TRAUMA COUNSELLING

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TO

THE TSUNAMI SURVIVORS

AND

TO THE MEMORY

OF THE TSUNAMI VICTIMS

OF 26TH DECEMBER 2004

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1
INTRODUCTION

The 26th of December 2004 was a memorable day in the world's history. It was on that day a tsunami of great magnitude devastated coastal areas of several countries. The world had never witnessed a tsunami such as this one. It was a harrowing experience for all the survivors. Though I had not been on the site, having seen the pictures on the TV itself was horrible enough. I felt depressed for a few days, especially over the news of the rising number of dead and missing people. At that time I imagined how it might have been for the survivors who bore the brunt of tsunami in all its fury and suffered a great loss of life and property.

Four months after the tsunami, I was about to return to India after my studies in Canada. It dawned on me that I may be called upon to do trauma counselling for people and train counsellors who would go to different areas affected by tsunami and counsel people. This thought made me collect materials on trauma counselling so that I could make use of them. I was convinced that I should present my materials to the public so that all could profit by my writing. Thus was born the idea of writing a book on 'trauma counselling.'

Though this book is on Post-Traumatic Stress Disorder, my predominant aim is to help people do tsunami counselling. Whether it is tsunami or any other disaster, the dynamics is the same with a little variation depending upon the type of disaster. Therefore, I speak of post-traumatic stress disorder and various types of traumas. One among them is natural catastrophe, which could be tsunami in this case. There is a commonality in all the types of trauma and the after-effects of post-traumatic stress disorder (PTSD).

I have used the term 'post-traumatic stress disorder' which is technically used in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). Not everyone is happy

with this term. There is already literature coming with a different term as 'post-traumatic stress response.' In the case of calling it a 'disorder' we somehow indicate that the person who has undergone a trauma has some deficiency, whereas the person is only responding to the effect of trauma. Therefore it is right in calling it a 'response.' All the same since DSM-IV is widely used in psychiatric circles, I have retained the term 'post-traumatic stress disorder.' By this I do not mean that the people who have undergone traumas have a basic disorder.

The materials are divided into three main parts. The first part gives an overview of trauma, explaining the diagnostic criteria of post-traumatic stress disorder. The second part deals with specific traumas and the third part is concerned about the healing process. I have restricted myself to giving an outline and general guidelines rather than a deep analysis of each trauma. A lot more research needs to be done in every aspect of trauma. Wherever possible I have endeavoured to highlight the cultural influences of the experience of trauma. From experience in mingling with various cultures, I have come to realize that what is understood as a devastating trauma in one culture is not taken that seriously by another culture. Besides, much depends upon the resilience of the individuals who have undergone traumas. In some cultures many of the ordinary hardships even are considered as traumatic for individuals. This being the case, one needs to be wary of interpreting trauma in every case. Nevertheless, whenever an experience is had as a trauma, then it will have the characteristics of post-traumatic stress disorder. With this brief introduction, I invite you to go through the pages.

PART - I

OVERVIEW OF TRAUMA

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POSTTRAUMATIC STRESS DISORDER

Posttraumatic Stress Disorder (PTSD)

(DSM-IV Code: 309.81 & ICD-10 Code: F43.1)

(DSM means Diagnostic and Statistical Manual of Mental Disorders and the number coming after it indicates the number of edition. ICD means International Classification of Diseases and the number coming after it indicates the number of edition. Every mental illness is coded both in DSM and ICD. DSM is by the American Psychiatric Association while ICD is by the World Health Organization. At present we have DSM-IV and ICD-10)

Posttraumatic stress disorder (PTSD) was first introduced in DSM-III, its inclusion being spurred in part by the increasing recognition of posttraumatic conditions in veterans of the Vietnam War. As in DSM-III-R, the disorder continues to be classified with the anxiety disorders, and the major criteria (an extreme precipitating stressor, intrusive recollections, emotional numbing, and hyperarousal) have been maintained in DSM-IV.

Not all agree that PTSD belongs with the anxiety disorders. Although anxiety is a prominent symptom, depression and dissociation are prominent as well. The diagnostic criterion of a precipitating stressor or trauma in PTSD makes this disorder different from other anxiety disorders and is more reminiscent of conditions such as brief reactive psychosis, acute stress disorder, pathological bereavement, and adjustment disorders. The International Classification of Diseases, 10th Revision (ICD-10; World Health Organization 1992), classifies all such disorders as 'stress related.'

Beyond the symptoms of PTSD per se, increasing attention has been drawn to an enduring constellation of traits that frequently develop in individuals subjected to chronic trauma as children or adults. Investigators such as Herman and van der Kolk have suggested that a discrete entity of complicated posttraumatic syndromes be recognized, otherwise designated as DESNOS (disorders of extreme stress not otherwise specified), characterized by lasting changes in identity, interpersonal relationships, and the sense of life's meaning. Similar personality changes are recognized by ICD-10 and classified as 'enduring personality change after catastrophic experience.'

1. PTSD

1) Diagnostic Criteria[1]

A person participates in the torture and murder of innocent children. A passenger is the sole survivor of a bus that plunges into a deep pit. A girl is raped and is beaten severely by an unknown assailant. The characteristic features that may develop after such traumatic events are psychic numbing, re-experiencing of the trauma, and increased autonomic arousal. The trauma is re-experienced in recurrent painful, intrusive recollections, daydreams, or nightmares. Dissociative states may occur, lasting from minutes to days, in which there is an actual re-lieving of the event. Psychic numbing or emotional anaesthesia is manifested by diminished responsiveness to the external world, involving feelings of being detached from other people, loss of interest in usual activities, and inability to feel emotions such as intimacy, tenderness, or sexual interest. Symptoms of excessive autonomic arousal may include hyperactivity and irritability, an exaggerated startle response, difficulty in concentrating, and sleep abnormalities. Rape or mugging victims sometimes become afraid to venture out alone for variable periods. Situations reminiscent of the original trauma may be systematically avoided.

There may be other symptoms like guilt about having survived, guilt about not having prevented the traumatic experience, depression, anxiety, panic attacks, shame, and rage. There may be prolonged episodes of intense affect; increased irritability, explosive, hostile behaviour; and impulsive behaviour. Still other ac-

companying symptoms include substance abuse, self-injurious behaviour and suicide attempts, occupational impairment, and interference with interpersonal relationships.

Diagnostic Criteria for Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behaviour

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of re-living the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). In young children trauma-specific reenactment may occur.

(4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) Efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) Inability to recall an important aspect of the trauma

(4) Markedly diminished interest or participation in significant activities

(5) Feeling of detachment or estrangement from others

(6) Restricted range of affect (e.g., unable to have loving feelings)

(7) Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

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

(1) Difficulty falling or staying asleep

(2) Irritability or outbursts of anger

(3) Difficulty concentrating

(4) Hypervigilance

(5) Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute : if duration of symptoms is less than 3 months
Chronic : if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

2) Aetiology

(1) Role of the stressor

The severity of the stressor in PTSD differs in magnitude from that in adjustment disorder; in adjustment disorder the stressor is usually less severe and within the range of common life experience. However, this relationship between the severity of the stressor and the type of subsequent symptomatology is not always predictable. Nevertheless, events such as rape and burglary, which are insults to personal integrity, self-esteem, and security are particularly likely to lead to PTSD. When stressors become extreme (e.g., rape, extended combat, torture, or concentration camp experiences), the rate of morbidity increases markedly.[2]

(2) Premorbid Predictors

There is some disagreement concerning whether premorbid factors predispose to the development of PTSD. Although the disorder can develop in people who do not have much preexisting psychopathology, some studies suggest that predisposing psychological factors and/or adverse childhood experiences may render individuals more vulnerable to the development of PTSD.

(3) Biological Theories

Janet, more than a century ago, described the breakdown in normal adaptation, information processing, and action that can result from overwhelming trauma and noted the automatic emotional and physical overreaction that occurs with reexposure. Freud implicated a biological basis to posttraumatic symptoms, in the form of a physical fixation to the trauma. Pavlov demonstrated chronic change in autonomic nervous system activity level in response to repeated traumatic exposure. Kardiner (1959) comprehensively described the phenomenology of war traumatic neurosis, identifying five cardinal features: 1. persistence of startle response, 2. fixation on the trauma, 3. atypical dream life, 4. explosive outbursts, and 5. overall constriction of personality.

(4) Course and Prognosis

Scrignar (1984) divided the clinical course of PTSD into three stages. Stage 1 involves the response to trauma. Nonsusceptible

persons may experience an adrenergic surge of symptoms immediately after the trauma but do not dwell on the incident. Predisposed persons have higher levels of anxiety at baseline, an exaggerated response to the trauma, and an obsessive preoccupation with the trauma after the trauma has occurred. If the symptoms persist beyond 4-6 weeks, the patient enters stage 2, or acute PTSD. Feelings of helplessness and loss of control, symptoms of increased autonomic arousal, re-living of the trauma, and somatic symptoms may occur. Life becomes centred around the trauma and there are changes in lifestyle, personality, and social functioning. Phobic avoidance, startle responses, and angry outbursts may occur. In stage 3, chronic PTSD develops, in which the patient experiences disability, demoralization, and despondency. The patient's emphasis changes from preoccupation with the actual trauma to preoccupation with the physical disability resulting from the trauma.[3]

(5) Differential Diagnosis[4]

In common with	Characteristics shared	Exclusively characteristic of posttraumatic stress disorder or of the disorder with which it is compared, or difference between the two disorders
Adjustment disorder	Stressor	In PTSD the stressor must be of an extreme (life-threatening) nature unlike in adjustment disorder in which the stressor can be of any severity
Acute stress disorder	Similar symptoms	The symptom pattern in acute stress disorder must occur within 4 weeks of the traumatic event and resolve within that 4-week period. If the symptoms persist more than a month then it is PTSD.
Obsessive-compulsive disorder	Recurrent intrusive thoughts	Unlike in PTSD, the recurrent intrusive thoughts are experienced as inappropriate

Schizophrenia, other psychotic disorders, mood disorder with psychotic features, delirium, substance-induced disorders, psychotic disorders due to a general medical condition	'Illusions' and 'hallucinations'	In PTSD they are flashbacks and not illusions and hallucinations in the proper sense as we find them in psychotic problems

2. ACUTE STRESS DISORDER

(DSM-IV Code: 308.3 & ICD-10 Code: F43.0)

The essential feature of Acute Stress Disorder is the development of characteristic anxiety, dissociative, and other symptoms that occurs within 1 month after exposure to an extreme traumatic stressor.

1) Diagnostic Criteria[5]

Diagnostic Criteria for Acute Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) The person's response involved intense fear, helplessness, or horror

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

(1) A subjective sense of numbing, detachment, or absence of emotional responsiveness

(2) Reduction in awareness of his or her surroundings (e.g.: 'being in a daze')

(3) Derealization

(4) Depersonalisation

(5) Dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of re-living the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, and people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

2) The Course of Acute Stress Disorder

The symptoms of Acute Stress Disorder are experienced during or immediately after the trauma, last for at least 2 days, and either resolve within 4 weeks after the conclusion of the traumatic event; or, the diagnosis is changed. When symptoms persist beyond 1 month, a diagnosis of Posttraumatic Stress Disorder may be appropriate if the full criteria for Posttraumatic Stress Disorder are met. The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors in determining the likelihood of development of Acute Stress Disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development of Acute Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

3) Differential Diagnosis[6]

In common with	Characteristics shared	Exclusively characteristic of acute stress disorder or of the disorder with which it is compared, or difference between the two disorders
Mental disorder due to a general medical condition	Similar symptoms	Here the cause is a general medical condition
Substance-induced disorder	Similar symptoms	Here the cause is a substance
Posttraumatic stress disorder	Similar symptoms	PTSD requires more than 1 month of symptoms
Brief psychotic disorder	Similar symptoms	Unlike acute stress disorder, brief psychotic disorder has psychotic symptoms
Adjustment disorder	Extreme stressor	If symptoms pattern does not meet the criteria for acute stress disorder, then it is adjustment disorder

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CLINICAL DIAGNOSIS OF PTSD

Having cited the diagnostic criteria of post-traumatic stress order according to DSM-IV, I now set to elaborate on the six criteria.

1. A Traumatic Event (Criterion A)

The person has been exposed to a traumatic event in which both of the following have been present:

- the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity, of self or others
- the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behaviour

Trauma in its strict sense should refer to situations in which a person is rendered powerless and in great danger. Trauma taken in this sense refers to events involving death and injury or the possibility of death and injury. It can also encompass events of such intensity or magnitude of horror that they would overtax any human's ability to cope.

In its broader sense, the word 'trauma' may mean: Natural catastrophes – tsunami, hurricanes, floods, fires, and earthquakes. Man-made catastrophes – war, concentration camp experiences, physical assault, sexual assault, and other forms of victimization involving a threat to life and limb. It also includes vehicular accidents, sustaining severe injuries in job, witnessing death or injury or its aftermath. A person is in a traumatic situation when he/she knows or believes that he/she may be injured or killed. Posttraumatic stress disorder can also develop in individuals who witness trauma on a daily basis or are subject to nearly constant and unabated stress as part of their job e.g., rescue workers, fire-fighters, health care teams, and police officers, nurses and doctors who serve in war torn areas.[1]

1) Trauma Means Wounding

The word 'trauma' can be understood differently both in medicine and in psychology. In medicine, trauma has two meanings. The first is that some part or particular organ of the body has been suddenly damaged by a force so great that the body's natural protections (e.g., skin, and skull) were unable to prevent injury. The second meaning refers to injuries in which the body's natural healing abilities are inadequate to mend the wound without medical assistance. On the psychological and mental levels, trauma involves wounding of the emotions, the spirit, the will to live, beliefs about the self and the world, one's dignity, and one's sense of security. The assault on one's psyche is understood to be so great that normal ways of thinking and feeling and the usual ways the individual has handled stress in the past are now inadequate.[2]

2) Depersonalization and Entrapment

There are two concepts that will elucidate the term trauma in relation to PTSD. They are depersonalization and entrapment. Depersonalisation means the stripping away of one's individuality and humanity. The alarming sense of being depersonalised or dehumanised is especially strong when the injuries sustained or the wounding and death witnessed seem senseless or preventable. When under attack, whether the assailant is a mugger, rapist, enemy soldier, or a hurricane, victims feel dehumanized in their loss of their right to safety, happiness, and health. While the attack is on, the individual is more like a thing, a vulnerable object subject to the will of a power or force greater than oneself. When the assailant is a natural force, such as a tsunami, the catastrophe can be explained away as an accident of fate (provided human error was not involved). When, for example, the assailant is another human person, trust in other humans and in society in general can be severely shaken or shattered entirely. There will be an inevitable loss of sense of self, of safety and trust, and of a logical predictability to life (as elements of PTSD).

There is another related loss –of having no control over one's life. Whatever is the type, duration and severity, every trauma carries with it the element of entrapment or the fact that all

escape routes are extremely dangerous or costly –considered in terms of morality, economy and in some other sense. One can identify emotional and sometimes moral aspects of the trauma that are really entrapping in the sense that none of the choices are desirable. An individual having unacceptable choices is really having no choice at all. Not having any acceptable choice makes trauma very destructive. There are examples like a mother in the tsunami having been unable to save both children, decides to save at least one and leaves the other. There are cases of combat medicos, doctors and nurses, and medical personnel who frequently have to make choices between who will live and who will die. All these people struggle with dilemma and emotional pain. Let us take the example of a woman who yields to the sexual abuser lest he should abuse her child. In guerrilla warfare there are instances of soldiers who kill women, children, or elderly people who might be spies or who might have been booby trapped or otherwise armed to destroy them. Definitely killing women and children is morally objectionable for any individual. But on the other hand, allowing themselves or their units to be injured or killed is also not acceptable. So such soldiers in reality face morally and emotionally irresolvable conflicts similar to the one experienced by other trauma survivors.

In every trauma, there are inherent elements of physical, moral, and emotional entrapment which reach their ultimate expression in situations where individuals become virtually captives. Some examples are: prisoners of war camps, hostage situations, and concentration camps, formal and informal prisons. Usually the victim is broken down by eroding if not breaking the victim's former attachments. This is done by isolating the victim from others; attempting to psychologically dominate or brainwash the victim into the perpetrator's mode of thinking; and making the victim emotionally, as well as financially, dependent on the perpetrator. Under such conditions of extreme control, victims are often coerced into betraying their own cherished values. They may be faced with morally and emotionally horrendous choices. Take, for example, a victim who is asked to choose either to be tortured and killed, and/or torture or kill someone very dear to him/her like parents, or siblings.[3]

2. Reexperiencing the Trauma (Criterion B)

The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of re-living the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). In young children trauma-specific reenactment may occur.

(4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

The basic dynamics underlying PTSD is a cycle of reexperiencing the trauma. It is usually followed by attempts to bury such memories of the trauma and all the feelings associated with the trauma. Thus we find a cycle of intrusive recall, followed by avoidance and numbing, and these have a strong biological component.

It is noted that during the second (acute) stage of the PTSD cycle, usually memories and the emotions associated with them emerge, in conscious or unconscious awareness, over and over again in a variety of forms. The victim may have intrusive thoughts or images, dreams and nightmares, and even flashbacks about the event he/she experienced. It is also likely that the victim may suddenly find himself/herself thinking or feeling as if back in the original trauma situation. All these are bound to be part of the process of reexperiencing the trauma.

Sigmund Freud said that reexperiencing the trauma (i.e., repeating it in present-day life) is a way of trying to dissipate the intense psychic energy generated by the original trauma and at-

tempting to gain mastery over it. It is like watching a movie that ended sadly. For the victim, the movie is replayed in the hope that perhaps this time the ending will be a happy one. The victim desperately hopes that enough repetition will make the movie end happily. Some victims become so absorbed with the unresolved trauma of their past that they have little psychic energy to devote to work, friends, and family, and most importantly to themselves, in the present.[4]

1) Sleep Disorders

Sleep disorders are commonly experienced by the victim. There could be dreams or nightmares about the traumatic event. When dreaming or having nightmares, the victim may shake, shout, and thrash about. In some cases the victim may not remember the dream upon awakening; nonetheless, the feelings of terror and fear experienced in the dream may persist for quite some time. In some instances, dreams or nightmares are almost the exact replays of the original traumatic event or are very similar. In some other cases, the dreams contain the feelings experienced during the trauma. They are mostly helplessness, fear, anger, and grief. Insomnia is also known to be a symptom. Because of dreams, falling asleep and staying asleep may be a major problem for the victim. It is likely that at night, without the distraction of the activities of the day, thoughts of the traumatic event can surface. Thus the victim may start thinking about the event itself or about other events involving losses and threats to safety. The individual may experience vague anxiety, nameless fears, or a generalized irritability. Alternatively, sleep problems may be an indication that the victim is suffering from a biochemical depression in addition to PTSD. Alcohol and drug use (frequently associated with PTSD) will affect the sleep patterns. Insomnia is often associated with increased arousal, or hyperarousal which is another symptom of PTSD.[5]

2) Flashbacks

Flashback is part of the PTSD process. A flashback is a sudden, vivid recollection of the traumatic event accompanied by a strong emotion. Usually during the flashback the victim does not black out or lose consciousness. The victim only temporarily leaves the present and reexperiences the original traumatic situation. The

victim may experience the trauma in all the senses –as if seeing the trauma, smelling it and hearing its sounds. The victim may or may not lose awareness of the present reality and may or may not act as if actually in the original traumatic situation. In some cases the victim may alternate between the current reality and reexperiencing the past. Flashbacks can last anywhere from a few seconds to several hours. What has been observed by researchers is that flashbacks tend to occur among individuals who had to endure situations where there was an intense, chronic or pervasive loss of security and lack of safety. Since the people around the victims ridicule them they are reluctant to report that they are having flashbacks. One should keep in mind that flashbacks are not in anyway indications that the victim is on the verge of a psychotic breakdown or some other loss of emotional or mental control. It is simply an experience of some traumatic material coming into consciousness. It is believed that the more the traumatic material is made conscious, through verbal discussions or creative therapies such as writing, dance, or art therapy, the less will be the need for it to emerge in flashbacks, nightmares, or dreams.[6]

3) Physiological Reactivity

Reexperiencing includes physiological reactivity with symptoms such as sweating, rapid heart beat, nausea, dizziness, dry mouth, hot flashes, chills, frequent urination, trouble swallowing, and diarrhoea or other abdominal problems. The source of these problems can be traced to the fight-or-flight or freeze reaction.[7]

4) Other forms of Reexperience

Besides what we have enumerated above, there are also other forms of reexperience. The victim may experience a kind of unconscious flashback which occurs when the victim suddenly has painful or angry feelings that do not seem clearly related to any particular memory of the traumatic event. Such experiences include irritability, panic attacks, rage reactions, or intense psychic pain, without any conscious thought of the traumatic event. There is a sudden and unexplained shift in mood which makes the victims feel out of control of themselves, as they did during the original traumatic event. In fact, their mood shifts may be a form of unconscious flashback, during which their psyche attempts to

dispel the tremendous energy aroused by the danger, anger, grief, and other feelings associated with the trauma. Awareness of how and why it happens may often help to restore the self-esteem in the victim.[8]

3. Numbing and Avoidance (Criterion C)

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Reexperiencing is known to be either cyclical or sporadic. The victim may be symptom-free for many weeks or months but then suddenly suffers as anniversaries approach. Any personal loss, or other current-life stress or change such as a wedding can call up memories or flashbacks. There could be also triggers in the environment such as people, places, and things that could remind the victim of the original trauma. These things can set off a memory. In any case, whenever the victim experiences the trauma, it is usually pure agony. The victim may alternate between being hyperalert and being numb or shut down, both emotionally and physically.[9]

1) Emotional Shutdown or Psychic Numbing

Whenever our body is injured, it is able to emit a natural anesthetic which permits us some time to take care of our wounds and to do whatever is necessary to protect ourselves from further injury. Severely wounded soldiers are known to walk miles to safety.

In similar fashion, trauma survivors enter a state of psychic numbing, often called 'shutdown.' In this case, the psyche in self-protection can numb itself against the onslaught of unbearable emotional pain. In any traumatic experience, it is essential for the survivor to put aside his/her feelings since experiencing and entertaining those emotions will be life-threatening. This deadening, or shutting off of emotions is known as psychic or emotional numbing. This emotional numbing is central to PTSD and is found in all forms of trauma survivors – suffering from both natural and man-made catastrophes.[10]

2) Avoidance and Triggers

Now while reexperiencing, the victim may have some of the feelings associated with the trauma that were not felt, or only partially felt, due to the psychic numbing which accompanies trauma. These could be feelings of fear, anger, sadness, and guilt which shake the victim to the core. As a result, the client may shut down, just as he/she did during the traumatic event. In any case, shutting down serves to reduce the intensity of the affect generated by the trauma. Usually victims may avoid situations that they found bring forth, or that they fear will bring forth either symptoms of numbing or hyperalertness. But this avoidance may lead to various degrees of mental, social, and physical retreat from society. For example, tsunami victims may avoid water-related activities. Every victim may have a set of triggers that can touch off memories of the trauma. By avoidance, the victims are trying to prevent a resurgence of their PTSD symptoms. But in relationships this can generate problems.[11]

3) Other Criterion C Symptoms

PTSD sufferers usually have memory impairment. Since the traumatic event was so traumatic, the victim needs to repress all or parts of his/her memories to maintain sanity and the ability to function. They might lose interest in one or more activities which had significance for them formerly. There could be also regression to previous states of development especially those who suffered extreme trauma. There are children who after a traumatic experience lost the ability to control themselves even though they had been toilet trained before the traumatic incident. If one has been

subjected to a long-term or severe trauma, one may suffer from a sense of doom about the future. Since one experienced powerlessness during the trauma, one believes that one cannot achieve one's goal in life such as career, marriage and family.[12]

4. Hyperarousal Symptoms (Criterion D)

Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

1) Fight-or-Flight and Freeze Reactions

For centuries studies have been made on mind-body relationships. What affects our mind can easily affect our body as well. Since trauma involves life-threatening situations, it gives rise to feelings of terror and anxiety. Even if one is not threatened personally, one may feel horror and grief at seeing others being injured or dying. There could also be anger at the circumstances causing the devastation. Fear, anxiety, and anger which are trauma-generated emotions, can have strong physiological components and can actually change the body's chemistry.

The change of body chemistry takes place in this way. In any dangerous situation, the adrenal glands may begin to pump either adrenaline or noradrenalin into the body. When adrenaline enters the body, it causes a state of hyperalertness in which the heart rate, blood pressure, muscle tension, and blood sugar levels increase. The pupils will dilate and the blood flow to the arms and legs will decrease, while the flow to the head and trunk increases in order that the victim can think and move better and more quickly. This is known as the fight-or-flight reaction. On the contrary, if the adrenals pump noradrenalin into the body, the victim may have a freeze reaction, during which moving or acting is difficult, if not impossible. There are victims who feel temporarily

unable to move at all. While freezing, one may experience some of the other symptoms of hyperarousal. The persistent hyperarousal symptoms caused by an adrenaline surge are similar to the one the victim experienced during the trauma. Hyperarousal symptoms or autonomic hyperactivity include insomnia, irritability or outbursts of anger, difficulty concentrating, hypervigilance and exaggerated startle response, diarrhoea or other abdominal distress, hot flushes or chills, frequent urination and trouble swallowing.[13]

5. Impaired Functioning (Criterion F)

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

In order to qualify as having PTSD, an individual must not only have experienced a traumatic event and reacted with the symptoms described in Criteria B, C, and D for over a month, but the symptoms and other reactions to the trauma must have significantly diminished the individual's capacity to work, love, and play.

Acute vs. Chronic PTSD

PTSD is considered acute if the symptoms exist for less than three months; chronic, if the duration of symptoms is three months or more.

Delayed Onset

The onset of symptoms was at least six months after the trauma.

In delayed-onset PTSD, the symptoms occur anytime later than six months after the traumatic event. This can be 1 year, 20 years, or even 40 years after the traumatic event. For example, previously asymptomatic 60-year-old people can develop PTSD in response to their having been sexually or physically abused when they were children.[14]

6. Factors Affecting Severity [15]

1) The Three Levels of Traumatic Response

Usually there are three levels of PTSD. The first is a crisis-level response, which can occur immediately or within four weeks

of the traumatic event. This crisis level response, called acute stress disorder in DSM-IV, includes PTSD symptoms, but the symptoms disappear or abate before the month specified in Criterion E for PTSD. A supportive family or community environment or crisis intervention work by a trained professional or even by a layperson can be critical in preventing the crisis reaction from becoming a more long-term disorder. The second level of PTSD conforms to the DSM-IV definition. The individual's psychological profile is relatively free of other disorders. The third level of PTSD, long-term untreated PTSD, is usually suffered by victims who did not have either community or family assistance immediately following their traumatic experience or adequate professional help at a later time. Here PTSD symptoms coexist with other disorders, which in some cases may appear to be the dominant problem. It so happens that a number of victims do not receive help for the trauma underlying their PTSD, because the symptoms that developed in the absence of positive intervention have come to dominate the PTSD symptoms. Therefore the victim presents to the mental health professional a diagnostic picture other than that of PTSD. So treatment is given to the more obvious symptoms. Consequently, the victim frequently never gets better, which reinforces his/her sense of helplessness which originated in the trauma.

2) Single-Trauma vs. Multiple-Trauma Survivors

It matters whether the victim suffered trauma once or more than once. One-time trauma is Type-1 and repeated trauma is Type-2. There is a difference between type-1 and type-2 traumas. Persons of type-2 traumas are more likely to show dissociation and other forms of self-hypnosis as well as extreme swings. It happens that in some cases, an earlier trauma will remain repressed until a subsequent trauma unearths it. For example persons who participated in wars were not so much traumatized by their experience of war as much as by their childhood traumas. Their childhood traumas remained buried until war traumas unearthed them. The multiple traumatized victim is more vulnerable to subsequent harm because the victim is more symptomatic than most people. He/she tends to be more harmful to himself/herself than single-trauma survivors.

3) Duration and Severity of Trauma

If the duration of the trauma lasts longer, higher will be the risk for the development of subsequent PTSD in the survivor. All the same, the effects of other factors also play a role in determining the impact of the trauma. One of the factors is the presence or absence of emotional support or other positive experiences associated with the trauma. The second factor is the presence or absence of blame or stigmatisation.

4) Ongoing Traumatization or its Threat

It also happens that some trauma survivors (who have endured a traumatic experience or set of experiences in the past) still continue to live in threat of danger, or are being actively abused or victimized in the present too. It is rather difficult for a victim who is still in danger or is being currently victimized to heal from PTSD. Take for example, incest survivors. They are often extremely ashamed to reveal that they are still being abused. They think that their revealing will amount to betraying the family. In a family setup the perpetrator usually instructs or threatens the victim not to tell anyone. Thus the abuse is kept secret by the victim and the healing does not take place. Even torture victims choose not to reveal the perpetrator lest they be further tortured or exterminated. At times, the ongoing-abuse victims are high-functioning, creative, normal individuals and so their abuse is not easy to detect.

5) Spiritual or Moral Concerns

Counsellors need to look into the spiritual or moral concerns of victims. Much depends upon how far the survivor has to transgress his/her moral or spiritual values or betray important emotional bonds in order to survive. Let us take for example two abuse victims who underwent the same abuse but one of them was asked to inflict injury to his/her family members or friend. He/she may be more traumatized than the one who was not asked to do so. It has been noticed that prisoners of war, and concentration camp survivors, who were made to deceive, hurt, torture, or kill family members or other prisoners, will suffer longer-term depression and other PTSD symptoms than those in almost identical situations but were not asked to participate in such objectionable activities. When they do oblige the perpetrator, they absolutely surrender to the individuals who held life-or-death power over them. In such situations where they are forced to surrender their moral identities to the perpetrator, extreme self-hate, guilt and loss of self usually follow. This ethical breakdown or moral corruption of the victims needs to be seen as an indication of the degree of traumatization, rather than as a sign of pretrauma mental illness. There are also soldiers who experience extreme conflict when they are torn between their loyalty to their motherland and their moral abhorrence of killing. Their conflict will be higher when the killing extended beyond acceptable limits to include non-military targets such as children.

6) Man-made vs. Natural Catastrophe

When we compare victims of natural catastrophes with man-made catastrophe victims, the latter suffer from longer-term and more intense PTSD. There are obviously two reasons for this phenomenon. First of all, natural catastrophes tend to be shorter in duration than the man-made ones. For example tsunami may last for 20 to 30 minutes whereas a war can last for years. Secondly, usually natural catastrophes do not involve human error, betrayal, or violence. Victims of man-made disasters must deal with the issue of trust in the healing process. All the same, in natural catastrophes, warning systems, emergency services, and disaster-relief agencies still have limitations. Victims may experience these limitations as betrayal. Take for example, the ordeals that victims undergo. They face long lines, delays, and considerable red tape before they receive the promised compensations for their losses and the compensation may not be adequate to cover the losses suffered. Thus, natural disaster survivors may have more in common with survivors of man-made catastrophes than is often thought of. But there is one difference, that is, natural catastrophe victims in general are spared the 'blame-the-victim' attitude that frequently afflicts survivors of man-made catastrophes. Generally, victims of rape, incest, and other types of abuse are blamed for either provoking the abuse or for accepting it, as if it had been their choice. Besides this, survivors of man-made catastrophes are much more likely to be seen by others as lacking in strength, caution, intelligence, or moral integrity.

7) Immediacy and Quality of Assistance

It is a fact that PTSD is a bio-socio-cognitive phenomenon as well as a psychological one. Hence, restorative experiences play a major role in the recovery process. When victims receive adequate psychological, economic, and other assistance as soon as possible following the incident, the effects are less severe and of shorter duration than if assistance is delayed, unavailable or connected with shame, degradation, and rejection. Therefore when a social support system, like significant others, important social groups and institutions, and the community at large, turns against trauma survivors, the negative effects of the trauma are compounded.

8) Meaning and Attachment Systems

Meaning system plays a vital role in the after-effects of trauma. The effects of trauma are greatly mitigated if the victim's meaning system is not significantly damaged. If the victims can make sense of their trauma, then the effect of trauma is not that severe. Thus when survivors can make sense of the trauma, they can better understand their reaction to it. Therefore they will not be as confused and disparaging of themselves as do victims who feel that their pain and suffering have no meaning. Take for example victims of physical or sexual abuse. They will be stripped of logic and sensibility when victims are told by their abuser or others that they provoked the abuse because they liked it, that they deserve it, that the abuse is a figment of their imagination, or that the abuse is not really so bad. These messages contradict the victims' sense of self-worth and their inner knowledge that they did not provoke the abuse, that they do not like and do not deserve it and that the abuse is real and painful. Usually victims' meaning system can also be challenged or destroyed by blame-the-victim messages and other secondary wounding experiences.

Research has proved that if the survivor has at least one person to turn to who can provide some assurance and emotional stability, recovery from the trauma is expedited. Victims who lose their families or other loved ones suffer a double loss. Such people not only lose a major attachment system, but also part of their meaning system as well. Every relationship has a meaning. If you have a friend and lost him/her, you are losing a meaning in your

life. Therefore to the extent that their role as family member or friend held an important meaning in your life, you lost that meaning when your relatives or friends died. For example, you can never again be daughter, wife, mother, husband, son or father if your family was destroyed.

7. What Severity Means in Terms of Treatment and Prognosis

Severity can be considered on two levels, the physical and the physiological, although the two are intimately related. Victims with a strong physical component may need to be referred to a physician for medical attention and to a psychiatrist for assessment for possible clinical depression. Clinical depression can result from two sources; it can result from prolonged untreated trauma and from physiological stress, such as hunger and exposure. There are also possible after-effects of starvation and malnutrition such as self-absorption, social isolation, propensities towards both aggressiveness and helplessness, stealing, and, in extreme situations, self-mutilation. In fact these after-effects are also symptoms of various psychiatric disorders, and can easily confuse the effects of trauma with a psychiatric disorder. Victims with histories of battering or sexual abuse may present with an eating disorder, which also may need medical attention as well as a psychiatric referral. With our limited knowledge of trauma at this point, it is difficult to predict prognosis, treatment length, or treatment modality by trauma type or severity. Added to that the uniqueness of victims makes it all the more difficult. In any case we can say that the more severe the trauma, the more intense the recovery period.

There are clients with acute reactions to a recent crisis. For them supportive counselling, education about the nature of PTSD, and crisis intervention counselling, along with eliciting family and community supports for the victims, may be all that is needed to assist the victim. One-time rape victims, if they get good help soon after the rape can recover in six months to a year. But incest survivors, depending on their age, and the duration and severity of their molestation, may require anywhere from two to three years or longer to heal. Type-1 survivors may be helped on an outpatient basis while type-2 survivors may require a period of inpatient care, followed by outpatient care. Anyway much depends a great deal on the cultural background of the victim and the psychotherapeutic approach.[16]

4
RAMIFICATIONS OF PTSD

The term PTSD originally was primarily used to refer to the struggles of Vietnam veterans. But of late, this term is used to describe the afflictions of a wide variety of trauma survivors: rape and crime victims, natural catastrophe survivors, refugees, torture survivors, abused women and children, and in some cases, survivors of vehicular accidents and technological disasters. Service and medical personnel who are constantly exposed to life-or-death situations like rescue squad workers, police officers, fire-fighters, and medical personnel in burns wards or in trauma units, have also been described as high-risk candidates for developing PTSD.

All trauma survivors suffer from the same syndrome, like helplessness in a situation of great danger. Every individual encounters his/her trauma with a unique personal history and means of coping. It is likely that different traumas tend to result in different sets of readjustment problems. However a similar and fairly predictable set of psychological and physiological reactions follow exposure to a life-threatening experience or set of experiences.

This set of reactions is what has been labelled as post-traumatic stress disorder or, if of short duration with minimum long-term effects, acute stress disorder. Although PTSD has existed for centuries, under different names, and is one of the most common reactions to trauma, it was only included in the Diagnostic and Statistical Manual of Mental Disorders in 1980 (DSM-III). The full-blown PTSD, as described in DSM-III-R and DSM-IV is not the only possible response to trauma. There are also other types of responses to trauma like psychosomatic problems, panic attacks, and other disorders. We are not yet sure about the full range of human reactions to life-threatening events. We also realize that insomnia, nightmares, substance abuse, anxiety, anger, depression, and the ever-present fear that the horror will return are common to those who suffer from PTSD.[1]

1. Trauma and Mental Illness

In former times, a number of medical and mental health professionals attributed depression and anxiety, as well as certain other symptoms, to internal psychological conflicts and problems, rather than as a response to external events. Nevertheless, in the case of trauma survivors, the trauma alone, regardless of any previous psychological problems, can lead to the development of a variety of symptoms. In the DSM-IV listing, PTSD and acute stress disorder are the only diagnoses that place the origin of the symptoms on external events rather than on individual personality. These two diagnoses are also the only ones to recognize that, subject to enough stress, any human being has the potential for developing stress symptoms and, if the symptoms persist for more than four weeks to point to PTSD or PTSD symptoms.

Ample research shows that, given sufficient stress, other factors such as an individual's previous mental stability and psychological state, are irrelevant in predicting the development of PTSD. In war veterans, the critical variable in the development of PTSD was the degree of exposure to combat – the degree of stress to which the soldier had been exposed. Similarly, a large-scale study of crime victims found that a victim's race, sex, educational status, or income level did not predict whether he or she would develop PTSD. Neither did a history of previous psychiatric illness (for example, panic disorder, agoraphobia, or depression) predict PTSD. The determining factor was instead the stressfulness of the crime. Over and over it has been found that the development of PTSD symptoms, and the severity of those symptoms, have more to do with the intensity and duration of the stressful event than any preexisting personality patterns. Although the pretrauma personality, belief systems, and values do affect reactions to and interpretations of the traumatic event, PTSD does not develop because of some inherent inferiority or weakness in the personality. It is only that the trauma changes the personalities.[2]

2. Physiological Component

When trauma occurs, it affects the whole being – not just the mind or the emotions, but also the central nervous system and other aspects of human physiology. The symptoms are the after-

effects of events severe enough to profoundly alter a person's thinking, emotions and physical reactions. It is not necessary that these events go on for years, months, or even hours. A single life-or-death incident lasting as little as a few seconds can be enough to traumatize an individual. In those few moments, an individual's emotions, identity, and sense of the world as an orderly, secure place can be severely shaken or shattered. An individual need not suffer permanent physical injury or loss in order to be traumatized. Although physical injuries and financial losses are often involved in trauma, even without them, trauma can cause profound rupture in the individual's sense of self-worth and trust in the world.[3]

3. Clinical Definition[4]

DSM-IV Criteria

There are six criteria for a PTSD diagnosis. To be diagnosed as having PTSD, an individual must meet all of the following criteria:

A. Have experienced at least one trauma or life-threatening event that had the potential for bodily harm and that the individual responded to with fear, helplessness, or horror.

B. Continue to re-live the trauma in the form of what are called reexperiencing phenomena, which include nightmares, flashbacks, and intrusive thoughts about the traumatic event.

C. Evidence of a persistent avoidance of situations reminiscent of the traumatic event and a numbing of emotions (which alternates with criterion D).

D. Evidence of persistent symptoms of physiological hyperarousal: startle response, irritability, difficulty falling asleep, hyperalertness, and other symptoms (alternates with criterion C).

E. Criteria B, C, and D must persist for at least one month after the traumatic event.

F. The traumatic event caused clinically significant distress or dysfunction in the individual's social, occupational, and family functioning or in other important areas of functioning.

1) Dynamics

The fundamental dynamics of PTSD consists of a cycle of intrusive recall of the traumatic event (usually called the intrusive stage), accompanied by reexperiencing symptoms and physiological hyperarousal symptoms, followed by a repression of the memories (usually called the numbing stage), usually accompanied by emotional numbing and in some cases partial or total amnesia of the event.

2) Symptoms

Symptoms of PTSD include, but are not limited to the following:

1. Sleep disturbances: insomnia, fitful sleep, nightmares, night sweats
2. Flashbacks: unwanted memories of the trauma and related events
3. Anxiety
4. Tendency to react under stress with survival mechanisms appropriate to the trauma (for example, abused children may react with placating or caretaking behaviours; incest victims with flirtatious or seductive behaviour; war veterans with threats or aggressive acts)
5. Emotional numbing
6. Loss of interest in work or activities
7. Suicidal thoughts and feelings
8. Fantasies of retaliation
9. Feelings of alienation and problems with intimate relationships or relationships in general
10. Cynicism and distrust of authority figures and public institutions
11. Hypersensitivity to injustice
12. Tendency to fits of rage or to passivity (may alternate between the two)
13. Hyperalertness
14. Hyperventilation
15. Overprotectiveness and fear of losing others
16. Social isolation or emotional distance from others

17. Survivor guilt
18. Avoidance of activities that arouse memories of trauma
19. All-or-nothing thinking
20. Fear of the trauma returning
21. Dissociation: trance states, denial, out-of-body experiences
22. Organ-specific psychosomatic problems and psychosomatic problems of long-standing
23. Mood swings
24. Difficulty concentrating

Polarities in Family Abuse Survivors

A number of polarities have been observed in some (not all) family abuse survivors.

1. Naivety alternating with cynicism or paranoia. A joyful 'all will be well' view of life versus an extremely negative view. The naivety and optimism reflect the survivor's denial of the abuse and wish that it did not exist. The cynicism or paranoia and negative view of life reflect the survivor's recognition of the abuse and generalization of the cruelty and manipulativeness of the abuser to other persons and to life in general.
2. Feelings of worthlessness alternating with feelings of specialness. Abusers often denigrate their victims, even to the point of relegating them to subhuman status. At other times, however, they make the victim feel special and important.
3. Self-punitive behaviour versus self-indulgent behaviour. In this polarity, survivors are mimicking the abuser's pattern of first punishing then indulging the victim. In addition, the self-punitive behaviour may reflect the survivors' self-hatred and feeling that they 'deserve' the abuse. At the same time they may reward themselves inappropriately out of feelings of deprivation or self-pity.
4. Intense dependency alternating with competent or excessive caretaking behaviour. Ironically, victims often function as the emotional, physical and in some instances the financial or sexual caretakers of their abusers. Abusers foster the victim's dependencies through forced isolation and appeals to the victim's sympathies.

3) Masked Presentations

The terms secondary elaborations, epiphenomena, and masked presentations –all refer to the psychological syndromes and problems that evolved to cope with trauma. These problems usually do not present as PTSD, but they suggest possible PTSD and should be carefully explored by counsellors for underlying causes. If the victim has suffered for a longer period from untreated PTSD, it is likely that one will find a secondary elaboration or epiphenomena of the traumatic event rather than clear PTSD syndrome. This happens especially when victims are in the numbing stages of PTSD and may have difficulties remembering the trauma ranging from partial recall to complete amnesia.

4) Secondary elaborations include:

1. Alcohol or drug abuse
2. Eating disorders: bulimia nervosa, anorexia nervosa, compulsive eating
3. Compulsive gambling or compulsive spending
4. Psychosomatic problems
5. Homicidal, suicidal, or self-mutilating behaviour
6. Amnesia
7. Phobias
8. Panic disorders
9. Delinquent or criminal behaviour
10. Depression or depressive symptoms
11. Dissociation symptoms
12. Fainting spells
13. Psychotic episodes
14. Previous diagnosis of a depressive disorder (a major depression, single episode; major depression, recurrent; dysthymia or depressive neurosis; depressive disorder not otherwise specified)

15. Previous diagnosis of a dissociative disorder (hysterical neurosis; multiple personality disorder; depersonalisation disorder; psychogenic fugue; or dissociative disorder not otherwise specified)
16. Borderline personality
17. Sleepwalk disorder

4. Three Stages of Recovery[5]

Paul Hansen (1992) identified three stages of recovery: the victim stage, the survivor stage, and the thriver stage. We need not always expect the victim to go through the three stages in a neat and orderly way. For example, the victim may suddenly have a memory of the trauma and then again lose memory of the event.

It is likely that the least traumatic memories emerge first and then the most traumatic memories. The survivor may be plunged (temporarily) back into some victim thinking, feeling, and behaving. The survivor may not be in the same stage in all areas of life. The victim may be in the thriver stage with regard to certain relationship but in the victim stage with regard to other aspects.

A victim is someone who is harmed or killed by another, or someone who is harmed or made to suffer from an act, circumstance, agency, or condition. A victim is also anyone who suffers as a result of ruthless design either incidentally or accidentally. The suffering and losses can be physical, psychological, or both.

People raised in poverty, and those subjected to racial, sexual, religious, or other forms of discrimination, are often viewed as victims of social and historical forces beyond their control. Similarly, people who acquire life-threatening or chronic illnesses or permanent disabilities can also be considered victims. We define a victim as someone who has suffered from at least one particularly negative, intensely disruptive event.

Victimization, which means the process of becoming a victim, can be considered to occur on three levels.

1. The traumatic event itself.
2. Secondary wounding experiences. These are experiences in which the institutions, caregivers, and others to whom the trauma survivor turns for emotional, legal, financial, medical, or other assistance respond by: disbelieving or discounting the victim's experiences; blaming the victim for the traumatic event; stigmatizing or negatively judging the victim for the trauma or for any long-term symptoms he or she may suffer; and denying the victim promised or expected services.
3. The acceptance of the victim label. On this level of victimization, the victim internalises society's perception of victims as incompetent, inferior, careless, or immoral or as having some other (usually negative) quality that caused the trauma to occur.

1) The Victim Stage

If an individual experiences trauma once, that is enough to qualify him/her as a victim. It is not necessary to have experienced trauma many times. The victim stage itself consists of three stages: prediscovery of the trauma, early awareness, and discovery. In the prediscovery stage, trauma victims suffer PTSD symptoms with little understanding of their origin or relationship to the trauma. During the early awareness stage, victims have a vague sense that they experienced a traumatic event, which leads to increased anxiety and some depression, irritability, and dissatis faction with themselves and others. When the trauma begins to come into awareness, there is initial disbelief and shock, vacillation between denying the trauma and allowing it to come into awareness, and an increase in PTSD symptoms such as flashbacks and nightmares.

2) The Survivor Stage

When one is in the victim stage, one is out of control – either of the situation at hand or of one's inner life. In the survivor stage and subsequently in the thriver stage, one has increased control over one's environment and one's inner self. In the survivor stage, the trauma is confronted partially or in whole, and the intense feelings associated with it begin to emerge from repression and might find constructive expression. As the victim moves from repression (into awareness and begins to examine the trauma and its emotional, mental, and other after-effects), the traumatic memo-

ries and formerly repressed feelings that controlled one's life and one's inner life, relationships, and external behaviours will lose much of their former power.

3) The Thriver Stage

In the thriver stage, the organizing principles are personal goals, not the trauma. Slowly the victim begins to pursue new education, job, and life goals which might change one's family life. There may not be many emotional upheavals and the thriver has greater inner peace and serenity. At this level, there may be some symptoms of PTSD, but they are fewer in number and less intense. The survivor might have acquired some skills to manage the symptoms. Therefore the victim experiences considerably less anxiety and panic in response to the symptoms.

5. Contributing Factors[6]

Some argue that family history, genetics, and personality variables explain why some individuals succumb to the disorder. Yet research shows that when the stressor is sufficiently great, almost any individual will develop PTSD. The degree of impact of the trauma, however, is not uniform. Some individuals suffer longer-term impairment and more severe symptoms than others, but this individual variability only highlights the fact that PTSD is complex and its manifestation subject to numerous individual personality and social factors. Victims who recover from trauma more readily are those with the following advantages: 1. Good health that is not significantly impaired by the trauma, 2. No physical disfigurement as a result of the trauma; 3. Adequate financial support or services; 4. The ability to resume functioning in some, if not all, pretrauma roles; and 5. A supportive network of significant others. We can reasonably conclude that the question of who gets PTSD includes consideration of antecedent variables, as well as the trauma itself, with a special emphasis on how their interaction might have created extra stress on the individual. For example, people with histories of emotional or other deprivation, previous trauma, or other significant emotional problems are probably more vulnerable to trauma and may be more likely to develop PTSD. Individuals who must face their trauma alone, without a comforting or nurturing friend or relative, have also been

shown to suffer more than individuals who have at least one source of consistent human concern and affection.

1) Antecedent Variables

To have a full picture of the meaning and impact of the trauma on the victim, we need to take into account relevant childhood or pretrauma characteristics. This in no way blames trauma survivors for their own pain. It is not also meant to support the predisposition theory, which attributes the development of PTSD to the client's predisposing personality and other antecedent variables. The predisposition theory has been disproved by numerous researches on Vietnam veterans and veterans from earlier wars. It was noted that PTSD did develop among even the most mentally healthy and dedicated of soldiers. It is possible that a negative experience may have a devastating impact on one individual and a mildly distressing effect on another. But sufficiently high stress levels will cause almost anyone to develop acute or long-term PTSD. Therefore it is not right to say that individuals predisposed to PTSD by inherent weakness or deficiency will develop the syndrome. This attitude is humiliating the victim and besides, it is not based on reason. To date we are still ignorant as to the precise interaction between trauma, constitutional factors, level of personality development, cultural factors and the ultimate expression in the form of altered affect, behaviour, pain, perception and somatic functioning.

2) Client Deficits

Just as the pretrauma conditions are not enough reason for blaming the victim, neither victim deficits should be construed to blame the victim for his/her pain. Victims go to counsellors not just because they are haunted by the trauma, but also for other difficulties within themselves, with interpersonal relationships, with their health, with the law, or with some other present area of life. Of course there are some difficulties that are clearly and directly trauma-related, but others are not. There are some problems that may have been created by the trauma, while at the same time the trauma exacerbated certain minor difficulties and converted them into major life obstacles. Trauma survivors experience emotional and cognitive changes that are appropriate to the

situation of the trauma. We should keep in mind that these changes often hold survival value and may even save lives during the traumatic episode.

If we take the survivors of incest and other forms of child abuse, they usually practice dissociation or learned to 'tune out' while being beaten, raped, or abused. They may continue to practice dissociation in the present and hence are vulnerable to revictimization by others since the dissociation covers up warning signs of possible danger. Appallingly, revictimization of family abuse survivors is very common. Revictimization need not be limited to physical or sexual abuse, but may include economic exploitation. These people have 'blind spots' and cannot pick up the usual warning signs that another person may be malevolent or exploitative. While counsellors identify the strengths of the victims, it is also important to identify their problem areas so that they may not be revictimized.

5
PHYSIOLOGY OF TRAUMA

Trauma survivors first of all have the challenge to cope with the traumatic incident or a series of incidents. Secondly, they face the challenge of understanding and coping with current life situations that, consciously or unconsciously, remind them of the trauma. Most of the time they find themselves either overreacting or underreacting to these situations. In either case, their responses are usually inappropriate and personally problematic. Survivors' self-esteem may be damaged not only because of stigmatization by society, friends, or family, but also because they greatly fear and grossly misunderstand their own trauma-related responses to present-day events. When the survivors do not understand the cause of their reactions, they may feel not only like failures but also like social misfits or as if they are emotionally aberrant.

PTSD is a bio-socio-psychological problem. In this chapter let us consider the biological aspect of it.

Abraham Kardiner described PTSD in 1941 as 'physioneurosis, a mental disorder with both psychological and physiological components. Our bodies when traumatized continue to be on the 'alert' for a likely return of the trauma and tend to react to even minor stresses with physiological emergency responses. Our central nervous system has a limited and rather consistent response to overwhelming life experiences. These responses to trauma are relatively consistent across various traumatic stimuli.

It is hypothesized that the following features of PTSD have physiological bases: persistent startle response and irritability, rage reactions, fixation on the trauma, constriction of the general level of personality functioning, and an atypical dream life. These biochemical shifts also have been found to create difficulties in four other areas of a survivor's current life: in thinking clearly, in regulating the intensity of emotions, in relating to other people, and in sustaining hope for the future. Trauma-induced biological changes

can also lead to or contribute to the development of clinical depression and substance abuse problems. Emotionally, the traumatic stressor gives rise to four affects which are, during the trauma, unbearable: fear, grief, rage, and heightened anxiety at confronting one's powerlessness and the possibility of death.

From the point of view of physiology, trauma can give rise to a number of bodily changes. Those changes are: increases in heart rate, blood sugar, muscle tension, and perspiration, dilation of the pupils, and hyperventilation (rapid shallow breathing from upper lung versus more normal gentle breathing from the lower lung). Due to hyperventilation, there will be irregular heart rate, dizziness, shortness of breath, choking sensations, lump in the throat, heartburn, chest pain, blurred vision, numbness or tingling of mouth, hands, or feet, muscle pains or spasms, nausea, shaking, fatigue, and confusion or inability to concentrate. As the adrenaline increases, it can lead to flight-or-fight or a freeze reaction, as well as biochemical shifts in certain neurotransmitters. Neurotransmitters are involved in regulating emotions. But changes in their functioning have serious consequences for the survivor's ability to handle subsequent intense emotional experiences and life stresses.[1]

1. Adrenalin Reactions

When we are in a life-threatening situation the adrenal glands are highly reactive. The adrenal glands are two diamond-shaped organs, located on top of the kidneys. They secrete large doses of either adrenalin or noradrenalin in response to the threat of danger. When activated, adrenalin provides a supercharge of energy, which enables us to move with more speed and power than in usual circumstances. When it is in surge, the heart rate increases, the pupils dilate, digestion slows down, and blood coagulates quicker, in order to prevent too much blood being lost in case of a possible injury. The lungs become more efficient, providing the increased oxygen necessary to fight back or run away as powerfully as possible. Sensations are perceived very sharply: thus sounds, smells, and other sensory data are perceived more vividly, and the brain uses the sensory data to assess the situation, thus maximizing the chances for survival. Just because there is the increased oxygen, the brain can work more quickly and efficiently to make the best decisions possible.

When noradrenalin is secreted, it makes us freeze or go numb. It is something similar to some animals playing dead when threatened. Here we need to note that adrenalin surges can be highly problematic, because they cannot be turned off at will. Once the surge has started, it takes its own time to subside, even when the threatened situation no more exists. That is why soldiers in battle are easily tempted to discharge their excess adrenalin through abusive violence, needless killings, or other acts of destruction. This is precisely what happens to some police officers and others involved in security work. Since they are under the grip of adrenalin surge, they mercilessly beat the victims even though it is evident that what they do is out of proportion.[2]

2. Depletion of Neurotransmitters

When we are under severe stress, there is an initial massive secretion of certain neurotransmitters. But when the stress is prolonged, there will follow a depletion of these neurotransmitters because of their over secretion. Some of the major neurotransmitters that tend to be depleted as a result of continuous or intense stress are norepinephrine (noradrenalin), dopamine, serotonin, endogenous opioids, and catecholamines. These are very important because they serve as 'emotional buffers' and help individuals regulate the intensity of their feelings. So when these neurotransmitters are depleted, the trauma victim is subject to clinical depression, difficulties in modulating emotions, leading to mood swings, explosive outbursts, startle response, and hyperreactivity to subsequent stress. Another consequence is the development of 'learned helplessness syndrome' which involves diminished motivation, clinical depression, and a decline in optimal functioning. Because of the depletion of some neurotransmitters, one either overdepends on other people, having feelings of 'I can't make it without you,' or 'I don't need anyone; I can make it on my own.' [3]

3. Learned Helplessness

Martin Seligman (1975) did notable research with animals. In his experiments, animals were given electric shock from which they could not escape. Whether they did something to escape or not, they received electric shock. In such situations, they usually fought, tried to get away, uttered cries of pain or anger, but later

gradually became listless and were desperate. These animals were later subjected to electric shock with the provision that with some very simple activities they could escape electric shock. But these animals would not do those simple activities to escape electric shock. What happened was that the animals had learned to be helpless. The animals were too defeated, or too changed neurologically due to their previous experiences that they could not take the simple actions that would end their suffering. It was noted that even when the animals did the simple activities and the responses succeeded in producing relief, they had trouble learning, perceiving, and believing that their responses worked. As a result, their emotional balance was seriously disturbed; depression and anxiety predominated. Because of this learned helplessness, victims do not leave the abusers and strike out on their own. Yet learned helplessness can be helped with education, counselling and psychotherapies. Victims can, with effort and support, unlearn what the trauma ingrained.[4]

4. Biological Basis of the PTSD Cycle

We realize that from the learned helplessness syndrome that there is a physiological basis for some of the basic characteristics of PTSD: the tendency to react to relatively minor stimuli, as if the trauma were recurring; the visual and motor re-living of the trauma through nightmares, flashbacks, intrusive thoughts, and behavioural re-enactments; and the emotional numbing with various forms of attendant passivity, listlessness, and despair. Since physiological arousal is paired with traumatic memories, being physiologically aroused over any stimulus, whether related to the trauma or not, can precipitate remembering or re-living of the trauma. In the same way, the reverse too can be true: any stimulus that reminds the trauma survivor of the trauma, whether a person, place, thing or emotion, can precipitate a state of physiological arousal and emotional overload, especially when the emotion-buffering neurotransmitters are lacking.[5]

5. Implications for Intrapersonal and Interpersonal Relationships[6]

It is seen that reliving the trauma and hyperarousal are connected, the victim learns to avoid situations of intense emotion or

stress. If the situation cannot be avoided, the individual may need to shut down, emotionally and/or physiologically. This in turn creates problems for the victim in dealing with other people and with one's own self-concept and self-esteem. Denying or fighting their trauma does not yield to healing. On the contrary when victims become educated about the nature of trauma and its possible emotional and physiological consequences, and accept their conditions, then healing is under way.

1) Difficulty Modulating Emotion and Poor Affect Tolerance

Usually trauma survivors may either respond to emotional stimulation with an intensity appropriate to the original traumatic situation they encountered, or they may not react at all. Because of their traumatic experience, their heightened emotions are paired with physiological hyperarousal and the possibility of re-living the trauma, both of which can lead to heightened anxiety. This anxiety can create cognitive and emotional disorganization, which may further increase anxiety. In this process both the depletion of the neurotransmitters responsible for helping individuals to modulate their emotions and any negative views victims have about emotional intensity and expressiveness can play a critical role. Thus victims may respond to the situation with action, with somatic symptoms, or by shutting down and avoidance, rather than with thoughtfulness. As we have noted early, this tendency of the trauma survivors to respond in an all-or-nothing fashion, is part of the fight-flight-freeze reaction. This is one of the physiological reactions to trauma.

2) Regression: Inability to Differentiate Emotions

Psychological regression can take place due to PTSD. As we mature, emotions become more specific and differentiated than when we were babies. If one regresses due to trauma, there can be loss of differentiation, and emotions may express themselves physically, in terms of psychosomatic illness. Victims who have regressed emotionally are in danger of becoming overwhelmed by their responses and may have to block their feelings completely.

3) Difficulty Modulating Dependency and Intimacy

As a result of trauma, biological shifts can take place and play a major role in creating depression, poor affect tolerance, and inability to modulate intimacy and dependency in victims. These shifts often cause victims feel not in control of their lives since many times they did not experience control over their emotions. Since they feel that they are not in control of their emotions, the awareness of the inappropriateness of their responses may in turn, cause them to either cling to a caretaker and become overly dependent, or to isolate, shun relationships, and adopt a counterdependent stance.

6. Depression as a Secondary Elaboration[7]

Depression is a clinical entity. Counsellors must be able to distinguish it from normal blues, from grieving, and from other emotional states with depressive components.

1) Definitions and Causes of Depression

All of us have blues from time to time. There is a difference between those blues and biochemical or clinical depression. Depression usually forms a part of the grieving process. When there is an external loss, grief is a response. But in clinical depression the grieving may be unconscious or only partly conscious. As opposed to normal grieving, there is usually grief over psychological or spiritual loss, such as a loss of innocence, a loss of a belief once held dear, or the loss of self-respect. If it is a normal grieving, depression tends to lessen over time, even though it may take years. In clinical depression, there is a mixed feeling toward oneself and others or active self-hatred and physiological problems such as sleep disturbances and fatigue. In it the negative feelings are so overwhelming that they impair the ability to function. For example, one stops going out and avoids socializing. Even the smallest task seems like a Herculean task and the individual finds it difficult to concentrate. One is not able to meet the most basic obligations to one's family or oneself. It can also impair reality testing. Therefore one becomes hypersensitive to the reactions of others and consequently may have a distorted view of others' feelings. Trauma survivors are liable to develop clinical depression. In some cases,

they may already have a clinical depression of which they are not aware. In any case, whether the depression predates the trauma or developed afterward, the effect is the same. One can safely say that clinical depression is caused by many factors, some of which are beyond one's control. Of course, several of these causes can be directly related to trauma. Let us consider some of the theories of clinical depressions.

(1) Biological Theory

In this theory, depression is the result of disturbances in the neurotransmitter system, usually caused by the depressed person having been subject to severe stress for a prolonged period of time. Because of stress or trauma, one's biochemistry becomes so strained that it cannot perform its functions as it did before the traumatic event. Once the neurotransmitter system breaks down, it can lead to low self-esteem, hopelessness, and other forms of negative thinking, and to difficulties with concentration, sleep, and decision making. It can also lead to irritability, anxiety, loss of the ability to experience pleasure, and hypersensitivity to the reactions of others – all of which are classic symptoms of depression.

Physical illnesses, severe injuries and permanent disabilities or multiple medications can cause depression. They usually tax the neurotransmitter system immensely. Besides these, they also put a strain on other bodily functions. Thus these stresses further disturb the biochemical balance and negatively affect the central nervous system.

(2) Loss and Grief Theory

According to Freud, depression was the result of grief over the loss of a love object. This grief is usually mixed with anger and hostility towards the loved one. Freud believed that the loved one need not be dead. It will suffice to have the end of the relationship with the loved one to cause depression. For Freud, the concept of the loved one can include a cherished ideal, certain spiritual values, or self-respect.

(3) Behavioural Theory

For the behavioural theorist, depression is the natural result of inadequate reinforcement, rewards, or recognition. When

one is inadequately rewarded or appreciated by others one can develop depression. Depression is also caused by individuals who are unable to adequately appreciate, reward, or lovingly care for themselves. It so happens that trauma survivors lack both reinforcement from others as well as self-reinforcement. If people denigrate trauma survivors or do not acknowledge them properly for their efforts to survive or if trauma survivors have withstood long-term traumatic conditions for which they received few rewards, they may be at risk for depression.

(4) Learned Helplessness Theory

Part of learned helplessness is a belief that one cannot exert control over the important events in one's life. If one has feeling of helpless resignation or believes strongly in fatalism that can lead the individual to a clinical depression. During trauma, there is a direct experience with powerlessness and trauma survivors experience biochemical changes by which they are especially susceptible to learned helplessness and consequently to depression.

(5) Cognitive Therapy

Depression is understood as a problem of thoughts and beliefs, rather than feelings. According to this theory, if one begins to think that one is helpless or ineffectual, then such thinking controls one's behaviour. Depressed individuals tend to misinterpret life events and thus distort their view of the world, themselves, and the future in a hopeless direction. Such distortions and misinterpretations are often directly related to trauma.

(6) Anger Turned Inward Theory

When we do not know how to express our anger, are afraid to express our anger, or feel we do not have the right to express it, we often turn that anger on ourselves, resulting in depression. During trauma, the individuals would have suppressed their anger since expressing anger could have caused their death or could have led to physical abuse or other forms of punishment. Even after the abuse or captivity is over, they tend to hold on to the habit of suppressing their anger and they find it difficult to unlearn this habit. When there is a large bureaucracy or institution which is non-responsive, the trauma survivors have no clear identifiable

target to express their anger, and thus they turn their anger inward. In the same way survivors of natural catastrophe have no identifiable target. One is not going to express anger toward nature. Even expressing anger with supernatural being like God is not that comforting, since one has to naturally turn to God for protection. Therefore for such people it is safer to turn their anger inward than to risk a loss of faith by blaming God.

(7) Unrelated Causes

There are also events that are not directly related to trauma and yet cause depression. Thus acute brain syndrome, some other organic mental disorder, or a psychiatric problem such as schizophrenia or paranoia can cause depression. Heredity also can play a role in causing depression. Thus depression can also be hereditary in the sense that the strain of the trauma can bring forth these and other latent genetic-based psychiatric disorders. Therefore, depression is known to run through families.

(8) Depression over Depression

It is not surprising to note that there are some people who are depressed about being depressed. They tend to interpret their depression as sign of inadequacy and failure and feel great shame and guilt over being depressed. This feeling is reinforced by three factors: first of all, there are societal attitudes that blame people for their own pain; secondly, there is societal ignorance about depression; and finally, there are cultural norms that view any person in emotional pain as weak or deficient.

7. Substance Abuse and Compulsion as Secondary Elaborations[8]

Addictions and compulsions are complex phenomena. There could be many possible causes, ranging from genetic and biochemical factors to social pressures to dysfunctional family backgrounds. Since trauma survivors suffer from symptoms of PTSD, addictions and compulsions seem to serve as forms of self-medication. There is definitely a lot of pain and frustration in being hyperalert and unable to sleep or the agony of being constantly on guard against others and against one's own mind. Even the numbing stage is very painful. For the trauma survivors to feel bored or

shut down can be an excruciating experience. Because of these intolerable experiences, some survivors reach out to mood-altering substances, such as alcohol, drugs, and food, or to mood-altering activities, such as compulsive gambling, shopping, or sexual behaviour. These substances and activities provide comfort and relief. These drug, food, and compulsive behaviours can serve as both stimulants for the numbing phase and sedatives for the hyperalert stage of PTSD. These are also helpful in fighting insomnia, bad dreams, and intrusive thoughts. For those trauma survivors who have problems of avoidance symptoms of PTSD, these can help them against the tendency to isolate themselves from others. Thus addictions or compulsions give them the courage and confidence they need to feel comfortable with others.

1) Addictions, Compulsions, and Depression

Several victims of PTSD become substance abusers via depression. There are noticeable correlations between alcoholism and depression and between eating disorders and depression. We are not sure yet whether the alcohol abuse comes first or the depression. But we know that prolonged alcohol use, with its debilitating effects on the body and on the individual's ability to function, can actually create biochemical depression. We are also not sure whether the eating disorder comes first or the depression. It is possible that eating disorder may have begun as a means of coping with the sad, lonely, angry, hopeless, and otherwise negative feelings associated with depression. However, it is also known that prolonged dieting can create biochemical depression by stressing the neurotransmitters and by depriving the body of adequate nutrients. It has been found that for controlling binge drinking and binge eating, anti-depressants are exceptionally successful. This indicates further evidence of the relationship between depression and addiction.

6

THREE LEVELS OF VICTIMIZATION

1. Level One: The Shattering of Assumptions[1]

Being victimized, whether in a car accident, tornado, mugging, war, or abusive relationship, shocks both one's body and emotions. Even worse, is the way it rocks one's basic beliefs about oneself, human nature, and the nature of the world. The challenge or shattering of these beliefs can greatly increase one's psychological distress. Any anxiety, confusion, depression, or disequilibrium experienced after the trauma is heightened by such thoughts as, whom or what should I trust now? After what happened, I don't know what to believe in anymore.

Victims usually are forced to reconsider at least three assumptions about themselves and the world: that they are personally invulnerable, that the world is orderly and meaningful, and that they are good and strong people.

1) Loss of Invulnerability

People do not think that something so devastating could happen to them. But it did happen to them! Therefore they may no longer feel safe. At the very least, they probably feel less safe than they did before the trauma. Since one is traumatized once, even if others assure that it cannot happen again, one fears it will. These feelings of vulnerability may develop into two of the classic symptoms of PTSD: a sense of doom or a foreshortened future, and an intense fear that the trauma will repeat itself.

2) Loss of an Orderly World

One might ask why such a thing should happen at all and why should it happen to one. One thinks that if one was careful, honest, and good, the disaster would not have happened. As a result of these questioning, one concludes that life is meaningless and incomprehensible. One might also think that one is singled out for pain and punishment because in some way one deserved

what happened. Perhaps one was deficient, bad, or unworthy. Some think that the event was God's will, or the work of the devil or some form of spiritual warfare.

3) Loss of Positive Self-Image

Being victimized or traumatized usually brings to the fore people's feelings of helplessness, vulnerability, and powerlessness. Therefore they find themselves feeling more dependent on others than ever before. Society views vulnerability and reliance on others as a weakness. This precisely makes it very difficult to accept neediness as a normal, even healthy, part of the response to trauma. These things affect the victim's self-image.

4) Other Common Victim Responses

The first level of victimization can also include the following reactions: feeling like a child, a desire to withdraw or isolate from others, feelings of anger or rage.

(1) Feeling Like a Child

Brutalisation, victimization, and losses make one a child. It is common for trauma survivors to want and need to cling to others for protection, assurance, comfort, and love, like children who have just witnessed something terrifying. As children we would like to be held and told that there is nothing to worry and that others are there with us to take care of us. The high substance-abuse rate among PTSD suffers can be partly explained as a way of dealing with the increased dependency and security needs normal to trauma survivors. There are environments and occupations in which feelings of helplessness and dependency are not welcome, such as in military, and in occupations such as police and rescue work. Victims may need physical assistance like medical or legal help or financial assistance. These nonemotional needs can contribute to feelings of childlike dependency.

(2) Withdrawing from Others

It is observed that along with the increased need for others, there is a strong need to isolate and withdraw. Victims may feel strong pull in two directions. One of them is to cling to others and get reassurance, and the other is to isolate, to hide one's confusion and self-doubt.

(3) Rage and Anger

Victims considerably experience anger. Specific persons, groups, organizations or governing bodies may have been responsible, in whole or in part, for the trauma itself. If one was proud of one's self-sufficiency prior to trauma, then the dependency now experienced may be infuriating. At this point one decides to hide one's feelings and needs from others and just pretend one is who one was before the trauma. One may have decided not to seek outside assistance, even financial or other help, fearing denial or rejection – or even being judged as crazy. Eventually the pretending can become very taxing.

5) Accepting Help

Victims need to be convinced gradually that needing help is normal and one can accept assistance from others. It is shown that trauma survivors who have someone to turn to are at lower risk for developing PTSD than those who must or who choose to cope with the trauma all alone. Victims who have someone to assure them that everything will be all right, and that he/she will be there to help, are less likely to develop long-term problems such as chronic illness or extreme dependency on others or on institutions for their care.

2. Level Two: Secondary Wounding[2]

Sometimes, unintentionally, people could be cruel. They could be friends, family members or helping professionals. Instead of being supported, one may have been made to feel ashamed of having been a part of a traumatic event in the first place, of one's reaction to the event or symptoms one has developed as a result, or even of asking for help. Some people might remark that one is not hurt enough to be entitled to such benefits, or they could say that the event happened weeks or months or years ago and so one should have got over it by now. Such attitudes can be very wounding to the victims.

1) Forms of Secondary Wounding

The attitudes and treatment by people, institutions, caregivers, and others to whom the victims turn for emotional, legal, financial, medical, or other assistance can cause secondary wounding. Let us consider what they are.

(1) Disbelief, denial, discounting

One of the common experience of victims is that people will deny or disbelieve the trauma survivor's account of the trauma. Or they will minimize or discount the magnitude of the event, its meaning to the victim, its impact on the victim's life.

(2) Blaming the victim

People might blame the victim for the traumatic event and thus increase the victim's sense of self-blame and low self-esteem.

(3) Stigmatisation

Stigmatisation occurs when others judge the victim negatively for normal reactions to the traumatic event or for any long-term symptoms he/she may suffer. These judgements can take the following forms: ridicule of, or condescension toward, the survivor; misinterpretation of the survivor's psychological distress as a sign of deep psychological problems or moral or mental deficiency, or otherwise giving the survivor's PTSD symptoms negative or pejorative labels; an implication or outright statement that the survivor's symptoms reflect his/her desire for financial gain, attention, or unwarranted sympathy; and punishment of the victim, rather than the offender, or in other ways depriving the victim of justice.

(4) Denial of Assistance

Trauma survivors are sometimes denied promised or expected services on the basis that they do not need or are not entitled to such services.

2) Causes of Secondary Wounding

Secondary wounding happens because people who have never been hurt have difficulty understanding and being patient with people who have been hurt. It could be because most people perhaps have never confronted human tragedy. There are some people who are not strong enough to accept the negatives in life. It might happen that other trauma survivors who deny or repress their own trauma, may reject or disparage other survivors.

Some of the common causes of secondary wounding are ignorance, burnout, just-world-philosophy and influence of culture. Ignorance is one of the causes of secondary wounding. Since people are not aware of the nature of trauma and its effects on individuals,

they do not understand the full implications. Burnout is another major cause that can happen with helping professionals like the police, rescue workers, doctors and other emergency room staff. Perhaps they themselves are suffering from some form of PTSD or burnout. Since they are working for years with trauma survivors, they are emotionally depleted as trauma survivors. They themselves feel unappreciated and unrecognised by the general public and by those in their workplace. Some of the victims suffer from just-world-philosophy according to which, people get what they deserve and deserve what they get. It presupposes that if you are sufficiently careful, intelligent, moral, or competent, you can avoid misfortune. Even if the victims are not directly blamed, they are seen as causing their victimization by being inherently weak or ineffectual. In certain cultures, self-sufficiency and independency is strongly emphasized. In those cultures victims who depend upon others are frowned upon.

3. Level Three: Victim Thinking[3]

The third level of victimization occurs when one internalises the victim status and thinks and acts as if one is still being victimized even though one is no longer in the original trauma situation. It involves the person adopting a lifelong label as a victim. The traumatic event and its aftermath become the central and dominating events in trauma survivors' lives, and control their self-esteem. In the first two levels of victimization, one has little or no control or personal power. But one can learn to take control of this third level.

1) Sources of Victim Thinking

One's victim thinking can be traced either to one of the four common cognitive mindsets that tend to emerge during traumatic or secondary wounding experiences or to one of the symptoms of PTSD. They are intolerance of mistakes in others and in yourself, denial of personal difficulties, all-or-nothing thinking, and continuation of survival tactics.

(1) Intolerance of mistakes

During certain traumatic events (combat, fires, floods, family violence) and in certain occupations that involve injury and

death (nursing, rescue work, fire fighting, police work), mistakes cannot be accepted. Even the smallest error can result in death or injury to another or to oneself. A trauma survivor may develop such an attitude of 'no-mistakes-allowed.' This mindset can easily lead to perfectionist values. Expecting perfection may inevitably lead to disappointment and conflict in relationships. This may reinforce victim thinking.

(2) Denial of Personal Difficulties

Certain occupations, for instance, medicine, police work, combat duty, and rescue work, emphasize the necessity for solid thinking, quick action, and endurance, both physical and psychological. There is no room for expression of emotions or for personal weaknesses. If they are emotionally honest they may be seen as cowards, weaklings, incompetents, or otherwise unfit. Trauma survivors too deny personal problems for fear of being seen as weak or defective because of their experiences. To avoid this stigma, they take up a stoic stance. But denial is counterproductive and makes one all the more vulnerable. Thus the victim thinking is generated.

(3) All-or-nothing Thinking

Trauma survivors may tend to view people as friends or enemies. They do not seem to have people in between. This is a black-and-white thinking which when applied to the trauma survivor, he/she may find himself/herself as a total failure or a total success. Absolutist thinking is especially strong among survivors who, due to the characteristics of the traumatic event, learned to trust some people almost entirely and some people not at all. They may not see themselves always as a success and so the feeling of failure is bound to come upon them. This is one of the sources of victim thinking.

(4) Continuation of Survival Tactics

One's survival tactic during one's traumatic event may have been anger and aggression, as in combat, or it may have been passivity, as in a domestic violence situation. These and other survival tactics during the traumatic event may have saved one's life. But later, they are not useful. This continuation of a tactic that was once useful to survive perpetuates victim thinking.

7
TRIGGER STIMULUS

All of us are gifted with memories. Memory is a very good device to make our life enjoyable. We can remember the pleasant things that took place in our lives and can enjoy them in the present. In the same way, we may be also tormented by the negative events that took place in our lives in the past. Thus memories can be acting on us either positively or negatively.

Traumatic memories are different from the other forms of memory. They are stored differently from other memories. Usually one remembers the trauma vividly with all its details. It can also happen that the trauma survivor suffers from some form of amnesia. Thus some aspects of the trauma may be forgotten entirely or recalled only in fragments. Whenever there has been an unpleasant experience, there is the possibility of amnesia. In nontraumatic memories one may have images of the event, but traumatic memories bring to surface not only the images but also the feelings, sounds, smells, and bodily states associated with the event. When something in the present reminds you of the past event, you may feel the feelings associated with the past event. The present-day events that call up events of the past are called triggers, because they trigger the emotions associated with the trauma. Triggers can bring up traumatic events about which one has total or partial amnesia. One might not remember the traumatic event since that is under amnesia, but may experience the emotions associated with the trauma.[1]

1. Triggers, Symptoms and the Adrenal Glands

All of us react emotionally to certain triggers. In the case of trauma survivors, their response is not purely an emotion, but they have responses from their adrenal glands. Their responses may not be in their best interests since they are out of control and out of proportion. If you are a trauma survivor, you have survived a life-or-death emergency state. The emergency state may have lasted

a few minutes, a few months, or even many years. During the emergency state, your adrenal glands would have responded with secretions that caused fight-or-flight or freeze reactions. Now the problem is that the brain does not distinguish between a real threat from the one that is stored in the mind. Thus, when the adrenals are set off by a situation in the present which we call trigger which reminds you of the trauma, or on the anniversary date of the traumatic episode, or loss, you may feel as threatened, angry, confused, or bereaved as you did during or after the original trauma. If the adrenals are aroused by a trigger event, your long-term memory tracts, in which memories of the traumatic event and secondary wounding experiences are stored, tend to be activated. This can cause increased nightmares, flashbacks, anxiety, rage reactions, and other PTSD symptoms. You may not remember consciously any associations but your brain makes the association. All of a sudden you may feel you are living in the emotional climate of the original traumatic event. For example, there are anniversary reactions which are triggers without your conscious knowledge. Even current stresses of any sort can trigger off a trauma and increase distress symptoms. It is also known that media presentations and conversations can trigger off trauma in individuals.[2]

2. Relaxation Techniques

Relaxation exercises, deep breathing, or physical exercises or some combination of these are good to undertake before confronting the trigger or trigger situation. But sometimes trigger situations confront you very suddenly! When the trigger is on, you can use breath control, or a modified form of muscle relaxation without anyone noticing it. A note of caution is necessary here. The lowered heart rate and increased oxygen flow induced by deep breathing or relaxation in some cases can interact negatively with certain medications. Therefore one needs to check with the doctor if there would be negative side effects. In any case, deep breathing, or relaxation exercises need not exceed an hour. There are some people for whom relaxation exercises can bring forth intolerable memories. If that happens, it is better to stop the exercise immediately.

1) Deep Breathing[3]

Our way of breathing betrays the degree of body tension. When one is under stress, one breathes shallowly. Therefore, conversely, one can learn to calm oneself by practicing deep breathing. Deep breathing is beneficial in the sense it increases the oxygen flow to one's brain, which increases one's capacity to think and concentrate and helps rid one's body of many toxins. There are two forms of breathing; one is abdominal breathing and the other is the calming breath.

(1) Abdominal Breathing

In abdominal breathing, one inhales slowly and deeply through one's nose into the bottom of the lungs, sends the air as low down as one can. The chest should move only slightly while one's abdomen expands. What happens in abdominal breathing is that the diaphragm moves downward, causing the muscles surrounding the abdominal cavity to push outward. When one has taken in a full breath, one pauses for a moment and then exhales slowly through one's nose or mouth, depending on one's preference. But one should make sure that one exhales fully. As one exhales, it is good to let one's body to just let go. One does ten slow, full abdominal breaths. It is good to keep one's breathing smooth and regular, without gulping in a big breath or letting one's breath out all at once. One should pause briefly at the end of each inhalation. This breathing has to be done at least for five minutes.

(2) The Calming Breath

Breathing from one's abdomen, one inhales slowly to a count of 5 (counting slowly '1…2…3…4…5' as one inhales). After this one pauses and holds one's breath to a count of 5. Then one exhales slowly, through one's nose or mouth, to a count of 5. One should exhale fully. When one has exhaled completely, one takes two breaths in one's normal rhythm, then repeats the exercise. It is good to keep up the exercise for at least 5 minutes. One should take two normal breaths between each cycle. Throughout the exercise, it is good to keep one's breathing smooth and regular, without gulping in breaths, or breathing out suddenly.

2) The Progressive Muscle Relaxation

Progressive muscle relaxation was developed over 50 years ago by Dr. Edmund Jacobsen as a means to deep relaxation. This technique can be especially effective if one feels anxiety physically, in the form of tightness in one's neck and shoulders or back, in the jaw, or around the eyes, or if one experiences high blood pressure, insomnia, muscle spasms, or headaches associated with tension. It involves tensing and then relaxing 16 different muscle groups. It takes only 15 to 20 minutes to do, and requires quiet and enough space to comfortably sit or lie down.

One sets aside enough time at a certain time of day for doing the exercise. It is better not to do it after eating. It is good to make sure that one is comfortable with the environment, temperature, clothing and sitting posture. If needed, one can use pillows for comfort. Better not to worry or think about outside events. The idea is to tense each muscle group hard (but not so hard that one strains) for about 10 seconds, and then to let go of it suddenly. One can give oneself 15 to 20 seconds to relax, noticing how the muscle group feels when relaxed in contrast to how it felt when tensed. One could also say 'I am relaxing,' 'I am letting go,' 'Let the tension flow away.' Throughout the exercise, one needs to maintain one's focus on one's muscles. When one tenses a particular muscle group, it should be done vigorously, without straining, for 7 to 10 seconds. When one releases the muscles, let it be done abruptly, and then relax, enjoying the sudden feeling of limpness. Let relaxation be allowed to develop for at least 15 to 20 seconds. It is good to allow all the other muscles in one's body to remain relaxed, as far as possible, while working on a particular muscle group.

To begin, one takes three deep abdominal breaths, exhaling slowly each time. As one exhales, let one imagine that tension throughout one's body begins to flow away. One clenches one's fists; holds 7 to 10 seconds, and then releases for 15 to 20 seconds. The same time intervals must be used for all other muscle groups. Then one tightens one's biceps by drawing one's forearms up toward one's shoulders and making a muscle with both arms. Then one tightens one's triceps – the muscles on the undersides of one's

upper arms – by extending one's arms out straight and locking one's elbows. One tenses the muscles in one's forehead by raising one's eyebrows as far as one can. Now one tenses the muscles around one's eyes by closings one's eyelids tightly shut. Then one tightens one's jaws by opening one's mouth so widely that one stretches the muscles around the hinges of one's jaw. Then one tightens the muscles in the back of one's neck by pulling one's head way back, as if one were going to touch one's head to one's back. Now one takes a few deep breaths and tunes in to the weight of one's head sinking into whatever surface it is resting on. One tightens one's shoulders by raising them up as if one were going to touch one's ears. One tightens the muscles around one's shoulder blades by pushing the shoulder blades back as if one were going to touch them together. Then one tightens the muscles of the chest by taking in a deep breath. One tightens one's stomach muscles by sucking one's stomach in, tightens one's lower back by arching it up. One tightens one's buttocks by pulling them together. Now one squeezes the muscles in one's thighs all the way down to one's knees. One tightens one's calf muscles by pulling one's legs toward oneself. One tightens one's feet by curling one's toes downward. One mentally scans one's body for any residual tension. If a particular area remains tense, one repeats one or two tense-relax sequences for that group of muscles. Now one imagines a wave of relaxation slowly spreading throughout one's body, starting at one's head and gradually penetrating every muscle group, all the way down to one's toes.[4]

3. Positive Self-Talk

There is an internal dialogue going on in us. What goes on by way of dialogue greatly impacts our health and healing. When one anticipates encountering the trigger event, one could engage oneself with positive self-talk. This technique usually reduces anxiety, but it may not totally eliminate anxiety. All the same getting some relief is better than suffering the whole impact of anxiety while encountering the trigger event.[5]

PART - II

SPEC IFIC TRAUMAS

8

CRIMES COMMITTED BY STRANGERS

Nowadays there are violent crimes which are often more brutal, more impersonal, and more senseless than ever before. Both the rising crime rate and the changing nature of crime have increased the degree of depersonalisation, mistrust, and alienation in our society as a whole. The sense of depersonalization is especially intense in cases of crime victims, since they often feel more like objects than like individuals, once the crime is committed. There are also cases which seem to express senseless evil. Then, the feelings of exploitation and humiliation can be exceptionally severe. What is worse in these cases is that the degree of depersonalization can be so intense that victims begin to lose faith in society, and much more, they lose faith in themselves. This is the saddest part of the story.

1. Acute Stress Reactions[1]

If an individual is victimized by crime, he/she experiences acute stress reaction. Many of the symptoms of PTSD are part of acute stress reactions such as numbing, sleep problems, mood swings, rage, amnesia, and depersonalization. When these symptoms persist for more than a month, they can develop into PTSD. The immediate stress reaction includes several stages. The first stage is called the shock stage. It can occur while the crime is actually taking place and immediately afterwards. This is known by symptoms like shock, physical or emotional numbing, and denial. The

second stage is called the recoil, or impact stage in which the shock and numbing lift. At this stage, the victim begins to absorb the reality and full meaning of the crime and to experience the feelings associated with it. The feelings experienced range from fear, anger, grief, resentment, dependency, powerlessness, desire for revenge to perhaps shame and guilt. It has been also noticed that victims experience troublesome mood swings, mental confusion, and hypersensitivity to the reactions of other people and to noise. There could be also physical symptoms which are not directly caused by the crime. These symptoms indicate stress put on the body and central nervous system by the psychological stress of the victim's realization that one was criminally victimized and is not immune to harm. These symptoms are headaches, backaches, and other body pains, nausea and other gastrointestinal problems, and intense shaking. There could be intensification of any medical, physical, or psychological problems that existed prior to the crime.

The third stage is called attribution stage in which the victim tries to figure out what caused the crime. The criminal or the victim or both may be blamed. In some cases the victim may even take responsibility for the crime. The fourth stage is known as the resolution or recovery stage. In this stage, the victim's emotional equilibrium returns to a certain degree. The victim has worked through the emotions pertaining to the crime and perhaps feels empowered by having taken measures to avoid becoming the victim of future crime. In case there is no resolution, this can lead to the development of phobias and fears, acute psychosomatic problems, and the intensification of any preexisting psychological problems, as well as to PTSD.

1) PTSD and crime

The severity of the crime determines the severity of the consequences and the possibility of developing PTSD or PTSD symptoms. Even non-violent crimes can cause PTSD symptoms, even though nobody is injured. Nevertheless, full-blown PTSD tends to develop primarily when there is physical injury or a threat to safety and life. Therefore we tend to say that the determining factors in the development of PTSD are, first of all, physical in-

jury as the result of the crime, and secondly, a perceived threat to life. Supposing a person felt his/her life was endangered during the crime, then regardless of whether that person was actually injured or not, the fear of injury or death contributed to the development of PTSD.

Violent Crimes: When a crime involves attempted or completed physical assault, it is traumatic for more obvious reasons. This crime is called violent crime. These violent crimes include robbery, rape, and other forms of sexual assault, physical assault, and homicide. When it is a murder, acute trauma reactions are likely to occur among the victim's family members, friends and neighbours. In certain cases, the trauma reactions of family members of homicide victims can reach PTSD proportions. PTSD is more likely to develop if the homicide victim is a child or very young person or if the incident involves multiple deaths.

Property Crimes: The extension of our personality is not our skin. It extends to the possessions we hold. Certain objects have irreplaceable sentimental value. Therefore it is not the particular event as such, but the meaning the event holds for the individual that determines its impact. Though psychologically speaking, a threat to life may be necessary for the development of PTSD, crimes against property, and other crimes that do not involve fear of injury or death, can also cause intense psychic pain, as well as acute stress reactions because the properties are valued as our own personalities.

2) A sense of violation

Irrespective of the type of crime committed, you feel you have been violated. Even minor cheating is felt as a great violation by individuals. Even when you or others involved were not injured or your financial losses were small, you may still have an extremely negative reaction to the crime. The core issue is the violation of your inner self, besides any physical or financial losses. Once cheated, you no longer feel safe in the world. Consequently your sense of trust in others and the society will diminish. One's sense of autonomy and control over one's life that is essential to one's functioning has been shattered. The shattering of one's trust

and sense of autonomy is followed by disorientation, fear, self-doubt, and heightened sense of vulnerability which affect every area of one's life.

2. The shock stage[2]

When the crime is committed or immediately afterward, one may experience a state of shock, disbelief, emotional or physical numbing, or experience other forms of disorientation. When the crime is happening, crime survivors may have been unable to believe it was really occurring. Usually it takes a while for the reality of the situation to register.

1) Adrenalin Reactions and Tunnel Vision

When one is under assault, one experiences an adrenalin surge, which can lead one to fight, flight, or freeze reactions. Since we are so complex, an individual may experience more than one of these reactions in the same episode. One may wonder and be confused looking back, how one behaved during the crime or immediately afterwards. One may not recall details about one's attacker, or one may not remember how long the attack occurred or the exact sequence of events. In case the attacker asked one to do something like unlocking a drawer, one may have experienced a physical or mental numbing that prevented one from cooperating.

2) Secondary Wounding and the Reactions of Others

The attitudes and treatment by people, institutions, caregivers, and others to whom the victims turn for emotional, legal, financial, medical, or other assistance can cause secondary wounding. They are experienced in the following ways: One of the common experiences of victims is that people will deny or disbelieve the trauma survivor's account of the trauma. Or they will minimize or discount the magnitude of the event, its meaning to the victim, its impact on the victim's life. People might blame the victim for the traumatic event and thus increase the victim's sense of self-blame and low self-esteem. People may judge the victim negatively for normal reactions to the traumatic event or for any long-term symptoms he/she may suffer. Trauma survivors are sometimes denied promised or expected services on the basis that they do not need or are not entitled to such services.

3. The recoil, or impact, stage[3]

Now comes the second stage of immediate stress reaction which starts when the shock and numbing have subsided and one's feelings begin to emerge. This is the recoil, or impact phase in which the feelings one experiences can range from anger at the perpetrator to intense self-hatred, guilt, and shame. The feelings may keep changing in such a way that sometimes one feels intensely emotional, other times numb. It is quite normal to experiencing waxing and waning of emotional awareness, like the confused and contradictory emotions.

1) Fear and Phobias

The dominant consequence of crime is fear. In this stage one may feel the fear that was suppressed or minimized during the criminal attack. Thus one may develop phobias or fears connected to specific objects, places, or the time of the day that the crime occurred. One may even find the idea of feeling afraid frightening in itself.

2) Critical Voices

Your fears will be validated if you were beaten or severely injured, or if the criminal was apprehended and confessed to intending to cause you bodily harm. You have every right to be afraid. There is no need of your defending your fear. Regardless of how non-violent the criminal appeared to be or how minimal the danger was perceived by others, the truth is that when you were being attacked or robbed, injury and death are always possibilities.

3) Issue of Fighting Back

Some researchers tell us that there is a greater possibility of injury when victims resist rather than submit. Others, on the contrary, suggest that resistance is better. Anyway there is no unanimity regarding what one should do. However, the police advise us that we be cooperative, polite, and as accommodating as possible and that we act calmly but quickly to meet the assaulter's demands and keep the transaction time at a minimum.

4) Anger

For trauma survivors, anger is always an issue. It is specially so for crime survivors. Anger sets in the moment the shock lifted and you realize that you had been victimized. But the criminal who is the target of your anger may not be there, or only rarely is the criminal apprehended on the spot, or even soon after the crime has taken place. Since in most cases the criminal is not available, your anger has no tangible target, and no place to go. But we know that it needs to go somewhere. Therefore you may find yourself taking your anger out on yourself in the form of depression or some self-destructive activity. You may also unleash it on friends and relatives. You may also displace the anger that belongs to your victimizer onto the police, medical staff, and others involved in your case.

The Judicial System: Anger also is involved in police and legal procedures. In most cases, the perpetrator of the crime is not apprehended. Even if arrested, it does not mean that the offender is prosecuted, sentenced, or even indicted for crime. It only means to say that an arrest has been made. The offender may not even be taken to trial. You may feel all the more enraged when you witness the court giving your assailant a much lighter punishment than you feel is deserved.

4. Attribution stage

Often people attribute the crime to the victim, rather than to the criminal, which is totally irrational. This attitude indicates that victims had some control over the incident. This type of attitude is reinforced by family members and friends either overtly or subliminally. This attitude alienates the victim from support system.

1) Masochism Myth as Applied to Crime Survivors

Criminals are a group of people who are impulsive in their behaviour. When they use or abuse alcohol or drugs, their behaviour which is already impulsive is more likely to be erratic and unpredictable. If you are a victim more than once, one might say that you are a masochist. A masochist by definition has an ongoing yearning to be punished and suffer. As a result the victim

either consciously or unconsciously creates a painful world for oneself. But the theory of masochism does not apply to crimes. For example, if you are a masochist wanting to be punished, you would not in all probability pick an unpredictable, chance type of victimization like crime. You would rather be involved in something predictable and longer term, such as a job where you allow yourself to be used by others or use a life-threatening addiction. A masochist would not waste time trying to lure some stranger into attacking him/her or his/her property. The fact is that the criminal chose you and not the other way around. There are many reasons why one is victimized more than once. It could simply be that you are poor. The poorer one is, the greater the chance of being a victim of crime repeatedly. May be you lack the information and finances with which to buy protection against crime. You may be also reluctant to go to the extreme measure to protect yourself. You may not venture away from your immediate neighbourhoods that are infested with crimes. Criminal attacks seem to occur in homes on Sunday mornings at 8:00, on busy streets at 3:00 in the afternoon, as well as in alleys at 2:00 in the morning. If you are attacked as you go about your life, it does not mean that you provoked or caused the attack.[4]

5. Resolution stage[5]

In this stage of resolution, your experience of victimization does not disappear. It has lost its control over you. Your fears, your anger, and your self-blame or the blame others may have heaped upon you, have less control over you. Supposing your criminal is apprehended and adequately punished, it is easy to reach the resolution stage. But if the criminal received too light a sentence or was never caught at all, you will struggle to make peace with your experience. Your difficulty may be all the more augmented if you are facing a prolonged court case or other procedures, or if you continue to need medical or psychological care for injuries. If your health or physical abilities are seriously or permanently impaired, you may remember the incident perhaps everyday. In any case, resolution means that you are going on in spite of the memories and the pain. It does not rule out feeling rage, fear, helplessness, or hurt again. It simply means that you have taken care of yourself in such a way that the rest of your life is not vitiated by

the incident. Even in cases of minimal physical hurt, it may take weeks or even months for you to feel emotionally stable again.

1) Difficulties reaching the resolution stage

If the resolution stage is not reached, you need not consider yourself a failure. Perhaps later someday you will get a certain resolution, in part at least. It is good to allow sufficient time and permit yourself the experience that promote your healing. May be the difficulties in resolving your crime trauma do not reside within you. The severity of the crime, the severity of your subsequent secondary wounding experiences, the lack of support from others, or the particular meaning of the crime to you somehow affect how fast you will attain the resolution stage. If it is a question of only a single trauma, your healing will be easier than if you have had multiple traumas.

2) When acute stress reaction becomes PTSD

Usually emotional support from friends, family members, or others will be enough to help you attain the stage of resolution. When such helps are not available, or if the symptoms persist for over a month, it is good to consult a professional mental health worker. When not attended, the emotional aftermath of criminal victimization leads not only to PTSD but also to phobias or psychosomatic problems that can severely restrict your life.

9
RAPE AND SEXUAL ASSAULT

It has been estimated that on an international level, anywhere from 10 to 50 percent of women have experienced some form of sexual assault. From our culture we get a lot of confusing messages about sexual behaviour. Therefore, with regard to rape, many individuals and institutions tend to blame the victim for her, or his, trauma. It is likely that you have internalized the society's victim-blaming attitudes.[1]

1. Myths of rape[2]

It so happens that one of the most common emotions that the rape victims feel is shame. The rape victim feels as though he/she is like spoiled goods. In most cases, a part of the victim may even blame oneself for the assault, especially if the person who violated the victim was not a stranger, but a friend or a close acquaintant, or even a parent.

1) Myth 1: Only Bad Girls Get Raped

No doubt there is a lot of prejudice about women, and men cherish a kind of double standard with regard to sexual behaviour. It seems all right for men to have many affairs but it is absolutely forbidden for women. Therefore people in general believe that women who get raped are those who consciously or unconsciously ask for it. This attitude is due to the fact people, usually men, have a double standard regarding the sexual behaviour of women.

2) Myth 2: All Women Enjoy a Little Rape Now and Then

It may be true that women enjoy imagining themselves being sexually victimized. That is why some people believe that unconsciously every woman desires to be raped. A woman could have a strong sexual desire of being carried into sexual bliss by a powerful lover. If women could let go of inhibitions and taboos that the society and culture have imposed on them, and if men too

change their attitudes regarding what a healthy woman is, then women could feel free to experience sex as men do, then there may not be any need for them to fantasize that way. They could as well enjoy their sexuality free of guilt. Women might also think that good girls do not or should not like sex; so they may sometimes fantasize about rape. When they fantasize rape, it serves as a means for enjoying their sexual selves without encumbrance and danger. The need for rape fantasies lies not in the desire for being harmed or victimized but in the sexist notion that having sexual desire is bad and degrading to women. There is a difference between fantasizing rape and actually being raped. When in fantasy, you are in control but in reality you are not in control. The pain in one's fantasies may simply be a means of punishing oneself for having sexual desires.

3) Myth 3: Men Rape for Sexual Release

Definitely sexual behaviour and sex organs are involved in rape. But, rape is not a sexual act; perhaps it has very little to do with sexual passion. May be to meet other needs one takes to sexual behaviour in the form of rape. That is why rape is called a pseudosexual act, because in the majority of cases it is committed in order to fulfil nonsexual needs. We can safely say that very few rapists fit into the category of lonely, socially inadequate men who we think rape because they cannot find a sexual partner. Research shows that the majority of rapists already have a sex partner and many of them have more than one sexual partner.

Acts of rape and sexual assault can be grouped into three categories: power rape, anger rape, and sadistic rape. The first group refers to men who feel powerless or frustrated in life and so they may rape in order to feel powerful. Rape also has been related to negative economic conditions in which men find themselves powerless and are unable to meet their vocational or economic goals and dreams. Such men may resort to the most primitive, but also the most available, way of providing power to themselves, that is, by abusing women and children. These men take to women and children since the latter two categories are considered weaker and smaller and they become easy targets. Men who are angry at life in general, men who have a negative attitude towards women because of their onetime negative experience with some particular women

and those who were sexually abused by a female relative seem to commit crimes against women. Sadistic rape is identified by mental and physical abuse while engaging in rape. Men might use objects to penetrate the vagina and the anus, and may employ many forms of nonsexual torture.

4) Myth 4: Rape is a Sign of Virility

In some cultures, maleness is equated with sexual aggression and so men resort to physical force to win over women. In some other cultures, using physical force is frowned upon and so men seem to take pride in using their sex appeal, their intellect or wit, and their personal charm to win a woman's favours. Therefore raping need not be a sign of virility but rather a cultural bias.

5) Myth 5: Date Rape is Not Really Rape

Acquaintance or date rape can really hurt the victim as much as being raped by a stranger. Some researches show no difference between these two types of rapes, whereas some other researches suggest important differences. The latter indicate that women raped by strangers are more fearful for a longer period of time and women raped by a date or a friend suffer more from self-doubt. A woman raped by a friend may wonder what is wrong with her that made her accept a date or become friends with a rapist. These women are taken aback by this breach of trust. It deflates their trust in men as compared to women who were raped by strangers. They feel that they were betrayed and deceived, not by some unknown character, but by someone they loved, liked, or at least trusted enough to go out with or be with socially.

Basically there are three kinds of date or acquaintance rape: beginning rape, early date rape, and relational date rape. Beginning date rape occurs on the very first date. Usually the rapist has a personality problem and designs the date specifically to rape the victim. In the early date rape, the assaulter rapes the victim after a few dates. The female usually wants to be just friends, but the man wants to sexualise the relationship and forces the issue. In the relational date rape, the couple may have already engaged in some sort of slight sexual activity and kissing but not intercourse. The man feels that he has the right to intercourse, may be because of the money he has spent, and forces the victim for the intercourse.

Even if the couple had engaged in intercourse previously, yet on the particular date if the victim was unwilling, then the forced intercourse is still a rape. Using psychological manipulation for sexual intercourse is also labelled rape.

6) Myth 6: Only Attractive Women Get Raped

It is not true that only attractive women get raped. The fact is that women who are overweight and elderly are also frequently raped. These people do not fit the cultural stereotype for attractiveness. When attractive women are raped, they are accused of having provoked the rape in order to get attention or be seen as sexually desirable. Since both attractive and unattractive women are raped, we cannot conclude that only attractive women get raped. Attractive women may get raped but they are not the only ones to be raped.

7) Myth 7: If you did not resist, you must have wanted it

There are two options for the woman being raped. Either she can fight back or submit herself to the rapist. If a woman was passive during rape, it could probably be a combination of sex role conditioning and a defensive noradrenalin reaction, resulting in a freeze or numbing response. Men are usually perceived as physically strong. Women in general may not have training in physical fighting or self-defence. Since the rapist may have planned the attack, he is mentally and physically prepared to fight and his passion may supply all the energy needed to subdue the victim. The woman might have been caught off guard. By the time the victim got over the shock and numbness of being attacked, the rapist would already have had the advantage. It has also been noted that psychological obstacles can be equally and at times more powerful. Since each rape case is unique, there is no conclusive evidence as to whether the victim should fight back or submit. There are instances of women pleading and offering something else and escaped rape, and there are also equally instances when pleading caused more savage beatings. There are also women who submitted passively and saved their lives and there are also women who remained passive and thus angered the rapist all the more by their passivity.

(1) Sexual pleasure and orgasm during rape

Sexual organs may respond to stimulation. Thus a woman is likely to feel lubrication and climaxed several times during the rape, since it is a physical response. It only confirms that the woman was sexually alive, not necessarily wanted it. Since the sexual organs are designed to respond to stimulation, they do respond. Therefore a sexual response during rape is not uncommon for a rape victim.

(2) Placating behaviour toward the rapist

Sometimes we notice placating behaviour among rape victims. It is not unusual for a rape victim to cook him dinner, mend his clothing, talk with him at length, or in other ways acted as if he were one's friend or lover, not one's assailant. After such placating behaviours one might feel ashamed. One explanation for placating behaviour is that when the rapist overtakes the victim physically, he also crushed her spirit and sense of autonomy. Therefore the woman's behaviour following the rape is simply an extension of his crime, not an expression of something inherently wrong with the woman. There could also be other altruistic reasons such as avoiding physical harm not only to herself but to her children or other loved ones. That is why she would have displayed placating friendly behaviour towards the rapist.

8) Myth 8: Men Don't Get Raped

Most of the time the male is the offender and the female, the victim. Nevertheless men too are raped more than has been commonly thought. Usually most male rape victims are raped by other men. The following sexual activities may be undertaken: they may be forced to submit to anal intercourse, oral sex, mutual masturbation, masturbation of the offender, or other sex acts. Fear of bodily harm can also cause a man to have an erection. When it is the question of females raping men, men may be coerced or intimidated into sexual behaviour they do not desire. A significant number of sexual abuse is perpetrated by adult females on young boys.

2. Dealing with the emotional after-effects of rape[3]

There are a number of common psychological symptoms reported by women after rape. They include fear, depression, anxiety, sexual disinterest, reduced pleasure in life, and sleeping problems. There are some common physical symptoms as well. They include irritated throats, vaginal infections, gastrointestinal upsets, and skin rashes. Many of the victims make drastic changes in their life-styles thus increasing their personal security, restricting their activities so as to feel safer, or changing neighbourhoods, jobs, or phone numbers. It is likely that for about a year after the rape, victims tend to decrease their sexual activity. If at all they engage in sex, they report less satisfaction than they had before the rape. Whenever they have sexual experiences, they are interrupted by flashbacks to the rape and feelings of fear and depression.

1) Getting Help as Soon as Possible

The immediate stress reactions after the rape need not develop into PTSD. Nevertheless they can frequently do. When adequate help is given, the long-term consequences of rape or other sexual assaults need not occur. If a rape victim receives qualified help within six months to a year after a rape, he/she may have his/her emotional equilibrium restored. It is a good idea to find someone with whom one can talk about the rape as soon as it has taken place.

2) Pseudorecovery and Delayed Reactions

Clinically many rape victims show up for treatment some five to six years after the rape. Most likely, these individuals might have had some immediate stress reactions after the rape, but then quickly repressed them all. They might have had the need to prove to themselves, and perhaps to others, that even though they may have been helpless victims during the rape, they are no longer victims, but strong people. In such cases what has taken place is pseudorecovery, which is a partial or superficial recuperation after the rape. In pseudorecovery one bounces back to normalcy without having processed the feelings associated with the rape. If victims do not develop any symptom, that may be fine for the time being. But someday, when rape victims experience some other loss in their lives when they are under severe stress at work or in some other difficult situation, the repressed experiences may surface and interfere with the normal functioning.

3) Viewing the Rape as a Challenge

After the rape, victims may crumble for a while, but they need not have to stay that way for too long, perhaps more than needed. They need to retreat for a while to have time and room to experience their sadness, grief, anger, fear, and other feelings, without distraction. All the same it is vital for victims to continue to function as best as they can. If they continue to be involved with life, then the braver, stronger, and more capable they will feel. In short, instead of repressing their feelings associated with the rape, they need to acknowledge, process and integrate them into the mainstream of their lives. That way, they are likely to be healed sooner.

3. Decision to prosecute[4]

There may be strong need for revenge and to express rage at the offender. Taking legal action is one way of taking revenge. It is good to ponder whether taking legal actions against the rapist is in the best interest of the victim. This decision is better taken by the victim himself/herself. If at all a decision is taken to prosecute, then the first step is definitely to file a report at one's local police station. It may be a time-consuming, energy-draining process. Victims may be subjected to some additional secondary wounding experiences. Certainly filing charges and seeing one's case through to the end can be an excellent outlet for one's rage and need for revenge. In any case, many factors are to be considered in making a decision to take legal action against the rapist.

1) When the Rapist Threatens to Retaliate

Victims may meet with threats from rapists. The offender may harm the victim again in some way, or someone the victim cares about, if one reports the rape or took him to court. Sometimes the rapist may act on his threats; at other times he may not do anything about it. The victim may not feel like being threatened and controlled by the rapist and at the same time one cannot just dismiss threats as meaningless. Therefore it is good to make one's decision taking into account the pros and cons of taking up prosecution. At all times, the best interest of the victim has to be taken into account.

10

DOMESTIC VIOLENCE AND SEXUAL ABUSE

1. Abuse

The word 'abuse' is used in this chapter as a broad term that encompasses any kind of physical cruelty in a domestic situation. Sexual abuse, which could be of an adult or child, means unwanted sexual contact of any kind, regardless of the victim's age, sex, or relationship with the abuser. Emotional abuse and manipulation also may be involved in both physical and sexual abuse. Usually women and children are most often victimized in these ways. There are also increasing number of elderly people and grown up people who are abused.[1]

1) Battering

Physical abuse of adults, or battering, is considered a multidimensional phenomenon. In order for the relationship to be considered a battering one, there must be physical assault. But often, battering includes not only emotional abuse, but also economic, social, and sexual abuse. In economic battering, the abuser uses money as a coercive tool. In social battering, the abuser attempts to isolate the victim and severely limits or controls the victim's public interactions. Besides bodily assault, battering includes any statements or actions that indicate the intent to assault. In some countries, the threats of violence is a crime. Battering will range from slapping to punching to threat or attack with a weapon, including burning, biting, and shoving. For a pattern of battering to be identified, there must have been at least two deliberate, severe physical assaults. Just like physical aggression, psychological humiliation and degradation are devastating. Since damage is inflicted on the psyche as well as to the body, battering might best be defined as any violation of the physical or psychological space of another person within an intimate or bonded relationship.

One might feel unhappy in a relationship due to lack of love, respect or appreciation. But this does not amount to a battering relationship. The person must have experienced at least one life-threatening situation and know that the abuser is capable of killing him/her. It simply means that the victim has been terrorized or humiliated into a submissive posture by the threat of injury or death.[2]

2) Child Abuse

Child abuse refers to the repeated battering, neglect, or sexual molestation of a child by a parent, relative, or other caretaker, but not just a one-time assault. Technically, an abuse is committed to a person under the age of 18, whose physical or emotional health is harmed or threatened with harm by acts of omission or commission by parents or other persons responsible for his/her welfare. From country to country, the notions vary on what legally constitutes child abuse. However, there are four types of abuse recognized. They are physical abuse, neglect, emotional abuse, and sexual abuse.

Physical abuse includes assault by an offender with a weapon, burns, fractures, or other actions leading to injury of a child. Neglect of a child can be physical or educational. Physical neglect includes abandonment of the child; refusal to seek, allow or provide treatment for illness or impairment; inadequate physical supervision; disregard of health hazards in the home; and inadequate nutrition, clothing or hygiene where services are available. Educational neglect includes a number of things. It ranges from knowingly permitting chronic truancy, keeping the child home from school repeatedly without cause, to failure to enrol a child in school. Emotional abuse includes verbal and/or emotional assault and closed confinement such as tying or locking in a closet; inadequate nurturance, such as that affecting failure-to-thrive babies; knowingly permitting antisocial behaviour, such as delinquency, serious drug or alcohol abuse; and refusal to allow medical care for a diagnosed medical or emotional problem.[3]

3) Child Sexual Abuse

Sexual molestation, incest, and exploitation for prostitution or the production of pornographic materials constitute child sexual

abuse. One is considered a child if that person is under the age of 18. The abuser's age could be any. Even children who are under the age of 18 are considered perpetrators of sexual abuse if they are older than the victim or have some degree of power or authority over the abused child. One will be considered sexually abused, if under the age of 18, one was fondled, penetrated, or made to engage in oral sex or other sexual acts by an elder person against one's will. If a child was made to pose for pictures in the nude or in provocative poses, to observe or touch genitals, or to expose one's genitals (even if one were not touched). The child can be considered sexually abused even if no stimulation or penetration occurred.[4]

2. The structure of abuse[5]

When one is physically assaulted by a stranger, it is traumatic. If one is abused by someone from one's own family, it is even worse. A victim of family violence is hurt by someone who claims to love the victim or who has promised or is obliged to take care of the victim.

1) Denial

Denial is a common phenomenon in many of the psychological experiences of individuals. In the same way it is seen in violent homes too. Surprisingly both the abuser and the abused person, as well as other family members, tend to deny, discount, or trivialize the abuse. It could be an unconscious process. There could be also other family members who take it upon themselves to try to rescue the victim. But what usually happens is that they too share in the denial, numb themselves to the violence, or imitate the aggressor. They sometimes identify with and copy the aggressor's behaviour and thus may also begin to abuse the victim, another family member, or people or property outside the home. Along with denying and discounting the violence, come denial and discounting of the feelings that go along with abuse.

2) Guilt and Shame

Apart from denial, guilt and shame are the hallmarks of family abuse survivors. The feelings of guilt and shame are based on two myths. The first one refers to the abused persons who often

feel that they deserved the abuse. The second one refers to the belief that they should have been able to prevent it.

(1) Myth 1: It must be my fault

An abused child usually thinks that if only he/she had been better or more loveable, he/she would not have been beaten. Actually the abuser is responsible for the abuse behaviour. It is not the personal inadequacy and failure of the victim that caused the abuse. Abuse often creates feelings of inferiority and exacerbates any preexisting sense of inadequacy or failure. What is experienced usually in abuse is that both the violent incident and the emotional abuse that goes with it have more to do with the abuser's feelings of inadequacies and failures than any failure on the part of the victim. Violence in the home indicates the emotional temperament of the abuser, not the actions or personality of the victim.

(2) Myth 2: I let it happen

The second myth underlying guilt and shame revolves around the victim allegedly having allowed the abuse. In an abuse, one may feel as if one betrayed oneself – one's dignity, one's self-esteem, and one's worth as a person – by staying in a situation in which one was being harmed. For example, if one was abused as a child, one had no choice but to stay with one's parent or caretaker. There are innumerable ways in which even a bright, financially independent, and psychologically well-balanced individual can become entrapped in family violence.

3) Traps

There are numerous complex and powerful forces that keep people stuck in emotionally and physically destructive situations. Due to these forces, many adolescents and adults get entrapped in their battering relationships. Physical traps: Abusers often threaten to physically harm or kill their victims, other people, pets, or even themselves if the victim protests or reports the abuse or tries to leave the relationship. The victim may be physically held locked in a room or handcuffed. Financial trap: Abusers take control of or squander the victim's income or property or by threatening financial warfare or ruin should the victim decide to protest the

abuse, leave the relationship, or otherwise make difficulties. Emotional traps: Often these emotional traps revolve around love and need. One emotional trap is that the abuser may have brainwashed the victim into thinking that the victim is not capable of living without the abuser. Another force that keeps people in battering or sexually abusive relationship is the abuser's threat of suicide. Some abusers' extreme emotional dependence on their victim may cause them to threaten to kill themselves if the victim leaves.

4) The Battering Cycle

Battering is considered to be neither random nor constant, especially when abuse occurs in marriage or a sexual relationship. In most cases, battering occurs in a repeated pattern. It has a cycle with three distinct stages: 1. The tension-building stage, 2. The acute battering incident, 3. The phase of kindness and contrite, loving behaviour – the honeymoon stage. The first one automatically leads to the second and the second leads to the third. Since the abusers shower affection on the victim at the third stage, the battered women and incest victims may have protective, loving feelings toward their abuser. Often the violent homes tend to be isolated. The abuser usually cuts the victim off from other people and relationships, lest the victim should realize that abuse is not normal and consequently try to leave. Because the victim is deprived of the affirmation and validation of others, the victim becomes all the more vulnerable to the attentions of the abuser. The violence in the home fosters or increases the victim's dependence on the abuser. Thus it is easy for the offender to perpetuate the violence at home.

3. Generation to generation: The inheritance of violence[6]

We cannot say that violence is genetic. Nevertheless, it can be multigenerational in the sense that seemingly it can be passed down from one generation to the next. Behaviour patterns and attitudes are usually learned. Therefore the girls in a family of violence seeing their mother being abused by their father can learn to accept violence as a normal part of marriage. Likewise boys who see their father beating their mother can think that it is all right to beat one's wife. Thus they learn to be abusers. But we cannot say that most abused children grow up to be child abusers

themselves. Children brought up in violent homes can have any one of the two attitudes: they may either become abusers themselves, or abstain from abusing others.

1) The Parentified Children

It happens that children growing up in violent homes are rarely nurtured sufficiently or properly. Many of such children have role reversal in which a child takes care of one or both of his/her parents. For example, one of the parents may be the victim, and the child is responsible for nurturing either the victim, or the abuser, or both of them. Such children are called parentified children. The parentified children are prematurely forced to act like a parent or caretaker. The role reversal seen in this is that at an age when the parents should be taking care of the child, the child is instead taking care of one or both of the parents. Later, when the parentified children become parents themselves, they may expect to be nurtured or parented by their own children (or spouses). When the family members fail to provide such love, support or help that they long for, then they begin to strike out. Thus violence can be passed on from one generation to the next.

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SUICIDE OF A LOVED ONE

In this chapter we deal with suicide survivors, not those who have attempted suicide and survived, but the relatives, friends, co-workers, and other associates of suicide victims.

1. The Emotional Aftermaths of Suicide[1]

Suicide is an act of heroism in some cultures but in others it is an act of cowardice. Many cultures view it as shameful, for both the victim and the survivors. People who commit suicide are considered to be emotional weaklings, moral failures, or otherwise deficient. They are considered as not strong enough to endure the pain of living, and those associated with them tend to be blamed, shamed, and stigmatized. Since there is a negative evaluation involved in suicide, many people keep the suicide of their loved ones a secret calling it as heart attack, accidental poisoning, or of unknown causes. Usually the feelings of shame and guilt are part of the story. Along with them there are also more severe effects felt such as a prolongation and intensification of the grieving process, clinical depression, and post-traumatic stress disorder.

1) Suicide and PTSD

If one witnessed the suicide, discovered the body, or was in some way exposed to the violence or aggression concerning the suicide, one is at risk for developing acute stress disorder or long-term post-traumatic stress disorder. If the suicide brought to the surface a previous trauma in one's life that prior to the suicide one had been able to manage with minimal stress symptoms, then one is also at risk for developing PTSD. In this situation, one will be coping not only with the suicide, but with the traumatic feelings and memories belonging to the past. Thus the 'double trauma' prolongs one's adjustment to the suicide and makes it more painful and complex. PTSD following a suicide also tends to develop when there is a family history of depression, substance abuse, or

suicide; when survivors themselves have a history of depression, substance abuse, or suicide attempts; or when the survivor is a child who either discovered the body or witnessed some domestic discord prior to the suicide of a parent. In such cases, children tend to blame themselves not only for the parental fighting but for the subsequent suicide. In cases of marital suicide-homicide, where one parent kills the other and then commits suicide, the emotional scars on the child are even more devastating.

2) Clinical Depression and Suicide

PTSD is one possible consequence to the survivors of suicide. More common is the development of a clinical depression or an intensification of the depression stage of the grieving process. When we compare mourners, suicide survivors often have a longer and more agonizing grieving process than those who are mourning the death of a loved one due to accident, illness, or natural causes. Besides the loss, suicide survivors have to deal with the issues of shame and social stigma. Their self-blame and guilt in themselves and anger towards the deceased tend to be more intense than that of other mourners. A grieving person does feel anger and at times intense anger towards the deceased person for leaving or abandoning him/her but it is difficult for one to admit it. Yet unless this anger is squarely and honestly met with, the grieving process is arrested. At highest risk for developing a clinical depression following the suicide of a loved one are mothers, siblings, and children of the suicide victim, adolescent friends of the victim, and individuals who already suffer from PTSD or other symptoms of depression due to previous trauma.

2. The Causes of Suicide[2]

People commit suicide for various reasons. Often there is more than one reason for suicide. Some of the classical reasons for suicide are revenge, the wish to end pain, and the desire to reconnect or unite with a deceased loved one like a child, parent, or buddy. As an act of self-assertion, people might commit suicide or as a means of taking control over one's life. When people are trapped in horrible circumstances in which they had little or no control over their fate, they tend to escape and self-determine to take their own lives. In such circumstances, they kill themselves to preserve

their dignity and self-respect and to defy those who had enslaved them. Suicide can also be committed as an act of self-hatred, as well as an act of hostility towards others. In a vast majority of cases, suicide is the result of untreated or inadequately treated clinical depression, or depression so severe that individuals can no longer resist their suicidal thoughts.

There are some additional causes of suicide. They are 1. penetrating hopelessness – the person's state of mind is such that the feelings of hopelessness penetrate every or almost every aspect of his/her life; 2. inner chaos – the person experiences so much ambivalence about so many aspects of himself/herself and feels so indecisive in matters large and small that he/she feels without identity and is unable to relate to others; 3. unbearable or unending pain – an emotional or physical condition of so much agony that death seems like the only remedy; 4. acknowledgement – the person hopes to find in death the recognition and appreciation he/she did not receive in life; and 5. desire for peace and calm – the person has exhausted his/her ability to cope with stress and sees death as a means of obtaining love, peace, and relief from the current exploitation and suffering.

1) The Precipitating Events

We can identify the precipitating events for every suicide. Yet a single occurrence seldom causes a person's suicide except in cases of catastrophic trauma like in war and refugee situations in which people may commit suicide after witnessing family members being slaughtered or witnessing or being forced to participate in other atrocities. Usually suicide does not occur because of one precipitating event but because this event occurred in the context of a chain of numerous other negative events that are interpreted by the individual in despairing or vengeful ways.

3) Suicide and Self-Blame[3]

The one who commits suicide leaves behind him/her his/her parents, family members, friends, neighbours, and others who are beset not only with grief but with a multitude of agonizing, often-unanswerable questions such as 'Why did it happen?' 'Did I miss some of the warning signs?' 'Why did not I pay attention to the warning signs?' and 'What could I have done to prevent it?' If

you are a suicide survivor, you will want to have a clearer picture of the suicide of your loved one and any part you may have played in it.

1) False Guilt

There could be a lot of false guilt. Children think that the world revolves around them and that they control everything that happens. This is one of the forms of false guilt which is called 'childhood omnipotent guilt.' Children think that if they wish something it might come true. When children become frustrated with a parent or sibling, they often think or say that they hate the parent or the sibling and desire that they are dead. If for some reasons the parent or the sibling becomes ill and dies, the child might think that his/her wishing has caused the death of his/her parent or sibling. This is magical thinking, since hating someone or wishing someone else's death does not cause the harm. Suicide survivors may be having magical thinking either consciously or unconsciously. They think that their thinking or saying caused the suicide of their loved one.

4. Coping with the Effects on Your Life

The suicide of a loved one brings about profound changes in the life-style, identity, health, and life goals of suicide survivors. Some of the changes may be positive, and others negative. One has every right to feel abandoned and angry at the victim not only for leaving one, but for leaving the one with a 'legacy' of guilt and shame, as well as loss. If one does not acknowledge the anger one has towards the deceased, then one may turn that anger towards oneself and experience depression. It is likely that some of the anger one feels towards others, or oneself, is anger towards the deceased, which one displaced onto oneself or others. In such cases it is good to write a therapeutic letter to the deceased one or anyone who one thinks was responsible for the suicide, and one need not post the letter. It is only a therapeutic letter.

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NATURAL CATASTROPHES

If someone has experienced a storm, flood, fire, earthquake, tsunami, or volcanic eruption that caused death and destruction, then that person could develop partial or even full-blown PTSD, in addition to other stress symptoms. The symptoms range from depression, anxiety, and psychosomatic complaints, to partial or full PTSD. Some of them can also develop phobias or compulsive rituals, which may serve symbolically as attempts to prevent the disaster from recurring.[1]

1. Natural Catastrophes vs. Other Types of Trauma

It is commonly believed that the survivors of natural catastrophes suffer less psychological devastation than the survivors of traumas caused by human beings such as war, crime, and domestic violence. There could be two reasons for this way of thinking. First of all, natural catastrophes tend to be shorter in duration than man-made ones. For example, a tsunami lasts perhaps for 20 minutes whereas a war can last months or years. Secondly, natural catastrophes do not involve human error, betrayal, or violence. But such a view overlooks two significant aspects of the natural disasters: the man-made elements involved in most natural disasters, and the impact of the recovery environment on the natural disaster survivor. Usually both the recovery environment and the recovery process are heavily influenced by human beings and governmental and other institutions. To make matters worse, following a natural catastrophe both domestic violence and stranger crime can be rampant. There are limitations with regard to warning systems, emergency services, and disaster-relief agencies. Survivors of the catastrophe may experience these limitations as betrayal. It is not uncommon that warning systems and other parts of an infrastructure sometimes simply fail. In most cases, survivors of natural catastrophes direct much of their rage at those individuals or agencies perceived to be the cause of such failure, rather than at the impersonal forces of nature that are the underlying cause.[2]

2. Common Reactions to Natural Catastrophes[3]

We naturally tend to think that only the victims of natural catastrophes are bound to suffer from PTSD and other stress symptoms. But police officials, fire-fighters, medical personnel, and others involved in rescue and relief efforts too suffer from PTSD and other stress related symptoms. The exposure to death and injury and the destruction of homes, public buildings, and sometimes entire communities and cities seem to affect all the involved.

Psychologists have identified common adult reactions to any natural catastrophes, which are: 1. feeling of being personally victimized, 2. frustration, intolerance, and irritability, 3. emotional numbness, 4. changes in appetite –inability to eat or overeating, 5. impaired memory or difficulty in concentrating, 6. nightmares and other sleeping problems, 7. substance abuse for self-medicating purposes, 8. feelings of being overwhelmed or easily fatigued, 9. somatic complaints, including headaches and gastrointestinal problems, 10. anxiety or fear or dread that the big quake or tsunami is yet to happen, 11. insecurity in both inter- and intrapersonal relationships, 12. anger toward city, country, emergency, and federal organizations, 13. grief over the loss of loved ones, property, possessions, or landmarks; intrusive recollections or flashbacks of the event, 14. psychogenic amnesia regarding important details of the event or its aftermath, 15. a sense of foreshortened future, 16. feelings of omnipotence, 17. avoidance of discussing the event or its effect, 18. denial that the earthquake or tsunami had any emotional effect.

1) How long do the symptoms last?

Usually during natural disasters, people react calmly and appropriately. It has been noticed that only a small percentage become hysterical or immobilized in other ways. Once the acute crisis has subsided, many of those who reacted so rationally at the time of the disaster, develop symptoms that reveal their emotional reactions to the disaster. The duration can vary from person to person and from situation to situation. It was observed that following a cyclone, psychiatric and emotional distress gradually decreased over a period of 14 months. In the long term, however, survivors of the cyclone still tended to have more emotional problems than the general population.

2) Waxing and waning of symptoms

People might have experienced some symptoms immediately after the crisis. Then comes the phase of diminished or disappeared symptoms for several months, only to re-emerge two or three years later in response to a current crisis or loss, or perhaps for no readily apparent reason. It is not uncommon that even in conditions of relative safety, the pangs of fear may return, for the threat is recorded in memory and the human mind tends to review the threat to prepare for its possible repetition. One experiences negative emotions associated with the catastrophe, because subconsciously one's mind is reviewing the disaster in case it happens again.

3) Resurrection of the unresolved emotional issues

One or more unresolved emotional issues are likely to come to the fore after the traumatic encounter with a natural catastrophe. For example, internal conflicts or conflicts with the significant others that in the past one was willing or able to let slide may come to the forefront of one's mind. Even it can resurrect the negative feelings one has toward others. Being in a natural catastrophe can also bring to the fore any childhood or other traumas that one had repressed or discounted.

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VEHICULAR ACCIDENTS

In our modern society we rely heavily on vehicles of all sorts – from cars, trucks, and buses to ships, airplanes, and trains. But for these vehicles our mobility will reach a standstill. We so much depend on these vehicles for our day-to-day life that we view vehicular accidents, particularly car accidents, as an inevitable evil. In our technological society, car accidents cost many lives. A person involved in the accident will not consider the accident as an inevitable evil.[1]

1. Acute Stress Reaction

Our lives may be dramatically changed due to any vehicular accident, especially if one is severely injured, if one of the loved ones was severely injured or killed, or if someone else was killed in the accident. Accidents create long-term problems if the person involved holds himself/herself responsible, either in whole or in part, for the accident, regardless of whether one's sense of guilt is grounded in reality. As a vehicular accident survivor, one is vulnerable to developing any number of acute stress reactions shortly after the accident. The reactions that follow immediately after the accident may involve several stages, namely the shock stage, the recoil or impact stage, the attribution stage and the resolution, or recovery stage. If there has not been any resolution, that can lead to the development of phobias and fears, acute psychosomatic problems, and intensification of any pre-existing psychological problems. In some cases, the acute trauma reaction can develop into full-blown PTSD.[2]

2. The Shock Stage

Usually following the accident one will probably be in the shock and denial phase; one feels dazed or confused. One's disorientation and numbing may have been physical, mental, emotional,

or all three. It is also possible that one is injured, but experiences little or no physical pain at all. One may be bleeding, but may be emotionally detached from one's wounds, or one dismisses them as unimportant. One's denial and shock may be so absolute that one does not believe that the accident had actually occurred.

When one is in the initial shock and denial stage, one probably experiences the adrenaline reactions common to people in life-threatening situations. These reactions are the fight, flight, and freeze reactions. The adrenal produces extra adrenaline, which energizes and mobilizes one for action. Alternatively, the adrenals may also produce noradrenalin, which slows down one's functioning. When one is in the freeze reaction it may be experienced as a shock. In that stage, one may lose consciousness or find oneself physically immobilized but aware of what is going on around oneself.

Both adrenaline and noradrenalin reactions are known to be normal. Likewise it is normal to feel cool, calm, and collected immediately following an accident. There are some people who have near-death or out-of-body experiences. Such experiences are known to occur to people who are close to dying, who have died but have been resuscitated, or who are undergoing an intense biological or psychological stress, e.g., a vehicular accident or criminal assault.

When one is having near-death or out-of-body experience, one may feel as if one has left one's body and is in the sky or somewhere else removed from the immediate accident, and one may view the immediate situation from a safe distance. During that stage, one may have a spiritual revelation or encounter. Some of the people, if they have out-of-body experience, may experience peace. Alternatively, they may also experience mental, emotional, or spiritual confusion.[3]

3. The Recoil or impact stage[4]

There comes the impact stage after the shock and denial. During this stage, the feelings that were repressed during the initial shock phase begin to flood one's awareness overwhelmingly. These feelings are known to range from anxiety and anger to fear and grief to self-hatred, guilt, and shame. Individuals are known to

vacillate from one extreme of the emotional spectrum to another within a single day, or even an hour. For example, one may all of a sudden feel revengeful to someone who caused the harm and suddenly feel remorse and guilt for not having saved the life of a victim. In this impact stage, one is likely to be confused, since one's feelings keep changing often and in contradictory ways. One is all the more confused when at times one may feel nothing at all. This numb stage is considered as giving one a rest from the intensity of the emotions experienced at other times. In this stage, fear is the most dominant emotion. One may fear that the impact stage may never come to an end. It may be advisable to allow this stage to run its course and one must not try to interrupt it with some form of substance abuse or escapist activity. Counsellors advise us to feel them in this stage as much as possible and not try to stifle them.

1) Coping with Fear

One may fear that the accident will repeat itself the next time one is in a vehicle or with a vehicle associated with the original event. For accident survivors, some vehicles or even all vehicles may probably serve as a trigger of fear, and at times of all the other emotions associated with the trauma, like helplessness and dependency. It is not unrealistic to experience the fear of being involved in another accident. So one may decide to take as many precautions as possible to avoid another accident.

2) Dealing with Anger

If one is an accident survivor, one is most likely to have plenty to be angry about. One may be angry with the driver or pilot, or at other organizations that may have failed to keep the safety precautions, at the inadequacy of the rescue operations, and many other things like these. Anger can also stem from the type of secondary wounding experience especially when one is not compensated for the injuries or one's case is not fully or professionally investigated.

4. The Attribution stage

Now comes the attribution stage that is often called the stage of self-doubts or the 'what-if' and 'if-only' stage. In this stage,

thoughts such as 'if only I had' and 'what if I had not' are common. Perhaps these thoughts arise in one's mind to attempt to alter the stark realities of the accident and mitigate the losses involved. Individuals who sustain serious injuries themselves sometimes feel guilty that they were not injured as badly as others in the accident. When it is carried too far, or for too long, feelings of self-blame and survivor guilt become self-destructive and impede the healing process.[5]

5. The Resolution stage

The last stage is the resolution stage. In this stage, although the memories and feelings about the accident do not disappear, they lose some of their power. Literally, this will mean that one is less controlled by one's fears, anger, self-blame and the blame of others. Certain conditions favour reaching the resolution stage, as for example if one did not contribute to the accident, or one has been adequately compensated for any damages incurred during the accident, or if the individuals or institutions wholly or partly responsible for the accident have acknowledged their role in the accident and at least attempted to make restitution with the individual concerned and other victims. It will be really difficult to reach the resolution stage if one has lost a loved one, suffer from major physical injuries, or played a role in causing the accident. The fact that one reached the resolution stage does not mean that one will never again feel anger, self-hatred, fear, or helplessness. It will simply mean that one is determined to go on living, taking care of oneself, and giving back to the world, despite what occurred.[6]

6. When the Acute Stress Reaction Becomes PTSD

It does good to seek out emotional support from friends, family members, and others. Thus while in acute stress reactions when one reaches out, then this will save one from the development of more serious emotional and physical problems later. When the symptoms of acute stress reactions are not attended to, then it may induce long-term phobias, psychosomatic problems, or full-blown PTSD. Since PTSD may be chronic and difficult to treat when not recognized, early intervention is greatly desirable.[7]

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WAR AND COMBAT

1. War and Mental Health

We often think of war as a glamorous adventure. It is during war that men test and prove their manhood. This is one side of war but it also has the other side. The reality of war is actually very complex. Though war has its exhilarating moments for some, it is also ugly, brutal and bloody. Individuals involved in war, both officers and soldiers, can be incompetent, corrupt, or malicious. One can feel the glamour of war receding when someone for example betrays from one's side. We need to accept that war can produce acts of incredible courage and heroism. Down the centuries war has generated camaraderie unmatched in civilian life.

Although war can bring out the best in individuals, it can also bring out the worst in human nature. War has been creating a host of short- and long-term readjustment problems. Among such problems is war-related PTSD. We should also note that not all war veterans suffer from PTSD, and those who do vary in the degree to which the PTSD affects their personal and vocational lives. Whenever there is an exposure to combat, to abusive violence, and to atrocities, it increases the risk for developing PTSD. If the combat is heavier and longer, the greater will be the probability that the soldier will develop symptoms. If one belongs to a minority group, then the chance of developing PTSD is greater.

Though it is commonly believed that combat veterans develop PTSD, PTSD has also been found among people who spent time in war zones where they experience life-threatening situations or are surrounded by death. This happens to medical personnel, transporters, body-bag counters, embalmers, administrative officers, and numerous civilians who lived or served in or near combat zones. Surprisingly during the World War II, war neurosis was not only found among combatants for whom the threats of death were ever present, but it was also prevalent among soldiers

in the grave-registration units and in air corps emergency units. We should not take war veterans with PTSD as mentally ill. Though many war veterans display stress reactions to the war, they are, all the same, psychologically healthy. Even in the survivors of other catastrophes, we find the coexistence of stress reactions with healthy adjustment.[1]

1) PTSD and War –A Historical Account

The term post-traumatic stress disorder was commonly associated with the Vietnam veterans. Nevertheless PTSD or PTSD-like symptoms have been experienced by soldiers throughout the ages. War-related PTSD has been well documented by historians, dramatists, military officials, and others clearly from the ancient Greeks and Romans. Though there were elaborate psychological screening procedures intended to weed out those susceptible to mental collapse, in World War II, the psychiatric casualty rate was also high. After the experience of World War II, it was believed that the trauma of war was sufficiently enough to impair even the strongest and toughest of men. What would have happened to the veterans of the World War I and II is that those who suffered from PTSD might have kept their problems to themselves or drowned them in alcohol. Immediate on-site help was provided to afflicted serviceman during the Korean War. There is no doubt that anybody can be traumatized in a couple of seconds. Perhaps, the availability of alcohol and drugs combined with alternative military procedures would have suppressed many combat-related symptoms. Thus symptoms were held under control during the war but emerged later, upon the soldiers' return home. May be, the symptoms returned years later, even after 20 years.[2]

2) The Circumstances of War[3]

During war there is always the threat of participants being killed or maimed. Besides this, many other factors contribute to the trauma of war. They are: 1. The soldier is uprooted, dislocated, and disoriented due to leaving his family and community. The soldier is in a foreign soil most of the time and he also experiences a change in culture. 2. Military training is itself a great stressor. One specific goal of such training is to inculcate surrender to military authority, which robs the soldier of his sense of individuality.

3. A soldier in combat is subject to physical fatigue, extremes of temperatures, inadequate meals, and other forms of physical stress.
4. A soldier in war is not only powerless but also powerful. The possibility of the soldier being killed is always present and in that sense one is powerless, but one could also kill another almost at will. The soldier is given weapons and permission to kill and act out his aggressions. This practice can create problems for the soldier in civilian life later, since managing anger by violence is unacceptable and punishable by law.

(1) Psychopathology and War

A great deal of psychopathology can be generated from the combatants to their officers to the civilians involved. In every society there are a few of the least principled and most character-disordered individuals. These individuals usually dominate the formal and informal power structures of military units. Many examples can be had with regard to prisoners of war and the way they had been treated. In a war situation, there is no law and order, and the other usual moral restraints. In such situations, individuals with sadistic, egomaniacal, or otherwise morally defective tendency have more opportunities for free rein in a war zone than in civilian society. They are also the apt candidates to become leaders and they exert considerable influence over others. A psychopath may be known by his egoism, amorality, aggressiveness, and other undesirable qualities. These qualities are not useful or valued in peacetime society. But they are extremely valued and useful in war conditions. When such psychopaths exert power, formally or informally, reactions to them by the individual soldiers may range anywhere from aversion to worship. In history we find that very outstanding psychopaths were either admired or avoided with aversion. When such leaders command soldiers to commit or witness non-sanctioned wartime activities, it may create a moral dilemma for the soldiers. If the soldiers by chance admired such psychopathic leaders, later when they recollect how they could have done it, it may bring about mixed feelings about the characters of such leaders and about their own character for having admired and actively obeyed them.

(2) The Battle heat, blood lust, and the shadow

To engage in battle, a lot of physical energy is required. This energy can stem from the fear born out of a sense of powerlessness. This is experienced as the battle heat or blood lust. Though it supplies energy, it has its own negative effects. According to the psychologist Carl Jung, all of us have a persona: the face or mask we present to the world. The persona includes socially acceptable traits and behaviours. Besides the persona, we also have a shadow, or darker side of our personality. Our shadow includes lust, greed, murderousness, and all the other socially unacceptable feelings and desires. No human being is exempt from these two phenomena. We usually do not accept our shadow. Therefore when we encounter our shadow side, we may experience some degree of guilt and shame. In normal day-to-day life our shadows are not recognized but in the battleground they are not only recognized but also encouraged and rewarded. Combat veterans are not only forced to recognize their shadows but are given every opportunity to let them out loose. There is the attendant guilt feelings when fostering the shadow side of our personality. When it has been done over many years it may pose a spiritual or moral dilemma for many soldiers. In every war, society has forgiven warriors by justifying the killing by calling it 'a just war.' There are also instances when the society does not see the killing as just. If that happens the moral pain of killing can be even more intense. There are people who can afford to deal with killing and seeing the killing, but others cannot. Those who have the highest moral standards do suffer the most moral pain in war. They are the ones who are not able to tolerate viewing or being part of any form of brutality.

2. Self-blame[4]

Self-blame is one of the experiences soldiers have to deal with. There is usually so much of chaos in war and this chaos makes it almost inevitable that soldiers mistakenly kill others, may be even from their own side. There could also be a friendly fire that kills comrades and friends. If mistakes result in the loss of friends or comrades, or in civilian casualties, the individuals' self-blame can

be enormous. Often such feelings are brushed aside, only to emerge years later, directly or indirectly. When there is no adequate help, then this guilt can last a lifetime. The common forms of indirect expression of self-blame are psychosomatic pains, addictions, and any of a host of self-destructive activities. Guilt usually produces chronic, but disguised, low self-esteem. PTSD by itself is a manifestation of unresolved war issues, including self-blame and survivor guilt.

1) Survivor Guilt and Self-Blame

In any catastrophe the survivors might feel guilty for having escaped live while their comrades, friends, and relatives died in the same situation. Survivor guilt will be all the stronger for the individuals who by some act of cowardice, aggression, or incompetence on their part contributed to the death of the fellow combatant(s). In any case it is appropriate to feel sad about someone having died in a traumatic situation. Nevertheless, it is not rational or appropriate to feel total responsibility for that individual's death.

3. Anger and grief

Guilt can lead to PTSD; likewise when grief and anger are left unresolved, they may lead to PTSD. Military training considers emotions such as fear and grief as signs of weakness. Anger on the contrary is not only tolerated, but encouraged. In most cases, anger is purely not anger. Anger is often a disguise or defence against grief, confusion, fear, and the sense of powerlessness. A soldier may express his grief over the death of his buddy in his unit through rape, abuse, or revenge killings of enemy prisoners or civilians. Often anger-motivated acts can also be a cover-up for anger at oneself for having made a mistake, for feeling cowardly, or for somehow not having lived up to one's expectations of oneself as a soldier. Anger is also known to serve as a substitute for many different emotions. There are many kinds of grief. There could be loss of lives, loss of limbs, loss of faith, loss of belief in authority or institutions, loss of friends and parents or children. One might grieve for all these.[5]

4. Premature death and suicide

When we compare combat veterans with their contemporaries, the combat veterans die younger. They might die for a variety of reasons: 1. Physiological strains of the war experience or the physical strain on the body caused perhaps by injuries incurred in combat. 2. Physiological strain, accidents, and other results of alcoholism, drug abuse, or other forms of addiction used by the individuals to cope with their readjustment problems. 3. Unresolved psychological stresses from the war that express themselves in forms of stress that damage the body. 4. There are also car accidents and other kinds of accidents which can be interpreted as suicidal or 'part-suicidal' in motivation.[6]

PART - III

HEALING PROCESS

For many problems, people console us saying that time will heal. Healing is a process and a nonlinear process. That means it does not run a straight path but inevitably involves a number of setbacks. Like alcoholics who are sincere in being converted and yet fall prey to alcohol, there will be a number of lapses in the healing process. The healing process can be divided into three stages for convenience: 1. Remembering the trauma and reconstructing it mentally – the cognitive stage; 2. Feeling the feelings associated with the trauma – the emotional stage; and 3. Empowerment – the mastery stage. Depending upon the intensity and duration of a particular traumatic experience, healing may take months or even years to fully remember or gain perspective on the events that trouble the individuals. One's healing process will be heavily influenced by what has happened to one since the trauma. If one had secondary wounding experiences, then the healing duration will be longer. If there are good restorative experiences which are economic, vocational, political, and interpersonal, then the prospect of healing is faster. Extreme state of depression, anxiety, of hyperalertness may need medication. In order to begin the healing process, one needs to feel and be safe. In most cases counselling is useful but in some cases counselling can worsen the situation. For some focusing on the trauma made them feel helpless once again. If that is the case, it is better to focus on current problems rather than on the trauma. If a trauma survivor has suicidal or homicidal thoughts, disorientation, hyperventilation, shaking, irregular heartbeat, then it is advisable to seek professional help instead of counselling to start with.[1]

15

COGNITIVE STAGE

Remembering the Trauma

Stage - 1

Perhaps, being there in the traumatic situation may not be as traumatic as remembering. Remembering a trauma can really be worse than facing a trauma. Because, in the traumatic situation one may have been anesthetized to physical, emotional, and moral pain. One's body may have emitted a natural emotional or physical anesthetic, or one may have numbed oneself with some kind of substance or compulsive behaviour. Actually while in trauma, one's mind was focused on survival rather than on anything else. But later, when one feels somewhat safe, one could begin to comprehend, and feel, the full extent of one's losses.

1. The Difficulties in Uncovering the Trauma

It is not always easy to remember the traumatic event in full details for a variety of reasons. There is definitely pain, and besides pain various factors contribute to make the trauma difficult to remember. Trauma memories are stored in a way that makes it rather difficult to remember the whole incident in a coherent and narrative form. Therefore, these memories become cut off from the conscious mind. Once cut off they exist as fragments on the semiconscious or unconscious level. Perhaps much later the memories may return. Even when the memories return, they are not as coherent stories, but rather in bits and pieces, as fragmentary memories of the original event. In some cases, memories can return as terrifying perceptions, obsessional preoccupations, somatic complaints or as a number of other symptoms. Until the memories are pulled together into at least a semicoherent story, trauma survivors will have difficulty in understanding themselves. They may be ignorant of the connection between the trauma and what they experience as depression, fear, anxiety, irritability, hyperalertness,

or emotional shutdown. Since they are ignorant of the underlying connection between the trauma and the present distress, they feel 'controlled' by strong, mysterious, and incomprehensible internal forces. The strong sense of being 'out of control' of their emotions and inner life will deepen the fear, depression, and sense of powerlessness that they are already experiencing intensely. Incest survivors usually dissociate during the trauma, as a defence, and later they cannot understand why they react to people, places, or objects reminiscent of the abuse with anxiety, fear, rage, or other symptoms. It is a fact that though our mind cannot remember, our body can very well remember.[2]

2. The Remembering Aids[3]

It is important for the trauma survivor to recall as much of their story as possible. They could make use of prompts, storytelling, dancing, drawing, and other forms of art therapy, talking to others, reading, and professional techniques such as traumatic incident reduction therapy and hypnosis.

1) Using Prompts

Objects can trigger memories. Photographs of oneself before, after, or even during the traumatic event, or photographs of the significant others from that time can be used.

2) Revisiting the Scene

One can also stimulate one's memory by returning to the original site of the trauma. There are cases of individuals completely falling apart when they returned to the scene of the trauma without adequate preparation or support.

3) Talking to Other People

The survivor can talk with people who knew the survivor or who were present during the trauma or otherwise have information about it.

4) Talking to other survivors and reading survivor literature

The trauma survivors' memory can also be stimulated by talking to other trauma survivors. They can be found in various support groups, community, or workplace. They may also read

pamphlets, and books on how the tough survivors overcame their distress.

5) Storytelling

One could record one's story on a tape or tell it to someone one trusts.

6) Dancing, painting, and other art forms

For individuals who are non-talkative, art and dance therapy is widely recognized as highly therapeutic. Besides, some find it easier to express themselves physically or artistically, through dance, painting, pottery, sculpture, or some other forms of art, than they do verbally. One can start by drawing a picture that depicts the trauma, may be beginning just with a line or a circle or square. One can draw as many pictures one wants to draw, with whatever tools one likes like water-colour or oil paints, coloured pencils or crayons. There are individuals who are good at expressing themselves in movements. In that case, it is good to begin by finding a song or tune that somehow reminds one of the traumatic event or one's feelings about the event; and then move one's body to the music. If one is unable to move one's entire body at first, then one can simply tap one's fingers or toes. Gradually one builds up to using one's arms and legs, until one's whole body is involved. As one dances or paints, one may be able to recall the event and the feelings associated with it. Later, one can share the experience with the others he/she trusts.

7) Coping with stuck points

While trying to remember, one may reach blocks, or points where one gets stuck. That means one cannot remember anymore or it is simply too painful to go on. When this happens, it is good to stop and return to it later.

3. Professional Assistance

1) Traumatic-incident reduction therapy

It is a sort of short-term therapy. In this the counsellor asks the survivor to tell his/her story. In this way, it is a simple technique. The counsellor remains for the most part relatively silent, only asking the client to indicate where the trauma begins and

where, in the survivor's view, it ends. Then comes the 'million-dollar question.' The counsellor asks the client 'What is the significance of these events to you?' After the client has responded, the counsellor asks, 'Is that all or is there more?' Once again, the survivor responds, and then the counsellor asks him/her to repeat the story of the trauma. There comes the point when the survivor feels the story has been told completely. The counsellor asks again, 'What is the significance of these events to you?' This process is repeated several times, providing the client with a rare opportunity to tell the whole story, as many times as needed, to a willing counsellor. Trauma survivors may like to tell the story often. Telling the story repeatedly provides numerous opportunities to rethink the event, to remember details that may have been forgotten but are vitally important to understanding the meaning of the trauma, and to express the anger, grief, confusion, guilt, and any other feelings associated with the trauma.[4]

2) Eye movement desensitization and reprocessing (EMDR)[5]

Francine Shapiro developed the EMDR. It integrates a wide range of procedural elements along with the use of rhythmic eye movements and other bilateral stimulation to treat the traumatic stress and memories of clients. It is a form of exposure therapy designed to assist clients in dealing with traumatic memories. It is a trauma that causes posttraumatic stress disorder (PTSD) in people. Children, couples, sexual abuse victims, combat veterans, victims of crime, rape survivors, accident victims, and persons dealing with anxiety, panic, depression, grief, addictions, and phobias can greatly benefit from EMDR.

EMDR integrates important aspects of many other types of therapy such as psychodynamic, cognitive, behavioural, and interactional. It has an eight-phase approach. They are: 1. client history and treatment planning, 2. preparation, 3. assessment, 4. desensitization, 5. installation, 6. body scan, 7. closure and 8. evaluation.

1. Client History and Treatment Planning: First of all, the history of the client with regard to the problem has to be taken. It involves conceptualizing and defining the client's problem and identifying and evaluating specific outcome goals. Specific targets are

selected such as dysfunctional memories that set the groundwork for pathology, present situations that trigger the disturbance, and specific skills and behaviour necessary for adaptive future action.

2. Preparation Phase: This step involves establishing a therapeutic alliance. The EMDR process and its effects are explained to the clients. Any concerns or expectations of the clients are discussed. Relaxation procedures are initiated and a safe climate is created where the client is able to engage in emotive imagery.

3. Assessment Phase: Here the therapist identifies a traumatic memory that results in anxiety, and the emotions and physical sensations associated with the traumatic event; he/she evaluates the Subjective Unit of Disturbance (SUD) Scale of images, identifies a negative cognition that is associated with the disturbing event and finds an adaptive belief (or positive cognition) that would lessen the anxiety surrounding the traumatic event.

The client is asked to hold the disturbing event in mind and rate it on the 0-10 SUD Scale, in which 0 is neutral or no disturbance, and 10 is the greatest disturbance imaginable. How the client interprets the events to himself/herself is to be determined. This is done by asking the client to concentrate on a specific memory and say which words automatically come to mind that describe his/her feelings about himself/herself or his/her behaviour in the situation. Thus one gets the negative self-beliefs or negative lessons the client learned about himself/herself from his/her trauma; as for example, one would say 'I am a worthless person.' The adaptive belief or positive cognition that is needed has to be identified and measured. It is done on a Validity of Cognition (VOC) Scale from 1-7 in which 1 means completely false and 7 means completely true. The client will be asked to report how true his/her positive cognition (belief) feels using the VOC Scale. After doing the EMDR therapy, of course, the client is asked to report any increase in how his positive cognition (belief) feels.

4. Desensitization Phase: The client visualizes the traumatic image, verbalizes the maladaptive belief (or negative cognition), and pays attention to the physical sensations. It is a limited exposure and the client may have direct exposure to the most disturbing element for less than one minute per session. During this process, the client is instructed to visually tract the therapist's

index finger as it is moves rapidly and rhythmically back and forth across the client's line of vision (12 to 24 times) with appropriate variations and changes of focus until the SUD level of the client is reduced to 0 or, if appropriate, to 1 or 2. The movement of the index finger could be done diagonally, horizontally or back and forth. Now the client is instructed to block out the negative experience momentarily and breathe deeply and to report what he/she is imagining, feeling, and thinking.

5. Installation Phase: This phase consists of installing and increasing the strength of the positive cognition the client has identified as a replacement for the original negative cognition. For example, a person who witnessed the drowning of a child in the river may have negative belief 'I did not do enough to save the child.' But now he/she might say 'Well, I did all that was possible within my power at that moment.' How deeply the client feels his/her positive cognition is then measured using the VOC Scale. The goal is for the client to accept the full truth of his/her positive self-statement at the level of 7 (completely true).

6. Body Scan Phase: At this juncture the client is asked to visualize the traumatic event and the positive cognition and to scan his/her body mentally from top to bottom and identify any bodily tension states. Once the positive cognition has been installed and strengthened, the client is asked to bring the original target event to mind and see if he/she notices any residual tension in his/her body. If so, these physical sensations are targeted for reprocessing. The reason behind this procedure is a physical resonance to unresolved thoughts. When a person is negatively affected by a trauma, information about the traumatic event is stored in the motoric (or body systems) memory, rather than in the narrative memory and the person retains the negative emotions and physical sensations of the original event. When the information is processed, it can move to the narrative (or verbalizable) memory, and the body sensations and negative feelings associated with it disappear. Therefore, the EMDR treatment session is considered complete only when the client brings up the original target image without feeling any body tension.

7. Closing Phase: Every session has to be brought to an adequate closure. The client is asked to maintain a log or journal and record any disturbing material. The use of the log and relaxation or

visualization techniques are needed for client stability between the sessions.

8. Re-evaluation Phase: The home work of the client is reviewed at the beginning of each session. This phase comprises reconceptualizing the client's problems, establishing the work of cognitive restructuring, continuing the self-monitoring process and collaboratively evaluating the outcome of treatment.

3) V.K. Dissociation[6]

V.K. Dissociation means visual and kinesthetic dissociation. This therapy is meant to deal with traumatic and phobic experiences. Let us take an example of a lady who, when she got up in the middle of the night, met a thief walking on the corridor of her house and coming towards her.

Let her imagine being seated with you in a theatre and make sure that she has a vivid picture of the situation of the theatre and the screen. Let her put a still picture of herself before the starting of the problem, that is, before sighting the thief. Now let her float out of her body along with you and go to the projection booth from where she is able to see her body seated in the theatre and also is able to view the still picture of herself on the screen. Now hold her hand interlocked with your fingers and this forms a resourceful state. She can squeeze your fingers when she is frightened and get the necessary resources. When these things are ready, ask her to run the film on the screen; she sees the thief who comes towards her and she runs to her room and locks the door. The whole episode is seen and digested by her. This in short is the therapy of V.K. Dissociation.

4) Desensitizing therapy[7]

1. Systematic Desensitization: This is based on the principle of classical conditioning which states that an anxiety response is learned or conditioned, and can be inhibited by substituting an activity that is antagonistic to it. This is mainly used for anxiety and avoidance reactions, especially phobic reactions. First of all, a behaviour analysis of stimuli that evoke anxiety and the constructing of a hierarchy of anxiety-producing situations are done. Then the client is taught relaxation procedures, which are paired with the imagined scenes. The client moves from the least threatening scene

to the most threatening scene step by step. Thus the anxiety-producing stimuli are repeatedly paired with relaxation training until the connection between those stimuli and the response of anxiety is eliminated.

There are three steps in the process of systematic desensitization. Relaxation training, development of the anxiety hierarchy, and systematic desensitization proper. (1) Relaxation Training: A few initial sessions are spent in teaching the client how to relax. With a quiet and soft voice the therapist gently teaches the progressive muscular relaxation technique. The client will have to create the imagery of previously relaxing situations. (2) Development of the anxiety hierarchy: An analysis of the stimuli that elicit anxiety in a particular area like rejection, jealousy, criticism, disapproval or any phobia is had. A ranked list of situations that elicit increasing degree of anxiety or avoidance is constructed. The hierarchy is arranged from the most threatening to the least threatening. (3) Systematic Desensitization: After a number of sessions of relaxation with homework also, the client starts with his/her eyes closed to view a neutral scene and then progressively moves from the least anxiety-producing scene to the most threatening scene. The whole exercise is accompanied by relaxation. The treatment can be terminated when the client remains relaxed while imagining the most threatening scene.

2. In Vivo Desensitization: It means exposing the client in real life to the actually feared situations in the hierarchy rather than simply imagining situations. The clients attempt to experience the feared events in brief and graduated series of exposures.

5) Flooding[8]

Flooding refers to either imagined or in vivo exposure to anxiety-evoking stimuli for a prolonged period of time. According to this theory, maladaptive behaviour is considered as involving the conditioned avoidance of the anxiety-arousing stimuli, and the client is asked to imagine and relive the aversive situations associated with his/her anxiety. Here instead of avoiding anxiety, the therapist deliberately attempts to elicit a massive flood or 'implosion' of anxiety. With repeated exposures in a safe setting, the stimulus loses its power to elicit anxiety, and the maladaptive avoidance

behaviour is extinguished. Once the procedure starts, the therapist makes every effort to encourage the client to lose himself/herself in the part that he/she is playing and live the scenes with genuine emotions. The therapist attempts to evoke a maximal level of anxiety from the client. When a high level of anxiety is achieved, the client is held on this level until some sign of spontaneous reduction in the anxiety-reducing value of the cues appears (extinction). This process is repeated until a significant diminution in anxiety has resulted.

6) Hypnosis

Hypnosis too can be used to help trauma survivors. Hypnosis creates a semiconscious state of deep relaxation and can be useful to bring forth memories that are partially or totally repressed. For hypnosis to work, first of all the client should trust the counsellor, and should let down his/her guard. But trauma survivors usually have difficulty in these two areas.[9]

4. Reconstructing the Trauma Mentally[10]

Once a clearer and more detailed picture of what occurred is obtained, then one needs to begin the process of viewing the trauma from a new perspective. Here the focus is on viewing the trauma objectively, rather than judgementally. Any moral or other concerns one might have are legitimate and definitely important. Here what is important is to obtain a clear picture of the trauma, the pressures one was under, and the real choices available to one under those conditions.

1) Visualizing the trauma

The first step in getting an objective picture involves visualization. To begin, the client needs to centre himself/herself. This may mean taking a few calming breaths or doing a relaxation exercise, or it may mean prayer or going for a long walk – whatever it be, let the client feel calm, relaxed, and at peace. Next, let the client imagine that he/she is watching a television show or movie about his/her trauma, or that the client is seeing his/her story being acted out in the next room, a room from which the client is separated by a one-way glass. As best he/she can, let the client pretend the star of this show is not the client even though it is. As

the client watches, let him/her observe what he/she is thinking or feeling about that person. Let the client make a note of those things that person is doing to survive that the client finds admirable. Also let the client make a note of whatever things the star is doing to survive that the client finds objectionable or of questionable morality or worth. Especially let the client note any inconsistencies in the star's behaviour. Is he or she responding one way one minute and another, seemingly contradictory way, the next? Let the client write about why he/she thinks the star is behaving in such a manner. Once the movie is finished, the client needs to spend some time honouring what the client did to survive.

2) Getting Feedback from Others

It would be beneficial for the client to take his/her writing about his/her survival behaviours to others and get feedback. If the client chooses, he/she can be selective in sharing his/her visualization and get feedback from others.

3) Self-Forgiveness

For healing it is essential the client should forgive himself/herself for some of the choices, behaviours, and feelings the client had during the traumatic incident. It might surprise us to know that forgiving oneself is as hard as, or harder than, making some kind of peace with the individual, institution, or natural force that harmed the client.

4) What if it were someone you love

Visualization can be done in different ways. One of them is to think of the family members and friends the client dearly loves. Now let the client rerun the story of the trauma or his/her imaginary movie, but let him\her make the star one of the people he/she loves. Let him/her have the star do, think, and say exactly what the client did during the trauma. As before, let the client make notes about what the client condemns or blames the person for. Let the client note if the client is being kinder to the star than the client is to himself/herself. Let the client say if he/she would be able to forgive a loved one for some of the actions or inactions the client blames himself/herself for. If the client is able to forgive the star, why can't he/she forgive himself/herself for the very same behaviours, attitudes, feelings, actions or inactions?

5) Making Amends

After all these visualization, the client could still feel guilty or ashamed about some aspects of his/her behaviour or attitude during the traumatic event. In such a situation, let the client consider making amends to the individuals or organizations the client feels he/she has hurt. Punishing oneself helps no one. Instead of self-punishment, it is good to consider whether there is something positive one can do to make amends. Sometimes we find that there are some abusive survivors who are not only victims but offenders themselves. Perhaps abusing others was their way of dealing with the anger they felt toward their abusers. Since they feared confronting their abuser with that anger, they displaced their anger on smaller, safer targets.

To conclude, the client works hard to look at his/her traumatic experience as a detached observer instead of as an emotionally involved participant. This naturally results in the following four gains: 1. A clearer, more objective assessment of what your real choices were during the traumatic event, 2. A greater appreciation of how the trauma itself influenced your thoughts, actions, and feelings, 3. Reduced self-blame, and 4. A sharper definition of the people, institutions, or forces you feel anger or rage toward.

16
EMOTIONAL STAGE

Feeling the Feelings

Stage - 2

It is not just enough that the client has an improved understanding of the traumatic event. Just by rethinking we just do not erase the effects of the trauma. It has been found that therapies that focused on helping survivors view the trauma more rationally are only partially effective in reducing of the symptoms of PTSD. Such therapies are necessary, but they suffer from a major limitation; they only address the mental aspect of the healing process. That aspect is only one part of a greater whole.[1]

1. Necessity of Feeling

To be healed completely, the trauma must be reworked not only on the mental level, but also on the emotional level. In this, two processes are involved. They are: 1. The feelings generated by the trauma that were not felt at the time need to be identified, and 2. the feelings must be experienced, at least in part, on a gut level.

However self-possessed a person is, the traumatic event inevitably generates feelings in that individual. The feelings generated by trauma are perhaps the most powerful feelings known to us. Among those feelings fear, anger, grief, and guilt are common. We can think of two kinds of courage. One of them is the courage to act and the other is the courage to feel. Many people are courageous to act but not so with feeling.[2]

1) Fear of Feeling

Fear of feeling may be associated with two other fears. They are fear of losing control of oneself and fear of suffering. When one takes the risk of feeling one's emotions, periods of suffering are almost inevitable. Of course, suffering takes courage. Fear of feeling can be pervasive and devastating for two reasons: 1. The

emotions surrounding the traumatic event (and its aftermath) are extremely powerful, because trauma and secondary wounding experiences, by their very nature, are physically and emotionally powerful events. 2. The feeling of being overwhelmed by emotions can recreate the emotional climate of the original traumatic event, in which the survivor felt overwhelmed, not in control, and helpless in the face of an attacking person or force.[3]

2) Take your time

Feeling is healing but the client need not push himself/herself to feel, or allow others to push him/her. Let the client allow his/her own internal healing process, not outside pressures or sources, to bring his/her feelings to the surface. If the client is overstimulated emotionally, the emotions may emerge too soon, before the client is ready to handle them. The client's emotions should come forth when they are ready, not when others think that they should be ready. Perhaps some of the feelings of trauma may need to stay buried for the time being, for many months, may be even forever. Those emotions will manifest themselves in their own time, in their own way. If some of the feelings of trauma never surface, may be that is what is best for you. Healing process does not require that you become emotional about every aspect of the trauma you have experienced. There are four reasons for the feelings not to emerge. They are: 1. The client is already on overload – emotional, physical, or otherwise – due to present life stresses, and it would not be productive, if not destructive, for the client to be dealing with the trauma. 2. Perhaps the client is not ready to handle these feelings for some reason or other. 3. May be the client does not have an adequate support system to help him/her when the client starts to hurt. 4. The client might have fears and concerns about his/her emotional side or about specific emotions that are preventing his/her growth in this area. Forcing the client to feel the feelings and get rid of them by a set date may not work.

It is likely that your feelings start to emerge by themselves. It means that your routine is temporarily interrupted. If the following symptoms appear, one should seek immediate professional help: 1. fainting spells, 2. hallucinations, 3. total immobilization for more than 2 or 3 hours, 4. feelings of being out of touch with reality, 5. the urge to hurt oneself, 6. suicidal or homicidal thoughts or behaviour, 6. being unable to function at all for more than a day.[4]

3) Managing your emotions

Feeling one's emotion does not mean that one necessarily has to act on it. Once we realize this, feeling one's emotion will not be very frightening. All one has to do is to feel an emotion is to feel it. There may be some fear that if one has an emotion, it will take over. Of course it does happen that way, but it is only a temporary condition. Mostly the opposite is true. It is only when we deny our emotions that they exert massive control over our behaviour. Mastering our emotions does not mean that we can make them go away at will or reduce or lessen the intensity of our emotions. It only means that we can tolerate the intensity and duration of our feelings without abusing ourselves or others. It will also mean that we can choose as to which emotion we just want to feel and which emotion we want to work on. Our common experience dictates that the more we identify and surrender to our emotions, allowing ourselves to accept that we have them and feel them, the more we will ultimately be able to exert control over our life.[5]

2. PTSD – Anger, Grief, or Helplessness?[6]

The relative importance of grief versus anger versus helplessness varies from one trauma survivor to another. One may be volcanic in one's rage but is yet to shed a tear over one's losses. Or one may have grieved profoundly but have yet to confront one's rage. Perhaps one is still stifling it with alcohol, drugs, or some other substance, or distracting oneself from it with overwork or some other compulsion. Feeling helpless can generate both anger and grief, and feeling intense anger and grief can also make one feel helpless to cope with the power of these emotions.

1) Anger and Grief – The Intimate Connection

Anger and grief are intimately related for trauma survivors. As such, the losses endured as a result of the trauma inevitably generate a lot of anger, especially if the trauma involves some form of social injustice. There would be anger as pure rage at whatever force caused the damage or the death of loved ones. This anger also may reflect grief for personal losses, as well as sorrow and disappointment over the failure of certain government, religious, or other institutions to live up to their stated purposes and standards.

17

LIVING WITH ANGER

Emotional Stage – Continued

Stage-2 – Continued

The client may be unaware of the ways anger affects his/her life. The client may not feel any anger at all, or very little. It is also possible that the client is all too aware of his/her feelings of anger – even rage – and the impact those emotions have on his/her life and the lives of those around him/her. In any case, it is good to identify the sources of anger, acknowledge the importance of those feelings, and learn strategies for coping with anger so that it does not dominate the client's life.[1]

1. Dealing with Anger in Doses

People are afraid of experiencing even a flicker of their anger for fear that it might suddenly turn into a raging fire that will destroy their life or hurt someone else. Usually this fear is prevalent among PTSD sufferers, especially multiple-trauma survivors and abuse survivors. What typically happens to abuse survivors is that they have to stifle their anger at the abuser out of fear of retaliation. If the abuse continues for a longer period of time, then larger will be the anger suppressed. It is good to handle anger and rage in doses. The client needs to examine one piece at a time, in small, manageable doses.[2]

2. Anger at the Self: Self-Blame and Survivor Guilt Revisited

Trauma survivors have to deal with their self-blame and survivor guilt. If they do not deal with these, then they tend to subject themselves to emotional pain and various forms of deprivation and self-punishment. If the clients have not caused the trauma, they need not blame themselves or feel guilty of their survival. It may be that the client was at the wrong place at the wrong time or

was the victim of someone or something more powerful than the client himself/herself. Therefore, as such, the client should not blame himself/herself for what happened, how he/she acted, or for surviving when others did not. Nevertheless the client is burdened with these feelings as though these seem to be inherent to trauma. Even people who, to any observer, appear innocent of any wrongdoing or mistake have been found to blame themselves. When we look for the source of this self-blame we find that it is the helplessness inherent to traumatic experiences. There is also another source of self-blame which is the society's blame-the-victim attitude. What happens with trauma survivors who blame themselves is that they may have internalised that attitude and now consequently continue to victimize themselves, even though the trauma and secondary wounding experiences are over. The third source of self-blame is the shattering of certain illusions. Perhaps the client thought that if he/she is good enough, he/she will be rewarded with a good life. The client erroneously thinks so. But safety and security cannot be purchased with morality or even with religious dedication. It is also possible that the self-blame and survivor guilt may also be rooted in the client's analysis of and judgements about what he/she did or did not do during the traumatic event or its aftermath.[3]

3. Anger at Others

1) Obstacles to Acknowledging and the Feeling Anger[4]

(1) Pretrauma problems with anger: past training

Problem regarding identifying or experiencing anger may arise due to what the client learned about anger from others. There should have been some negative messages regarding the experience of anger. It is good to be aware of some important facts about anger in this context. 1. Anger is a normal human emotion. 2. Anger is an emotion, not an aggressive act. 3. Anger need not lead to acts of aggression. Though some angry people go to the extent of committing aggressive action, there are many other ways of coping with anger. 4. Anger can be used to improve one's life. In fact anger is a signal that one is living in a way that does not meet at least some of the basic needs. These needs could be physical or psychological or both. It is not uncommon for people who did not have adequate sleep and good nutrition to feel angry.

(2) Viewing anger as a character defect

There are some institutes that conduct programmes for anger management. They may describe anger as a character defect, which is not true especially in trauma survivors. We need to keep in mind that being misused or traumatized creates a different kind of anger than the anger born of selfish, childish, or less-than-noble wishes. Trauma survivors did not consciously choose to be in life-threatening situations, or injured, or witnesses to the death and injury of others. Therefore the resulting anger is perfectly normal and we need not negatively label anger as some kind of personal inadequacy.

(3) Amorphous, diffuse, or absent targets

There is another reason for the difficulty in identifying or experiencing one's anger. It is the fact that the target of the client's anger may be unavailable to the client, or because the target is so amorphous and diffuse that the client cannot focus his/her anger on any specific person. There may be a certain impossibility, as for example, to show one's anger towards the dead person. With regard to natural calamities, how is the client going to get angry with, for example, earthquake or tsunami?

(4) Freshness of the trauma

When a client is fresh from a traumatic event, he/she may be distraught, anxious, and confused that he/she cannot concentrate on dealing with any one emotion in depth at any time initially, since most of the emotions may be crowding or coming successively.

(5) Clinical depression

Often clinical depression presupposes suppressed anger. When anger is suppressed for a long duration, it manifests itself in depression. When a client is having a clinical depression, he/she may not be able to get in touch with his/her anger because it is so deeply suppressed. The client may also fear that he/she will suddenly be flooded with all the anger he/she has stored up over the years, and he/she will explode somehow.

(6) Chemical imbalance

When people are subjected to repeated or prolonged victimization, they suffer from certain chemical imbalances. These chemi-

cal imbalances often lead to all-or-nothing thinking, or fight-or-flight or freeze reactions. Depending upon what one experiences there could be either rage or complete emotional shutdown. A fight-or-flight reaction can trigger intense rage, and a freeze reaction may trigger the opposite, an almost complete emotional shutdown.

(7) Murderous fantasies

If the client has conscious or unconscious homicidal or sadistic fantasies, then he/she will have difficulty in unearthing his/her anger. The client may fear that if he/she allows even a small portion of his/her anger to rise to the surface, then he/she will lose control and seek revenge by torturing, killing or destroying the property of those who have injured or offended him/her.

4. Managing your anger[5]

1) Anger is a feeling – not an action

No doubt anger affects our body. When we get angry we may feel hot, start breathing hard, and become tight and tense. It may also cause a rush of adrenaline, an increase in heart rate, blood pressure, blood sugar, and other physiological changes that energize us to act. However, this does not mean that we must act by all means. Feeling angry is not the same as acting on our anger.

2) Taking time out

Time-outs are easy methods to arrest anger. When we realize that our anger is going to reach the danger point it is good to call time-out. This is done by leaving the room or the immediate situation and do something else, preferably something physical, such as walking or other exercises. We could wait until the intense anger has subsided before we take action on the situation at hand. If we are living with others it is good to make known to others in advance our need for time-outs or any other strategy we might have for coping with our anger. We do not fly into a rage with no warning. In all probability there is enough indication that we are going to get angry. It is good to be aware of our emotional and physical feelings that generally precede an angry outburst or the desire for such an outburst. We need to know ourselves and take the time necessary to identify and catch the early warning signs of an angry outburst. Long before the outburst becomes almost inevitable, it is good to take action, such as calling a time-out.

18

UNDERSTANDING GRIEF AND SORROW

Emotional Stage -Continued

Stage-2 –Continued

Grieving is harder than raging. Grieving and coping with losses are the most difficult tasks. We may like to get angry rather than grieve. It is definitely easier to be angry than sad. When we rage, there is a surge of adrenaline and we fume with energy. We feel so powerful and strong that we want to vent out our rage and we can finally get what we want. On the contrary, when we grieve we are like collapsed balloons. When we grieve, the pain of loss engulfs us and we feel vulnerable, defenceless, and weak. We hurt so much that we feel like we are dying inside. But if we want to be healed, then we need to grieve. We need to surrender to the sorrow and let ourselves feel it.[1]

1. The Benefits of grieving[2]

Grieving is beneficial for many reasons. When grief is unresolved, it contributes to the development or perpetuation of a wide range of psychological problems like anger or outbursts of rage, restlessness, depression, addiction, compulsion, anxiety ranging from mild to severe, and panic disorders. Unresolved grief is the cause of the development or worsening of medical problems such as diabetes, heart disease, hypertension, cancer, asthma, and a variety of allergies, rashes, and aches and pains. Even if there is an attempt to mourn one's losses, then the risk of these medical and psychological problems can be lessened. Grieving need not go on forever. It rises to a level and then it declines. When we have fully grieved a loss, then we are free to move on to new involvements.

1) The Three levels of loss

Psychologists have understood loss at three levels. The first level of loss is grief over the specific person, object, or physical, emotional, or spiritual aspect of ourselves that we have lost. For example, losing the meaning of life will also involve grief. The second level of loss includes grieving the fact of our powerlessness. The moments we realize that we are utterly powerless, we do moan. We would like to live with power. When something is lost, we know that nothing can replace what we have lost. This could be an experience of powerlessness. The third level of loss involves grieving our mortality. All of us are instinctively aware that we are mortals and one day we will die. This in fact is the ultimate expression of our powerlessness. Somehow, loss is connected to our powerlessness.

2) Identifying your losses

1. Financial Costs: Here the client makes a list of all the financial losses he/she suffered due to trauma or any secondary wounding experiences. For example, if a robber had mugged you and stolen your goods then you would have materially lost some valuables. 2. Emotional Costs: Here the client acknowledges what emotional symptoms he/she suffered and for how long. For most people the emotional costs could be higher than the financial costs. 3. Medical and Physical Costs: Usually trauma and secondary wounding experiences affect the physical and mental abilities of the client. 4. Philosophical, Spiritual, and Moral Costs: The client's cherished beliefs about himself/herself, specific people, people in general, and specific groups, organizations, or institutions were negatively affected by the trauma or by secondary wounding experiences.

2. The Five stages of Grief

1. Denial. Denial or shock – at this level the client has not acknowledged the loss caused by the trauma and its aftermath. 2. Anger. Once the stage of denial is gone, there comes anger. The client may be angry at life in general for giving him/her such hardships – some of the conditions that cannot be reversed. A religious person may experience anger at God or the Supernatural Being. If the client was abused, he/she may experience intense rage at the

individual who abused him/her. A teenager who was abused sexually by her uncle used to speak with rage that she was prepared to kill her uncle. 3. Bargaining. In this stage the client imagines 'what if' and 'if only.' He/she gives rein to his/her imagination, thinking about all the alternatives that have not taken place instead of the trauma. 4. Depression. There are many kinds of depression. Usually we have the normal fluctuations in mood experienced by almost all of us. There is also the clinical depression. It is a prolonged and deep experience of sadness. There is also the depression associated with the grieving process. When we lose something precious, we become depressed. 5. Acceptance. Finally there comes the stage when the client feels less depressed and enraged about the trauma. The client comes to the point of accepting the trauma and the emotional toll it has taken on him/her, his/her family, and any others involved.[3]

3. Expressing the Grief

Expressing the grief can be healing. Expression of grief can be done in a variety of ways. The client, for example, may want to express his/her anger in a safe, constructive manner; likewise grief. Male persons are ashamed of weeping and wailing. These are cultural constraints which make people all the more sick. It is good to ignore such dictates of culture and give expression to one's weeping. One should be allowed to scream, wail, and cry as long as one wants. Clients could write about how they feel. Usually writing, drawing, dancing, and other art forms can also serve as outlets. Clients can be coached to write letters to or about the individuals they have lost or to those who now they feel alienated from. People also make use of singing, drawing, painting, or making a piece of sculpture that express their grief. Some clients also find gardening as a form of expressing grief. People give dignity to their grief by remembering that the people, qualities, or values they are mourning are worthy of their grief. This they do by creating a memorial for it. They might hold a religious service, with people and friends who understand their pain. A fund could be raised in honour of the deceased. There are also people who set aside a place or a desk or drawer in the house where they keep the mementos or writings about the trauma as a form of memorial. One could also execute what the deceased wanted as a commemoration.[4]

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EMPOWERMENT STAGE

Stage - 3

This is the third stage: empowerment. Clients were rendered powerless due to the traumatic event and the secondary wounding experiences. However, they can use what they have learned in healing from their wrenching experiences to exert increasing mastery and control over their lives. This of course literally means regaining their strength to start a new life. This might involve physical strength, but the major task of empowering themselves lies in the arenas of making healthy, independent choices for themselves.

1. Appreciating your progress

Clients would have gone a long way since they first began the healing process. They have mustered their courage to look at their trauma and the secondary wounding experiences, rather than running away from them. Perhaps they have started to share their experiences with intimate friends and relatives. In a way they have started to view their experiences more objectively.[1]

1) Emotional and spiritual progress

Clients have taken the risk of not only looking at the trauma but also their feelings. It is painful to look at one's feelings that are not comfortable. Clients would have wondered if the trouble will be over at all. Everything seemed endless. Since clients were in a way forced to confront their emotional selves, they would have understood their emotional workings on a deeper level. Thus they more, not less, control their behaviour and their life than if they were blind to their emotions. It can be said that their trauma strengthened, rather than weakened them. Maybe, because they have learned to cope with the aftermath of their trauma, now they have certain skills to deal with a variety of other life stresses and problems. Besides, the trauma would have enabled them to grow

existentially or spiritually. Most trauma clients would have touched upon their own death. Therefore, the dealing with the trauma would have encouraged the clients to take greater control of their life and push them toward pursuing their dreams and goals more vigorously than ever before.[2]

2. Self-Care and Safety

Empowerment should begin with safety and taking care of oneself physically and emotionally. First of all, the sense of safety should begin on a physical level. If the client is in danger of physical harm, there will not be any feeling of safety. If the client is a crime or family abuse victim, then let the client make sure that no further harm is done him/her. Bodily safety is one of the priorities of the client. Physical and medical needs are to be adequately met to feel safe. There should be adequate sleep, good exercise and nourishment. To feel safe with one's emotions, one needs to understand one's post-traumatic stress disorder or other responses to the trauma and, for as long as necessary, avail oneself of the help of mental health professionals, family members, and friends.[3]

3. Avoiding Revictimization

It is likely that people who have been traumatized or victimized once are likely to be traumatized or victimized a second time. Revictimization rates are especially high among family abuse survivors like abused children, incest survivors, and battered wives. In many instances, revictimization is directly related to the original trauma and its secondary wounding experiences. Trauma and the secondary wounding experiences that follow can so incapacitate people that they are literally set up for future misfortunes. The psychological distress caused by having to adjust to a lower standard of living can exacerbate PTSD, other stress symptoms, and any medical problems. Such psychological debilitation, in combination with economic need and possible physical disability, makes survivors of a variety of traumas vulnerable to financial, psychological, and other forms of exploitation.[4]

4. Accepting the Scars

Clients suffer deep scars of the trauma. Whether the scars are physical or psychological, they do hurt. Some of the scars are

permanent. Though the thoughts of the incidents may not be in the forefront of the client's mind, they are nonetheless there at the back of their mind. They are, as trauma survivors subject to unwanted, recurring thoughts of the trauma, to nightmares, and perhaps even to flashbacks. Clients may have times of rage, emotional pain, numbing, anxiety attacks, physical pain, and other symptoms related to the trauma. Nothing can entirely erase the scars of the trauma. There are also not many choices left to the clients. They may either give up and let the wounds crush them or accept the scars and go on with their life. All PTSD symptoms cannot disappear because they are constantly being triggered by anniversary dates, current losses and disappointments in life, and by therapy or counselling.[5]

5. The Promise of Healing

The promise of healing includes, but is not limited to, the following: 1. reduced frequency of symptoms, 2. reduced fear of the symptoms, 3. reduced fear of insanity, 4. rechanneling of the anger and grief in positive directions, 5. change from victim to survivor status, 6. change from rigidity to flexibility and spontaneity, 7. increased appreciation of life, 8. a sense of humour, 9. a profound empathy for others who suffer. Clients would have learned some ways of turning the ordeal of the trauma into a source of strength and empowerment although the scars are real and some of them permanent. At this level, empowerment will mean taking increasing control over their life, including the power to reward themselves. Instead of waiting for others to compensate for their loss, they have to learn some ways of rewarding themselves. Clients need not deny that the emotional aftermath and psychological scars of the trauma do not exist. Strength and power come with just accepting them. Clients can find ways of using their newfound strength and power to get more out of life than has seemed possible since the trauma. The clients can even make use of their new strength and knowledge to change other areas of their life where they thought themselves powerless, in addition to those aspects directly related to the trauma. This indeed is a deep empowerment which is the lasting gift of the healing process.[6]

20

THERAPEUTIC PROCESS

1. Client Assessment

Very early in the therapeutic process, PTSD should be assessed –usually after five or six sessions. The main purpose of doing it is not to label the clients for the sake of labelling, but to provide proper care and therapeutic assistance. Diagnosis in psychiatry is not that perfect.[1]

1) Assessing for Trauma and PTSD

During the intake procedure, enquiry about traumas needs to be a routine part for all clients. Usually severe repression or amnesia is found in individuals who were severely traumatized. It can be the case with persons traumatized at the preverbal level or before the age of five, or who were threatened with harm if they disclosed the traumatic incident. What we commonly observe among trauma victims are amnesia regarding the trauma, fear of harm, or fear of loss of personal control if the traumatic incident is shared. Counsellors will have difficulties detecting PTSD or a history of trauma if we encounter a client during the numbing-avoidance phase of the PTSD cycle.

In sum, it is highly unlikely that the counsellor will uncover the core trauma during his/her initial assessment, especially if the client is new to therapy. In assessing for PTSD, structured questions that are based on the DSM-IV work well. We can say to the client that it is time for us to assess whether or not he/she suffers from PTSD.[2]

2) Considering Family History

First of all, a counsellor should determine whether clients themselves suffer a traumatic event. Secondly, it is good to enquire about any family history of trauma. There is a phenomenon called secondary traumatization which occurs when young children

internalise a parent's or other relative's trauma to such a degree that they actually become traumatized by the events that traumatized the family members. Where there is a secondary traumatization, there will be the transmission of anger. For example, an adult trauma survivor who vents his/her anger destructively in the home is teaching his/her children to do likewise. Such children may verbally or physically abuse others or destroy property, and may consequently manifest outbursts of rage similar to those of the adult trauma survivor. This is an example of transgenerational transmission of symptoms.[3]

3) Assessment for Concurrent Problems

PTSD can coexist with other mental disorders. Surprisingly in some cases PTSD is not the primary diagnosis. If the client already had a pre-existing mental disorder, it would be exacerbated by the trauma and result in PTSD. In this case, if the trauma issue only is treated, the pre-existing mental problems will continue to remain. Conversely, untreated PTSD can develop into personality disorder, depression, or some other mental health problem. In such cases, the PTSD symptoms may be hard or even impossible to detect until significant strides have first been made in treating the other disorder. There are cases in which PTSD symptoms overlap with the symptoms of a variety of other disorders such as borderline personality disorder, antisocial personality disorder, and multiple personality disorder (MPD). Some consider MPD as a form of chronic PTSD, others see MPD as a special form of borderline personality, still others contend that borderline personalities are actually multiple personalities and consider both of them as forms of PTSD.

There are five ways in which PTSD can interrelate with the diagnosis of personality or character disorder: 1. The personality disorder preceded and coexists with PTSD; 2. The personality disorder preceded the trauma and therefore predisposed the individual to PTSD due to inadequate coping skills; 3. The individual had a latent tendency toward personality disorder that was crystallized by the trauma; 4. The PTSD masques as a personality disorder. This is more likely if the PTSD is chronic; and 5. The personality disorder was not present prior to the PTSD. Due to lack of inadequate treatment, the PTSD caused the personality disorder.

The easiest way to find out candidates with primary diagnosis of PTSD is to check if there are intrusive recall-numbing cycle accompanied by excessive guilt, irrational self-blame, and an avoidance of situations reminiscent of the trauma. Some avoid talking about trauma and yet there may be others who are fixated on trauma and keep on talking about it. Thus either talking, or avoiding talking, about the trauma is possible. Another sign is a fear of loss of control. If clients are diagnosed with PTSD and personality disorder, they do not suffer from the self-reproach characteristic of clients with a primary diagnosis of PTSD. On the contrary, these dually afflicted individuals almost entirely blame others and societal institutions for their problems. Somehow they rarely evidence any introspective awareness of the destructiveness of their behaviours to themselves or others. They frequently explode with outbursts with little concern for their effects on others. They do not manifest the fear of loss of control common among the trauma survivors with a primary diagnosis of PTSD.

Flashbacks, nightmares and intrusive thoughts are found in individuals of PTSD and in individuals with the visual and auditory hallucinations associated with various psychoses. Psychotic patients can suffer from PTSD, and individuals with untreated PTSD may become temporarily psychotic.

An easy clue that the counsellor is dealing with a flashback or some other PTSD symptom, rather than a psychosis, is that the auditory and visual images of PTSD individuals are the exact replays of the original event, or portray events or persons closely associated with the original trauma, or contain themes or feelings reminiscent of the trauma, such as powerlessness, violence, danger, blood, being attacked or chased, chaos, natural disaster, and sudden noises. Usually the object of attack or danger may be the client, or one of the client's family members or close friends, or some other individuals (or pet or object) that the client highly values. This will not be the case with the auditory and visual hallucinations of psychotic patients.

Survivors of long-term, repeated, or intense traumas may have coexisting mental disorders. Among the one-time trauma survivors, coexisting mental disorders are rarely found. If the counsel-

lor suspects that a client suffers from another disorder, or if he/she tells the counsellor about previous disorders, it is better to look out for those disorders using the appropriate DSM-IV criteria.[4]

2. Substance Abuse and Depression

Some trauma survivors may have the dual diagnosis of PTSD and substance abuse. Therefore it is important to differentiate which individuals suffer primarily from PTSD and which individuals primarily from substance abuse. The following will be helpful in differentiating the two categories. Individuals with a primary diagnosis of PTSD use their substance of choice for purpose of medicating the symptoms of PTSD. Their use of substance tend to increase with the onset, or expected onset, of symptoms and at anniversary times. Such individuals frankly admit that they have a substance abuse problem, and are aware of its negative psychological and medical costs, but feel they need it to get by. On the contrary, the individuals with primary diagnosis of substance abuse deny or minimize their substance abuse problem, discount its impact on their lives, or blame totally others for it. They will not easily give up their substance and attend PTSD therapy. As therapy progresses, individuals with a primary diagnosis of PTSD, experience a remission or lesser need for their substance. But individuals with a primary diagnosis of substance abuse do not experience or report any decrease or remission of their addiction once insight into trauma-related issues has begun.

The counsellor needs to determine whether the substance abuse began before the trauma, during the trauma or immediately afterwards, or only after other losses were experienced. For a counsellor, the relationship between the addiction and the trauma is critical not only for diagnosing but also for formulating an effective treatment plan.

Depression presents a similar, and perhaps more difficult, problem of dual diagnosis. It is perhaps the most common presenting problem of survivors of long-term trauma, but is itself often misdiagnosed. The counsellor needs to familiarize himself/herself with the DSM-IV criteria for depression and assess the clients for depression during the early stages of therapy. Even when

there is no prior or family history of depression, the counsellor needs to be on the lookout for depression throughout the entire course of therapy.[5]

3. Medical Problems

The counsellor should also inquire about medical problems and encourage clients to get a complete physical examination. Special attention needs to be paid to medical problems that are the direct result of the trauma experience or secondary wounding experiences, as well as to medical problems that were exacerbated by the trauma and subsequent stress. Some of the major medical problems in the client's family of origin might play a role in the present medical problems of the client. Therefore the counsellor could also enquire about it. Many physician and mental health professionals regard stomach problems, rashes, backaches, headaches, warts, minor tumours, allergies, and susceptibility to colds and certain diseases to be stress related or have strong psychological component. They say, that the financial, psychological, and social pressures that are part of the trauma and its aftermath can severely tax the immune system of the body, making it more susceptible to a wide variety of medical problems. It is good to consider a neurological examination or psychological testing oriented towards detecting organic factors if the counsellor suspects a client to have suffered from the trauma of the head.[6]

4. Self-Mutilation

A eleven year old girl was brought to me for counselling by her grandmother. The presenting problem was that she had scratched her hands with a needle making visible wounds. The girl became suddenly withdrawn and would not communicate as she used to do. From her early childhood onwards, her uncle was sexually abusing her. As a little girl she did not know what it was all about. Now as she has grown up she realized what had been happening to her. She could not speak this to anybody and so she kept scratching her hands with a needle.

DSM-IV does not list self-mutilation as a symptom of PTSD though it occurs with sufficient frequency among the victims of repeated trauma, especially family abuse survivors. Therefore it is good to take into consideration self-mutilation in the diagnostic

process. Some of the self-mutilating behaviours include burning; hitting; cutting; excessive scratching; using harsh abrasives on skin or scalp; poking sharp objects into the flesh; head-banging; pulling out hair or eyebrows for non-cosmetic purposes; inserting objects into the orifices of the body; refusing to drink, eat, or take necessary medication, and various forms of self-surgery. Some psychologists also consider substance abuse and eating disorders as forms of self-mutilation. Excessive tattooing and excessive exercise can, in many cases, be considered forms of self-mutilation – depending on the function of these behaviours for the individual involved.

Self-mutilation among abuse survivors can be interpreted in many different ways, and serves different functions for different people. For some, self-mutilation is their way of talking, their way of telling the world 'I hurt' or 'I was hurt.' Another major function of self-mutilating behaviour is that it serves to contain or externalise the affect (emotions), memories, and other psychological effects generated by the trauma. What is bothering the client internally is given expression outwardly by self-mutilation. By this act the client gets a relief from the internal psychological pressures of the trauma.

Sometimes certain wrong therapeutic processes may push a client to self-mutilation. For example, the counsellor may push a client to reveal or discuss incidents that arouse feelings or traumatic materials that either the client or the counsellor is not prepared to handle. At such times, the client may attempt to mange his/her heightened feelings and heightened physiological arousal levels through self-mutilation. Another possible interpretation is that self-mutilation is a form of re-enactment of the trauma. We cannot also rule out another possible interpretation – that self-mutilation is self-punishment. The client may feel excessive guilt for having gotten into trouble or invited trouble and suffered the trauma and so he/she wants to punish himself/herself. It could also be self-protection. It may look like self-harm and hurt the client but it actually saves the client. It is not logical but for the client it is a wishful thinking. Many times it is a means of reducing the rage at the perpetrator, especially when anger is too dangerous if expressed or when the perpetrator is unavailable. Thus it

becomes a displaced activity for the client. Instead of directing it to the proper target, it is taken out on oneself. This type of self-protection in its extreme form is suicide. By committing suicide, the client intends to save himself/herself from further harm.

Sometimes being attractive is the reason for sexual abuse by a perpetrator; the individual may disfigure himself/herself with self-mutilation to make oneself unattractive and thus protect oneself. Another possibility is that the survivor was conditioned by the perpetrator to associate pain with sexual pleasure or with a respite from abuse and even love. A battering incident is usually followed by a honeymoon stage in which the perpetrator asks the victim for forgiveness and showers her/him with love, attention, gifts, and praise. Therefore physical pain may signal to the victim that the abuse is over and that a period of positive relationship or respite from abuse is forthcoming. Counsellors need to be suspicious of self-mutilation when clients seem 'overdressed' or dressed in clothing that is inappropriate for the hot weather.[7]

5. Treatment

1) Pharmacotherapy

A variety of different psychopharmacological agents have been used in the treatment of PTSD by clinicians and reported in the literature as case reports, open clinical trials, and controlled studies. Thus adrenergic blockers, tricyclics, monoamine oxidase inhibitors, lithium, anticonvulsants, serotonin reuptake inhibitors and buspirone are used.[8]

2) Psychotherapy[9]

Some form of psychotherapy is necessary in the treatment of posttraumatic pathology. Crisis intervention shortly after the traumatic event is effective in reducing the immediate distress, possibly prevents chronic or delayed responses, and, if the pathological response is still tentative, may allow for briefer interventions.

Brief dynamic psychotherapy has been advocated both as an immediate treatment procedure and as a way of preventing chronic disorder. Embry (1990) has outlined seven major parameters for effective psychotherapy in war veterans with chronic PTSD: 1. initial rapport building, 2. limit setting and supportive confron-

tation, 3. affective modelling, 4. defocusing on stress and focusing on current life events, 5. sensitivity to the transference-counter-transference issues, 6. understanding of the secondary gain, and 7. the therapist's maintaining a positive treatment attitude. Group therapy can also serve as an adjunctive treatment, or as the central treatment mode. The identification, support, and hopefulness of peer settings can facilitate the therapeutic change.

A variety of behavioural techniques have been applied. People involved in traumatic events such as accidents frequently develop phobias or phobic anxiety related to or associated with these situations. Systematic desensitisation or graded exposure has been found to be effective in cases of phobia or phobic anxiety associated with PTSD. This technique is based on the principle that when patients are gradually exposed to a phobic or anxiety-provoking stimulus, they will become habituated or deconditioned to the stimulus. Variations of this treatment include using imaginal techniques (i.e., imaginal desensitisation) and exposure to real-life situation (i.e., in vivo desensitisation). Prolonged exposure (i.e., flooding), if tolerated by the clients, can be useful and has been reported to be successful.

Relaxation techniques produce the beneficial physiological result of reducing motor tension and lowering the activity of the autonomic nervous system. Progressive muscle relaxation involves contracting and relaxing various muscle groups to induce the relaxation response.

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CONCLUSION

Trauma can happen to anybody at anytime. Trauma is like accidents. It strikes people all of a sudden and leaves a lasting negative impression. Some people struggle for a while and regain their poise, and there are others who may struggle all their life to make life meaningful. People do have choices: either to succumb to the ravages of the trauma or to transcend its limitation and live happily, though with the memory of the trauma.

I have often been surprised by the resilience and toughness of many a trauma survivor. They have gone through terrific traumas and have come out of them with renewed strength for a new lease of life. Most of the trauma survivors had been on the brink of death. When at last they came out of it, they could not believe that they were alive. Though they had suffered immensely, they feel grateful for what they came to realize at the end. They had been resilient, and restart their lives with earnestness though one could perceive certain signs of the trauma. On the whole, things improved for them, and their lives started on a new plane they never dreamt of. Perhaps these people have integrated what had happened to them. What has been integrated ceases to be painful.

There are also cases of trauma survivors who have not come to an end and put a full stop to their agony. They are unable to bring themselves to let go of the after-effects of the trauma. Physically, mentally and psychologically they have to start a new beginning. In most cases the physical disfiguration leaves them with no choice to integrate the negative effects in their lives. Every time they remember the incident and the possible alternatives that could have been present, they surge with a wave of overwhelming feelings. They seem almost coming to a resolution but collapse again as they realize that fresh wounds are being created. Old scars do not leave them easily and new wounds are created over the old scars. It is a struggle to come to terms with what had happened,

and much less to find meaning of the incident. When trauma is coupled with already preexisting mental illness, the process of recovery takes very long. At times it is difficult to know which is predominant, the mental illness or the effects of the trauma.

In normal circumstances it is ideal to aim at integration. Integration always means reconciling the opposites. The trauma is something negative that refuses to let itself to be integrated. But the cure consists in permitting it as part of the ongoing life process. An integrated trauma is no more a trauma. It may be a past incident but right now it may not have the 'sting.' But how many do really achieve integration is a question.

There are many factors that contribute to the integration of the trauma. There are internal and external factors that contribute to the well being of the trauma survivors. One among the external factors that deserves special attention is a support system. Friends and relatives usually play a vital role in assisting the trauma survivors to squarely look at the trauma and integrate it. Their positive interventions and support go a long way in bringing about healing. Trauma survivors without a support system usually take very long to heal. Sometimes secondary wounding experiences aggravate the trauma.

The role of the counsellor dealing with trauma is significant. Counsellors with a lot of empathy do a magnificent job in the healing of trauma. Trauma survivors need a lot of support and empathy. Lack of empathy on the part of the counsellor may be interpreted by the trauma survivors as secondary wounding. The apathy of the counsellor may let them feel that they are in some sense responsible for what had happened. Therefore, counsellors will do well to make the clients feel safe as a first step. Only in an atmosphere of safety, empathy and trust, do the trauma survivors thrive and get healed.

ENDNOTES

1

Introduction

2

PTSD & Acute Stress Disorder

1. Glen O. Gabbard & Sarah D. Atkinson, (Eds.), *Synopsis of Treatments of Psychiatric Disorders.* 2nd ed. Washington: American Psychiatric Press, 1996, pp.137-142; Henry E. Adams & Patricia B. Sutker, (Eds.), *Comprehensive Handbook of Psychopathology.* 3rd ed. New York: Kluwer Academic/Plenum Publishers, 2001, pp.183-203; Harold I. Kaplan & Benjamin J. Sadock, (Eds.), C*omprehensive Textbook of Psychiatry/VI.* Philadelphia: Williams & Wilkins, 1995, pp.1227-1235; Robert E. Hales, Stuart C. Yudofsky & John A. Talbott, (Eds.), *Textbook of Psychiatry.* 3rd ed. Washington: American Psychiatric Press, 1999, pp.610-612; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. Washington: American Psychiatric Association, 1994, pp.427-429.
2. Robert E. Hales, Stuart C. Yudofsky & John A. Talbott, (Eds.), *Textbook of Psychiatry.* 3rd ed. op.cit., p.612.
3. Robert E. Hales, Stuart C. Yudofsky & John A. Talbott, (Eds.), *Textbook of Psychiatry.* 3rd ed. op.cit., pp.615-616.
4. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. op.cit., p.427.
5. Harold I. Kaplan & Benjamin J. Sadock, (Eds.), C*omprehensive Textbook of Psychiatry/VI.* op.cit., pp.1236-1248; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. op.cit.,pp.430-432.
6. Glen O. Gabbard & Sarah D. Atkinson, (Eds.), *Synopsis of Treatments of Psychiatric Disorders.* 2nd ed. op.cit., pp.137-142; Henry E. Adams & Patricia B. Sutker, (Eds.), *Comprehensive Handbook of Psychopathology.* 3rd ed. op.cit., pp.183-203; Harold I. Kaplan & Benjamin J. Sadock, (Eds.),C*omprehensive Textbook of Psychiatry/VI.* op.cit., pp.1227-1235; Robert E. Hales, Stuart C. Yudofsky & John A. Talbott,(Eds.), *Textbook of Psychiatry.* 3rd ed. op.cit., pp.610-612; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. op.cit.,pp.427-429.

3

Clinical Diagnosis of PTSD

1. Aphrodite Matsakis, *Post-Traumatic Stress Disorder.* Oakland: New Harbinger Publications, 1994, pp. 27-28; Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Oakland: New Harbinger Publications, 1996, pp.16-17.

2. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 28; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, pp.17-18.
3. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 29-31; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, pp.18-20.
4. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 32, 161-162; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., p.21.
5. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 32-33, 167-171; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 21-22; Elizabeth A. Waites, *Trauma and Survival*. New York: W.W. Norton & Company, 1993, pp. 102-104; Mariann Hybels-Steer, *Aftermath*. New York: A Fireside Book, 1995, p.30.
6. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 33; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., p. 22; Mariann Hybels-Steer, *Aftermath*. New York: A Fireside Book, 1995, pp. 65-70; Diana Sullivan Everstine & Louis Everstine, *The Trauma Response*. New York: W. W. Norton & Company, 1993, pp. 74-76.
7. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p.34.
8. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 34; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 22-24.
9. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 34-35, 171-172; Jonathan R. T. Davidson & Edna B. Foa (Eds.), *Posttraumatic Stress Disorder: DSM-IV and Beyond*. Washington, DC: American Psychiatric Press, 1993, pp. 24-25; Charles R. Figley (Ed.), *Trauma and Its Wake*. New York: Brunner/Mazel, 1985, p. 270; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 24-25.
10. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 35-36; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., p.25;
11. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 36; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 25-27.
12. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 36; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 25-27.
13. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp.37-38; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 27-29; Judith Lewis Herman, *Trauma and Recovery*. New York: Basic Books, 1992, pp..35-36; Mariann Hybels-Steer, *Aftermath*. New York: A Fireside Book, 1995, p.29; Lori Haskell, *First Stage Trauma Treatment*. Toronto, CAMH, 2003, p.34.
14. N. Duncan Sinclair, *Horrific Traumata*. New York: The Haworth Pastoral Press, 1993, pp. 49-50; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 38; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., p.30.

15. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 30-34, 41-42; Lori Haskell, *First Stage Trauma Treatment*. Toronto, CAMH, 2003, pp. 52-53; N. Duncan Sinclair, *Horrific Traumata*. New York: The Haworth Pastoral Press, 1993, pp. 45-47; Daléne Fuller Rogers, *Pastoral Care for Post-Traumatic Stress Disorder*. New York: The Haworth Pastoral Press, 2002, pp. 8-9; Thom Spiers (Ed.), *Trauma*. New York: Taylor & Francis, 2001, pp.165-188; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 46-47.
16. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 47-48.

4

Ramifications of PTSD

1. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Oakland: New Harbinger Publications, 1994, p. 16.
2. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 17.
3. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 18.
4. Diane Myers & David F. Wee, *Disaster*. New York: Brunner-Routledge, 2005, pp. 50-52; Lori Haskell, *Bridging Responses*. Toronto: CAMH, 2001, pp. 16-18; Lori Hashell, *Women, Abuse and Trauma Therapy*. Toronto: CAMH, 2004, pp. 2-4; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 18-21.
5. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 21-23.
6. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 23-26.

5

Physiology of Trauma

1. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Oakland: New Harbinger Publications, 1994, pp. 49-51; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, pp. 40-41.
2. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 52-53; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 41-43.
3. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 53; 17.54.
4. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 54; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 43-45.
5. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 54-55; Lori Haskell, *First Stage Trauma Treatment*. Toronto, CAMH, 2003, pp.54-55.
6. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 55-57.
7. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 57-62; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 45-51.
8. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 62-64; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 51-64.

6

Three Levels of Victimization

1. Charles R. Figley (Ed.), *Trauma and Its Wake*. New York: Brunner/Mazel, 1985, pp. 17-21; Lori Haskell, *First Stage Trauma Treatment*. Toronto, CAMH, 2003, p.55; Charles R. Figley (Ed.), *Trauma and Its Wake*. New York: Brunner/Mazel, 1985, pp. 19-21; Mariann Hybels-Steer, *Aftermath*. New York: A Fireside Book, 1995, pp. 72-73, 86-88; Lori Haskell, *First Stage Trauma Treatment*. Toronto, CAMH, 2003, p. 49; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, pp. 85-89.
2. Mariann Hybels-Steer, *Aftermath*. New York: A Fireside Book, 1995, pp.59-64; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 188, 195; Lori Haskell, *First Stage Trauma Treatment*. Toronto, CAMH, 2003, pp.49-50; Diana Sullivan Everstine & Louis Everstine, *The Trauma Response*. New York: W. W. Norton & Company, 1993, p. 130; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 90-94.
3. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., p.103, 106-109; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Oakland: New Harbinger Publications, 1994, pp. 205-207.

7

Trigger Stimulus

1. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, pp. 113-114; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 140-148.
2. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 114-118; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 147-148.
3. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 129-131.
4. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 131-132,134.
5. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 135- 139.

8

Crimes Committed by Strangers

1. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, pp. 249-252; Jonathan R. T. Davidson & Edna B. Foa (Eds.), *Posttraumatic Stress Disorder: DSM-IV and Beyond*. Washington, DC: American Psychiatric Press, 1993, pp. 64-66,125-130.
2. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 252-254.
3. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 257-263; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 148-154.
4. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 264-266.
5. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 266-267.

9

Rape and Sexual Assault

1. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, pp. 269-270; Charles R. Figley (Ed.), *Trauma and Its Wake*. New York: Brunner/Mazel, 1985, pp. 114-115; Jonathan R. T. Davidson & Edna B. Foa (Eds.), *Posttraumatic Stress Disorder: DSM-IV and Beyond*. Washington, DC: American Psychiatric Press, 1993, pp. 67-69.
2. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 271-278.
3. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 280-282; Andrew J. Weaver et al, Counselling *Survivors of Traumatic Events*. Nashville: Abingdon Press, 2003, pp. 122-123; Daléne Fuller Rogers, *Pastoral Care for Post-Traumatic Stress Disorder*. New York: The Haworth Pastoral Press, 2002, p. 3; John Briere, *Psychological Assessment of Adult Posttraumatic States*. Washington, DC: American Psychological Association, 1997, pp. 8-9; Elizabeth A. Waites, *Trauma and Survival*. New York: W.W. Norton & Company, 1993, pp. 85-90; Charles R. Figley (Ed.), *Trauma and Its Wake*. New York: Brunner/Mazel, 1985, pp. 116-118; Bruce H. Young & Dudley D. Blake, *Group Treatments for Post-Traumatic Stress Disorder*. Philadelphia: Brunner/Mazel, 1999, pp. 35-36.
4. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 283-284.

10

Domestic Violence and Sexual Abuse

1. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, p.289.
2. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 290; John Briere, *Psychological Assessment of Adult Posttraumatic States*. Washington, DC: American Psychological Association, 1997, pp. 9-10.
3. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., p. 291; John Briere, *Psychological Assessment of Adult Posttraumatic States*. Washington, DC: American Psychological Association, 1997, pp. 12-13; Bruce H. Young & Dudley D. Blake, *Group Treatments for Post-Traumatic Stress Disorder*. Philadelphia: Brunner/Mazel, 1999, pp. 201-203; Lori Haskell, *Bridging Responses*. Toronto: CAMH, 2001, pp.10-11; Diana Sullivan Everstine & Louis Everstine, *The Trauma Response*. New York: W. W. Norton & Company, 1993, pp. 167-171.
4. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 292; Judith Lewis Herman, *Trauma and Recovery*. New York: Basic Books, 1992, pp. 96-97; Victoria M. Follette et al. (Eds.), *Cognitive-Behavioural Therapies for Trauma*. New York: The Guilford Press, 1998, pp. 355-356; Diana Sullivan Everstine & Louis Everstine, *The Trauma Response*. New York: W. W. Norton & Company, 1993, pp. 163-167.
5. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 292-301.
6. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 302-303.

11
Suicide of a Loved One

1. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Oakland: New Harbinger Publications, 1996, pp. 305-307; Andrew J. Weaver et al, Counselling *Survivors of Traumatic Events.* Nashville: Abingdon Press, 2003, pp. 82-83; Diana Sullivan Everstine & Louis Everstine, *The Trauma Response.* New York: W. W. Norton & Company, 1993, pp. 171-172.
2. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 308-309.
3. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., p.310, 312-317.

12
Natural Catastrophes

1. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Oakland: New Harbinger Publications, 1996, pp. 319; Jonathan R. T. Davidson & Edna B. Foa (Eds.), *Posttraumatic Stress Disorder: DSM-IV and Beyond.* Washington, DC: American Psychiatric Press, 1993, pp. 58-61.
2. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 320-321; Bruce H. Young & Dudley D. Blake, *Group Treatments for Post-Traumatic Stress Disorder.* Philadelphia: Brunner/Mazel, 1999, pp. 149-150.
3. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 321-323; Andrew J. Weaver et al, Counselling *Survivors of Traumatic Events.* Nashville: Abingdon Press, 2003, p. 59; John Briere, *Psychological Assessment of Adult Posttraumatic States.* Washington, DC: American Psychological Association, 1997, p. 5; Diana Sullivan Everstine & Louis Everstine, *The Trauma Response.* New York: W. W. Norton & Company, 1993, pp. 148-150.

13
Vehicular Accidents

1. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Oakland: New Harbinger Publications, 1996, pp. 327; Jonathan R. T. Davidson & Edna B. Foa (Eds.), *Posttraumatic Stress Disorder: DSM-IV and Beyond.* Washington, DC: American Psychiatric Press, 1993, p. 69.
2. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 328-329; Andrew J. Weaver et al, Counselling *Survivors of Traumatic Events.* Nashville: Abingdon Press, 2003, pp. 50-51; John Briere, *Psychological Assessment of Adult Posttraumatic States.* Washington, DC: American Psychological Association, 1997, pp. 5-6; Bruce H. Young & Dudley D. Blake, *Group Treatments for Post-Traumatic Stress Disorder.* Philadelphia: Brunner/Mazel, 1999, pp. 101-102.
3. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 329-331.
4. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 332-333, 335.
5. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 336-337.
6. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 338-339.
7. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 339.

14
War and Combat

1. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Oakland: New Harbinger Publications, 1996, pp. 342-343; Judith Lewis Herman, *Trauma and Recovery.* New York: Basic Books, 1992, pp. 20-28; Andrew J. Weaver et al, *Counselling Survivors of Traumatic Events.* Nashville: Abingdon Press, 2003, p. 149; Daléne Fuller Rogers, *Pastoral Care for Post-Traumatic Stress Disorder.* New York: The Haworth Pastoral Press, 2002, pp. 43-49; John Briere, *Psychological Assessment of Adult Posttraumatic States.* Washington, DC: American Psychological Association, 1997, pp. 6-8; Charles R. Figley (Ed.), *Trauma and Its Wake.* New York: Brunner/Mazel, 1985, pp. 76-77; Bruce H. Young & Dudley D. Blake, *Group Treatments for Post-Traumatic Stress Disorder.* Philadelphia: Brunner/Mazel, 1999, pp. 75-76.
2. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 343-344.
3. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 344-347; Charles R. Figley (Ed.), *Trauma and Its Wake.* New York: Brunner/Mazel, 1985, pp. 79-88; Jonathan R. T. Davidson & Edna B. Foa (Eds.), *Posttraumatic Stress Disorder: DSM-IV and Beyond.* Washington, DC: American Psychiatric Press, 1993, pp. 61-64, 104-106.
4. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 73-75, 347-348; Charles R. Figley (Ed.), *Trauma and Its Wake.* New York: Brunner/Mazel, 1985, pp. 28-30; Aphrodite Matsakis, *Post-Traumatic Stress Disorder.* Op.cit., pp.181-182.
5. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 349-350.
6. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp.352-353.

15
Cognitive Stage

1. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Oakland: New Harbinger Publications, 1996, pp. 141-146.
2. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 151-153.
3. Aphrodite Matsakis, *Post-Traumatic Stress Disorder.* Op.cit., pp. 232-236; Judith Lewis Herman, *Trauma and Recovery.* New York: Basic Books, 1992, pp. 175-181; Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 153-159.
4. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 160; Thom Spiers (Ed.), *Trauma.* New York: Taylor & Francis, 2001, pp. 122-123.
5. Aphrodite Matsakis, *I Can't Get Over It.* 2nd ed. Op.cit., pp. 160-163; Thom Spiers (Ed.), *Trauma.* New York: Taylor & Francis, 2001, pp. 123-130; Victoria M. Follette et al. (Eds.), *Cognitive-Behavioural Therapies for Trauma.* New York: The Guilford Press, 1998, pp. 27-33; Lori Hashell, *Women, Abuse and Trauma Therapy.* Toronto: CAMH, 2004, p. 25; D. John Antony, *Psychotherapies in Counselling.* Dindigul: Anugraha Publications, 2003, pp. 165-170.

6. D. John Antony, *Psychotherapies in Counselling*. Dindigul: Anugraha Publications, 2003, pp. 198-200.
7. Victoria M. Follette et al. (Eds.), *Cognitive-Behavioural Therapies for Trauma*. New York: The Guilford Press, 1998, pp. 22-27; D. John Antony, *Psychotherapies in Counselling*. Dindigul: Anugraha Publications, 2003, pp. 159-162.
8. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., p. 163; Victoria M. Follette et al. (Eds.), *Cognitive-Behavioural Therapies for Trauma*. New York: The Guilford Press, 1998, pp. 22-27; D. John Antony, *Psychotherapies in Counselling*. Dindigul: Anugraha Publications, 2003, pp. 163-165.
9. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 162-163.
10. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 163-167; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 231.

16
Emotional Stage

1. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, p.167.
2. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., p.168; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 241-242.
3. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 168-169; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 242; Lori Haskell, *First Stage Trauma Treatment*. Toronto, CAMH, 2003, p. 46.
4. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 169-171.
5. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., p.171; Lori Haskell, *First Stage Trauma Treatment*. Toronto, CAMH, 2003, pp. 43-44.
6. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 177-178.

17
Living with Anger

1. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, pp. 181; Victoria M. Follette et al. (Eds.), *Cognitive-Behavioural Therapies for Trauma*. New York: The Guilford Press, 1998, pp. 169-172.
2. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 182-183.
3. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 183-184; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 254; Victoria M. Follette et al. (Eds.), *Cognitive-Behavioural Therapies for Trauma*. New York: The Guilford Press, 1998, p. 126.
4. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Oakland: New Harbinger Publications, 1994, pp. 255-256; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 187-189; Mariann Hybels-Steer, *Aftermath*. New York: A Fireside Book, 1995, p.79.
5. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 191-194; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 155-161.

18
Understanding Grief and Sorrow

1. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, p.201; Judith Lewis Herman, *Trauma and Recovery*. New York: Basic Books, 1992, pp. 188-195.
2. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Oakland: New Harbinger Publications, 1994, pp. 260-261; Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 202-204.
3. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 204-206; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 261-263; Daléne Fuller Rogers, *Pastoral Care for Post-Traumatic Stress Disorder*. New York: The Haworth Pastoral Press, 2002, pp. 20.24.
4. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 210-213; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 267-269.

19
Empowerment

1. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996, pp.217-218.
2. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 218-219.
3. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 222-224.
4. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 224-225; Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Oakland: New Harbinger Publications, 1994, pp. 207-209.
5. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., p.241.
6. Aphrodite Matsakis, *I Can't Get Over It*. 2nd ed. Op.cit., pp. 242-243.

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Therapeutic Process

1. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Oakland: New Harbinger Publications, 1994, p. 71.
2. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 72-73.
3. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., p. 87.
4. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 88-91.
5. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 91-92.
6. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 92-93.
7. Aphrodite Matsakis, *Post-Traumatic Stress Disorder*. Op.cit., pp. 93-95, 173-176, 308-310; Elizabeth A. Waites, *Trauma and Survival*. New York: W.W. Norton & Company, 1993, pp. 191-201; Lori Haskell, *First Stage Trauma Treatment*. Toronto, CAMH, 2003, p.46.
8. Robert E. Hales, Stuart C. Yudofsky & John A. Talbott,(Eds.), *Textbook of Psychiatry*. 3rd ed. Washington: American Psychiatric Press, 1999, pp.617-618.
9. Robert E. Hales, Stuart C. Yudofsky & John A. Talbott,(Eds.), *Textbook of Psychiatry*. 3rd ed. op.cit., pp.618-619.

BIBLIOGRAPHY

Adams, Henry E. & Patricia B. Sutker, (Eds.). *Comprehensive Handbook of Psychopathology*. 3rd Ed. New York: Kluwer Academic/ Plenum Publishers, 2001.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington: American Psychiatric Association, 1994.

Briere, John. *Psychological Assessment of Adult Posttraumatic States*. Washington, DC: American Psychological Association, 1997.

Davidson, Jonathan R. T.& Edna B. Foa (Eds.). *Posttraumatic Stress Disorder: DSM-IV and Beyond*. Washington, DC: American Psychiatric Press, 1993.

Everstine, Diana Sullivan & Louis Everstine. *The Trauma Response*. New York: W. W. Norton & Company, 1993.

Figley, Charles R. (Ed.). *Trauma and Its Wake*. New York: Brunner/Mazel, 1985.

Follette,Victoria M.etal.(Eds.). *Cognitive-Behavioural Therapies for Trauma*. New York: The Guilford Press, 1998.

Gabbard, Glen O. & Sarah D. Atkinson, (Eds.). *Synopsis of Treatments of Psychiatric Disorders*. 2nd ed. Washington: American Psychiatric Press, 1996.

Hales,Robert E.,Stuart C. Yudofsky & John A. Talbott, (Eds.). *Textbook of Psychiatry*. 3rd ed. Washington: American Psychiatric Press, 1999.

Hashell, Lori. *Women, Abuse and Trauma Therapy*. Toronto: CAMH, 2004.

Haskell, Lori. *Bridging Responses*. Toronto: CAMH, 2001.

Haskell, Lori. *First Stage Trauma Treatment*. Toronto, CAMH, 2003.

Herman, Judith Lewis. *Trauma and Recovery*. New York: Basic Books, 1992.

Hybels-Steer, Mariann. *Aftermath*. New York: A Fireside Book, 1995.

John Antony, D. *Psychotherapies in Counselling*. Dindigul: Anugraha Publications, 2003.

Kaplan, Harold I.& Benjamin J. Sadock (Eds.). *Comprehensive Textbook of Psychiatry/ VI*. Philadelphia: Williams & Wilkins, 1995.

Matsakis, Aphrodite. *I Can't Get Over It*. 2nd ed. Oakland: New Harbinger Publications, 1996.

Matsakis, Aphrodite. *Post-Traumatic Stress Disorder*. Oakland: New Harbinger Publications, 1994.

Myers, Diane & David F. Wee. *Disaster*. New York: Brunner-Routledge, 2005.

Nader,Kathleen et al.(Eds.). *Honouring Differences: Cultural Issues in the Treatment of Trauma and Loss*. Philadelphia: Brunner/Mazel, 1999.

Rogers, Daléne Fuller. *Pastoral Care for Post-Traumatic Stress Disorder*. New York: The Haworth Pastoral Press, 2002.

Sinclair, N. Duncan. *Horrific Traumata*. New York: The Haworth Pastoral Press, 1993.

Spiers, Thom (Ed.). *Trauma*. New York: Taylor & Francis, 2001.

Waites, Elizabeth A. *Trauma and Survival*. New York: W.W. Norton & Company, 1993.

Weaver, Andrew J. et al. *Counselling Survivors of Traumatic Events*. Nashville: Abingdon Press, 2003.

Wilson, John P. & Jacob D. Lindy (Eds.). *Countertransference in the Treatment of PTSD*. New York: The Guilford Press, 1994.

Young, Bruce H. & Dudley D. Blake. *Group Treatments for Post-Traumatic Stress Disorder*. Philadelphia: Brunner/Mazel, 1999.