 48) have asserted that there are three selves in time:

- the remembered self—memories of significant past events involving oneself;
- the present self—the present evaluation and conceptualisation of the self; and
- the desired self—the self that is hoped for (future-orientated).

These three selves unite past present and future into the coherent narrative or life story. The total self has a store of memories and evaluations associated with each of these time-referenced selves. These memories of the self remain due to their affective/emotional intensity. It is to memory and the self we now turn.

Memory and the self

There are two primary categories of memory and the self: autobiographical and self-defining memory. These categories overlap to a large extent, but have very significant distinguishing features that require discussion.

Autobiographical memory

This form of memory is essentially built around a life story, or narrative. The creation of a personal narrative is central to the establishment of an identity (McAdam 1989; Tomkins 1981). This narrative consists of salient and significant scenes that form the core of one's sense of self and place in the world. Autobiographical memory is a store of events and their evaluations that together make up a coherent life-defining narrative.

Self-defining memories

The scenes in autobiographical memory are called ‘self-defining memories’ (SDM) (Singer and Salovey 1993, p. 4). These scenes have special significance in defining the core elements of a person’s identity. SDM have five characteristics:

- *Affect intensity.* Singer and Salovey (1993) note that SDM are impassioned—that is, these memories have deep and strong emotions attached to them. It is these intense emotions that join the narrative, or SDM, together.
- *Vividness.* When these memories appear in consciousness, they are experienced as extremely vivid. They are often experienced as though the person is reliving the event to some extent.
- *Repetition.* These memories always seem to be with you. They are not episodic. They are easily recalled and, in the right social circumstances, recounted with sensed clarity.
- *Linkage to similar memories.* These memories also have the feature of rapid and strong connective associations to other SDM. This has the effect of what Tomkins (1981) calls psychological magnification. The process of recalling these memories in sequences reinforces the subsequent and previous memories such that the whole cluster of memories is experienced as beyond dispute.
- *Enduring concern or unresolved conflict.* Negative SDM are organised around an enduring concern or unresolved conflict. The role of this cluster in self-definition is possibly one of focusing on distressing aspects of the self-concept with the purpose of resolving the situation.

Good enough development and self-defining memories

In the course of average expectable nurturance by good enough caregivers (I borrow the concept from Donald Winnicott [1972]), a person develops a personal narrative consisting of a large number of SDM. These SDM consist of scenes involving intimacy, acceptance, competency/success, failures and limitations. The overall effect of these SDM is to create an individual’s identity which is rooted in their experience of their social world. The basic tenor of these memories sets the level of such variables as self-esteem/self-worth, as well as the felt sense of self-efficacy.

The normal sense of self and a store of ‘good enough’ memories

are the fundamental components for the development of a healthy psyche. If this process of gathering a coherent set of SDM is disrupted, then the formation of a healthy self is also disrupted. Disruption may occur due to illness, family tragedy, child abuse or a range of other terrible events. These events may interfere with the development of a sufficient number (idiosyncratically defined) of good events to bring about an overall positive self-concept. The adaptive capacity of human beings is such that processes—or defences, if you like—will be used to preserve the psychological integrity of the person. This is a general process, and is not limited to any particular age range or developmental level. Children often defend against psychological harm by the use of dissociation. Before I turn to the concept of dissociation and how it impacts on the process of self-concept development, I need to explore the concept of memory in trauma.

Trauma, memory and coping

This book has largely followed a definition of trauma developed by Horowitz (1997) and others that has emphasised the shock and outrage that impact on survivors. Another definition of trauma is ‘an inescapable stressful event that overwhelms people’s existing coping mechanisms’ (van der Kolk 1996, p. 279). This definition is appropriate to the present discussion as it emphasises the coping mechanisms. I would assert that the emotion system is crucial to the coping process. The state that follows a traumatic experience is of extreme hyper-arousal. This hyper-arousal is what Janet called ‘vehement emotion’ (quoted in van der Kolk et al. 1996, p. 309). The memory process associated with this hyper-arousal is a very important concept in our understanding of both the phenomenon and treatment of trauma.

Traumatic memory in adults

For information to be stored in long-term memory, the hippocampus must be engaged at the time of learning. The hippocampus is the main connection between the limbic system and the neocortex. High-level activation of the amygdala inhibits the operation of the hippocampus (see LeDoux 1998, Ch. 9).

Affect storms, as they are known, inhibit the categorisation and elaboration of stimuli. This process may be a way of allowing the brain and associated systems to concentrate on survival actions without being distracted by higher order thinking processes. Humans react rapidly, and then attempt to sort out what happened. The process of understanding what happened comes after—generally at a time of safety or during a lull in the action (Damasio 1999). Thus memory for trauma is often fragmentary. However, provided the trauma is circumscribed, the adult with an intact self-system will be able to integrate the event, even if it is by a process of narrative construction based on incomplete memories and gathered material (e.g. from witnesses).

Memory for trauma and Terr's two types of trauma in adults

Terr's trauma types have already been mentioned. Type 1 trauma is produced by one sudden external blow that renders the person temporarily helpless. The stress created breaks past ordinary coping and defensive operations and creates terrifying emotional experiences. Type 2 trauma is most often associated with captivity/war, domestic violence and child abuse. The traumatic events here became part of the total life experience of the survivor. Their social and physical worlds are permeated by heightened arousal with threats to personal and psychological integrity.

Memory in type 1 trauma

The result of these terrifying emotions is that the personal memories of the event(s) become split off. This is often experienced as a phobia of memory. The survivor undergoes a 'form of continuous and retrograde amnesia' (van der Kolk et al. 1996, p. 309). These split-off memories need to be integrated into a personal narrative, otherwise they continue to intrude as terrifying perceptions and somatic re-experiences. The traumatic event potentially becomes a SDM which may disrupt other SDM due to the intensity of the emotions associated with the event. Treatment (Horowitz 1997) involves processes of recall and integration into one's personal narrative.

Memory in type 2 trauma

Memory for type 2 trauma in adults is similar to that of type 1. There are fragments coupled with emotions that are distressing.

These memories are often tinged with guilt about participation (e.g. war action or collusion in abuse situations). The process for an adult is a cyclic one, as outlined in Chapter 5. This is the situation for individuals who were adults when the trauma started. For individuals who were children when the chronic trauma started, the situation is much more complicated and convoluted.

Traumatic abuse as experienced by a child

The effects of type 1 trauma on children should not be underestimated or minimised. Surviving terrible events such as automobile accidents and natural disasters (e.g. an earthquake) will require assistance and in many cases treatment. However, the situation for children who are subjected to chronic or type 2 trauma is significantly different. These children will have their basic self-structure defined in terms of the abuse. This will fundamentally alter their understanding of themselves and their interactions with both the social and physical worlds.

For children, complex experiences are associated with trauma. The intensity of the physiological arousal is an important element of a traumatic experience. This bodily experience alone is fear-invoking for children.

When children think about their physical integrity, the focus is on the fear of the harm that they imagine will be done to them. They use defences that deal with the fantasised level of threat. This creates a situation where a child defends against an elaborated trauma situation that is thus not easily amenable to 'logical refutation'.

Developmental impact

There are five main impacts of chronic trauma on the psychological and physical development of children. These effects have far-reaching implications for the sense of self that a traumatised child will develop. They are:

- *Failure in social referencing and alarm reactions.* As children develop, they gradually acquire a sense of what they need to be alarmed about. This is gained across a range of social and physical experiences. Gradually the child is able to distinguish those aspects of their existence requiring a response that is characterised as being 'alarmed'. The abused child is in an

environment where situations that should be protective and supportive, and therefore not alarming, are in fact extremely distressing. The social reference aspect of the development of alarm schema is in fact alarming. The child therefore cannot develop an adaptive alarm system as there is no safe base upon which to build it. The basis of the alarm reaction is the emotion system. This system has been over-active for the abused child, so the child cannot use heightened arousal as a signal.

- *Inability to resist coercive violation.* One of the benefits of a cohesive and resilient self is the ability to resist coercion. Children who have not developed such a self are vulnerable to coercion. They are unable to resist due to the absence of a safe system from which to experience the confidence of the exercise of such resistance. Abusive adults use children and do not respect the child's right to self-determination and a sense of agency.
- *Betrayal of basic affiliative assumptions.* The assumption of a good enough environment that all children deserve is shattered in the situation of an abused child. Their social and physical world is a very unsafe place. They are particularly unsafe in the interpersonal realm. The basic betrayal carried out by family or close intimates of the family is extremely damaging. The people who are essential for their survival are also either responsible for, or perpetrators of, these terrible actions. The affiliative world is thus malfunctioning and threatening.
- *Failure of emerging emotions as protective signals.* The role of emotions as danger signals is compromised by abuse. Within abusive situations, emotions do not perform the protective and supportive function for the child that they do in non-abusive situations. The child experiences emotions as intertwined with the abuse. The emotions that they either feel or, less often, express serve no protective function. They are simply part of the abuse. These emotions are also the things that often come back to haunt the child in dreams or flashbacks.
- *Sense of resignation about ability to protect oneself.* One of the hallmarks of children who have unresolved experiences of trauma is a foreshortened future. This is often shown in the child's sense of having no idealised future. That is, the child does not live in a world of possibilities but is only able to think in the present—and that is not a very hopeful present either. In the case of abused children, the world is a place that exerts

control over the child. This is experienced by the child as an inability to protect themselves. The abused child comes to 'accept' their abused situation. They are therefore often compliant. This is one of the characteristics that often confuses members of the general public. They can't fathom why the child did not 'fight' the abuser. While such a reaction is understandable, it fails to give appropriate weight to the psychological factors that inhibit a child's response to abuse—particularly intra-familial abuse.

Summary: The effects of repeated traumatising on children

Repeated traumatising (Terr's type 2) includes child abuse, famine and war. The child's developing self is deprived both of normal attachment security and the modulation of emotions. The child is exposed to unrestrained vehement emotions, in Janet's terms (van der Kolk and van der Hart, 1989). They experience these emotions as inescapable, so they are in a state of overstimulation and arousal. The question is how children survive such environments. For that matter, how do adults survive such chronic traumatic environments? Dissociation provides an important perspective on surviving trauma.

Dissociation

Definition

Dissociation is a psychological process whereby parts of a person's experience are kept out of conscious awareness. Van der Kolk et al. (1996) describe dissociation as 'a way of organizing information' and later observe that dissociation 'refers to a compartmentalisation of experience' (1996, p. 306). It is this compartmentalisation that is the key to understanding dissociation.

History

The concept of dissociation is, to say the least, controversial in both the popular and professional literatures. It was Charcot in France in the 1880s who made famous the study of 'dissociative'

phenomena. He was renowned for his ‘demonstrations’ of dissociation. His work was both populist and scientific, and deserves to be recognised as pioneering in its own way. He influenced both Freud and Janet.

Janet’s work

As mentioned in Chapter 1, the work of Janet is significant in terms of his careful documentation and conceptualisation of the process of dissociation. Janet made the connection between dissociative psychopathology and trauma. He pioneered hypnotic and abreactive treatment techniques to recover and rework the material he termed, the ‘traumatic memory of an unassimilated event’ (quoted in Putnam 1989b, p. 414).

Dissociative continuum

Modern studies of dissociation have established that dissociative phenomena range from common daydreaming through psychogenic amnesia to full Dissociative Identity Disorder (DID). Investigations using the Dissociative Experiences Scale (DES) (Bernstein and Putnam 1986) have shown that dissociative ability is a skewed distribution in both general populations and samples of psychiatric patients. Figure 7.3 shows the Dissociative Experiences Scale scores for a range of groups. The groups include a number of psychological disorders such as sufferers of phobia (PHOB), organic brain syndrome (OBS) and sufferers of schizophrenia (SCH). There are also a number of non-pathological groups including normal people (NORM), adolescents (ADOL), and sufferers of the medial condition of epilepsy (EPIL). The two groups at the right of the figure are of most interest for our present discussion. Those with Dissociative Identity Disorder (formerly known as multiple personality disorder, or MPD) and survivors of PTSD have relatively high scores on the DES. The fact that such a diverse collection of groups display dissociative features should be taken to indicate that dissociation is a part of human information processing and not only a psychopathological process. As well, the high scores for PTSD and DID (MPD) indicate that dissociation is a potentially prominent feature of these two psychological conditions.

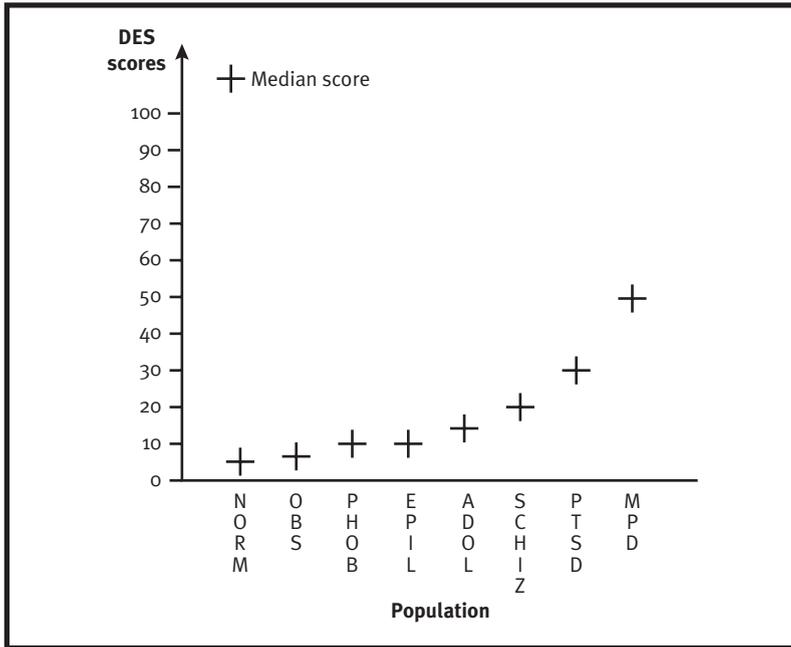


Figure 7.3 Dissociation scores across groups (adapted from Putnam 1989a, p. 11)

Pathological dissociation

Hilgard (1973, p. 406) asserted that 'daily life is full of many small dissociations'. The concept of dissociation as a normal process requires that we recognise the adaptive function of compartmentalisation. Its purpose under minimal or no-stress conditions seems to be a kind of cognitive resting mode. Events go on, but there is little attention necessary to enable these activities to be undertaken. Under conditions of extreme stress, the purpose of dissociation is to prevent the person from being overwhelmed by strong emotions.

So when does dissociation become a problematic process for individuals and/or society? Nemiah (1981) has posited two principles:

- The person experiences a significant alteration in her sense of identity (e.g. in psychogenic amnesia a person cannot remember self-referential material such as 'name').

- The person manifests disturbance of memory (e.g. amnesia for events whilst in the dissociative state).

The most extreme form of psychopathology associated with dissociation is Dissociative Identity Disorder (DID).

Dissociative Identity Disorder

The development of Dissociative Identity Disorder has been the subject of much research and clinical investigation, as well as the subject of motion pictures—for example, *Sybil* starring Sally Field and Joanne Woodward (Lorimar Productions 1976). The sufferers of this disorder develop multiple identities or, in the older terminology, ‘personalities’. The ‘alters’, as they are referred to, have distinct characteristics, including vocal qualities, personal histories and often mannerisms that are highly specialised, including characteristic emotion states. As Altrocchi (1998, p. 408) observes, ‘each alter has a very limited range of emotions and a particular set of personally central emotions’. The set of characteristics is segmented, and one alter may not know of the existence of the other(s). This compartmentalisation is both protective and problematic.

Dissociation, psychopathology and surviving trauma

The relationship between Post Traumatic Stress Disorder (PTSD) and Dissociative Identity Disorder (DID) is presently much debated. Spiegel et al. (1994) assert that dissociative reactions play a central role in responses to trauma. Although PTSD is included as an anxiety disorder in the DSM IV TR (APA 1994), most of the symptoms listed have a dissociative flavour—for example, intrusive recollections, flashbacks, nightmares, emotional numbing, feelings of isolation and detachment (Speigel et al. 1988). At the symptom level, there seems to be a clear relationship between PTSD and DID. Indeed, transient dissociation is a very common reaction to traumatic events (Petridis 2002).

A common defence used by children who are regularly subjected to sexual abuse is trance dissociation, in which their bodies go numb or they are just ‘not there’ (Milne 1993). Depersonalisation can occur in any internal or external sensory mode, manifesting symptoms specific to that state (Ross et al. 1991).

Women whose experience of abuse was in latency (life stage before puberty) rarely resort to massive repression; instead, they seem to use a combination of partial repression, dissociation and intellectualisation (Herman and Schatzow 1987). The move from transient dissociation to DID is well summed up by Altrocchi (1998, p. 409) when he states that: 'Automatic dissociation can be triggered by an overwhelming trauma but it is believed that what produce and maintain separated alters are repeated, overwhelming traumas.' In fact, the two symptoms most predictive of an abuse history are dissociation and somatisation (Briere and Runtz 1988). Dissociative responses to trauma include depersonalisation, derealisation, stupor, numbing and amnesia for the traumatic event(s) (Speigel et al. 1994). Disturbances in time, memory, concentration and senses are widely reported (Shengold 1989).

Dissociation and the 'self/selves'

Gaps in the life story: Amnesia and fugues

Amnesia is defined in the DSM IV as an 'inability to recall important personal information . . . that is too extensive to be explained by ordinary forgetfulness' (APA 1994, p. 477). A Fugue is defined as a 'sudden, unexpected travel away from home or one's customary place of work, accompanied by an inability to recall one's past . . .' (APA, 1994, p. 477). Both of these definitions focus on disruptions to the memory of one's actions and experience. Herman and Schatzow (1987) note that women from latency onward [and men] experiencing traumatic events such as rape utilise these forms of 'partial dissociation'. Amnesia and fugues are examples of partial dissociation used to deal with the overwhelming emotions generated in trauma. The origins of these processes may lie in the individual's ability to dissociate under stressful conditions. If an individual is capable of such a defence, then they preserve their psychological integrity by compartmentalising and containing the event out of their conscious registration. The dissociated events thus do not become part of the process of modification to an individual's sense and definition of themselves. They cannot become part of the self-defining memory or, more importantly, part of the autobiographical memory. These processes thus isolate the person from negative and destructive aspects that are often associated with traumatic events.

However, these dissociative processes create gaps in the

personal narrative. If the gaps are only minor and do not cause disquiet to the individual, then the person may dismiss them as forgetfulness. However, they can become a problem through either self-reflection (e.g. realising there are gaps in one's life) or social consequences (e.g. being accused of some action for which the person has no memory or explanation). The experience of the gaps can become very distressing, leading to concerns over one's mental health. But they are not experienced as major dissections of the life story.

Multiple identities occupying the one body

The history of the diagnosis of Dissociative Identity Disorder is both complicated and controversial. Popular books such as *Sybil* (Schreiber 1973), the story of a woman with DID and her treatment, have further complicated the issues surrounding the disorder. It is not my intention to examine the controversy or the populist approach to this disorder. I accept that there is such a phenomenon as multiple selves, whether described as personalities or identities. The advantage of such an acceptance is that the process of dissociation, and its relationship to trauma and emotion, can be explored from a unique vantage point.

The definition used in the DSM IV of Dissociative Identity Disorder is 'the presence of two or more distinct identities or personality states that recurrently take control of the individual's behavior accompanied by an inability to recall important personal information' (APA 1994, p. 477). This definition captures two of the most important aspects of DID: control and memory. Persons with DID exhibit behaviours that are often contradictory to observers. The behaviours are initially adaptive, but eventually they become disquieting to the person themselves.

Dissociation, DID and trauma: compelling evidence

Putnam's (1989) analysis of 100 cases of Multiple Personality Disorder (DID), found that 97 per cent had experienced traumatic events whilst over 80 per cent had been sexually abused in childhood (1989, pp. 47–8). Based on this evidence, it can be asserted that the vast majority of those persons who display dissociative identity processes have been subjected to trauma in the formative years of their life. The elaboration and construction of a life narrative has therefore been greatly disrupted for these individuals. The presence of vehement emotions which are not modulated

by the primary or associated caregivers become destructive of identity coherency. The metaphor is one of vertical divisions within the life story. Memory is compartmentalised. In the case of repeated abuse, the child aggregates scenes around a self, the definition of which is drawn from the manner of their treatment. The emotions generated by the abuse are the key to the development of the 'alters'.

The formation of the new identity as protective process

The onset of terrifying or vehement emotions results in the formation of a new protective identity. The process is one of enabling the individual to survive by containing the emotions and experiences through associating them with the separate identity. The self-defining memory is attached to this identity, and so kept separate from the core identity. Figure 7.4 presents a pictorial way of conceptualising this process. The three cardinal aspects of DID are represented as the axes of the diagram. They are the degree of experienced emotion dysregulation, dissociative ability and level of threat. The speckled surface of the diagram should be viewed as a set of potential memory fields of the identity. Moving around the surface can be thought of as life review via association of events and the person's part in those events. Line L1 represents a person with minimal to low dissociative ability. As this person experiences threat, they will be aware of their rising emotions. They will have a coherent memory of the experience that may or may not form part of their self-defining memory set. Line L2 represents someone who has considerable dissociative ability. When they are put under threat, they are initially less aware of emotion problems. But at point P1 they may experience a complete break with their memory of the experience. This may represent the onset of a fugue. Point P2 is where the reinterpreted set of SDM cluster around a dissociated state. As the threat increases, the dissociative process contains the emotion. The fact that this is a movement upward should not be interpreted as indicating any form of improvement. If this dissociative process were to occur infrequently, then a substantial fugue state may result. For individuals who are subjected to repeated high-level threat, the development of a DID state may be the result. For the individual who traverses L1, there is a coherent memory of their reactions and the totality of their experience. For the individual

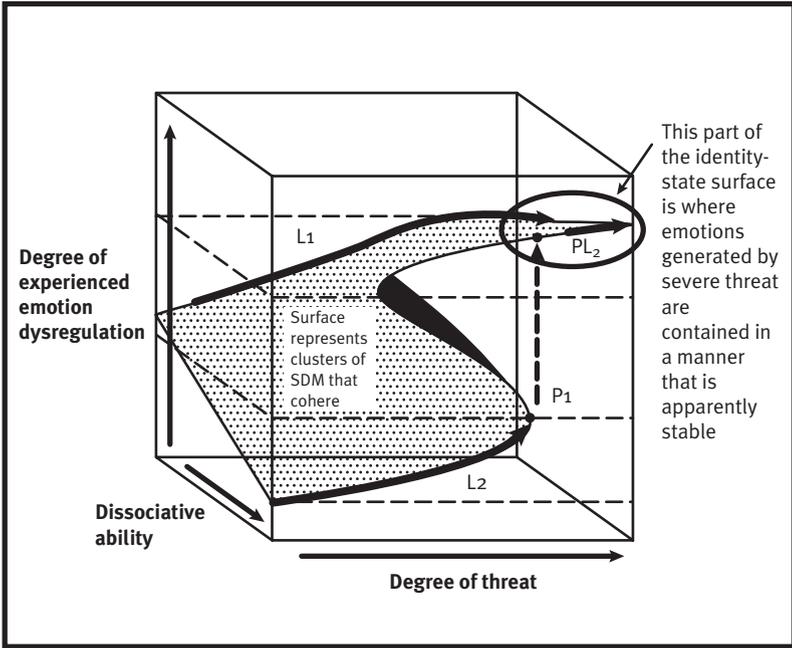


Figure 7.4 Pictorial representation of dissociative processes and identity formation using a catastrophe model (see Sashin 1985)

who traverses L2, there is a break in the memory of the experience at P1 as pertaining to one individual. Through therapy or other means, they may eventually recall the experience elements after point P2, but the dissociation that has taken place is their way of containing the threat of the experience of emotion dysregulation.

The emotion dysregulation is associated with strong emotions. Survivors of childhood abuse who can dissociate effectively create distance from horrific memories. Those who develop DID partition those memories off on to the lives of the various alters. The alters develop ‘personality styles’ that cope with these memories, and thus preserve the life of the whole person. The vertical barriers between memory clusters or ‘alters’ are, however, surmountable. Some alters do ‘know’ of the others. These knowing ones have the function of coordinated protection for the whole person. The role of dissociation is to isolate identity-

destructive memories away from the total or core self. By compartmentalising the abuse, the child/later adult is not swept away into psychological collapse. The question for therapists is how to change the collection of memories of abuse, and the often resultant fragmentation of the self that accompanies such memories, into a more acceptable and coherent self-defining memory set.

A comparison of memories in abusive and non-abusive contexts

The impact of traumatic abuse on the memory process can be seen clearly in Table 7.1. The table illustrates how stored memories of abuse increase the real risk of severe psychological harm by being threatened with horrific material from which there is no escape. The horror is not integrated, but simply re-terrifies when recalled.

Narrative reconstruction and emotion in trauma-induced DID

The treatment of DID consists of the gradual reconstitution of a coherent self. The aim of therapy is to assist the survivor to

Table 7.1 Self-defining memories and dissociation

Feature	Non-abusive memories	Abusive memories
Affective intensity	Strong emotions which join the narrative elements.	Vehement emotions which threaten psychic death.
Vividness	Vividness to the point of seeming re-enactment.	The reliving of the abuse is terrifying for the child.
Repetition	Memory is always with you.	Repeating such memories would drive the child/adult to deep depression/suicide.
Linkage	Magnify memory by shared content and emotion.	Magnification of already horrific material threatens their very existence.
Enduring concerns	Unresolved issues for which the person seeks resolution are based on the hope of resolution.	Memories of abuse are laced with helplessness and fear, not hope.

construct a life narrative that is whole in both time and space. This process is often long and full of cyclic progress and regress. The role of emotion in this process is critical. This chapter has emphasised that the aim of the adaptive process of dissociation is to contain 'vehement emotions'. It is these emotions that must be integrated before the self can be whole again. The treatment processes outlined in Chapter 5 are more complicated for DID trauma survivors. However, they are not dissimilar. The additional burden is on the integration of the SDM clusters into one autobiographical narrative, and hence a single identity.

What about those who can't dissociate?

I have examined in some depth the relationship between dissociation and the containment of powerful emotion states, the extreme outcome of dissociation being DID. This raises the question of children who are not able to dissociate. What is their outcome from early child abuse experiences? There is evidence (Herman et al. 1989) that, for these survivors of abuse, there is likely to be the development of either full-featured Borderline Personality Disorder (BPD) or, as Sperry (1995) notes, a borderline personality style (BPS). The central feature of both these psychological conditions for our purposes is the inability to modulate emotions, particularly within interpersonal contexts (Wastell 1992, 1993, 1996). In a sense, BPD and BPS are methods of dealing with the vehement emotions. They do this by not allowing the strong emotions to influence the self-reflective interpersonal awareness. Thus there is no shame. This lack of shame is consistent with the abuse having taken place in early childhood when this emotion was emerging from the general hedonic tone of emotional experience as outlined by Mahoney (1991) and others. BPD and BPS deal with strong emotions not by clustering the attendant SDMs around an identity, but by failing to register their impact on personality development. The emotions are so strong that they wash over the child, who fails to absorb them into their self-structure. This results in the characteristic emotional lability of BPD, where the expression of strong and often vitriolic emotions seems to pass unnoticed by the BPD person.

Summary

I began this chapter by asserting that the topics of the self, memory and dissociation could all be examined within the experience of trauma. The fundamental point is that the construction of a coherent and functioning self depends on a collection of ‘good enough’ memories of a self, primarily in relationship to others but also active in many ways to establish a sense of agency. These self-defining memories together constitute an autobiographical memory that forms a narrative of the person’s life. When experiences—especially in childhood—are dominated by powerful and threatening emotions, the young person adapts as best they can. In the case of those who have a considerable ability to dissociate, repeated experiences of childhood abuse can result in Dissociative Identity Disorder. For those who do not have this ability, then the development of Borderline Personality Disorder is likely. Both of these disorders are attempts to preserve the core being of the person. They are essentially functional from the point of view of the ultimate survival of the person. Problems arise when these coping strategies come into conflict with wider social expectations of the functioning adult. The central lesson of the material of this chapter is the attempt of the person as a child to contain the damage of extremely strong emotions. It is the strength of the emotions that calls forth these extreme survival measures. The child survives at a considerable cost, but nevertheless they do survive. This is a paradigm of the experience of trauma survivors generally. They do whatever it takes to survive, and it is often the residues of these survival processes that require therapy and other assistance.

APPENDIX A | DSM III-R CRITERIA

DSM III-R PTSD Criteria

Diagnostic criteria for 309.89 Post-traumatic Stress Disorder

- A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.
- B. The traumatic event is re-experienced in at least one of the following ways:
 - (1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
 - (2) recurrent distressing dreams of the event
 - (3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated).
 - (4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma.
- C. Persistent avoidance of stimuli associated with trauma or numbing of general responsiveness (not present before

trauma), as indicated by at least three of the following:

- (1) efforts to avoid thoughts or feelings associated with the trauma
- (2) efforts to avoid activities or situations that arouse recollections of the trauma
- (3) inability to recall an important aspect of the trauma (psychogenic amnesia)
- (4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)
- (5) feeling of detachment or estrangement from others
- (6) restricted range of affect, e.g., unable to have loving feelings
- (7) sense of a foreshortened future, e.g., does not expect to have a career, marriage, or children, or a long life

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response
- (6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

E. Duration of the disturbance of at least one month. Specify delayed onset if the onset of symptoms was at least six months after the trauma.

APPENDIX B | DSM IV TR CRITERIA

DSM IVTR PTSD Criteria

Diagnostic criteria for 309.81 Post-traumatic Stress Disorder

- A. The person has been exposed to a traumatic event in which both of the following were present:
 - (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior.
- B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
 - (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) recurrent distressing dreams of the event. **Note:** In young children, there may be frightening dreams without recognizable content.
 - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).

Note: in young children, trauma-specific re-enactment may occur.

- (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
 - (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) markedly diminished interest or participation in significant activities
 - (5) feeling detachment or estrangement from others
 - (6) restricted range of affect (e.g. unable to have loving feelings)
 - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- (1) difficulty falling or staying asleep
 - (2) irritability or outbursts of anger
 - (3) difficulty concentrating
 - (4) hypervigilance
 - (5) exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other areas of functioning.
- Specify if:
- **Acute:** if duration of symptoms is less than 3 months;
 - **Chronic:** if duration of symptoms is 3 months or more.
- Specify if:
- **With delayed onset:** if onset of symptoms is at least 6 months after the stressor.

APPENDIX C | THE ICD-10 CLASSIFICATION OF MENTAL AND BEHAVIOURAL DISORDERS

F43.1 Post-traumatic Stress Disorder

- A. The patient must have been exposed to a stressful event or situation (either short- or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.
- B. There must be persistent remembering or 'reliving' of the stressor or intrusive 'flashbacks', vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.
- C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.
- D. Either of the following must be present:
 - (1) inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor;
 - (2) persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor, shown by any two of the following:
 - (a) difficulty in falling or staying asleep;
 - (b) irritability or outbursts of anger;
 - (c) difficulty in concentrating;
 - (d) hypervigilance;

- (e) exaggerated startle response.
- E. Criteria B, C and D must all be met within 6 months of the stressful event or of the end of a period of stress. (For some purposes, onset delayed more than 6 months may be included, but this should be clearly specified.)

GLOSSARY

The glossary contains a number of specialist terms and phrases. More information on many of the terms can be found in Reber (1985) and the texts referred to in the book.

Term or phrase	Definition
Abreaction	Type of psychoanalytic treatment that involves some form of reliving or re-experiencing of traumatic event.
Active memory	Term used by Horowitz (1997) to mean memories generated by highly charged emotional experiences which then press for incorporation into current schemas.
Acute stress disorder	A brief reactive disorder of similar structure to PTSD, but of limited duration.
Adrenal system	Set of structures that release adrenalin/epinephrine and associated chemicals into the bloodstream.
Affect	This term is used to signify physiological aspects of emotion processes. These reactions are the bodily basis of emotion. Basch (1988, p. 77) emphasises that these physiological reactions do not involve reflective evaluation.
Affiliative assumptions	These include the basic elements of trust and security which are seen as essential to 'good enough' parenting, and which provide a secure base for development.
Alexithymia	Means literally 'no words for emotions'. This trait is therefore associated with an inability

- to use emotion signals at a physiological level as information in either social or physical domains.
- Amnesia** Loss of memory than can be either retrograde (i.e. unable to remember events before the trauma) or anterograde (i.e. unable to recall events after the trauma).
- Amygdala** Small almond-shaped structure of the limbic system that is vital in registering and utilisation of emotion and associated behavioural expressions.
- Attachment** The term signifies a binding between two ‘objects’—most commonly humans in trauma terms, but not exclusively so. It is characterised by a strong emotional tie.
- Autobiographical memory** A store of events and their evaluations that together make up a coherent life-defining narrative.
- Borderline Personality Disorder (BPD)** A personality disorder that is characterised by unstable interpersonal relationships and highly unstable emotions.
- Borderline personality style** Similar to BPD, but the lability is less extreme
- Catastrophic trauma** Term used by Krystal to indicate that the trauma has produced massive disruption to - the self structure of the survivor.
- Circumscribed trauma** A category of trauma that includes death of spouse, threat of death to self (by accident, criminal act or natural disaster). The key element is the duration and limited effect on the development of the self-structure of the survivor. The circumscribed nature means that the self-structure has not been defined in terms of the traumatic context of the survivor’s life.
- Coercive control** As the term implies, this refers to a survivor of some form of captivity trauma such as hostage or domestic violence. The perpetrator has exercise control over the survivor by forms of coercion that may include threats of or actual physical violence but may also

- include other means of control that invalidate the wishes of the survivor.
- Cognitive behavioural therapy** A form of psychological therapy originally based on behaviour therapy, but expanded to incorporate the insights of cognitive aspects such as the use of imagery, self-talk and other instructional aspects consistent with rational approaches to therapy.
- Cognitive schemas** Mental plans of events, objects, relationships. They are templates for living and acting.
- Complex trauma** Term used to describe a survivor's experience of trauma that involved the development of, or alteration to, fundamental self-structures in line with their experience of the trauma. Typically, complex traumas extend over a considerable period of time, though this is not absolutely necessary.
- Constructivist** An approach to psychological phenomena that emphasises the subjective element in the construction of concepts such as the self and assumptions.
- Counter-transference** The inevitable displacement of the therapist's emotions on to the client. This may be a distortion of, or potential benefit of, therapy.
- Debriefing** A process developed by Mitchell (1983, 1984) to assist emergency services personnel (ESP) to deal with the horrors of their work. Though its effectiveness with respect to Post Traumatic Stress Disorder is disputed, it is often used by managers to demonstrate responsible care for any employees who have experienced a trauma-like event. Usually conducted in a fairly consistent format over a number of meetings.
- Defence** Used in this sense, defence means any action that the person takes to protect their psychological existence. This may range from fully psychotic to mature defences. The person may or may not be conscious of using such processes.

Defusing	A process similar to debriefing, but of much shorter duration and with more restricted objectives.
Depersonalisation	Loss of contact with one's own self and personal identity. The sufferer has a sense of estrangement from themselves even to the point of detachment from their own body parts.
Derealisation	A situation where one has lost contact with reality, especially one's sense of external reality.
Dissociation	From one viewpoint, dissociation refers to the compartmentalisation of aspects of the person, which are separated off from other aspects of the person. The person becomes fragmented in the sense that part of their life is not integrated with the remainder of it. The other aspect of dissociation is the loss of memory of events. This can be for quite small time periods or single events, but also for prolonged periods and widespread sets of events.
Dissociative Identity Disorder (DID)	A disorder where the normal coordinating functions of consciousness break down. The disorder is characterised by the development of two or more personalities or identities. It was formerly known as Multiple Personality Disorder.
Ego	One of the components of Freud's tripartite model of the psyche. It is responsible for cognitive and memory processes, and in general attempts to adapt the individual to the demands of reality while dealing with the internal pressures exerted by both the id and the superego.
EMDR	Eye movement desensitisation and reprocessing. A form of treatment for trauma and many other disorders that relies on the controlled movement of the eyes across the midline of the face while recalling events or other memories. The technique is somewhat contentious and the underlying mechanisms are not understood.

- Emergency services personnel (ESP) Personnel involved in the rescue and treatment of survivors of accidents and other misfortune. Includes paramedics, medical staff (especially in the emergency room), incident response counsellors and anyone treating survivors close to the occurrence of traumatic events.
- Emotion differentiation The ability to differentiate between the various emotions such as joy, anger, fear and love, to name a few. The ability to use emotion signals is important in many circumstances, but especially in social situations.
- Emotional memory Recording of the emotion elements of experience. This aspect of memory is infused with bodily registration, but may also include the naming and associated reflections of the person concerning events that generated the emotion.
- Emotions A term often used to describe the named elements of affective experiences. The states of the various emotions are associated with particular facial expressions, and in many cases particular behavioural responses.
- Empathic strain The experience of therapists where they are not able to maintain an empathic connection to their clients. This may be the result of a number of factors, including counter-transference or other breaks in the therapeutic alliance.
- Empathy A vicarious and experiential identification of emotions and cognitive appraisals of another person. This may lead to a fuller understanding of another person's experience and an ability to better interpret their behaviour. Empathy is a central process in many forms of psychological therapy.
- Employee assistance programs Programs of assistance designed to address psychological stress in the workplace. They address the impact of traumatic events on

(EAP)	employees. These programs are very popular in the West and are often monitored along economic rationalist lines.
Endocrine system	Glands that internally secrete hormones and other chemicals into the blood system.
Expressive motor behaviour	In Izard's theory (1977), this is the facial and or postural activity generated by the neural activity associated with an emotion.
Feelings	The term is used with a variety of meanings. The emphasis here follows Basch (1988, p. 77), who describes feelings as the result of involuntary affective reactions that are related to the self.
Fight	The engagement of the organism or person in actions that will attack or prevent or minimise harm to the organism or person.
Flashbacks	Intrusive phenomena which include sudden recall of images, smells, sounds or other events associated with a traumatic event. They are often accompanied by strong emotions and other bodily reactions.
Flight	The actions undertaken to remove oneself from danger.
Folk psychology	A set of beliefs and precepts concerning social and psychological phenomena that are the result of consensual development among the members of a particular group within a society. These beliefs do not develop as a result of scientific validation and testing, but rely on experience and socially sanctioned interpretation.
Freeze	Reaction to the threat of death that occurs when the individual is unable to flee or fight. This is the overload situation where the psychological impact is such that the person is simply paralysed by the overwhelming experience.
Glove anaesthesia	The effect of psychological stress and processes on the functioning of the nervous system to register pain. The example of the glove-shaped effect runs contrary to any

- explanation of the dysfunction of the nerves of the hand.
- Hedonic** Relating to the pleasure–unpleasure dimension of affect.
- Hippocampus** Structure in the brain that is involved in many functions including olfaction and visceral processes; more importantly for the present discussion, it has a role in the formation of long-term memory and other cognitive processes associated with learning.
- Hyper-alert/
hyper-vigilance** State of heightened alertness; therefore associated with increased vigilance.
- Hysteria** The symptoms most often noted for hysteria include somnambulism, functional anesthesia, paralysis and dissociation. The disorder has had a controversial history, relating in part to its early identification as a disorder of women.
- Id** Most primitive part of the Freudian tripartite model of the psyche. It is said that all the animalistic instinctive aspects reside in the id. Its aim is the gratification of these instincts consideration for the realistic constraints that may limit gratification.
- Intrusion** Material that forces its way into consciousness.
The experience ranges from unpleasantness to full-blown horrific memories that approach retraumatisation. The remembered or imagined material may be coherent or in fragments, or even in experienced but unspecified affect states.
- Isolation** The defence of isolation functions by separating affect from the material of the memory. The severing of the psychological ties is central to the defence, as it is an attempt to contain the potentially explosive affect.
- Lability
of emotions** In the case of some disorders, the emotions are unstable and highly unpredictable. For the sufferer, the emotions come and go in

	storms of affect and associated interpersonal reactions of outrage and often vitriole.
Large muscle groups	This includes all the muscles used in fight/flight/freeze reactions to extreme threat. Muscles included are in the thighs, shoulder and trunk.
Limbic system	A collection of brain structures including the amygdala, hippocampus and hypothalamus. Generally it is agreed that these structures are involved in emotion and motivation processes.
Modulating emotions	The ability to control and manage one's emotions. Modulating is not suppression, but suppression may be a temporary part of a modulating process.
Multiple Personality Disorder	Former term for the development of separate personalities as a result of significant dissociative activity in a person's development (<i>see</i> Dissociative Identity Disorder).
Narrative memory	The story or memory of a person's life cast as a narrative. The emphasis is on placing memories in a historical sequence with associated meanings and significance.
Near-trauma	Term used by Krystal (1988) to describe a lesser level of trauma that does not destroy - structure or personality of the survivor.
Numbness	A general detachment from emotion reactions. Life in this state is often experienced as unreal and somewhat indeterminant.
Operative thinking	Unreflective and procedural thinking that is characterised by a lack of insight and emotional valance.
Periodic amnesia	At a social level, this is the pattern of acknowledgment then denial of the existence and prevalence of trauma in society, especially with respect to trauma inflicted on women and children but not exclusively so.
Perpetrator	Any person (male or female) who carries out acts of harm towards another person. The term is generally used to refer to males, but females are also potential perpetrators.

Phenomenological	The focus is on the actual actions, activities and substance of the experience rather than on abstractions concerning those events. The emphasis is on contemplation that is near the experiences rather than separated by speculations and obscuring theory.
Physiological arousal	Heightened activity of the physiological systems, including the adrenal and other hormonal systems as well as other bodily responses.
Post Traumatic Stress Disorder (PTSD)	A serious disorder that is the result of exposure to a life-threatening event, either to oneself or to close associates (including family and friends).
Primal repression	The process of repression applied to primitive id impulses so that they never reach consciousness.
Psychoanalysis	Form of psychological therapy and theory founded by Sigmund Freud. Emphasises the hidden aspects of human mental processes.
Psychodynamic	Derivative of psychoanalysis but which incorporates later developments and has distanced itself from older models and constructs (e.g. Oedipus complex); it does, however, recognise the immense contribution of these older models to many important ideas, such as unconscious processes and defences.
Psychogenic amnesia	Amnesia generated due to psychological processes rather than due to head injury or other bodily process.
Psychosomatic	The relationship between psychological and bodily states and their interaction. In many clinical settings, this refers to reported physical ailments that upon investigation are found not to have an organic basis.
Railway spine	Early derisive term used to describe survivors of railway accidents who were making claims for compensation but were believed (especially by insurance companies) to be malingering.

Reflected appraisals	Term used to capture the element of self-structure appraisals formation that results from the reactions and interactions with others, especially primary caregivers.
Relaxation techniques	A set of activities designed to enable clients to exercise more control over bodily reactions and activation. Especially useful in managing panic and other anxiety experiences.
Retrograde amnesia	Amnesia for events before the trauma that caused the amnesia.
Role enactments (negative)	Refers to the roles a therapist plays within a counter-transferential situation. Negative enactments include 'hostile judge'.
Role enactments (positive)	Refers to the roles a therapist plays within a counter-transferential situation. Positive enactments include 'fellow sufferer'.
Role relationship models	Horowitz's (1991) concept of the scripts for how to conduct relation interchanges, both actual and imagined.
Schemas	A framework for organising concepts based on previous experience (Sternberg 1995).
Seduction theory	Early theory by Freud that acknowledged the reality of incest and other child sexual abuse in families of the period. Roundly condemned in the professional and popular press of the time, it was replaced by the Oedipus theory.
Self	A concept of the core ordering element of psychological health, incorporating a compelling sense of one's own unique etenixsce comprising conscious and unconscious elements.
Self-defining memories	Memories that focus on the elements of the self structure.
Self-efficacy	Term most often associated with Albert Bandura (1977), referring to one's self-belief in one's ability or competence to do things.
Shell shock	Early descriptive term for Post Traumatic Stress Disorder.
Significant adults	Those adults who play an important role in the nurturance and self-structure development of the person. Often includes parents,

- siblings, teachers and others who transmit socio-cultural values.
- Social denial** Part of the reaction to the reality of trauma on a social scale. An example is the rejection of Freud's seduction theory concerning child sexual assault, or the boom period following World War II when the traumatic reactions of the returning soldiers and civilian survivors minimised.
- Splitting of consciousness** Process in dissociation (and at other less extreme times) whereby the memory and experience of an event is split and partly contained as separated from the whole memory.
- Superego** Element of Freud's tripartite model of the psyche. Generally contained the moral elements and was associated with punishment.
- Supraordinate self-schemas** Overarching self-schemas that guide and coordinate other elements of self-schemas.
- Survivor syndrome** Term coined by Lifton (1968, 1973, 1976) which denotes a set of symptoms that are displayed by survivors of traumatic events. It includes anxiety, intrusions, numbness and a loss of interest in life.
- Temperament** Characteristic intensity and duration of emotions and the individual's particular pattern of these reactions.
- Therapeutic alliance** Important connection between client and therapist, sometimes called the working alliance to emphasise the collaborative nature of the therapeutic endeavour.
- Third Republic** Period in the history of France from 1870 to 1940.
- Transference** Projection by client of feelings or reactions that belong to another (person or circumstance) on to the therapist. Classically, this referred to childhood patterns but is now seen to be applicable to all ages.
- Traumatic memory** Memory of a traumatic event generally characterised by intense emotion.

Tripartite model	Freud's early model of the psyche consisting of the id, ego and superego and their interactions.
Type 1 trauma	Term coined by Leonore Terr (1991) to describe single event or at most extended circumscribed traumatic events.
Type 2 trauma	Terr's (1991) term for complex or chronic trauma.
Vicarious traumatisation	Traumatic reactions generated in therapists and other helpers as a result of hearing or witnessing the terrible events but not being directly threatened by them. Sometimes used to mean the traumatic reactions of people who hear about harm to loved ones in the sense of the DSM criteria A.
War neurosis	Term used for PTSD symptoms that developed in World War I.

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