TREATING THE TRAUMATIZED PATIENT AND VICTIMS OF VIOLENCE

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INTRODUCTION

The profound impact of traumatic experience on the health, well being, and development of the individual has been recognized since recorded history. The current understanding of the effects of traumatic experience is a result of the recognition of a delayed post-traumatic response among a significant proportion of the returning Vietnam veterans. The simultaneous recognition of the potentially devastating effects of child abuse, rape, domestic violence, disaster, kidnaping, torture, terrorism, and crime victimization led to a recognition that there is a universal human reaction to overwhelming stress. Further, it has been learned that reaction is psychobiologic and then mediated through complex individual and social contexts, all of which determine the final outcome of the adaptive process for each individual.

Trauma occurs when both internal and external resources are inadequate to cope with an external threat (van der Kolk, 1989). Trauma involves the experiencing, witnessing, anticipating, or being confronted with an event or events that involve actual or threatened death or serious injury, or threat to the physical integrity of one's self or others (American Psychiatric Association, 1994). The event or events lead to a response involving intense fear, helplessness, or horror. Children may express this response in disorganized or agitated behavior. To a great extent, trauma responses can be understood as normal reactions to abnormal stress. However, some persons exposed to insufficient trauma to satisfy the DSM-IV definition will nonetheless develop a trauma response syndrome, indicating some role for individual differences in vulnerability. Most agree that it is normal to develop some symptoms associated with posttraumatic

conditions transiently, but concur that when symptoms persist this may represent persistent damage and constitute a mental disorder. Shalev (1997) has hypothesized that traumatic stress disorder (PTSD) is best understood as a "biopsychosocial trap" in which there is a permanent alteration of neurobiological processes resulting in hyperarousal and excessive stimulus discrimination, the acquisition of conditioned fear responses to trauma-related stimuli, and altered cognitive schemata and social apprehension. In addition, the forms of trauma have a interpersonal and transgenerational impact, and give rise to identifiable and treatable forms of distress and dysfunction in the concerned others and in the offspring of the victim of violence.

Economics of Violence

Medical bills for the acute care of the child abuse patient averaged $35,641 per case. Tragically, even at this cost 70% died and 60% of the survivors had severe residual morbidity (Irazuta et al, 1997). Every incident of child sexual abuse has been estimated to cost the victim and society at least $99,000 (Miller, Cohen, and Wiersema, 1996). Domestic crime against adults accounts for over $67 billion a year (National Institute of Justice, 1996). The National Safe Workplace Institute reports that the average cost to employers of a single episode of workplace violence can amount to $250,000 in lost work time and legal expenses (Anfuso 1994). Further, 111,000 incidents of workplace violence cost employers an estimated $4.2 billion in 1993 (Yarborough 1994). Annually, gunshot wounds cost an estimated U.S. $126 billion, while knife wounds cost another U.S. $51 billion (Miller and Cohen, 1997). When the cost of pain, suffering, and the reduced quality of life is taken into consideration, the cost of crime to victims is an estimated $450 billion a year (Miller et al. 1996).

Epidemiology

Violence is commonplace, and claims many victims. Lifetime exposure to traumatic events in general American population ranges from 60-70 percent (Kessler et al.1995; Norris, 1992; Resnick et al, 1993). It is estimated that 21 percent of Americans have experienced a traumatic stressor in the last year. For example, one out of every eight adult women is raped, and 39 percent of them are raped more than once (National Victim Center, 1993). There is an overall lifetime prevalence of 6.5 percent for posttraumatic stress disorder, and a 30 day prevalence of 2.8 percent (van der Kolk, McFarlane, and Weisaeth, 1996).

The kinds of exposure vary. The most common traumatic events, affecting about 15 to 35 percent of the people surveyed were witnessing someone badly injured or killed;

being involved in a fire, flood, or other disaster, and being involved in a life-threatening accident. Also common were life-threatening experiences like robbery, and the sudden tragic death or injury of a close relation (Solomon and Davidson, 1997).

According to the American Medical Association (1994) more than 25 percent of the women in the United States will be abused by a current or former partner some time during their lives. In homes where spousal abuse is occurring, children are abused at a risk that is 1,500 percent higher than the national average (National Victims Center, 1993). The latest National Incidence Study of child abuse indicates that the incidence of maltreatment quadrupled between 1986 and 1993 (DHHS, 1996). Multiple studies have found that one-fifth to one-third of all women reported to have had a childhood sexual encounter with an adult male (Herman, 1981). Jenkins and Bell (1997) report on several studies done between 1982 to 1995 in which 26 to 55 percent of youth surveyed reported they had witnessed a shooting or stabbing. One out of every four employees was harassed, threatened or attacked at work between July 1992 and July 1993 (Yarborough, 1994). Statistics from the United States Department of Justice that 83 percent of Americans will be victims of violent crime at some point in their lives and about 25 percent will be victims of three or more violent crimes (Walinsky, 1995).

Patients with mental Illness may be predisposed victimization. Both the stigmatization of the mentally ill and the increased vulnerability associated with deficits associated with severe mental illness render those suffering mental disorders more likely to be victimized (Bell et al, 1988; Jenkins et al, 1990).

The Gamut of Trauma Responses

Overall, 20 to 25 percent of those exposed to DSM-IV criterion trauma develop PTSD. Because victimization and traumatization are common human experiences occurring to persons with a wide range of premorbid personality styles, ego strengths, diatheses for mental and physical illnesses, social supports, intercurrent stressors, and cultural backgrounds, there is no universal profile for victims of violence. Millions of traumatized individuals go unrecognized and untreated. Further, many specific populations are highly traumatized, including refugees, who in addition to trauma, also face the social and psychological disruption of losing their homeland. Studies demonstrate between 30 to 50 percent of refugees suffer chronic PTSD symptoms. Yet, while the core symptoms of PTSD occur in all cultures, their expression may vary widely across cultures.

The more one is exposed to trauma, in terms of severity and duration, the more likely one is to develop PTSD. For example, among American soldiers in Viet Nam, merely being a soldier was associated with a 17 percent rate of PTSD; experiencing median

levels of combat with 28 percent PTSD; and of those exposed to heavy levels of combat, 65 percent developed PTSD (Van der Kolk, McFarlane, and Weisaeth, 1996). Early and/or prior experiences of trauma makes a trauma victim more vulnerable to develop posttraumatic symptoms, and may increase the severity of those symptoms. Thus, when PTSD is complicated by both childhood and later adult trauma, it is one of the most difficult and complex disorders to treat, and may have strong characterologic components as well.

Although many people appear to recover from trauma without Intervention, many do not, and require ongoing attention to their distress and dysfunction. Some trauma victims experience the delayed onset of posttraumatic symptoms, even decades after the exposure to DSM IV criterion trauma. Posttraumatic symptoms may wax and wane in intensity and there may be asymptomatic periods. Reactivation or exacerbation of posttraumatic symptoms may be triggered by anniversaries of the traumatic events, other stressors including trauma failing short of the DSM-IV criterion trauma, and both gross and subtle stimuli reminiscent, suggestive, or symbolic of the criterion trauma.

The short term sequelae of trauma may include re-experiencing the traumatic event in several ways, avoidance of stimuli associated with the trauma, defensive numbing, dissociative symptoms, symptoms of increased arousal, problems with affective regulation, somatization, demoralization, and psychobiologic abnormalities, such as extreme autonomic responses to stimuli related to the trauma. Long term sequelae of trauma may include the persistence of the short term sequelae, with, in addition, chronic characterologic changes such as chronic guilt and shame, a sense of personal helplessness and ineffectiveness, the sense of being permanently damaged, difficulties trusting or maintaining relationships with others, vulnerability to re-victimization, and becoming a perpetrator. Autonomic dysregulation, neuroendocrine dysfunction, and neuroanatomic lesions may occur.

The Elements of the Trauma Response

1. The traumatic event is persistently re-experienced in one or more of the following ways: recurrent and intrusive distressing recollections of the event, and/or dreams of the event, and/or acting or feeling as if the event were recurring, and/or distress and or psychophysiological reactivity upon exposure to inner or outer cues that symbolize or resemble aspects of the event(s).

2. Avoidance of stimuli associated with the trauma and numbing of general responsiveness as manifested by: efforts to avoid thoughts, feelings, or conversations associated with the trauma; and/or efforts to avoid activities, places, or people that arouse recollections of the trauma; and/or amnesia for

aspects of the trauma; and/or diminished interest or participation in significant activities; and/or detachment or estrangement from others; and/or restricted range of affect; and/or a foreshortened sense of the future. Meaningful attachments may be lost, and the person may fail to participate in planning or preparing for the future.

3. Dissociative symptoms, such as numbing, detachment, or an absence of emotional responsiveness; a diminished awareness of one's surroundings (e.g., "being in a daze" or "trancing out"); problems with concentration and attention; derealization; depersonalization; and dissociative amnesia.

4. Persistent symptoms of increased arousal, such as difficulty falling or staying asleep, irritability or outbursts of anger; difficulty concentrating; hyper vigilance; and exaggerated startle response.

5. Problems in regulating affective arousal, such as chronic affect dysregulation, difficulty modulating anger, self-destructive and suicidal behavior, difficulty modulating sexual involvement, and impulsive and risk-taking behaviors.

6. Somatization, including so-called "body memories," in which the physical sensations associated with traumatization recur in a manner analogous to a flashback, without conscious connection with the traumatic scenario in which the physical sensations were experienced.

7. Chronic characterologic changes, such as: alterations in self-perception, including chronic guilt and shame, self-blame, a sense of personal helplessness or ineffectiveness, a sense of being permanently damaged; alterations in one's perception of the perpetrator, including adopting distorted beliefs and/or idealizing the perpetrator; and alterations in relationships with others, including an inability to trust or maintain relationships with others, re-victimization, and victimizing others.

8. Alterations in one's systems of meaning, such as: loss of trust, hope, and sense of energy (i.e., despair); loss of "thought as experimental action"; loss of previously sustaining beliefs; and loss of belief in the future.

9 Psychobiologic abnormalities, including extreme autonomic responses to stimuli reminiscent of the trauma, hyperarousal to intense but neutral stimuli, elevated urinary catecholamines, decreased resting glucocorticoids and glucocorticoid responses to stress, decreased serotonin activity (animal studies), increased endogenous opioid response to stimuli reminiscent of trauma, decreased hippocampal volume, and activation of the amygdala and its connections and sensory areas during flashbacks.

10. Increased vulnerability to physical illnesses and other mental disorders. Some forms of victimization also predispose victims to re-victimization. Those persons traumatized by those to whom they also have affectionate and dependent ties often develop a constellation of severe symptoms, problematic dynamics, socialization to failures in self-protection, and cognitive distortions that make them more vulnerable to be victimized once again.

Psychiatric Comorbidity

There is an considerably high rate of comorbid psychiatric disorders in the victimized population. Patients with PTSD were two to four times more likely than those without PTSD to have virtually any other psychiatric disorder, particularly somatization (Solomon and Davidson, 1997). In the study by Breslau and colleagues (1991).those with PTSD were more than six times as likely to have some other psychiatric disorder. Kessler and others (1995) found that those with PTSD are almost eight times as likely to have three or more disorders - 88 percent of men and 79 percent of women with PTSD had a history of at least one other disorder. Kessler's study also showed men with PTSD were six to ten times more likely and women four to five times more likely to have affective disorders than those without PTSD. Similar figures appear with anxiety disorders with men three to seven times more likely and women two to four times more likely to have another anxiety disorder along with their PTSD. It has also been shown that between 25 percent and 58 percent of those seeking substance abuse treatment also were comorbid for PTSD (Grady, 1997). Prolonged exposure to combat, torture, captivity, death and destruction, and repeated sexual abuse can also bring about long-lasting personality change (Herman, Perry and Van der Kolk, 1989; Perry et al., 1990; Pollack et al., 1992; Southwick, Yehuda, & Giller, 1993). Further, a number of studies have also found correlations between trauma exposure and panic disorder (Pollack, et al. 1992); suicide attempts (Angst, Degonda, and Ernst, 1992); eating disorders (Connors and Morse, 1993); depression, bulimia and generalized anxiety (Bushnell, Wells, and Oakley-Browne. 1992); chemical dependency (Ellason, et al. 1996); and increased risk for lifetime diagnoses of major depression, panic disorder, phobia, somatization disorder, chronic pain and drug abuse (Leserman, Toomey and Drossman, 1995; Walker et al., 1992). The high rate of comorbidity presents particular challenges in assessment of victims. Comorbid disorders, such as depression, may be the victim's primary reason for seeking treatment. Thus, in the face of such high rates of comorbidity, the history of trauma can often be overlooked.

Physical Comorbidity

The evaluation and treatment of victims of violence also requires a team of medical and psychiatric care givers. Victims present significant difficulties for medical providers who often misdiagnose their medical problems as psychiatric, thus compounding the psychiatric and medical problems. Alternately, they may over diagnose medical problems that have a psychiatric origin, thus exposing the patient to unnecessary medical and surgical procedures, and an increased risk of prescription drug abuse. Many victims also experience physical problems that may be related to the effects of chronic stress on various organ symptoms or the somatic equivalent of the intrusive sensory phenomena so often associated with PTSD. Sexual and physical abuse results in a greater number of hospital admissions and surgical procedures, somatization, and hypochondriasis in adulthood (Salmon and Calderbank, 1996). Victimization, particularly exposure to chronic trauma, has been associated with many kinds of chronic gastrointestinal symptoms (Drossman, 1995; Fukudo, 1993; Irwin et al., 1996; Lesserman, 1996; Walker et al., 1992; 1996 - See Chapter 6), chronic pelvic pain (Badura et al., 1997; Drossman, 1995; Plichta and Abraham, 1996 - See Chapter 6; Walling et al., 1994; Walker et al, 1996 - See Chapter 6), chronic pain syndromes (Benedikt and Kolb, 1986; Geisser et al. 1996; Pecukonis, 1996 - See Chapter 6; Walling et al., 1994): fibromyalgia (Amir et al., 1997) asthma (Davidson et al., 1991); and peptic ulcer (Davidson et al., 1991). Koss et al (1991) found that compared with non-victims, victimized women reported more distress, less well-being, visited the doctor twice as frequently and had outpatient costs that were 2.5 times greater.

INITIAL EVALUATION

Recognizing victim's of violence requires alertness on the part of the examiner to the elements of the trauma response and the symptoms of disorders associated with victimization, a keen appreciation of the fact that many forces may cause a person to withhold a victimization history, and taking enough time to build rapport and perform a comprehensive assessment. Some victims' distress is evident to the observer, while others contain their pain. Victim's of violence should receive an initial evaluation that evaluates all aspects of posttraumatic symptomatology and all posttraumatic sequelae and all comorbidity thought to be relevant. It is important not to rely on the presence of intrusive symptoms and fail to give attention to those symptoms associated with avoidance. Imaging techniques to assess for possible changes in brain neuroanatomy, neuroendocrine dysregulation, and neuropsychological assessment of cognitive functioning may be necessary. Specialized interviews to assess the degree of dissociative psychopathology, which commonly accompanies the victimization response, and is frequently overlooked may be indicated. Often victims' treatment founders

because the full spectrum of posttraumatic sequelae has not been identified and addressed.

On occasion the patient may be able to recount an accurate history of past victimization at the initial interview. However, the clinician cannot be guaranteed that such information will be forthcoming for several reasons. Shame, memory difficulties, ongoing re-victimization or fear of danger, insufficient rapport, and/or failure to make the connection between life experiences and current symptoms all lead to information being withheld or unavailable. A thorough evaluation may require several visits, the review of records, interviews with ancillary sources, and additional consultations (e.g. neurological assessment, psychological testing, family interviews). Given these potential barriers, the clinician must retain a high index of suspicion, even in the absence of historical details, if the stigmata of victimization are present. At the same time, it is vital that the patients' boundaries be respected and that they be given the opportunity to explore and reveal their own history at the pace that is safe for them to do so.

If the patient's safety cannot be assured, either because they cannot control their impulses towards self-harm, they cannot self-protect, or they are living in circumstances that are life-threatening, then the first step in treatment is to achieve safety while properly evaluating the situation. The question of safety is a broad one, encompassing various levels of safety including physical, psychological, social, and even moral safety (Bloom, 1997). The initial evaluation must focus on the establishment of a safety contract that may include family and friends as well as the patient. Obvious suicidal ideation or attempts must be taken seriously, regardless of their past frequency. A more subtle differentiation may have to be made in the case of other self-destructive behaviors like self-mutilation, binging and purging, compulsive sexual behaviors, or compulsive risk-taking behaviors that are attempts to manage overwhelming affect. More important than whether or not they self-mutilate may be whether there has been a change in the patterns of self-mutilation which may signal a loss of affect control and impulse control that is potentially life-threatening. The level of safety will determine the level of care: inpatient, intensive outpatient, partial hospitalization, and outpatient. Victims are often reluctant to seek treatment and therefore their situation is often critical by the time they actually get to a care giver. As a result, it is not unusual to find that survivors of victimization, particularly if chronic, require an inpatient hospitalization in order to stabilize their mental and physical condition, achieve a sense of safety, and begin the process of reeducation and integration. The clinician, however, must be able to assure the patient that the hospital stay itself will not duplicate previous victimization experiences of captivity, powerlessness, forced dependency, and disempowerment. This mandates that the clinician have available hospital-based resources that can adequately respond to the needs of victims without causing "sanctuary trauma" (Bloom, 1997; Silver, 1986).

Much of the outcome of the evaluation may hinge on how educated the patient is about his or her disorder. Educating the patient from the beginning of treatment about the effects of trauma is in itself a powerful intervention. Since the experience of helplessness is key in understanding the trauma response, efforts should be made from the very first contact that encouragement self-empowerment, self-efficacy, and self-control. Patients who have become familiar with the course of their own treatment and who are playing an active role in their care can often provide a clinician unfamiliar with their history, with valuable information as to their present level of safety.

Many diagnostic errors occur when the clinician, unfamiliar with flashbacks, severe dissociative states, complicated bereavement and the other intrusive symptoms of trauma, mistakes these symptoms for those of psychosis. Obtaining information from friends and family members, or previous care givers, can be an asset in these cases. A patient who has been victimized may appear to be paranoid and unreasonable if the historical details of their experience are lacking, particularly if the attitude of the interviewer triggers their underlying distrust and fears of re-victimization. Responding to a terrified trauma victim as if they were a dangerous and irrational psychotic can re-traumatize the patient and create secondary problems. Inappropriate medication with antipsychotic drugs can produce iatrogenically-induced resistance to further treatment. At the same time, however, psychosis and trauma-related syndromes may co-exist, and sometimes the use of antipsychotics can break the cycle of escalating hyperarousal and flashbacks.

It may be necessary to take a trauma history many times. In the treatment of complicated cases, it may be necessary to retake the history because initial amnesia or other factors such as shame or apprehension may preclude discussion of certain events and reactions early in treatment. Trauma checklists may be useful in this regard.

The Stage-Oriented Treatment of Trauma

Treatment works, especially when it is made available shortly after the traumatization as chronicity and comorbidity may complicate responsiveness to treatment. Some trauma victims can only tolerate supportive therapy as even reviewing their traumata in detail may be too disruptive to them. For these patients, accepting the severity of their situations and being with them is the most viable therapeutic stance. As the victim of violence is often in a vulnerable and precarious state, it is important to observe the Hippocratic axiom, “First, do no harm”.

There is general consensus that when psychotherapeutic intervention is warranted, it should follow the model of Herman (1992) in which a first stage of safety is followed by a second stage of remembrance and mourning, and then by a third stage of

reconnection. The stage of safety is designed to help the patient feel safe, understood, protected, and empathized with. It must result in the patient's tolerance of the intimacy in the therapeutic environment (Lindy, 1996). Traumatic material should not be approached until the goals of the safety phase of the treatment, including the establishment of a firm therapeutic alliance, have been achieved. The patient should be willing to approach the material and have rational motivation to do. In the context of this holding environment, the patient is strengthened and supported, and helped to learn and master new coping strategies and methods of symptom containment. In the stage of remembrance and mourning, the patient is helped to tell his or her story, to express feelings associated with and about the trauma and its sequelae, to process the experience in a manner in which it can be integrated with the patient's identity, and to grieve the impact of the trauma and the losses associated with the experience of traumatization on the patient himself or herself, as well as to grieve those who may have been lost or injured in the traumatic event. Despite the controversies associated with traumatic memory and recovered memory, this stage of treatment must address the patient's subjective experience of traumatization. Although it may not be clear that the traumatic material that is presented is historically accurate, and additional material of uncertain veracity may emerge in the course of the therapy, this material communicates the patient's narrative of his or her experience, and it must be addressed. If efforts must be made to lift an amnesia in order to address some symptoms or problem areas, it is crucial to explain to the patient that any material that may be recovered must be regarded as tentative, and of uncertain historical accuracy. Informed consent should be obtained before proceeding with such efforts. It is important to appreciate that in many patients, most traumatic material will never receive either definitive confirmation or disconfirmation. Although many deplore the difficulties and discomforts associated with this stage of therapy, most authorities concur that full recovery is unlikely to occur in its absence. Memories must be processed in order for continuity of personal identity to be restored, and for the patient to make sense of what has befallen him or her. The final stage, reconnection, involves the bringing together of the patient's identity, the reintegration of the patient into his or her social roles and responsibilities, and the resolution of the impacts of the various dysregulations associated with the trauma response. To as great an extent as possible, the patient's sense of having been damaged, demoralized, and made different in a negative and shameful way as a result of the trauma must be mollified and eliminated.

THE ORIENTATION OF THE TREATMENT

Treatment must be individualized, and accept the unique configuration of strengths, vulnerabilities, comorbidities, values, cultural factors, and existential and spiritual

concerns of the patient. Consequently, in treating chronic posttraumatic stress it may be necessary to develop a treatment plan that involves many modalities of treatment in concert. Short term treatments may prove ineffective, inappropriate, and raise false hopes, which, when dashed, may further complicate the patient's treatment. While some such therapies may proceed smoothly within a given modality, many treatments come to resemble a series of short-term psycho therapies imbricated within a single long-term psychotherapy. Continuity of care is an important aspect of long-term treatment, and the object constancy and reliability of the therapist may be one of the most important factors in treatment success. When managed care organizations dictate a brief or limited treatment, the psychiatrist should try to address the need for more extensive care with that organization. In treating the patient, it may be necessary to rely more heavily on medication and symptom reduction and have briefer or more spread out sessions than is considered appropriate care.

Treatment of the victimized patient must be supportive and exploratory while having a here-and-now focus in addition to addressing traumatic material. This combination test the capacity of the patient and the therapist to collaborate. It is useful to address traumatic material early in the session, reserving the final third of the session for the re-stabilization of the patient. The status of comorbid conditions should be optimized. The therapist should have the requisite skills, and the logistics of the treatment should be capable of supporting the effort. In unusual circumstances the therapist may conclude that even though a patient is unstable, only work with particular traumatic material will make stabilization possible. When a decision is made to proceed in this manner, it is essential to address only the amount of trauma that must be dealt with before returning to work on stabilization (Kluft, 1997). In a given treatment, the unique situation of the patient, the stage of the treatment, the material under discussion, life circumstances (stressors, crises, and supports) and comorbid conditions will determine how the treatment should be directed. The therapist must be prepared to be flexible and responsive as circumstances change.

In general trauma patient populations are on a continuum regarding comorbidity and intactness. Some patients are relatively intact and have had little or no comorbidity accompanying his or her posttraumatic sequelae. The trauma is either recent enough so that major characterologic changes have not occurred, or, if they have, they have not solidified. Such patients are more likely to have, overall, a more exploratory than supportive therapy, unless they recover with a brief period of support. Their difficulties are mostly in connection with the trauma, and the trauma must be a major focus. Another group has considerable comorbidity and/or some compromise of ego strength and/or more severity and chronicity of the posttraumatic response. This group may be more depleted, and/or have had less ego strength. Its course is likely to be more up and down, and more prolonged, with more attention to coping and here-and-now issues which often proves to have a trauma-based origin, and will alternate between an

exploratory and a supportive focus, moving forward with the trauma work at advantageous and stable moments, which Briere (1985) has described as windows of opportunity. Often the patient will require long periods of work on issues related to comorbid conditions and situational crises. At the end of the continuum is a group has great severity and or chronicity in the trauma response, and severe ego weakness and/or comorbidity. Such patients often are destabilized by trauma work. Most of the therapy is directed at efforts to keep the patient stabilized, and to coach the patient through the vicissitudes of day to day life. There may be occasions in which the traumatic material is briefly addressed, but in general, as soon as it has been dealt with acutely, the focus of treatment returns to a supportive focus. With such patients the treatment is palliative and limited in its goals. As therapy progresses, patients in each category may change their characteristics and be able to shift into another category.

It is often helpful to intervene with the trauma victim's family and/or partner both to help concerned others both support and cope with the situation and behaviors of the traumatized person, and also to address the interpersonal consequences of traumatic sequelae, such as difficulties with intimacy or anger management.

Memory

Many traumatic incidents are recalled very clearly, some are recalled only partially, and some may be absent from available memory for long periods of time. Generally when traumata are recalled, the general nature of the events, "gist memory," is well retained, but details may be absent or supplied by a reconstructive process. Most so-called recovered memories of trauma do not take place in or in association with therapy. There is evidence that some recovered memories are inaccurate (called confabulations or pseudo memories), some are rather accurate, and some involve admixtures of accurate and inaccurate components. There are no data to indicate what percentage of so-called recovered memories are inaccurate, but there is data to indicate 47 to 95 percent of recovered memories of conventional child abuse are confirmed, while only 1 to 3 percent of bizarre abuse memories are confirmed (Bowman, 1996a & b). A recent study demonstrated that 74 percent of recovered memories could be confirmed (Dahlenberg, 1996). No characteristics of memories, such as their being clear, emotional, detailed, or held with conviction, are definitively associated with veracity.

Accordingly, considerable controversy surrounds the impact of trauma on memory, the accuracy of memories of trauma, and the accuracy of memories of trauma that enter awareness after a period of amnesia (ISTSS, 1998). Despite this fact, since dissociative disorders are usually associated with trauma, the issue of memory must be addressed. Notwithstanding the difficulties associated with autobiographical memory, especially when elements of memory are recovered**,** most authorities concur that unless

memories are processed it is difficult to bring about a full recovery in which continuity of personal identity is restored and the patient is able to make sense of what has befallen him or her. As treatment begins, the patient's accounts of his or her circumstances should be heard with empathy and respect. It is not appropriate to begin treatment with efforts to document or disconfirm the patient's allegations of traumatization, although a decision may be made to do so if it is the patient's wish to do so. It is not appropriate to assume that other sources' disagreement with the patient's given history invalidate it, especially if these other sources might be culpable if the patient's allegations were accurate. Therefore, this therapeutic work is pursued, but appropriate cautions about memory issues are provided to the patient (acknowledging both the importance of work with autobiographical memories of trauma in the treatment of trauma, and the difficulties that may be encountered in work with human memory), whose treatment occurs under the aegis of informed consent which is documented. It is not appropriate for the therapist either to assume that an allegations of trauma is true or false, or that all continuously held memories are accurate, and all memories returning to awareness, or emerging in the course of therapy are false. Clinicians should be aware that the only proof of the accuracy or inaccuracy of a memory Is reliable corroboration by external evidence or witnesses other than alleged abusers. Without corroboration, legal action on the basis of memories that emerge in the course of therapy are usually contraindicated.

The Stance of the Therapist

The stance of the therapist should be warm, friendly, and engaging in order to make an outreach to the patient, who may feel damaged, shamed, guilty, and defective. The therapist must have firm boundaries without being punitive or rejecting. Many victims experience boundary violations, however trivial, as hints that the treatment situation is dangerous and that the therapist cannot be trusted. Trauma treatment can be painful in and of itself, and must be conducted in a carefully paced manner that respects the strengths and vulnerabilities of the patient, and preserves and enhances function as much as possible.

The trauma victim must be treated in a way that is sensitive to and respectful of the culture, cultural signifiers, and cultural values of the victim and the victim's family. It is vitally important that the therapy be conducted in a manner that does not estrange the victim from his or her family and community on these grounds. Notwithstanding the availability of effective trauma treatments, their application with certain groups may have an unacceptable cost-benefit ratio and may prove either unsuccessful or deleterious. For example, in some Southeast Asian populations, contrary to the case for North Americans and Europeans, it may be contraindicated to attempt to identify and process traumatic experiences.

As in any form of psychotherapeutic intervention, the stance of the therapist in relation to the patient is critical in determining outcome (Blank, 1994). The clinician must be someone who understands post-traumatic syndromes as related initially to external events that are then worked upon by the particular dynamics, fantasies, experience, and meaning-making of the individual patient. Any therapist who hopes to be successful in the treatment of complicated trauma-based syndromes must be willing to develop an understanding of repression, dissociation, isolation of affect, amnesia for parts of events, disguised traumatic dreams, holding of traumatic memories, conflicts and impacted affects in the unconscious over time, symbolic expression of anxiety, and identification with the aggressor (Blank, 1994). Therapists must recognize that by definition, trauma is a boundary violation and therefore violated patients may have no concept of normal boundary formation or maintenance (Kluft, 1993a, p. 26). It will therefore be the responsibility of the therapist to define and protect boundaries within the therapeutic context. This may necessitate early and open discussion of the therapeutic frame including length and time of sessions, fee and payment arrangements, the use of health insurance, confidentiality and its limits, therapist availability between sessions, procedure if hospitalization is necessary, patient charts and who has access to them, the use (or non-use) of physical contact with the therapist, involvement of the patient's family or significant others in the treatment, discussion of the therapist's expectations concerning management by the patient of self-destructive behavior, legal ramifications of the use of hypnosis as part of the treatment (i.e., material recalled in trance is not likely to be admissible evidence in any legal action undertaken by the patient), among others (ISSD, 1997).

Trauma survivors are often driven to unconsciously and nonverbally reenact their experiences within the context of close relationships and this traumatic re-enactment may drive the therapeutic relationship to destruction if it is not properly understood, analyzed, and transmuted. Even experienced clinicians may find themselves unwittingly drawn into scenarios in which they are alternately playing out the roles of helpless victim, powerless rescuer, or malicious perpetrator. The management of such complex, nonverbal enactment often necessitates ongoing consultation with trusted colleagues in the form of individual or group supervision which can play a vital role in helping the therapist maintain balance and maintaining the safety of the therapeutic alliance (Bloom, 1997).

The treatment of the traumatized has the potential to make a strong impact upon the therapist. The clinician who works with traumatized individuals must make efforts to monitor his or her counter transference, and to monitor him or herself for secondary or vicarious posttraumatic stress also referred to as "compassion fatigue" (Figley, 1995a & b), "vicarious traumatization" (McCann & Pearlman, 1990; Pearlman, 1995; Pearlman & Saakvitne, 1995), and co-victimization (Hartsough & Myers, 1985). People, who are repeatedly exposed to the effects of violence, even though only secondarily, can be

traumatized themselves and even experience symptoms similar to victims of post-traumatic stress. It is somewhat different from "burnout" which is a state of physical, emotional, and mental exhaustion caused by the long-term involvement in very emotionally draining situations (Pines and Arnson 1988). Burnout emerges gradually while secondary traumatic stress can emerge suddenly and without much warning, often accompanied by a sense of confusion and helplessness (Figley 1995a & b). In such cases, exposure to a traumatizing event experienced by one person becomes a traumatizing event for the second person. The hallmark of vicarious traumatization is a disrupted frame of reference. Repeated exposure to man-made violence can impact on our willingness and ability to relate to others, on how we make sense of a frightening world. As a result of exposure to victims of violence, clinicians may experience disruptions in their sense of identity, world view, and spirituality that may interfere dramatically with treatment if not addressed in some way, often through peer supervision (Pearlman, 1995; Pearlman and Saakvitne, 1995).

The Principles of Good Trauma Therapy

Traumatized persons with posttraumatic conditions have become "stuck" on the trauma and its sequelae. The treatment aims "to help them move from being haunted by the past and interpreting subsequent emotionally arousing stimuli as a return of the trauma, to being fully engaged in the present and becoming capable of responding to current exigencies" (van der Kolk et al, 1996, p. 419). They must regain control over their emotional responses and place the trauma in perspective as a historical event or events that occurred in the past and can be expected not to recur, if they take charge of their lives. They must come to integrate what has occurred, however ego-alien, unacceptable, terrifying, and incomprehensible into their self-concepts; and they must make these elements integrated rather than dissociated, so they are no longer intrusive and destabilizing. Their anxieties must be de-conditioned, and they must change their views of themselves and the world by establishing a sense of personal integrity and control (van der Kolk et al, 1996). Typically, intrusive experiencing, autonomic hyperarousal, avoidant and numbing strategies, emotional dysregulation, difficulties with learning and mastery, problems with amnesia and dissociation, aggression toward self and others, and somatization will have to be addressed.

Kluft (1996a) put forward several principles for the therapist who deals with the traumatized. 1) As trauma involves the breaking of boundaries, an effective trauma treatment will have a secure treatment frame and firm consistent boundaries; 2) As trauma imposes dyscontrol and helplessness, a successful treatment will focus on mastery and the patient's active participation in the treatment process; 3) As trauma is imposed involuntarily, a successful trauma therapy will build and maintain a strong therapeutic alliance; 4) As trauma leads to dissociation and a failure to integrate

experience into memory and identity, what has been hidden away must be returned to awareness, and associated emotional responses verbalized with feeling; 5) As trauma often leads to dissociated alternate perceptions or narratives of life events, these must be clear communication and efforts to integrate disparate perceptions; 6) As trauma often results in the shattering of basic assumptions (invulnerability, life is meaningful, and self esteem), positive efforts must be made to restore morale and to inculcate realistic hope; 7) As trauma overwhelms a patient's resources and supports, treatment must be carefully paced making efforts to minimize avoidable overwhelming experiences and aggressively address issues of hyperarousal; 8) As trauma often is related to the irresponsibility of important others, the therapist must model, teache and reinforce responsibility; 9) As trauma usually induces shame, the therapist must take an active, warm, and flexible stance, that emphasizes empathic connectedness with the patient. 10) As trauma often interferes with learning and cognition, therapy must address and attempt to correct defective cognition and work strenuously to help the patient find words that match his experiences.

Because the target symptoms may be numerous and involve all manner of psychobiosocial matters, eclecticism and the collaboration with other colleagues who may have contributions to make to the treatment are essential. For example, dissociation disorders usually require specific treatments in order to achieve resolution. Whether a dissociative disorder is the main manifestation of the trauma response or a comorbid condition, the therapist should be prepared to either provide specific treatment or to collaborate with a colleague who can provide this element of the psychotherapy.

It is important to appreciate that these principles apply to all treatment modalities and across all treatment settings. Hospital units that address the treatment of the traumatized must model these goals, attitudes, and principles if they are to participate meaningfully in the continuum of care for trauma patients.

Hospitalizing the Traumatized Patient

The inpatient milieu treatment of these patients deserves special mention since their rate of hospitalization can be quite high. Likewise, on any general psychiatric inpatient unit, a significant proportion of the population will have experienced a history of traumatic events that may be playing an important and unrecognized role in the development and maintenance of their psychiatric symptoms. Bloom (1997) has written

about the implications of what is described above as "good trauma therapy" for the short-term inpatient unit.

The indications for hospitalization of the trauma patient include: 1) suicidality/homicidality; 2) psychosis; 3) affective instability/deterioration of a mood disorder to the point that function is impaired; 4) a significant problem with the outpatient treatment team and/or dynamic which places the patient at risk e.g. therapist is in trouble; 5) diagnostic clarification i.e. psychotic disorder versus/and/or a dissociative disorder versus/and/or a medical problem; 6) significant re-enactment behaviors which are interfering significantly with home/work/parenting/relationships and not responding to usual outpatient interventions; 7) other self-destructive behavior (i.e. self-mutilation, binging & purging) that is escalating and increasingly out of the patient's ability to control; 8) serious threat to patient's life and well-being secondary to a violent relationship.

The patients who end up hospitalized often suffer from very complex clinical pictures and therefore benefit enormously from the power of a team approach to evaluation and treatment. The purpose of hospitalization is to build a better outpatient (Kluft, 1996b), and this is effectively accomplished by mobilizing a group of people to look simultaneously at various aspects of the problem, including medical ones. Due to short hospital stays, treatment planning must be well-organized and supervised. Goals must be clearly defined and limited to what is attainable during a brief stay. Usually, the major goal is the achievement of safety with self and others and the patient must be an active agent in all treatment decisions. As much as possible, nothing should be done that encourages further helplessness and regression. All interventions must be directed towards the empowerment of the patient in service of the restoration of self-control. Everyone in the milieu must maintain clear and well-defined boundaries and expectations, while providing an environment that is open to the construction of a narrative that helps put the traumatic experience into perspective. The safety of the inpatient unit is necessary as memories of the past flood into consciousness, producing overwhelming hyperarousal and unmodulated affect. The restoration of memories should only be encouraged if the patient has demonstrated sufficient capacity for safety that regression will not occur (Bloom, 1997).

The power of the therapeutic community, even in a short-term unit, should be drawn upon to help patients mobilize their own internal resources and draw on the strengths of others. Extensive efforts should be made to education everyone in the milieu, usually through psycho educational groups, about the effects of trauma, the responsible use of medications, the hazards of self-destructive coping skills, and the need for withdrawal from self-medication, self-mutilation, and other forms of destructive attempts at affect management.

Given the fact that these patients frequently need much more time in a protective environment than they can currently get, it should come as no surprise that there is a high rate of "recidivism" in this population. Good communication between inpatient and outpatient therapists can at least make necessary transitions as positive as possible, despite the current, often extreme, limitations of the system.

Modalities of Treatment

Traumatized individuals may manifest extremely complex presentations accompanied by considerable morbidity that changes over time. It is essential to individualize psychotherapy and to anticipate using different modalities over the course of the treatment. Since additional modalities provided by additional therapists may prove essential to the treatment, it becomes essential for the primary therapist to maintain rapport with the patient even when many parties may play a role in the treatment and even while the application of some additional modalities may temporarily interrupt work with the primary therapist. The socializing of the patient to the therapy and the discussion of the therapeutic alliance should address from the first the possibility of involving additional mental health professionals as the treatment proceeds.

Although cognitive-behavioral techniques have been researched most thoroughly, many specialized approaches to trauma are currently being developed and applied. Hypnosis has a venerable history in the treatment of trauma, and remains a useful tool not withstanding controversy about its impact on memory. Eye Movement Desensitization and Reprocessing (EMDR) is gaining popularity and appears quite useful. Single modality approaches have been most successful for single adult traumata. However, with patients exposed to extensive childhood trauma, trauma has not only had its usual consequences, it often has interrupted developmental processes. When dissociative psychopathology is a significant aspect of the posttraumatic symptomatology, approaches specific to the resolution of dissociative difficulties should be introduced. In addition to a basic individual psychotherapy, and other technique-oriented individual interventions, ancillary approaches such as group psychotherapy, art therapy, movement therapy, music therapy, and body-oriented treatments may play a valuable role for some selected patients. Treatment should be begun as rapidly as possible in order to event both psychobiological consequences and demoralization.

Symptom reduction is extremely important both to treat posttraumatic and comorbid conditions, and to stabilize the patient sufficiently to proceed to and manage the stage of remembrance and mourning. In this regard medication may play a valuable role. Symptom reduction, especially for intrusive symptoms and sleep difficulties, may also facilitate the engagement of the patient in therapy.

Psychopharmacology

There is no definitive psychopharmacological treatment for trauma-related symptoms, understandable given that so many different neurobiological systems seem to be involved in post-traumatic disorders. So far, it appears that PTSD at least, is associated with abnormalities in the adrenergic, hypothalamic-pituitary-adrenocortical, opioid, dopaminergic, and thyroid systems, and possibly with alternations in the serotonergic, gamma-amino butyric acid-benzodiazepine and the N-methyl-D-aspartate systems (Friedman & Southwick, 1995). Medications may help some of the symptoms of posttraumatic stress; they are much more successful in alleviating depression, sleep disorders, anxiety, and hyperarousal symptoms than they are helping withdrawal and numbing. To complicate matters, many patients with trauma-related syndromes use a variety of substances in an effort at self-medication. Among treatment-seeking patients, from 60% to 80% suffer from alcohol or drug abuse/dependence. There are relatively few controlled, double-blind studies of the efficacy of medications in these disorders and those that have been done has largely been tried on combat veterans.

Davidson and van der Kolk (1996) have suggested drug therapy based on utilizing a rationale grounded in the major biological models for PTSD. Adrenergic dysregulation suggests the use of antidepressants of all groups (MAO inhibitors and tricyclic antidepressants) may be helpful. Other drugs like clonidine - an alpha 1 agonist that reduces hyperarousal symptoms and nightmares by reducing central nervous system norepinephrine may also be used. Further, many dissociative patients often do well klonazepam or other benzodiazepines. It is important not to misdiagnose dissociative phenomenology as psychosis and initiate a regimen that will not lead to the resolution of the dissociative symptomatology. Beta-adrenergic blockers might also be used for adrenergic dysregulation. Serotonergic dysfunction suggests the use of serotonergic drugs such as SSRIs which has been supported by recent clinical trials. The kindling hypotheses for traumatic stress suggests the use of anti-kindling drugs like carbamazepine. Finally, the increased startle responsiveness suggest the possibility that clonazepam and buspirone may be effective.

According to these authors, the purposes of medication in PTSD are as follows: 1) Reduction of frequency and/or severity of intrusive symptoms; 2) Reduction in the tendency to interpret incoming stimuli are recurrences of the trauma; 3) Reduction in conditioned hyperarousal to stimuli reminiscent of the trauma, as well as in generalized hyperarousal; 4) Reduction in avoidance behavior; 5) Improvement in depressed mood and numbing; 6) Reduction in psychotic or dissociative symptoms; 7) Reduction of impulsive aggression against self and others. In selected patients a wide variety of medications and many combinations of medications can prove useful. In view of the

myriad psychobiological lesions associated with trauma, it is not surprising that polypharmacy is usually necessary in order to achieve maximal symptom reduction.

In practice, it is important to remember that no drug cures trauma and that medication is generally directed at the treatment of depression, anxiety, obsessions, compulsions, and psychosis - all of which can co-exist with, or be a part of, trauma-related syndromes. The symptom relief often enables the person to move ahead in therapy and achieve a higher degree of function when used in concert with other forms of treatment. It is especially crucial that the psychiatrist avoid both the Scylla and Charybdis of the psychopharmacology of the traumatized -either under medicating a seriously distressed patient or trying to make the medication a substitute for an appropriate trauma resolving psychotherapy.

RECOMMENDATIONS

Mental health professionals should promote awareness of victimization, a biopsychosocial phenomenon, as important in the development of psychopathology, increased comorbidity for both mental and physical disorders, and economic costs to society. Accordingly, psychiatry should advocate for education about victimization, trauma-related disorders, and the treatment of the victimization in residency training. In addition, psychiatrists should advocate for insurance to provide trauma victims with access for care adequate to their need, which are often long-term. Psychiatrists should support the systematic assessment of patients for histories of trauma, for trauma-related disorders, and for the sequelae of trauma as part of routine psychiatric, medical, and medical emergency assessment. This includes encouraging psychiatrists in practice to obtain up-to-date knowledge about trauma, its consequences, and its treatment. Psychiatrists should support both clinical assessments and research that studies the impact of trauma on the individual, family, and community, and that studies factors associated with an individual's being vulnerable to disruption by trauma, and with resilience. There needs to be increasingly robust science of memory as it is relevant to the treatment of the traumatized, which clearly indicates the polarized positions that recovered memories are inherently reliable and that recovered memories are inherently unreliable, are inconsistent with established data.

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