In the Shadow of the World Trade Center Disaster: From Trauma to Recovery

Sandra Bloom, MD, last October at the Downtown Club where ISF honored her for her work on trauma and recovery.

By Sandra L. Bloom, MD

(Last October, ISF held its second annual family violence event at the Downtown Club where we honored Dr. Sandra Bloom for her work on trauma and recovery. Sandy spoke to a group of over 130 people on the "Aftermath of September 11th." One year later, the following excerpt from her talk is as potent today. It reminds us of what is important and what we need to do to stay engaged and move forward with the healing process.)

Humans are incredibly resilient. Never write anyone off. Challenge them to move on. Don't let death have the victory. Even if you feel scared, bewildered and hopeless, you have to offer hope to them. There is a powerful life force moving us forward – always. Provide company on the journey into the darkness, but always hold on to the rope that goes into the light or you will just get lost in there with them. Have your friends and colleagues holding on to the other end of the rope for you. If you are losing your own way, reach out to your colleagues. Help each other.

Every part of a person can be injured from a traumatic event. Traumatic experience often hurts the body and may put us into close touch with death and dying. This represents a loss of physical safety. So the body needs time to heal and the body needs protection. But it also impacts on our sense of competency in the world, on our sense of self. This represents a loss of psychological safety. So we need to restore a sense of mastery and competency in the world – even if the gestures we make are logically inconsistent or even absurd. Trauma damages our social self as well and at first increases our attachment to other people in the face of a true emergency, but then erodes our sense of trust as we come to terms with the origin of the violence, as other people fail us or let us down, as we become increasingly unsure about who represents the next source of danger. This represents a loss of social safety. So we must do what we can to connect to each other to provide refuge, home, even temporary places of rest, laughter, and relief in the face of chaos. And trauma robs us of our sense of fundamental security in the world. The world doesn't make sense at all right now and we are compelled to question the most central aspects of our existence. This represents a loss of moral safety. Making meaning out of a traumatic experience is a central aspect of the reparative process and comes in as many forms as there are human beings.

Context matters. Just as physical wounds require the proper circumstances for natural healing to occur, so too do psychological wounds. Focus on creating safe, reassuring, supportive, hopeful, and inspiring contexts that promote healing. A context that promotes healing and recovery directly counteracts the effects of trauma and is a culture of belonging, empowerment, containment, communication, and involvement. It is a culture that provides physical safety, psychological safety, social safety, and moral safety.

The goal is to create a "trauma-sensitive culture" within which it is understood that most human behavioral pathology is related to overwhelming experiences of exposure to abusive power, disabling losses and disrupted attachment and therefore symptoms must be understood and responded to within the context of these dynamic forces. In a trauma-sensitive culture, the guiding question is not *"what's wrong with you?"* but *"What's happened to you?"* – it is the difference between looking at people as sick or bad psychological specimens and understanding that our work revolves around helping injured people get back on their literal and figurative "feet".

Ultimately, trauma survivors need to find a "survivor mission", something that transforms traumatic experience into something better than what was given. Encourage people's helping inclinations in any way you can. Support their wish to do something, as long as the doing is not destructive. Socially, we must all eventually transform this experience if, as a society, we are not to stay stuck or regress. There are many forms of social transformation of trauma, including helping and rescuing, mutual self-help groups, education and prevention, political and social action, humor, and artistic creation. In the United States, New York is the capital of the arts. Use them, support them, bring the artists out of the concert halls, art galleries, and performance stages and into the streets.

Sandy closed her talk with the following story.

On Nov. 18, 1995, Itzhak Perlman, the violinist, came on stage to give a concert at Avery Fisher Hall at Lincoln Center in New York City. If you have ever been to a Perlman concert, you know that getting on stage is no small achievement for him. He was stricken with polio as a child, and so he has braces on both legs and walks with the aid of two crutches. To see him walk across the stage one step at a time, painfully and slowly, is an

continued, top of next page

continued from previous page.

awesome sight. He walks painfully, yet majestically, until he reaches his chair. Then he sits down, slowly, puts his crutches on the floor, undoes the clasps on his legs, tucks one foot back and extends the other foot forward. Then he bends down and picks up the violin, puts it under his chin, nods to the conductor and proceeds to play. By now, the audience is used to this ritual. They sit quietly while he makes his way across the stage to his chair. They remain reverently silent while he undoes the clasps on his legs. They wait until he is ready to play. But this time, something went wrong. Just as he finished the first few bars, one of the strings on his violin broke. You could hear it snap - it went off like gunfire across the room. There was no mistaking what that sound meant. There was no mistaking what he had to do. People who were there that night thought to themselves: "We figured that he would have to get up, put on the clasps again, pick up the crutches and limp his way off stage - to either find another violin or else find another string for this one." But he didn't. Instead, he waited a moment, closed his eyes and then signaled the conductor to begin again. The orchestra began, and he played from where he had left off. And he played with such passion and such power and such purity as they had never heard before. Of course, anyone knows that it is impossible to play a symphonic work with just three strings. I know that, and you know that, but that night Itzhak Perlman refused to know that. You could see him modulating, changing, re-composing the piece in his head. At one point, it sounded like he was de-tuning the strings to get new sounds from them that they had never made before. When he finished, there was an awesome silence in the room. And then people rose and cheered. There was an extraordinary outburst of applause from every corner of the auditorium. We were all on our feet, screaming and cheering, doing everything we could to show how much we appreciated what he had done. He smiled, wiped the sweat from this brow, raised his bow to quiet us, and then he said - not boastfully, but in a quiet, pensive, reverent tone - "You know, sometimes it is the artist's task to find out how much music you can still make with what you have left."

"OUR LIVES BEGIN TO END THE DAY WE BECOME SILENT ABOUT THE THINGS THAT MATTER."

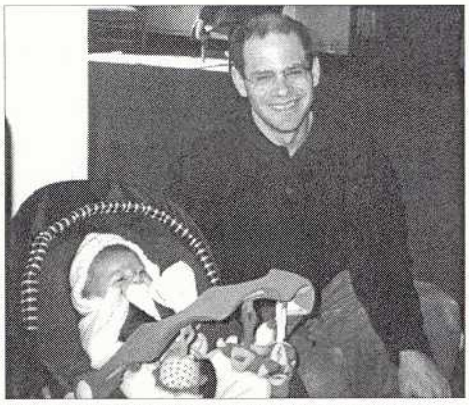
Martin Luther King, Jr.

WHAT ABOUT THE MEN?

By Jeffrey Jaeger, MD

Over the years that representatives of ISF have been performing trainings for health care and service providers throughout the Delaware Valley and elsewhere, one question has been raised again and again: "What about the men?" While a focus on women as victims and survivors is absolutely necessary and appropriate, it has always been evident to those involved in medical and other service delivery that a comprehensive approach to the problem of family and interpersonal violence (IPV) must address issues related to men. With that in mind, two years ago, a group of dedicated clinicians, advocates, social workers and others began meeting as the Clinical Network on Men and Violence. The group was originally convened as an effort to get clinicians from a wide variety of backgrounds to begin talking about how those in clinical medicine might approach men as perpetrators of domestic violence. After a few months of discussions, we realized that there had been little work in this field. We began to focus on developing a tool that practitioners might use to help them identify which men in their practices were involved in violent interpersonal relationships, with a goal of making an appropriate intervention and stopping the cycle of violence.

Originally, our intent was to help practitioners identify which of their patients might be perpetrators of IPV. We consulted with Anne Ganley, PhD, national expert on working with men as perpetrators in the health care setting, and with Sarah Buel, JD, a nationally known lawyer and advocate for survivors of domestic violence, in developing our tool. With their help, and through progressive discussions among the group, we came to realize that a simple approach to "men as perpetrators" was not going to be sufficient. It was recognized that a broader approach would be necessary. Our tool had to acknowledge that there are male victims of IPV as well as male perpetrators, and fairness



ISF Board member and leader of ISF's Clinical Network on Men and Violence, Jeffrey Jaeger, MD and his son, Lucas.

demands that we screen for both situations if we are to screen for either. Also, our tool had to acknowledge men's different utilization of the health care system, and the effect that a disclosure of perpetration might have on the provider-patient relationship. We have also had discussions about the ethics of uncovering perpetration without necessarily having the skills to help a patient process and deal with this behavior, and without having enough social resources to which a patient might be referred.

After many drafts and much discussion, we have developed a screening tool based on the successful and widely known RADAR protocol that is appropriate for use with both men and women, and which assesses for both perpetration and victimization. If a perpetrator is identified, a script is provided which allows the provider to provide initial supportive counseling and assures the safety of the perpetrator's partner. The counseling strategy focuses on the behavior, not the person, and encourages the perpetrator that the behavior he or she has described may have serious consequences to his or her health and other qualities he or she might value (freedom, the safety of loved ones). We have recently completed a survey study in which the protocol has been distributed to 80 primary care doctors for their input and feed back as we work to hone and modify the tool. With the feedback we obtain from this survey study, we will use this modified tool in several clinical settings is an effort to both determine the prevalence of male victims and perpetrators in clinical practice, and to begin the process of identification and appropriate referral of any and all of our patients involved in IPV. (Jeffrey Jaeger, MD and Darren Spielman, PhD will discuss this work at the National Conference on Health Care and Domestic Violence in Atlanta on September 27.)