reached when she bought herself a notebook in which to record her weekly tasks and began to check off each accomplishment with a bright red felt-tip marker.

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

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

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

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

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

Carmen caused an uproar in her family by accusing her father, a wealthy and prominent businessman, of sexually abusing her. Her parents threatened to take her out of school and commit her to a psychiatric facility. She initially sought treatment in order to prove she was not crazy and to avoid being literally imprisoned by her father. On evaluation, she was found to have many symptoms of a complex post-traumatic syndrome. However, she was not acutely suicidal, homicidal, or unable to care for herself, so there were no grounds for involuntary hospitalization.

The therapist initially made clear that he believed Carmen's story. However, he also advised Carmen to consider the realities of power in her situation and to avoid a battle that she was not in a position to win. A compromise was reached: Carmen retracted her accusation and agreed to enter outpatient psychiatric treatment, with a therapist of her choice. As soon as she recanted, her parents calmed down and agreed to allow her to continue school. Her father also agreed to pay for her treatment.

In therapy, Carmen recovered more memories and became more certain that incest had in fact occurred; however, she felt obliged to keep silent out of fear that her father would cut off payments for therapy or school. She was accustomed to her family's affluent lifestyle and felt incapable of supporting herself thus, she felt entirely at her father's mercy. Finally she realized that she was at an impasse: she could not progress any further with her treatment as long as her father retained financial control of her life.

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

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

COMPLETING THE FIRST STAGE

Because the tasks of the first stage of recovery are arduous and demanding, patient and therapist alike frequently try to bypass them. It is often tempting to overlook the requirements of safety and to rush headlong into the later stages of therapeutic work. Though the single most common therapeutic error is avoidance of the traumatic material, probably the second most common error is premature or precipitate engagement in

exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance.

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

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

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

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

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

When the best course of action is unclear, the therapist is better off to err on the side of safety. By so doing, she puts the patient in a position to demonstrate that she is in fact capable of taking good care of herself and that the therapist is being overly cautious. If, on the contrary, the therapist minimizes the danger, the patient may be forced to demonstrate her lack of safety in a dramatic way.

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

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

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

CHAPTER 9: Remembrance and Mourning

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

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

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

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

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

RECONSTRUCTING THE STORY

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

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

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

simultaneously reexperience the feelings in all their intensity while holding on to the sense of safe connec lion that was destroyed in the traumatic moment.

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

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

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

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

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

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

fails to ask detailed questions, she risks superimposing her own feelings and her own interpretation onto the patient's story. What seems like a minor detail to the therapist may be the most important aspect of the story to the patient. Conversely, an aspect of the story that the therapist finds intolerable may be of lesser significance to the patient. Clarifying these discrepant points of view can enhance the mutual understanding of the trauma story. The case of Stephanie, an 18-year-old college freshman who was gang-raped at a fraternity party, illustrates the importance of clarifying each detail of the story:

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

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

Both patient and therapist must develop tolerance for some degree of uncertainty, even regarding the basic facts of the story. In the course of reconstruction, the story may change as missing pieces are recovered. This is particularly true in situations where the patient has experienced significant gaps in memory. Thus, both patient and therapist must accept the fact that they do not have complete knowledge, and they must learn to live with ambiguity while exploring at a tolerable pace.

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

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

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

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

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

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

TRANSFORMING TRAUMATIC MEMORY

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

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

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

The social and political components of the testimony method of treatment are far more explicit and developed than in the more narrowly behavioral flooding. This should not be surprising, since the testimony method developed within organizations committed to human rights activism, whereas the flooding method developed within an institution of the United States government. What is surprising is the degree of congruence in these techniques. Both models require an active collaboration of patient and therapist to construct a fully detailed, written trauma narrative. Both treat this narrative with formality and solemnity. And both use the structure of the narrative to foster an intense reliving experience within the context of a safe relationship.

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

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

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

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

Unless the relational aspect of the trauma is also addressed, even the limited goal of relieving intrusive symptoms may remain out of reach. The patient may be reluctant to give up symptoms such as nightmares or flashbacks, because they have acquired important meaning. The symptoms may be a symbolic means of keeping faith with a lost person, a substitute for mourning, or an expression of unresolved guilt. In the absence of a socially meaningful form of testimony, many traumatized people choose to keep their symptoms. In the words of the war poet Wilfred Owen: "I confess I *bring on* what few war dreams I now have, entirely by *willingly* considering war of an evening. I have my duty to perform towards War."

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

Breaking through the barriers of amnesia is not in fact the difficult part of reconstruction, for any number of techniques will usually work. The hard part of this task is to come face-to-face with the horrors on the other side of the amnesiac barrier and to

integrate these experiences into a fully developed life narrative. This slow, painstaking, often frustrating process resembles putting together a difficult picture puzzle. First the outlines are assembled, and then each new piece of information has to be examined from many different angles to see how it fits into the whole. A hundred years ago Freud used this same image of solving a puzzle to describe the uncovering of early sexual trauma. The reward for patience is the occasional breakthrough moment when a number of pieces suddenly fall into place and a new part of the picture becomes clear.

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

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

At first Denise belittled the importance of this current information. She was looking for something much more dramatic, something that her family would take seriously. The therapist asked Denise what she felt when her father fondled her in public. Denise described feeling disgusted, humiliated, and helpless. This reminded her of the “body feeling” she had reported at the start of therapy. As she explored her feelings in the present, she began to recall many instances in childhood when she had sought protection from her father, only to have her complaints ridiculed and dismissed. Eventually she recovered memories of her father entering her bed at night. The patient’s present, daily experience is usually rich in clues to dissociated past memories. The observance of holidays and special occasions often affords an entry into past associations. In addition to following the ordinary clues of daily life, the patient may explore the past by viewing photographs, constructing a family tree, or visiting the site of childhood experiences. Post-traumatic symptoms such as flashbacks or nightmares are also valuable access routes to memory. Sharon Simone describes how a flashback triggered by sexual intercourse offered a due to her forgotten childhood history of incest: “I was having sex with my husband, and I had come to a place in the middle of it where I felt like I was three years old. I was very sad, and he was doing the sex, and I remember looking around the room and thinking, ‘Emily’ (who’s my therapist), ‘please come and get me out from under this man.’ I knew ‘this man’ wasn’t my husband, but I didn’t yet say ‘Dad.’”

In the majority of cases, an adequate narrative can be constructed without resort to formal induction of altered states of consciousness. Occasionally, however, major amnesiac gaps in the story remain even after careful and painstaking exploration. At these times, the judicious use of powerful techniques such as hypnotherapy is warranted. The resolution of traumatic memories through hypnosis, however, requires a

high degree of skill. Each venture into uncovering work must be preceded by careful preparation and followed by an adequate period for integration.

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

We might use an age regression technique like holding a ribbon or a rope that goes to the past. For some survivors you can't use ropes. There are a lot of standard techniques that you have to change the language for. Another technique that works well for a lot of people is imagining they are watching a portable TV. When we use this, they become accustomed to having a "safe" channel, and that's always where we tune in first. The working channel is a VCR channel. It has a tape that covers the traumatic experience, and we can use it in slow-motion, we can fast-forward it, we can reverse it. They also know how to use the volume control to modulate the intensity of their feelings. Some people like to just dream. They'll be in their protected place and have a dream about the trauma. These are all hypnotic projective techniques.

Then I will suggest that the tape or the dream is going to tell us something about the trauma. I will count and then they will begin to report to me. I watch very closely for changes in facial expression, body movements. If a memory is going to come up, it comes at this time. We work with whatever comes up. Sometimes when it's an image of a very young child being abused, I will check whether it's all right to continue. People in trance can be clearly aware that they are split: there is the observing adult part and the experiencing child part. It's intense, no question about it, but the idea is to keep it bearable.

People come out of trance with a lot of affect but also with some distance. A lot of the affect is sadness, and feeling appalled and stunned by the brutality. On coming out of trance they frequently will begin to make connections for themselves. There are suggestions to help them do that: they will remember only what they are ready to remember, they will have thoughts, images, feelings, and dreams that will help them understand it better over time, they *will* be able to talk about it in therapy. It's pretty incredible when you're sitting with it. There are those moments of having to reassure yourself that this really is helpful. But people do feel better after they've retrieved the memory.

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

This careful structuring applies even to the design of the uncovering session itself. Richard Kluft, who works with patients with multiple personality disorder, expresses this principle as the "rule of thirds." If "dirty work" is to be done, it should begin within the

first third of the session; otherwise it should be postponed. Intense exploration is done in the second third of the session, while the last third is set aside to allow the patient to reorient and calm herself.

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

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

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

MOURNING TRAUMATIC LOSS

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

The descent into mourning is at once the most necessary and the most dreaded task of this stage of recovery. Patients often fear that the task is insurmountable, that once they allow themselves to start grieving, they will never stop. Danieli quotes a 74-year-old widow who survived the Nazi Holocaust: "Even if it takes one year to mourn

each loss, and even if I live to be 107 [and mourn all members of my family], what do I do about the rest of the six million?"

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

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

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

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

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

During the process of mourning, the survivor must come to terms with the impossibility of getting even. As she vents her rage in safety, her helpless fury gradually

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

Revolted by the fantasy of revenge, some survivors attempt to bypass their outrage altogether through a fantasy of forgiveness. This fantasy, like its polar opposite, is an attempt at empowerment. The survivor imagines that she can transcend her rage and erase the impact of the trauma through a willed, defiant act of love. But it is not possible to exorcise the trauma, through either hatred or love. Like revenge, the fantasy of forgiveness often becomes a cruel torture, because it remains out of reach for most ordinary human beings. Folk wisdom recognizes that to forgive is divine. And even divine forgiveness, in most religious systems, is not unconditional. True forgiveness cannot be granted until the perpetrator has sought and earned it through confession, repentance, and restitution.

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

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

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

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

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

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

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

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

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

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

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

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

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

Taking responsibility has an additional meaning for survivors who have themselves harmed others, either in the desperation of the moment or in the slow degradation of captivity. The combat veteran who has committed atrocities may feel he no longer belongs in a civilized community. The political prisoner who has betrayed others under duress or the battered woman who has failed to protect her children may feel she has committed a worse crime than the perpetrator. Although the survivor may come to understand that these violations of relationship were committed under extreme circumstances, this understanding by itself does not fully resolve the profound feelings of guilt and shame. The survivor needs to mourn for the loss of her moral integrity and to find her own way to atone for what cannot be undone. This restitution in no way exonerates the perpetrator of his crimes; rather, it reaffirms the survivor's claim to moral choice in the present. The case of Renee illustrates how one survivor took action to repair the harm for which she felt responsible.

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

The therapist acknowledged that Renee might well have reasons to feel guilty and ashamed. She argued, however, that allowing her sons to misbehave would make the harm even worse. If Renee really wanted to make amends to her sons, she had no right to give up on them or on herself. She would have to learn how to command their

respect and enforce discipline without violence. Renee agreed to enroll in a parenting course as a way of making restitution to her sons.

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

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

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

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

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

The turning point in Mrs. K’s treatment came when she “confessed” that she had been married and had given birth to a baby in the ghetto whom she “gave to the Nazis.” Her guilt, shame, and feeling “filthy” were exacerbated when she was warned after liberation by “well-meaning people” that if she told her new fiance, he would never marry her. The baby, whom she bore and kept alive for two and a half years under the most horrendously inhuman conditions, was torn from her arms and murdered when his whimper alerted the Nazi officer that he was hidden under her coat . . .

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

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

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

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

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

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

CHAPTER 10: Reconnection

HAVING COME TO TERMS with the traumatic past, the survivor faces the task of creating a future. She has mourned the old self that the trauma destroyed; now she must develop a new self. Her relationships have been tested and forever changed by the trauma; now she must develop new relationships. The old beliefs that gave meaning to her life have been challenged; now she must find anew a sustaining faith. These are the tasks of the third stage of recovery. In accomplishing this work, the survivor reclaims her world. Survivors whose personality has been shaped in the traumatic environment often feel at this stage of recovery as though they are refugees entering a new country. For political exiles, this may be literally true; but for many others, such as battered women or survivors of childhood abuse, the psychological experience can only be compared to immigration. They must build a new life within a radically different culture from the one they have left behind. Emerging from an environment of total control, they feel simultaneously the wonder and uncertainty of freedom. They speak of losing and regaining the world. The psychiatrist Michael Stone, drawing on his work with incest survivors, describes the immensity of this adaptive task: "All victims of incest have, by definition, been taught that the strong can do as they please, without regard for convention. . . . *Re-education* is often indicated, pertaining to what is typical, average, wholesome, and 'normal' in the intimate life of ordinary people. Victims of incest tend to be woefully ignorant of these matters, owing to their skewed and secretive early environments. Although victims in their original homes, they are like strangers in. a foreign country, once 'safely' outside."

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

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

LEARNING TO FIGHT

Taking power in real-life situations often involves a conscious choice to face danger. By this stage of recovery, survivors understand that their post-traumatic

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

For those who have never learned the basics of physical self-defense, this instruction can become a method of both psychological mastery and physiological reconditioning. For women, it is also a repudiation of the social demand for the submissive, placating stance of traditional femininity. Melissa Soalt, a therapist and instructor in self-defense for women, describes how her training program reconditions the response to threat through a graded series of exercises, in which instructors simulate increasingly aggressive attacks that the students learn to repel:

Our goal is to have them taste fear but know that they can fight back anyway. By the end of the first class, the sense of power starts to outweigh the fear—or at least runs neck and neck. They're beginning to develop a sensation tolerance for the adrenaline. They get used to the feeling of their hearts pounding. We teach them how to breathe, how to settle under pressure. . . .

The fourth class is often the most intense. . . . It includes a really long fight, where the model muggers keep going and keep going and keep going. People get to a point where they feel like they can't go on, but they have to. And so people discover that they have a reservoir deeper than they thought, even when they some out of that fight exhausted or crying and shaking like a leaf. That's a very important breakthrough.

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

Other forms of disciplined, controlled challenges to fear may be equally important for survivors at this stage of recovery. For example, some treatment programs or self-help organizations offer wilderness trips as a carefully planned encounter with danger. These chosen experiences offer an opportunity to restructure the survivor's maladaptive social responses as well as her physiological and psychological responses to fear. In the words of Jean Goodwin, who has participated as a therapist in wilderness trips with survivors of childhood abuse:

"Magical or neurotic means of ensuring safety do not work in this setting. Being 'sweet,' not making demands, 'disappearing,' making excessive and narcissistic demands, waiting for a rescuer: none of these maneuvers puts breakfast on the table. On the other hand, victims are surprised and delighted at the effectiveness of their realistic coping. In reality, they are able to learn to rappel down a cliff; their adult skills . . .

outweigh the fears and low estimation of themselves that initially made them judge this impossible."

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

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

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

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

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

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

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

In practice, family disclosures or confrontations require careful preparation and attention to detail. Because so many family interactions are habitual and taken for granted, the dynamics of dominance and submission are frequently relived even in apparently trivial encounters. The survivor should be encouraged to take charge of the planning of the session and to establish explicit ground rules. For some survivors, it is a completely novel experience to be the maker of rules rather than the one who automatically obeys them.

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

Finally, the survivor should anticipate and plan for the various possible outcomes of her disclosure. While she may be clear about the desired outcome, she must be prepared to accept whatever the outcome may be. A successful disclosure is almost always followed by both exhilaration and disappointment. On the one hand, the survivor

feels surprised at her own courage and daring. She no longer feels intimidated by her family or compelled to participate in destructive family relationships. She is no longer confined by secrecy; she has nothing more to hide. On the other hand, she gains a clearer sense of her family's limitations. An incest survivor describes her feelings after disclosing the secret to her family:

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

RECONCILING WITH ONESELF

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

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

> Now is the time to rise above the sameness of your days and explore the risk of testing your abilities, the expansive feeling that comes from . . . growth. Perhaps you've been taught that while everyone of course wants all that, it's just adolescent nonsense to expect it. Maybe you believe mature people settle down to a dull life and make do with what they have. It may, indeed, be impractical to recapture and act upon your girlhood dreams. This may not be the time to go (with or without the children) off to Hollywood to

become a star. But don't count it, or anything, out until you've come up with some good reasons. . . . If you really "always wanted to act," don't go to your grave saying that regretfully. Get out and join a little theater group.

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

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

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

As survivors recognize and "let go" of those aspects of themselves that were formed by the traumatic environment, they also become more forgiving of themselves. They are more willing to acknowledge the damage done to their character when they no longer feel that such damage must be permanent. The more actively survivors are able to engage in rebuilding their lives, the more generous and accepting they can be toward the memory of the traumatized self. Linda Lovelace reflects on the ordeal of being coerced into her career as a pornographic movie star: "I'm not so hard on myself these days. Maybe it's because I'm so busy taking care of a three-year-old son, a husband, a house, and two cats. I look back at Linda Lovelace and I understand her; I know why she did what she did. It was because she felt it was better to live than to die."

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

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

RECONNECTING WITH OTHERS

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

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

Because the survivor is focusing on issues of identity and intimacy, she often feels at this stage as though she is in a second adolescence. The survivor who has grown up in an abusive environment has in fact been denied a first adolescence and often lacks the social skills that normally develop during this stage of life. The awkwardness and self-consciousness that make normal adolescence tumultuous and painful are often magnified in adult survivors, who may be exquisitely ashamed of their "backwardness" in skills that other adults take for granted. Adolescent styles of coping may also be prominent at this time. Just as adolescents giggle in order to ward off their embarrassment, adult survivors may find in laughter an antidote to their shame. Just as adolescents band together in tight friendships in order to risk exploring a wider world, survivors may find themselves developing intense new loyalties as they rebuild their lives. A mother of two children created such a bond in the renewal of an old friendship after she had escaped from her battering husband: "My girlfriend from Utah moved here. Hot mama one and two! . . . We're like teenagers sometimes. Somebody said we're like primates picking out fleas, and we are. We give each other that kind of attention. She's the only one I'd do without for."

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

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

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

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

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

FINDING A SURVIVOR MISSION

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

Social action offers the survivor a source of power that draws upon her own initiative, energy, and resourcefulness but that magnifies these qualities far beyond her own capacities. It offers her an alliance with others based on cooperation and shared purpose. Participation in organized, demanding social efforts calls upon the survivor's most mature and adaptive coping strategies of patience, anticipation, altruism, and humor. It brings out the best in her; in return, the survivor gains the sense of connection with the best in other people. In this sense of reciprocal connection, the survivor can transcend the boundaries of her particular time and place. At times the survivor may even attain a feeling of participation in an order of creation that transcends ordinary reality. Natan Sharansky, a prisoner of conscience, describes this spiritual dimension of his survivor mission:

Back in Lefortovo [prison], Socrates and Don Quixote, Ulysses and Gargantua, Oedipus and Hamlet, had rushed to my aid. I felt a spiritual bond with these figures; their struggles reverberated with my own, their laughter with mine. They accompanied me through prisons and camps, through cells and transports. At some point I began to feel a curious reverse connection: not only was it important to me how these characters behaved in various circumstances, but it was also important to them, who had been

created many centuries ago, to know how I was acting today. And just as they had influenced the conduct of individuals in many lands and over many centuries, so I, too, with my decisions and choices had the power to inspire or disenchant those who had existed in the past as well as those who would come in the future. This mystical feeling of the interconnection of human souls was forged in the gloomy prison-camp world when our zeks' solidarity was the one weapon we had to oppose the world of evil.

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

Survivors undertake to speak about the unspeakable in public in the belief that this will help others. In so doing, they feel connected to a power larger than themselves. A graduate of an incest survivors' group describes how she felt after members of her group presented an educational program on sexual abuse for child protective workers: "That we could come to this point and do this at all is a miracle of major proportions. The power we all felt at reaching 40 people at once, each of whom will touch the lives of 40 children, was so exhilarating. It almost overcame the fear." Sarah Buel, once a battered woman and now a district attorney in charge of domestic violence prosecutions, describes the central importance of her own story as a gift to others: "I want women to have some sense of hope, because I can just remember how terrifying it was not to have any hope—the days I felt there was no way out. I feel very much like that's part of my mission, part of why God didn't allow me to die in that marriage, so that I could talk openly and publicly—and it's taken me so many years to be able to do it—about having been battered."

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

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

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

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

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

The sense of participation in meaningful social action enables the survivor to engage in legal battle with the perpetrator from a position of strength. As in the case of private, family confrontations, the survivor draws power from her ability to stand up in public and speak the truth without fear of the consequences. She knows that truth is what the perpetrator most fears. The survivor also gains satisfaction from the public exercise of power in the service of herself and others. Buel describes her feeling of triumph in advocating for battered women: "I love court. There's some adrenaline rush about court. It feels so wonderful to have learned enough about the law and to care enough about this woman so I know the facts cold. It feels wonderful to walk into court and the judge has to listen to me. That's exactly what I've wanted to do for fourteen years: to force the system to treat women respectfully. To make this system that victimized . . . so many women work for us, not being mean or corrupt about it, but playing by their rules and making it work: there's a sense of power."

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

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

RESOLVING THE TRAUMA

Resolution of the trauma is never final; recovery is never complete. The impact of a traumatic event continues to reverberate throughout the survivor’s lifecycle. Issues that were sufficiently resolved at one stage of recovery may be reawakened as the survivor reaches new milestones in her development. Marriage or divorce, a birth or death in the family, illness or retirement, are frequent occasions for a resurgence of traumatic memories. For example, as the fighters and refugees of the Second World War encounter the losses of old age, they experience a revival of post-traumatic symptoms. A survivor of childhood abuse who has resolved her trauma sufficiently to work and love may suffer a return of symptoms when she marries, or when she has her first child, or when her child reaches the same age that she was when the abuse began. A survivor of severe childhood abuse, who returned to treatment several years after completing a successful course of psychotherapy, describes how her symptoms came back when her toddler son began to defy her, “Everything was going so well until the baby reached the ‘terrible twos.’ He had been such an easy baby; now all of a sudden he was giving me a hard time. I couldn’t cope with his tantrums. I felt like beating him until he shut up. I had a vivid image of smothering him with a pillow till he stopped moving. I know now what my mother did to me. And I know what I could have done to my child if I hadn’t gotten help.”

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

is absolute or final. When a course of treatment comes to its natural conclusion, the door should be left open for the possibility of a return at some point in the future.

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

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

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

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

CHAPTER 11: Commonality

TRAUMATIC EVENTS destroy the sustaining bonds between individual and community. Those who have survived learn that their sense of self, of worth, of humanity, depends upon a feeling of connection to others. The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience. Trauma isolates; the group re-creates a sense of belonging. Trauma shames and stigmatizes; the group bears witness and affirms. Trauma degrades the victim; the group exalts her. Trauma dehumanizes the victim; the group restores her humanity.

Repeatedly in the testimony of survivors there comes a moment when a sense of connection is restored by another person's unaffected display of generosity. Something in herself that the victim believes to be irretrievably destroyed—faith, decency, courage—is reawakened by an example of common altruism. Mirrored in the actions of others, the survivor recognizes and reclaims a lost part of herself. At that moment, the survivor begins to rejoin the human commonality. Primo Levi describes this moment in his liberation from a Nazi concentration camp:

When the broken window was repaired and the stove began to spread its heat, something seemed to relax in everyone, and at that moment [one prisoner] proposed to the others that each of them offer a slice of bread to us three who had been working. And so it was agreed. Only a day before a similar event would have been inconceivable. The law of the [camp] said: "Eat your own bread, and if you can, that of your neighbor," and left no room for gratitude. It really meant the [camp] was dead. It was the first human gesture that occurred among us. I believe that that moment can be dated as the beginning of the change by which we who had not died slowly changed from [prisoners] to men again.

The restoration of social bonds begins with the discovery that one is not alone. Nowhere is this experience more immediate, powerful, or convincing than in a group. Irvin Yalom, an authority on group psychotherapy, calls this the experience of "universality." The therapeutic impact of universality is especially profound for people who have felt isolated by shameful secrets. Because traumatized people feel so alienated by their experience, survivor groups have a special place in the recovery process. Such groups afford a degree of support and understanding that is simply not available in the survivor's ordinary social environment. The encounter with others who have undergone similar trials dissolves feelings of isolation, shame, and stigma.

Groups have proved invaluable for survivors of extreme situations, including combat, rape, political persecution, battering, and childhood abuse. Participants repeatedly describe their solace in simply being present with others who have endured similar ordeals. Ken Smith describes his first reaction to joining a group for combat veterans of the Vietnam War: "Since Vietnam I'd never had a friend. I had a lot of acquaintances, I knew a lot of women, but I never really had a friend, someone I could call at four o'clock in the morning and say I feel like putting a 45 in my mouth because it's the anniversary of what happened to me at Xuan Loc or whatever the anniversary is. . . . Vietnam vets are misunderstood, and it takes another Vietnam vet to understand us. These guys perfectly understood when I started talking about . . . certain things. I felt this overwhelming relief. It was like this deep dark secret I'd never told anybody."

An incest survivor uses almost the same language to describe how she regained a feeling of connection to other people by participating in a group: “I’ve broken through the isolation which had plagued me all my life. I have a group of six women from whom I have *no secrets.* For the first time in my life I really *belong* to something. I feel accepted for what I really am, not my facade.”

When groups develop cohesion and intimacy, a complex mirroring process comes into play. As each participant extends herself to others, she becomes more capable of receiving the gifts that others have to offer. The tolerance, compassion, and love she grants to others begin to rebound upon herself. Though this type of mutually enhancing interaction can take place in any relationship, it occurs most powerfully in the context of a group. Yalom describes this process as an “adaptive spiral,” in which group acceptance increases each member’s self-esteem, and each member in turn becomes more accepting toward Others. Three women describe this adaptive spiral in an incest survivors’ group:

I will look to this group experience as a turning point in my life, and remember the shock of recognition when I realized that the strength I so readily saw in the other women who have survived this . . . violation was also within me.

I am more protective of myself. I seem “softer.” I allow myself to be happy (sometimes). All of this is the result of seeing my reflection in the mirror called “group.”

I’m better able to take in the love of others, and this is cyclical in allowing me to be more loving to myself, and then to others.

A combat veteran describes the same experience of mutuality in his veterans’ group: “It was reciprocal because I was giving to them and they were giving to me. It was a real good feeling. For the first time in a long time it was like, ‘Wow! I started feeling good about myself.’”

Groups provide the possibility not only of mutually rewarding relationships but also of collective empowerment. Group members approach one another as peers and equals. Though each is suffering and in need of help, each also has something to contribute. The group requisitions and nurtures the strengths of each of its members. As a result, the group as a whole has a capacity to bear and integrate traumatic experience that is greater than that of any individual member, and each member can draw upon the shared resources of the group to foster her own integration.

Evidence for the therapeutic potential of groups comes from across the spectrum of survivors. In one community survey, women escaping from battering relationships rated women’s groups as the most effective of all sources of help. The psychiatrists John Walker and James Nash, working with combat veterans, report that many of their patients who fared poorly in individual psychotherapy did well in a group. The veterans’ profound feelings of distrust and isolation were countered by the group “camaraderie” and “esprit de corps.” Yael Danieli affirms that the prognosis for recovery of Holocaust survivors is much better when the primary modality of treatment is group rather than individual. Similarly, Richard Mollica reports moving from therapeutic pessimism to optimism when his program for Southeast Asian refugees added a survivors’ support group.

While in principle groups for survivors are a good idea, in practice it soon becomes apparent that to organize a successful group is no simple matter. Groups that start out with hope and promise can dissolve acrimoniously, causing pain and disappointment to all involved. The destructive potential of groups is equal to their therapeutic promise. The role of the group leader carries with it a risk of the irresponsible exercise of authority. Conflicts that erupt among group members can all too easily re-create the dynamics of the traumatic event, with group members assuming the roles of perpetrator, accomplice, bystander, victim, and rescuer. Such conflicts can be hurtful to individual participants and can lead to the group's demise. In order to be successful, a group must have a clear and focused understanding of its therapeutic task and a structure that protects all participants adequately against the dangers of traumatic reenactment. Though groups may vary widely in composition and structure, these basic conditions must be fulfilled without exception.

Those who attempt to organize groups also quickly discover that there is no such thing as a "generic" group suitable for all survivors. Groups come in a variety of sizes and shapes, and no one group can be all things to all people. Different types of group are appropriate at different stages of recovery. The primary therapeutic tasks of the individual and group must be congruent. A group that might be well suited to a person at one stage of recovery might be ineffective or even harmful to the same person at another stage.

Some of the bewildering variability in groups begins to make sense when matched to the therapeutic tasks of the three major stages of recovery. First-stage groups concern themselves primarily with the task of establishing safety. They focus on basic self-care, one day at a time. Second-stage groups concern themselves primarily with the traumatic event. They focus on coming to terms with the past. Third-stage groups concern themselves primarily with reintegrating the survivor into the community of ordinary people. They focus on interpersonal relationships in the present. The structure of each type of group is adapted to its primary task.

GROUPS FOR SAFETY

Groups are rarely the first resource to consider in the immediate aftermath of a traumatic event. The survivor of a recent acute trauma is usually extremely frightened and flooded with intrusive symptoms, such as nightmares and flashbacks. Crisis intervention focuses on mobilizing the supportive people in the survivor's environment, for she usually prefers to be with familiar people than with strangers. This is not the time for a group. Though in theory the survivor may feel comforted by the notion that she is not alone in her experience, in practice she may feel overwhelmed by a group. Hearing the details of others' experiences may trigger her own intrusive symptoms to such a degree that she is able neither to listen empathically nor to accept emotional support. Accordingly, for survivors of an acute trauma, a waiting period of weeks or months is generally recommended from the time of the trauma until the time of entry into a group. At the Boston Area Rape Crisis Center, for example, crisis intervention may include individual and family counseling but not participation in a group. Survivors are advised to wait six months to a year before considering joining a group.

A group crisis intervention may at times be helpful sooner if all of the group members have suffered the impact of the same event, such as a large-scale accident,

natural disaster, or crime. In these cases, the shared experience of the group can be an important resource for recovery. A large group meeting may offer an opportunity for preventive education on the consequences of trauma and may help a community mobilize its resources. Under the name of “critical incident debriefings” or “traumatic stress debriefings,” such group meetings have become increasingly common in the wake of large-scale traumatic events and have even become routine in some high-risk occupations.

Debriefings, however, must observe the fundamental rule of safety. Just as it is never safe to assume that a traumatized individual’s family will be supportive, it is never safe to assume that a group of people will be able to rally and cohere simply because all of its members have suffered from the same terrible event. Underlying conflicts of interest may actually be exacerbated rather than overridden by the event. In a workplace accident, for example, management and labor may have very different perspectives on the incident. Where the event is the result of human negligence or crime, the debriefing may also contaminate or conflict with legal proceedings. For this reason, practitioners of large group debriefings increasingly emphasize the limitations of such exercises. The police psychologist Christine Dunning recommends that such debriefings adhere closely to an educational format, allowing options for individual follow-up but avoiding detailed storytelling and the ventilation of strong emotions in a large public meeting.

For survivors of prolonged, repeated trauma, groups can be a powerful source of validation and support during the first stage of recovery. However, once again the group must maintain its primary focus on the task of establishing safety. If this focus is lost, group members can easily frighten each other with both the horrors of their past experiences and the dangers in their present lives. An incest survivor describes how hearing other group members’ stories made her feel worse: “My expectation going into the group was that seeing a number of women who had shared a similar experience would make it easier. My most poignant anguish in the group was the realization that it *didn’t* make it easier—it only *multiplied* the horror.”

Group work in the first stage should therefore be highly cognitive and educational rather than exploratory. The group should provide a forum for exchanging information on the traumatic syndromes, identifying common symptom patterns, and sharing strategies for self-care and selfprotection. The group should be structured to foster the development of each survivor’s strengths and coping abilities and to offer all group members protection against being flooded with overwhelming memories and feelings.

One such protective structure is found in the many different kinds of self-help groups modeled upon Alcoholics Anonymous. These groups do not focus on in-depth exploration of the trauma itself. Rather, they offer a cognitive framework for understanding symptoms that may be secondary complications of the trauma, such as substance abuse, eating disorders, and other self-destructive behaviors. They also offer a set of instructions for personally empowering survivors and for restoring their connections with others, known generically as the “twelve steps.”

The structure of these self-help programs reflects a didactic purpose. Though group members may experience strong emotions during meetings, ventilation of feelings and detailed storytelling are not encouraged for their own sake. The focus remains on illustrating general principles through personal testimony and on learning from a

common source of instructions. Strong cohesion among group members is not required to create an atmosphere of safety; rather, the safety inheres in the rules of anonymity and confidentiality and in the educational approach of the group. Group members do not confront one another or offer highly personal, individual support. Sharing day-to-day experiences in such groups reduces shame and isolation, fosters practical problem-solving, and instills hope.

Protection against exploitative leadership in these self-help groups is explicitly built into a set of rules called the “twelve traditions.” Power is vested in the shared body of group tradition rather than in the position of the leader, which rotates among peer volunteers. Membership is homogeneous, in the sense that all participants have defined one common problem. Most groups, however, have no restrictions on membership or attendance at meetings; the group boundaries are flexible and inclusive. Participants are under no obligation to attend regularly or to speak. This flexibility allows each member to regulate the intensity of her involvement in the group. A person who simply wants to set eyes upon others who have had a similar experience is free to come once, observe silently, and leave at any time.

The structural safeguards built into the twelve traditions have held up well with wide replication. However, some self-help groups remain prone to exploitative leadership or an oppressive, idiosyncratic group agenda. This is particularly true for recently developed groups that lack the depth of practical experience and the range of choices available in mature twelve-step programs. Survivors who engage in self-help groups must be mindful of the instruction to take with them only what is helpful and to discard the rest.

Another variant of a first-stage group is the short-term stress-management group, which appears promising for survivors of chronic trauma in the early stages of recovery. Once again, the group’s work centers on establishing safety in the present. The structure is didactic, with a focus on symptom relief, problem-solving, and the daily tasks of self-care. The selection of group members can be inclusive, and new members may join or new groups may form after a cycle of a few sessions. The commitment required is of relatively low intensity, and strong group cohesion does not develop. Protection is offered by active, didactic group leadership and a concrete orientation to the task at hand. Group members do not reveal a great deal of themselves, nor do they confront one another.

Similar psychoeducational groups can be adapted to a wide variety of social situations. They are appropriate in any setting where the primary task is the establishment of basic safety, as in a psychiatric hospital inpatient service, a drug or alcoholism detoxification program, or a battered women’s shelter.

GROUPS FOR REMEMBRANCE AND MOURNING

While exploring traumatic experiences in a group can be highly disorganizing for a survivor in the first stage of recovery, the same work can be extremely productive once that survivor reaches the second stage. A well-organized group provides both a powerful stimulant for reconstruction of the survivor’s story and a sustaining source of emotional support during mourning. As each survivor shares her unique story, the group provides a profound experience of universality. The group bears witness to the survivor’s testimony,

giving it social as well as personal meaning. When the survivor tells her story only to one other person, the confessional, private aspect of the testimony is paramount. Telling the same story to a group represents a transition toward the judicial, public aspect of testimony. The group helps each individual survivor enlarge her story, releasing her from her isolation with the perpetrator and readmitting the fullness of the larger world from which she has been alienated.

A trauma-focused group should be highly structured and clearly oriented toward uncovering work. The group requires active leaders, well prepared and highly committed members, and a clear conception of its task. The psychologist Erwin Parson, who leads groups for combat veterans, invokes the metaphor of a platoon to convey the tight organization of the group: “The leader must be able to establish meaningful structure, laying out the group’s goals (the mission), and the particular terrain (emotional) to be traversed.” This imagery is appropriate to the shared military experience of the group members. Survivors of other types of trauma respond to different language and imagery; however, the basic structure of the trauma-focused group is similar for many different populations of traumatized people.

One model of a trauma-focused group is found in the incest survivors’ groups developed by myself and Emily Schatzow. This model has an inner logic and consistency that lends itself to broad replication. It has two essential structural features: a time limit and a focus on personal goals. The time limit serves several purposes. It establishes the boundaries for carrying out a carefully defined piece of work. It fosters a climate of high emotional intensity while assuring participants that the intensity will not last forever. And it promotes rapid bonding with other survivors while discouraging the development of a limited, exclusive survivor identity. The exact length of the time limit is less important than the fact of its existence. Most of these incest survivors’ groups have lasted twelve weeks, but several have lasted for four, six, or nine months. Though the group process develops at a more leisurely pace in the longer time frame, it follows the same predictable sequence toward both individual empowerment and communal sharing. Afterward, most participants complain about the time limit, no matter how long the group lasted, but most also state that they would not have wanted or been able to tolerate an open-ended group.

The focus on a personal goal provides an integrative and empowering context for uncovering work. Participants are each asked to define a concrete goal, related to the trauma, which they wish to accomplish within the time limit of the group. They are encouraged to seek help from the group both in outlining a meaningful goal and in taking the necessary actions to achieve it. The goals most frequently chosen include recovering new memories or telling some part of the story to another person. The sharing of the trauma story therefore serves a purpose beyond simple ventilation or catharsis; it is a means toward active mastery. The support of the group enables individuals to take emotional risks beyond what they had believed to be the limits of their capability. The examples of individual courage and success inspire a group with optimism and hope, even as the group is immersed in horror and grief.

The work of the group focuses on the shared experience of trauma in the past, not on interpersonal difficulties in the present. Conflicts and differences among group members are not particularly pertinent in the group; in fact, they divert the group from its task. The leaders must intervene actively to promote sharing and minimize conflict. In a

trauma-focused group, for example, the leaders assume responsibility for ensuring that each member has the opportunity to be heard, rather than allowing group members to fight out the issue of time-sharing among themselves.

A trauma-focused group requires active, engaged leadership. Leaders are responsible for defining the group task, creating a climate of safety, and ensuring that all group members are protected. The role of the group leader is emotionally demanding, because the leader must set an example of bearing witness. She must demonstrate to the group members that she can hear their stories without becoming overwhelmed. Most group leaders discover that they are no more capable than anyone else of doing this alone. For this reason, shared leadership is advisable.

The benefits of partnership extend from the coleaders to the group as a whole, for coleaders can offer a model of complementarity. Their ability to work out the differences that inevitably arise between them expands the group's tolerance for conflict and diversity. However, a climate of safety cannot be created where the dynamic of dominance and subordination, rather than peer cooperation, is reenacted in the leadership itself. The traditional pairing, for example, of a high-status man and lower--status woman as group leaders is absolutely inappropriate for a group of trauma survivors. Unfortunately, such a practice is still common.

In contrast to the flexible, open boundaries of first-stage groups, trauma-focused groups have rigid boundaries. Members quickly become attached to one another and come to rely on each others' presence. The departure or even the brief absence of a member can be highly disruptive. In time-limited groups, members should plan to attend every meeting, and no new members should be admitted once the group has begun.

Because of the emotional intensity of the task, the membership in trauma-focused group must be carefully selected. These groups require a high degree of readiness and motivation. Inclusion of a member who is not ready to engage in concentrated uncovering work can demoralize the group and damage that individual. For this reason, it is ill-advised to carry out uncovering, trauma-focused work in unscreened, unprotected groups such as large-scale "marathon" settings.

A survivor is ready for a trauma-focused group when her safety and self-care are securely established, her symptoms are under reasonable control, her social supports are reliable, and her life circumstances permit engagement in a demanding endeavor. Beyond this, however, she must be willing to commit herself to faithful attendance throughout the life of the group, and she must feel reasonably sure that her desire to reach out to others outweighs her dread and fear of a group.

The rewards of group participation are proportional to the demands. Strong group cohesion typically develops quickly. While participants usually report the aggravation of their distress symptoms at the start of the group, they simultaneously feel a kind of euphoria at finding one another. There is a feeling of being recognized and understood for the first time. Such strong and immediate bonding is a predictable feature of short-term, homogeneous groups.

The cohesion that develops in a trauma-focused group enables participants to embark upon the tasks of remembrance and mourning. The group provides a powerful

stimulus for the recovery of traumatic memories. As each group member reconstructs her own narrative, the details of her story almost inevitably evoke new recollections in each of the listeners. In the incest survivor groups, virtually every member who has defined a goal of recovering memories has been able to do so. Women who feel stymied by amnesia are encouraged to tell as much of their story as they do remember. Invariably the group offers a fresh emotional perspective that provides a bridge to new memories. In fact, the new memories often come too fast. At times it is necessary to slow the process down in order to keep it within the limits of the individual's and the group's tolerance.

A session from an incest survivors' group, led by Emily Schatzow and myself, illustrates how the group helps one member retrieve and integrate her memories, and how the progress of that member in turn inspires the other participants. Close to the end of the session Robin, a 32-year-old woman, asks for just a few minutes to talk about a "little problem" she has been having.

> ROBIN: I had a little bit of a hard week. I don't know if other people went through this—I'm having these images that come back to me. They're very terrifying. It's not like a memory. It's more like: "Oh my God! that's an awful image," and then sort of pushing it away, saying, "No, that couldn't have happened." But I feel like I want to share some of these images because I really was scared.
>
> I told you before that my father was alcoholic and he was very violent when he was drinking. My mother used to leave my sister and me alone with him. I must have been around ten. I could clearly remember our house, but what I left out was there was one room in the house that I didn't want to know too much about. I have this image of my father chasing me around this room. I tried to hide under the bed but he caught me. I don't have any memories of being raped. I just remember him swearing these terrible obscenities, like he'd say, "All I want is a little pussy," and on and on and on and on.
>
> Then the next night I had a horrible dream, a nightmare, that my father was having sex with me, and it was extremely painful. In the dream I was trying to call my mother. I was calling out, but she couldn't hear me. I couldn't scream loud enough. So in the dream what I decided to do was to separate my body and my mind. That was really weird. When I woke up, I was shaking.
>
> The reason I wanted to bring it here: the images are really frightening but at the same time I'm not really sure what happened. So I want to know from other people if these images get better—well, not better, but do they get clearer or what?

When Robin finishes speaking, there is a silence. Then the group members and the two leaders respond. First a group member, Lindsay, offers validation and support. Then one of the group leaders questions Robin in order to determine what additional feedback she needs from the group. Other listeners begin to chime in with their questions and opinions. In response, Robin comes forward with even more detailed memories, while at the same time sharing her confusion and doubts about the credibility of her story:

LINDSAY: The images should become clearer, because it seems like first you had this—I don't know—daydream of running around the room, but you didn't really feel anything. But then, in the dream, you felt pain and you were calling out for help. I have this problem of having a feeling and not being able to identify it or know where it comes from. So I guess that sounds like progress to me, because you had both those things together. Also, it is scary when your body and mind separate. I've had those kinds of feelings where I wonder, "Whose body is this?" But I like to tell myself it's transitory, it's manageable, it won't last forever, it's just something you have to go through.

SCHATZOW: Is your question whether, in the process of recovering memories, people started out with images?

ROBIN: Yes.

LEILA: I definitely did. I'd have little pieces, a dream and then a feeling.

ROBIN: Yeah. See, I had a whole story that happened, and this was like the missing piece of the story. My sister and I ended up in a foster home, and I never knew how that happened. My story at the time was that my father couldn't take care of us so he had to give us up against his will. But now I have to recover more of these—images—whatever they are . . .

LINDSAY: Happenings.

HERMAN: Experiences.

ROBIN: Thank you—now seems that we were taken away from him. I have an image of running away from home and being out on the street and then I'm in the foster home. I had all those pieces together, even the part about running away, but I didn't have the piece about the room. That just happened this week. It's still hard for me to believe that that happened to a little girl. I was only about ten years old.

LEILA: That's how old I was, too.

BELLE: Jesus!

ROBIN: But can I believe it?

LINDSAY: Yeah, do you believe it now?

ROBIN: It's still hard to believe it actually happened to *me.* I wish I could say I do and have a lot of conviction behind it, but I can't.

CORINNE: It's enough that you know the image. I mean, you don't have to swear on a stack of bibles.

At this point, Robin begins to laugh. As the dialogue continues, others join in the laughter.

ROBIN: Boy, am I glad you said that!

CORINNE: You've got it in your head, you know, and now you've got to deal with it.

ROBIN: Don't tell me that!

CORINNE: Well, we're all doing it.

By now it is time to end the meeting. Summing up, one of the leaders gives this feedback to Robin:

HERMAN: You really are responding to being in the group in a way that happens to many people. I think you have enough safety to allow yourself to go back and experience what happened. You couldn't do it before; it was too awful. Also, I think you're very brave about what you're going through. Even the way you presented it here, you did it in a way to spare us and spare yourself. You asked for just a few minutes at the end, and "Oh, by the way, I have a horror that I'm remembering." But we want to let you know that we understand what you're going through. And you are entitled to take more time to share it. People can stand to hear it. You don't need to protect us from it.

ROBIN: Whew! That's good.

Just before the meeting ends, a member who has been listening silently adds her own closing remark:

BELLE: Just now when you said that about protecting us, it's like I'm sitting here thinking we obviously are strong, because we survived to this point after what we've gone through. And meantime supposedly everybody else around us is all these fragile people and we have to protect *them.* How come it happens that way and not the other way around?

This session captures the traumatic memory at the moment of transformation from dissociated image to emotional narrative. The feedback to Robin from the other group members confirms her experience, encourages her to pay more attention to her feelings, and promises that others can tolerate her feelings and help her to bear them.

In the next week's session Robin reports that she has now recovered the complete memory and has told her story, with feeling, to her lover. She is no longer tormented by doubt. The group begins to speculate on the role of retrieving memory in the overall recovery process:

CORINNE: I can identify with your breaking down and crying. I did that a couple of months ago. I spent a couple of days saying, “I’m so scared, I’m so scared,” when the sexual memories first came up. It’s terrible to have to go back into your fear.

ROBIN: It is. If it wasn’t for this group, I don’t think I could have done it. I never could have done it alone.

LEILA: I have a question about going back. Do other women get to a point where they have gone back enough so it feels completed?

LINDSAY: I think you have to keep going back.

CORINNE: It does lose its charge, though. Like the first time you remember, the first time you feel the screams in your head, you’re real surprised, and all your senses are open. But then after you’ve done that enough times, somehow it’s like, “Yes, that happened,” and, “Fuckin’ bastard!” And now, there’s this. You know, you can leave it after awhile, or maybe you never leave it, but you can get over the grief of it and the anger of it.

HERMAN: From what I’ve seen, it’s not like it ever goes away, but somehow it loses its gripping quality, its ability to stop you in your tracks and make you feel completely undone. It loses its power.

LEILA: Did you feel like it lost its power over you?

ROBIN: Not a lot! But yeah, I did, a little bit, because once I understood what happened, then I felt a little more in control. Because what was really scaring me was having this incredible fear and not knowing. It wasn’t easy to know, but at least it’s better, because now I can share it with somebody, and I can say, “Hey! I survived it, and it didn’t screw me up too badly.”

JESSICA: It gives me a lot of hope to hear that you can survive those feelings.

This dialogue illustrates how group members help each other to bear the terror and confusion of recovering traumatic memories. Similarly, group members can help one another to bear the pain of mourning. The presence of other group members as witnesses makes it possible for each member to express grief that would be too overwhelming for a lone individual. As the group shares mourning, it simultaneously fosters the hope for new relationships. Groups lend a kind of formality and ritual solemnity to individual grief; they help the survivor at once to pay homage to her losses in the past and to repopulate her life in the present.

The creativity of the group often emerges in the construction of shared mourning rites and memorials. In one group a participant described being banished from her large and prominent family after disclosing the incest secret. The group supported this survivor’s determination not to recant but also acknowledged how painful the estrangement from her family must be. With group support, she was able to grieve for the things she most cherished about her family: the sense of belonging, pride, and loyalty. She completed her mourning by deciding to change her name. Group members

celebrated the signing of the legal papers with a ceremony in which they welcomed her into a “new family” of survivors.

Though group members share in the work of grieving, this task need not be approached with unrelieved solemnity. In fact, the group provides many redeeming moments of lightness. Group members have the capacity to bring out each other’s unsuspected strengths, including a sense of humor. Sometimes the most painful feelings can be detoxified by shared laughter. Revenge fantasies, for example, often lose their terrifying power when people realize they can be downright silly. An episode from another incest survivors’ group illustrates how one person’s revenge fantasies become manageable after they are transformed into group entertainment. Although this dialogue occurs late in the life of the group, when a strong feeling of trust has already been established, Melissa, a 24-year-old woman, is tentative and cautious when she first broaches the subject of revenge:

> MELISSA: I’m thinking of the boy who raped me. I’m so angry that he got away with it. I can still see that smug look on his face. I would like to scratch his face and leave big scars. I want some feedback. Do people think I’m awful because I’m so angry?

The group responds with a chorus of “No!” Other members encourage Melissa to go on by contributing revenge fantasies of their own:

> MARGOT: Scratching seems awfully mild for what he did.
>
> MELISSA: Well, actually, I had something more in mind. Actually . . . I’d like to break his knees with a bat.
>
> LAURA: He deserves it. I’ve had fantasies like that.
>
> MARGOT: Go on. Don’t stop now!
>
> MELISSA: I’d like to start methodically on one knee and then move on to the next. I chose that because it would make him feel really helpless. Then he’d know how I felt. Do people think I’m terrible?

Once again there is a loud chorus of “No!” Some group members have already begun to giggle. As the revenge fantasies become more and more outrageous, the group dissolves into hilarious laughter:

> LAURA: Are you sure you just want to do his knees?
>
> MARGOT: Yeah, I had a friend who had a problem with a tomcat. They said he was a lot less trouble since they had him fixed.
>
> MELISSA: Next time someone bothers me on the street, he’d better watch out. I’ll leave him crawling on the pavement.
>
> MARGOT: Maybe with a bus coming!

MELISSA: I wouldn't want to do something gross like put his eyes out because I'd want him to *see his knees!*

This coup de grace sets off an uproar of belly-laughing. After a while the laughter subsides, and several women wipe away tears as the group becomes serious again:

MELISSA: I'd like to show that boy who raped me that he might have broken my body but he didn't destroy my soul. He couldn't break that!

A woman who has joined in the laughter but has not spoken until this moment responds:

KYRA: It's wonderful to hear you sounding so strong. It's really true he couldn't touch your soul no matter what he did to you.

The women in this group are able to indulge their fantasies freely, knowing that even the quietest and most inhibited members are not frightened and are able to join in the laughter. As the fantasies are shared, they lose much of their intensity, and the women are able to recognize how little they actually need revenge.

Because a trauma-focused group is time-limited, much of the integrative work is accomplished in the termination. In the incest survivors' groups, the ending is highly formalized, and all group members put a great deal of effort and care into the rituals of farewell. Each participant is asked to prepare, in writing, an assessment of her own accomplishments during the group, as well as an estimate of the recovery work that lies ahead for her. She is asked to prepare the same kind of assessment for every other group member, as well as to provide feedback for the group leaders. Finally, each is asked to prepare an imaginary gift for every other member of the group. In their feedback to others, group members display to the fullest their empathy, imagination, and playfulness. Each takes away with her not only her own experience of having achieved a goal but also a tangible reminder of the group. The imaginary gifts often reflect the wish of group members to share a part of themselves. At one farewell ceremony a bold, outspoken group member offers this parting feedback to Johanna, a more reticent member: "I wish so many things for you, Johanna. I wish for you to take hold of that strong Johanna and not ever let go of yourself again. And I wish you strength to fight for your own existence on this earth. And I wish you determination to fight for the things you believe in: your independence, freedom, a healthy marriage, education, a career, and ORGASMS with a big 'O!' And I wish you more meat on your bones and no matches for your cigarettes! But most of all, Johanna, I wish for you to value what and who you are."

Highly structured, formal, and ritualized mirroring tasks are employed in many other trauma-focused groups. The psychologists Yael Fischman and Jaime Ross describe a group for exiled torture survivors in which the written "testimony" method is incorporated into the group process, and group members are asked to narrate one another's experiences: "By listening to another individual's presentation of personal feelings, participants gained a new perspective that allowed them to attain some control over their emotions. By listening to a series of such descriptions, they gained the experience of universality." Similarly, Yael Danieli in her group work with survivors of the Nazi Holocaust assigns each family the task of reconstructing a complete family tree, accounting for each member who survived or was murdered, and sharing this family tree with the wider group. In this case, too, the highly structured nature of the task offers

protection to group members, even as they immerse themselves in the overwhelming memories of the past. The rituals of sharing offer tangible reminders of present connections even as each survivor remembers her moment of being most alone.

The group member's farewell wish for another, "to value what and who you are," is generally borne out after the completion of a trauma-focused group. Graduates of the incest survivors' groups are asked to fill out a follow-up questionnaire six months after the group has ended. Consistently these women report improvement in how they feel about themselves. The great majority (over 80 percent) report that their feelings of shame, isolation, and stigma have diminished and they feel better able to protect themselves. These women, however, do not report global improvements in their lives. A restored sense of self may or may not lead to better relationships with others; indeed, many report that their family relationships and their sex lives have actually gotten worse or are more conflictual, because they no longer routinely disregard their own wishes and needs. As one survivor defines the change: "In this case, I think 'worse' is 'better.' I try to keep my distance and stay safe! I'm more open about how I feel and what I need. I find that I am less willing to put up with being taken advantage of or abused."

Similar results are reported from a follow-up study of combat veterans with post-traumatic stress disorder who completed a time-limited, intensive, inpatient group treatment program. The men most commonly described improved self-esteem and reduced feelings of isolation. Numbing symptoms diminished after the men confronted their histories in the protected group setting, and relationships with other people generally improved as the men emerged from their shame and numbed withdrawal. The post-treatment reports of these combat veterans read almost interchangeably with the similar testimony of the incest survivors' groups; repeatedly the men cite as the most important effects of the group the renewal of their capacities for trust, caring, and self-acceptance. As one veteran puts it: "Above all, I gained a sense of belonging somewhere and being a part of something good."

The veterans' follow-up study also suggests some limitations in the efficacy of group treatment. While the men generally felt better about themselves and more connected to others, they reported the least change in their intrusive symptoms. Many still complained of flashbacks, sleep disturbances, and nightmares. Similarly, many of the participants who completed the incest survivors' groups complained afterward that they were still bothered by flashbacks, particularly during sexual relations. Thus, group treatment complements the intensive, individual exploration of the trauma story, but does not necessarily replace it. The social, relational dimensions of the traumatic syndrome are more fully addressed in a group than in an individual treatment setting, while the *physioneurosis* of the trauma requires a highly specific, individualized focus on desensitizing the traumatic memory. Both components of treatment may be necessary for full recovery.

The model of a time-limited, goal-directed group appears to be widely applicable, with some variation, to survivors of many forms of trauma. By contrast, the model of an open-ended, loosely structured group appears to be much less suitable for the task of uncovering work with survivors. Such a model generally provides neither the safety nor the focus necessary for the undertaking. In only a few cases has such a model proven successful with trauma survivors. In one group of women with multiple personality disorder that met for over two years, the group itself seems to have evolved through

three stages—slowly building trust and focusing on the management of symptoms during the first year, beginning to discuss past traumas at the beginning of the second year, and starting to resolve conflicts among group members only in the middle of the second year. Whether these impressive results are capable of replication remains to be demonstrated.

GROUPS FOR RECONNECTION

Once the survivor has moved on to the third stage, her options expand. Different types of group may be useful, depending on how she defines her priorities. A trauma-focused group may still be the most appropriate choice if she wishes to tackle a specific, trauma-related problem that interferes with the development of more satisfying relationships in the present. A survivor of childhood abuse, for example, might wish to resolve the residual issue of secrecy, which presents a barrier to more authentic relationships within her family. The task of preparing a family disclosure is well suited to a time-limited, trauma-focused survivors' group. Group members have an almost uncanny ability to understand the dynamics of each others' families, and while they may feel immobilized and helpless with their own relatives, they have no such inhibitions regarding other families. The resourcefulness, imagination, and humor of other survivors offer invaluable aid to the individual who is attempting to negotiate changes in entrenched family relationships.

Similarly, post-traumatic sexual dysfunction is a problem that readily lends itself to focused, time-limited group therapy. In one of the few controlled studies in this area, the psychologist Judith Becker and her colleagues compared the results of ten sessions of individual or group treatment for trauma-related sexual problems. Both kinds of treatment were behaviorally oriented, with clearly defined techniques and goals. The purpose was to help each participant "gain control over her sexuality through gradual exposure to fear-inducing sexual situations, behaviors, and interactions." Either individual or group treatment proved to be highly effective for controlling such trauma-related symptoms as rape flashbacks. After three months, however, group treatment proved clearly superior to individual treatment in every respect; the women who participated in groups reported both broader and more lasting therapeutic gains.

In like manner, residual problems such as hyperarousal and fearfulness can be tackled productively in a group setting, such as a self-defense class. Once again, this is a task-focused, time-limited group experience, though it is not group therapy. Sophisticated self-defense instructors recognize the intensely emotional nature of their work and understand their responsibility for creating a psychological climate of safety, even though they make no therapeutic claims. The support of the group encourages the survivor to attempt new learning in spite of her fears, while the daring example of others offers hope and inspiration. Melissa Soalt emphasizes the importance of the group as a source of power when instructing women in self-defense: "Just the sense of having fifteen people there for you, cheering for your success-that's a very unusual experience for women in this culture. Those connections are what help reduce the fear or freeze response. People who have had to use their self-defense training later tell us that when they were in danger they actually heard the voices, the sound of the group cheering them on."

While a trauma-focused group may be useful for addressing certain circumscribed residual problems in the third stage of recovery, the survivor's broader difficulties in relationships are better addressed in an interpersonal psychotherapy group. Many survivors, especially those who have endured prolonged, repeated trauma, recognize that the trauma has limited and distorted their capacity to relate to other people. Sylvia Fraser reflects on her lifelong difficulties in forming mutual relationships with other people after surviving incest: "My main regret is excessive self-involvement. Too often I was sleepwalking through other people's lives, eyes turned inward while I washed the blood off my hands. My toughest lesson was to renounce my own sense of specialness, to let the princess die along with the guilt-ridden child in my closet, to see instead the specialness of the world around me."

Awareness alone is not sufficient to change long-entrenched patterns of relationship. Repeated practice is required. An open-ended, interpersonal psychotherapy group provides a protected space in which to practice. The group offers both empathic understanding and direct challenge. Group support makes it possible for each participant to acknowledge her own maladaptive behavior without excessive shame and to take the emotional risk of relating to others in new ways.

A group focused on interpersonal relationships has a completely different structure from a trauma-focused group. The contrasts in their structure reflect the differences in their therapeutic task. The time focus of the interpersonal group is on the present, not the past. Members are encouraged to attend to their interactions in the here-and-now. The membership of an interpersonal group aims for diversity rather than homogeneity. There is no reason to restrict membership to those who share a particular traumatic history, since the purpose of the group is to enlarge each member's sense of belonging to the human commonality in the present.

Whereas trauma-focused groups are usually time-limited, interpersonal groups are typically open-ended, with a stable, slowly evolving membership. Whereas trauma-focused groups are highly structured, with an active leadership, interpersonal groups are relatively unstructured, with a more permissive leadership style. Matters such as time-sharing, which are structured by the leader in a trauma-focused group, are settled by negotiation among group members in an ongoing psychotherapy group. Finally, while trauma-focused groups discourage conflict among members, interpersonal groups allow and encourage such conflict to develop, within safe limits. This conflict is in fact essential to the therapeutic task, for it is through understanding and resolution of conflict that insight and change occur. The feedback, both supportive and critical, that each member receives from others is a powerful therapeutic agent.

Participation in an interpersonal group represents a great challenge to the survivor who once felt totally outside the human social compact and who may have worked hard simply to get to the point where she feels that other survivors might be capable of understanding her. Now she confronts the possibility of rejoining a wider world and forming connections with a broader range of people. This is clearly a task of the last stage of recovery. The survivor must be ready to relinquish the "specialness" of her identity. Only at this point can she contemplate her story as one among many and envision her particular tragedy within the embrace of the human condition. Richard Rhodes, the survivor of severe childhood abuse, gives voice to this transformation: "I

understand that the world is full of terrible suffering, compared to which the small inconveniences of my childhood are as a drop of rain in the sea."

The survivor enters an interpersonal psychotherapy group burdened by knowledge that the trauma still lives on in her daily relations with other people. By the time she leaves the group, she has learned that the trauma can be surmounted in active engagement with others; she is capable of being fully present in mutual relationships. Though she will still bear the indelible imprint of past experience, she also understands her limitations more broadly as part of the human condition. She recognizes that to some degree everyone is a prisoner of the past. As she deepens her understanding of the difficulties of all human relationships, she also learns to cherish her hard-won moments of intimacy.

Commonality with other people carries with it all the meanings of the word *common*. It means belonging to a society, having a public role, being part of that which is universal. It means having a feeling of familiarity, of being known, of communion. It means taking part in the customary, the commonplace, the ordinary, and the everyday. It also carries with it a feeling of smallness, of insignificance, a sense that one's own troubles are "as a drop of rain in the sea." The survivor who has achieved commonality with others can rest from her labors. Her recovery is accomplished; all that remains before her is her life.

AFTERWORD: The Dialectic of Trauma Continues

IN WRITING *Trauma and Recovery,* it was my ambition to integrate the accumulated wisdom of the many clinicians, researchers, and political activists who had borne witness to the psychological effects of violence and to set forth in one comprehensive treatise a body of knowledge that had been periodically forgotten and rediscovered over the past century. I argued then that the study of psychological trauma is an inherently political enterprise because it calls attention to the experience of oppressed people. I predicted that our field would continue to be beset by controversy, no matter how solid its empirical foundation, because the same historical forces that in the past have consigned major discoveries to oblivion continue to operate in the world. I argued, finally, that only an ongoing connection with a global political movement for human rights could ultimately sustain our ability to speak about unspeakable things.

In the five years since the book's publication, new victims of violence have numbered in the millions. The massive communal atrocities committed during the course of wars in Europe, Asia, and Africa have focused international attention on the devastating impact of violence and have fostered the recognition that psychological trauma is indeed a worldwide phenomenon. At the same time, as observance of distinctions between civilians and combatants in war has widely broken down, the political nature of violence against women and children has become more apparent. The flagrant, systematic use of rape as a tool of warfare in many parts of the world has created a horrible occasion for consciousness-raising. As a result, rape has now been recognized internationally as a violation of human rights, and crimes against women and children have been accorded (at least in theory) the same gravity as other war crimes.

Within the U.S., a number of large-scale community studies have demonstrated that, even in peacetime, exposure to violence is both more commonplace and more damaging than anyone would like to believe. The enduring consequences of our endemic social violence have only begun to be appreciated. For example, one research team has undertaken an ambitious long-term study, following the fate of a group of girls who suffered documented sexual abuse as they grow into adolescence and adulthood. This study, now in its tenth year, is demonstrating the profound developmental impact of childhood trauma with a degree of rigor previously unattainable. These studies lend further weight to the massive body of evidence documenting the cost of violence.

As predicted, the study of psychological trauma has remained highly controversial. Many clinicians, researchers and political advocates who work with traumatized people have come under fierce attack. In spite of this onslaught, however, thus far the field has vigorously resisted being "disappeared." On the contrary, during the past five years, the scientific enterprise of traumatic stress studies has expanded and matured. The fundamental question of the existence of PTSD is no longer in dispute. With the basic outlines of the field defined, an early pioneering era has ended, and research has become both more technically sophisticated and in some respects more ordinary A new generation of studies has begun to enlarge the scope and increase the precision of our understanding of the impact of traumatic events.

Some of the most exciting recent advances in the field derive from highly technical laboratory studies of the biologic aspects of PTSD. It has become clear that traumatic exposure can produce lasting alterations in the endocrine, autononomic, and

central nervous systems. New lines of investigation are delineating complex changes in the regulation of stress hormones, and in the function and even the structure of specific areas of the brain. Abnormalities have been found particularly in the amygdala and the hippocampus, brain structures that create a link between fear and memory.

Biological, clinical, and social investigations have continued to converge on the fascinating phenomenon of dissociation. It has become clear that, as Janet observed one hundred years ago, dissociation lies at the heart of the traumatic stress disorders. Studies of survivors of disasters, terrorist attacks, and combat have demonstrated that people who enter a dissociative state at the time of the traumatic event are among most likely to develop long-lasting PTSD. Previously, many clinicians, myself included, viewed the capacity to disconnect mind from body as a merciful protection, even as a creative and adaptive psychodefense against overwhelming terror. It appears now that this rather benign view of dissociation must be reconsidered. Though dissociation offers a means of mental escape at the moment when no other escape is possible, it may be that this respite from terror is purchased at far too high a price.

Further evidence for the pathogenic role of dissociation has come from a large-scale clinical and community study of traumatized people conducted by a task force of the American Psychiatric Association. In this study, people who reported having dissociative symptoms were also quite likely to develop persistent somatic symptoms for which no physical cause could be found. They also frequently engaged in self--destructive attacks on their own bodies. The results of these investigations validate the century-old insight that traumatized people relive in their bodies the moments of terror that they can not describe in words. Dissociation appears to be the mechanism by which intense sensory and emotional experiences are disconnected from the social domain of language and memory, the internal mechanism by which terrorized people are silenced.

Laboratory studies have now begun to unravel the neurobiology of dissociation. For example, one elegant experiment has demonstrated that a similar mental state can be produced pharmacologically in. normal human subjects. This was done by administering ketamine, a drug that antagonizes the action of the neurotransmitter glutamate in the central nervous system. Unlike traumatized people, subjects who received ketamine did not report any subjective experience of fear. However, they did experience characteristic dissociative alterations in attention, perception and memory, including insensitivity to pain, time slowing, depersonalization, derealization, and amnesia. Ketamine is thought to work by inhibiting the activity of large neurons in the cerebral cortex. These neurons form a complex network of *associative* pathways, linking areas of the brain involved in memory, language, abstract thought, and social communication. Temporary inactivation of these pathways experimentally reproduces a dissociative state.

Thus *dissociation,* a descriptive term derived entirely from clinical observation, may turn out to be an accurate term for a neurobiological phenomenon as well. Future investigations are required to determine whether terror operates by a similar mechanism to inactivate cortical associative pathways in the brain. Preliminary results of brain scanning studies of patients with PTSD, using the sophisticated technique of positron emission tomography, suggest that during flashbacks, specific areas of the brain involved with language and communication may indeed be inactivated.

As evidence of the central importance of dissociation in traumatic stress disorders has continued to accumulate, it has also become apparent that dissociation offers a window into consciousness, memory, and the links between body and mind. Posttraumatic and dissociative phenomena have therefore begun to attract the attention of a new generation of basic researchers, whose interest does not stem primarily from engagement with traumatized people, but rather from a more abstract scientific curiosity. This development constitutes a welcome sign that traumatic stress studies are moving into a status of full legitimacy within the mainstream of scientific investigations.

Legitimacy, however, can be a mixed blessing. The next generation of researchers may lack the passionate intellectual and social commitment that inspired many of the most creative earlier investigations. In this new, more conventional phase of scientific inquiry, there is some cause for concern that integrative concepts and contextual understanding of psychological trauma may be lost, even as more precise and specific knowledge is gained. The very strength of the recent biological findings in PTSD may foster a narrowed, predominantly biological focus of research. As the field of traumatic stress studies matures, a new generation of researchers will need to rediscover the essential interconnection of biological, psychological, social, and political dimensions of trauma.

Particular care must be taken also to avoid the reenactment of a pattern of exploitative relationships within the research enterprise itself. Survivors of terrible events are often motivated to volunteer as research subjects in the hope that helping others may give meaning and dignity to their suffering. The relationship between survivor and investigator is subject to the same power imbalances and the same contagious emotions as any other relationship. Early investigators often felt strong personal bonds and political solidarity with trauma survivors, regarding them less as objects of dispassionate curiosity than as collaborators in a shared cause. This kind of closeness and mutuality may be difficult to sustain in a scientific culture where unbiased observation is often thought to require a distant and impersonal stance. Yet without it, the ability of authentic understanding is inevitably lost.

The collaborative working relationship with the trauma survivor also remains the cornerstone of treatment of PTSD. The principle of restoring human connection and agency remains central to the recovery process and no technical therapeutic advance is likely to replace it. At the same time, as evidence of the lasting biological alterations of PTSD *has* mounted, the search for a specific treatment that might mitigate these effects has also intensified. In the past five years, innovative treatment techniques have proliferated and a period of active competition for acceptance has begun. Comparison of new treatment methods developed independently by individual creative pioneers may yield some insight into their underlying common principles. Consensus on the most effective approaches to treatment of PTSD awaits the results of many more carefully controlled studies of treatment outcome. A number of such studies are now in development or already underway, and should come to fruition in the next few years.

Insight into the recovery process may also be gained by drawing upon the wisdom of the majority of trauma survivors worldwide, who never get formal treatment of any kind. To the extent that they recover, most survivors must invent their own methods, drawing on their individual strengths and the supportive relationships naturally available to them in their own communities. Systematic studies of resilience in untreated survivors

hold great promise for developing more effective and widely adaptable methods of therapeutic intervention. The search for simple and reproducible models of intervention has now become an international, cross-cultural project, as part of a growing effort to mount an international response to outbreaks of war and mass violence.

Stages of recovery can be observed not only in the healing of individuals but also in the healing of traumatized communities. International diplomatic, military and humanitarian efforts have been organized in an attempt to reestablish basic safety in many countries devastated by warfare. On this scale, safety requires putting an immediate stop to the violence, containment if not disarmament of the aggressors, and provision for the basic survival needs of the victims. All of the classic political conflicts between victims, perpetrators, and bystanders have been reenacted in these most recent peacemaking and peacekeeping efforts. Once again, victims have been outraged by the apparent indifference and passivity of bystanders. Once again, perpetrators of atrocities have gloated before the world. The many appalling inadequacies of international interventions in Africa and Southern Europe hardly bear repetition. Nevertheless, the organization of peacemaking on a scale that transcends the ordinary diplomatic goals and military interests of individual nation-states represents an important advance.

In many countries that have recently emerged from dictatorship or civil war, it has become apparent that putting an immediate stop to the violence and attending to basic survival needs of the affected populations are necessary but not sufficient conditions for social healing. In the aftermath of systematic political violence, entire communities can display symptoms of PTSD, trapped in alternating cycles of numbing and intrusion, silence and reenactment. Recovery requires remembrance and mourning. It has become clear from the experience of newly democratic countries in Latin America, Eastern Europe, and Africa, that restoring a sense of social community requires a public forum where victims can speak their truth and their suffering can be formally acknowledged. In addition, establishing any lasting peace requires an organized effort to hold individual perpetrators accountable for their crimes. At the very least, those responsible for the worst atrocities must be brought before the law. If there is no hope of justice, the helpless rage of victimized groups can fester, impervious to the passage of time. Demagogic political leaders well understand the power of this rage, and are only too willing to exploit it by offering to an aggrieved people the promise of collective revenge. Like traumatized individuals, traumatized countries need to remember, grieve, and atone for their wrongs in order to avoid reliving them.

In the aftermath of dictatorship and war, the dialectic of trauma is often played out as a ferocious battle over the question of impunity. Perpetrators of massive political crimes may still hold considerable residual power, even after their worst depredations have been curtailed, and they have no interest in public truth-telling. On the contrary, they remain implacably committed to secrecy, and fiercely opposed to any effort to establish a reckoning of their abuses. Faced with the prospect of accountability, perpetrators often become extremely aggressive. To resist being brought to justice, they will marshal the same methods of intimidation and deceit that they once used to dominate their victims. When newly elected governments in Southern Europe, Latin America, Central America, and South Africa have attempted to uncover the political crimes of the recent past, they have met with violent retaliation. Perpetrators will do

anything in their power to preserve the principle of impunity. They demand amnesty, a political form of amnesia.

Under the threat of renewed violence, one country after another has played out the conflict between knowing and not knowing, speech and silence, remembering and forgetting. In the interest of maintaining a hard-won peace, fragile democracies have often submitted to the demand for amnesty, even while trying to avoid succumbing to complete amnesia. In Latin America, many countries have permitted an official record of human rights violations to be established, but have recoiled from the attempt to bring perpetrators to justice. In the former Yugoslavia, the international community has supported the establishment of a War Crimes Tribunal, but has been unwilling to arrest and bring to trial indicted war criminals. In South Africa, the officially established Truth and Reconciliation Commission has offered perpetrators a limited time period in which amnesty will be granted in return for public confession. Implicit in this bargain is the belief that if full justice cannot be achieved, public acknowledgment of the truth is more important than punishment of the perpetrators. The principle of legal accountability has not been entirely compromised, however, since the government has made clear its determination to prosecute political criminals who do not voluntarily confess. The outcome of this most recent experiment in social healing has yet to be determined.

In still other parts of the world, newly established democracies have had to contend with a past record of abuses that were endemic to the entire political system. In these societies (for example, in Eastern Europe), dictatorship demanded not merely the acquiescence but the complicity of the general population. As a result, a great number of people violated the trust of their neighbors, friends, and relatives. These societies are now faced with the problem of establishing accountability for abuses that were pervasive and officially condoned at the time that they were committed. Holding all collaborators criminally responsible is simply not feasable, even if it were desirable. Yet without some form of public acknowledgement and restitution, all social relationships remain contaminated by the corrupt dynamics of denial and secrecy.

Our own society faces a similar dilemma with respect to the legacy of slavery. The unhealed racial divisions of our country create an ongoing potential for violence. The worst civil disturbance of the past few years, the Los Angeles riots, were provoked by the failure of the justice system to hold armed white police officers accountable for the severe beating of an unarmed black man. Within the African-American community, it was widely understood that such abuses were political crimes, carried out as part of a systematic pattern of racial oppression. The issue at trial was whether the larger society would condone the most flagrant of these human rights abuses. The responsibility to bear witness fell to the jury in the criminal trial. In their refusal to see the crime that was documented before their eyes, we can recognize the familiar defenses of denial, distancing, and dissociation. As is so often the case, the bystanders chose to identify with the perpetrators rather than with the victim, and it was this betrayal, not simply the violence of the police, that unleashed a communal outbreak of murderous rage. In the words of one community activist:

> you know, with No Justice, No Peace . . .
> I guess you might say it’s fairly simple,
> but to me it’s pretty, um
> not complex,

but then again it's deep,
it's nothin' shallow.
It basically means if there's no justice here
then we not gonna give them any peace.
You know, we don't have any peace.
They not gonna have no peace.

The problem of coming to terms with endemic abuses of power also pertains to crimes of sexual and domestic violence. Because subordination of women and children has been so deeply embedded in our culture, the use of force against women and children has only recently been recognized as a violation of basic human rights. Widespread patterns of coercive control such as battering, stalking, sexual harassment, and acquaintance rape were not even named, let alone understood to be crimes, until they were defined by the feminist movement. Even the forms of violence that were nominally criminalized, such as sexual abuse of children, have been so rarely reported or prosecuted in the past that perpetrators were effectively guaranteed impunity.

In the past two decades, however, legal reforms inspired by the feminist movement have opened the door a little bit wider for victims of sexual and domestic crimes to seek justice in court, and strong grassroots support services have encouraged more victims to confront their abusers. As a result, although the great majority of victims still avoid making any official complaint, perpetrators can no longer be entirely confident of escaping justice. In a number of highly publicized trials, prominent and powerful men (priests, politicians, star athletes) have been compelled to answer for crimes that they clearly felt entitled to commit against women or children. These trials have served as a kind of political theater, in which tragedy is reenacted, and the complex moral issues of accountability are debated.

Faced with the possibility of a public reckoning, accused perpetrators have organized to mount a renewed assault on the credibility of victims. Child advocates, psychotherapists, and others who bear witness and lend support to victims have also been subject to aggressive and organized attack. The conflict has been particularly bitter concerning sexual abuse of children. Because children are the most powerless of victims, often dependent upon their abusers, their chances for justice have ever been the most remote. In addition, children subjected to prolonged, repeated abuse are particularly prone to develop memory disturbances that further compromise their ability to tell their stories. Many states have sought to remedy this injustice by extending the statute of limitations for sexual assaults against children. Adult survivors who belatedly recall their abuse after a period of amnesia have been granted the opportunity to testify and seek redress in court. This reform has significantly expanded the potential reach of the law.

In response, advocates of accused perpetrators have argued that complaints based on delayed recall should be dismissed out of hand, because recovered memories can not possibly be true. They have maintained, rather, that such memories must be wholesale fabrications, invented by psychotherapists, and implanted in gullible minds by means of coercive persuasion. Survivors who come forward to reveal their childhood recollections have been portrayed as the pawns of a malignant cabal of psychotherapists with extraordinary suggestive powers.

When these arguments were first proposed several years ago, I found them almost ludicrously implausible, and thought that their frank appeal to prejudice would be transparent at once. The women's movement had just spent twenty years deconstructing the presumption that women and children are prone to lie, fantasize, or fabricate stories of sexual violation. If any principle had been established, surely it was that victims are competent to testify to their own experience. Yet once again, here were eminent authorities proclaiming that victims are too weak and foolish to know their own minds. Hadn't we just gone through all this? Did we really need to go through it again?

Apparently the answer was yes. The notion of a contagion of false complaints struck a responsive chord in the public media and some quarters of academia. The cry of "witch hunt" was raised, evoking the image of packs of irrational and vengeful women bent on indiscriminate slander. The "recovery movement" of survivors of childhood abuse and their therapist allies seemed to evoke particularly intense hostility and scorn. The press seemed to be tired of hearing about victims and eager to take the side of those who insisted that they had been wrongly accused.

Challenges to the credibility of victims and therapists also enjoyed some success in the courtroom. In a number of disturbing cases, adult women were denied the opportunity to give their testimony because of the concern that their minds might have been contaminated by psychotherapy. In one closely watched case, a father accused of incest by his daughter successfully sued for damages, in spite of the fact that the jury was unable to decide whether the accusations were true or false. The accusing daughter was not held responsible for harming her father. Rather, the jury found the daughter's *therapists* liable for encouraging her belief that she had been abused and helping her to retrieve her memories. The young woman, testifying in defense of her therapists, protested that she alone was responsible for her memories. "My father doesn't seem to get the point," she stated on the witness stand, "I'm the one telling him he abused me." The jury disregarded her testimony. Once again, a victim became invisible.

This trial put psychotherapists on notice that listening to survivors can carry certain risks and dangers. Underlying the attack on psychotherapy I believe, is a recognition of the potential power of any relationship of witnessing. The consulting room is a privileged space dedicated to memory. Within that space, survivors gain the freedom to know and tell their stories. Even the most private and confidential disclosure of past abuses increases the likelihood of eventual public disclosure. And public disclosure is something that perpetrators are determined to prevent. As in the case of more overtly political crimes, perpetrators will fight tenaciously to ensure that their abuses remain unseen, unacknowledged, and consigned to oblivion.

The dialectic of trauma is playing itself out once again. It is worth remembering that this is not the first time in history that those who have listened closely to trauma survivors have been subject to challenge. Nor will it be the last. In the past few years, many clinicians have had to learn to deal with the same tactics of harassment and intimidation that grassroots advocates for women, children and other oppressed groups have long endured. We, the bystanders, have had to look within ourselves to find some small portion of the courage that victims of violence must muster every day.

Some attacks have been downright silly; many have been quite ugly. Though frightening, these attacks are an implicit tribute to the power of the healing relationship.

They remind us that creating a protected space where survivors can speak their truth is an act of liberation. They remind us that bearing witness, even within the confines of that sanctuary, is an act of solidarity. They remind us also that moral neutrality in the conflict between victim and perpetrator is not an option. Like all other bystanders, therapists are sometimes forced to take sides. Those who stand with the victim will inevitably have to face the perpetrator’s unmasked fury. For many of us, there can be no greater honor.

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