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Introduction

Most victims of violence never seek professional therapy to deal with the emotional impact of traumatic events. If they did, they would be sorely disappointed. There are not enough therapists in the world to treat the millions of men, women, and children who have been assaulted, abused and violated as a result of war, tyranny, crime disaster, and family violence. When people do seek help suffering with posttraumatic symptoms they may find therapists who are ill equipped to provide assistance. The credentialed clinicians in psychiatry, psychology, nursing, social work, and the allied professions are only recently learning to catalog, evaluate, and refine a therapeutic armamentarium to serve traumatized clients. The ambitious collection of chapters in this volume is one such arsenal. The prodigious efforts of Charles Figley co-founder of the Society for Traumatic Stress, and organizer of the Psychosocial Stress book series (Brunner/Mazel) and the Stress and Coping Series (Plenum Press), are important resources for professionals concerned with traumatic stress reactions. A cadre of clinicians have also shared insights and approaches, face-to-face, and through written works, defining principles and techniques that address the worldwide problem of posttraumatic readjustment. Recently, I assembled a sampling of those clinical insights (Ochberg, 1988) and attempted to define the commonalities in assumptions and approaches to therapy. The common ground is the foundation of posttraumatic therapy (PTT). The individual distinctions that separate clinicians who share this common ground are the inevitable differences of creative minds.

My purpose in this chapter is to enlarge upon the foundation of PTT and clarify some of the clinical techniques that stand upon this foundation.

Foundation of Posttraumatic Therapy

Fundamental Principles

Several principles are fundamental to posttraumatic therapy, and discussing these at the outset of therapy is usually advisable. Since traumatized and victimized individuals are, by definition, reacting to abnormally stressful events, they may confuse the abnormality of the trauma with abnormality of themselves.

The first principle of PTT is, therefore, *the normalization principle*: There is a general pattern of posttraumatic adjustment and the thoughts and feelings that comprise this pattern are normal, although they may be painful and perplexing, and perhaps not well-understood by individuals and professionals not familiar with such expectable reactions. The word normal can mean many things. Offer and Sabshin (1966) described, among other connotations, the use of the term normal to designate health, an ideal, and a statistical mode. When a doctor says, "This is a normal reaction," any or all of those three possibilities could be implied. For example, after breaking a bone, a patient has the fracture examined and set. A few days later there is pain and swelling, some itching under the cast, but good circulation and no sign of infection or nerve damage. The doctor has seen this pattern many times before, knows the physiological reasons for discomfort, and the danger signals of disease. The doctor's reassurance, "This is normal," means that a healthy healing process is underway. Further explanation of the healing pattern allows the patient to participate actively in the recovery process, understanding the reasons for symptoms, the time course of reequilibration, and the signs of abnormal interference, such as a wound infection.

The emotional healing process often includes *reexperiencing, avoidance, sensitivity*, and *self-blame.* These symptoms are easily described, explained, and "set" in a context of adaptation and eventual mastery. By sharing such information, the second principle of PTT, the *collaborative* and *empowering principle*, is recognized: The therapeutic relationship must be collaborative, leading to empowerment of one who has been diminished in dignity and security. This principle is particularly important in work with victims of violent crime. The exposure to human cruelty, the feeling of dehumanization, and the experience of powerlessness create a diminished sense of self. This diminution is normal when it is proportional to the victimization. Survivors of natural disasters experience powerlessness, too, although they are not subjected to cruelty and subjugation. They benefit greatly from a therapeutic alliance that is experienced as collegial and empowering.

A third principle is the *individuality* principle: Every individual has a unique pathway to recovery after traumatic stress. Cannon (1939) and Selye (1956) may have identified common physiological and psychological reactions in states of extreme stress, but Weybrew (1967) and others noted the complexity of the human stress response and the fact that one's pattern is as singular as a fingerprint. This principle suggests that a unique pathway of posttraumatic adjustment is to be anticipated and valued, and not to be feared or disparaged. Therapist and client will walk the path together, aware of a general direction, of predictable pitfalls, but ready to discover new truths at every turn.

These three principles can be expressed in various ways and supplemented with other important tenets. For example, an appreciation of coping skills rather than personality limitations allows therapy to proceed without undue emphasis on negative characteristics, and the devastating implication that victimization is deserved (Wilson, 1988). PTT begins with the assumption that a normal individual encountered an abnormal event. To ameliorate the painful consequences, one must mobilize coping mechanisms. How dramatically different this is from the hypothesis that posttraumatic stress disorder and victimization symptoms are products of personality flaws and neurotic defenses that must be identified and treated according to traditional paradigms! Furthermore, an interdisciplinary approach, recognizing the contributions of biology, psychology, and social dynamics, stimulates clinician and client to see beyond any singular explanation for posttraumatic suffering and to search for remedies in many different fields. The contributions of pharmacology, education, nutrition, social work, law, and history are recognized and valued. Intervention may include introduction to a self-help network, exposure to inspirational literature, explanation of the victims' rights movement, establishment of an exercise regimen, or prescription of anxiolytics. PTT is interdisciplinary. Practitioners should therefore be aware of community resources that are of potential benefit and be willing to assess the merit of these adjuncts to their direct clinical intervention. Often, this requires personal meetings with colleagues from disparate fields. To some degree it also requires a cognitively flexible attitude as to how best serve the patient suffering from PTSD who may need many special (yet not traditional) therapeutic interventions to facilitate the stress recovery process.

Techniques of Posttraumatic Therapy

Many techniques have been used effectively to help survivors readjust after traumatic events. I have found it useful to classify the various methods into four categories:

1. The first category is educational and includes sharing books and articles, teaching the basic concepts of physiology to allow an appreciation of the stress response, discussing civil and criminal law with new participants in the process, and introducing the fundamentals of holistic health. The educational process is one of mutual exchange (i.e., a "two-way street"). The client may have resources that he or she finds helpful and wants to share with the clinician.

2. The second grouping of techniques falls within the category of holistic health. Although the term holistic health has its critics as well as its supporters, I offer it in the spirit of Merwin and

Smith-Kurtz (1988), who noted how physical activity, nutrition, spirituality, and humor contribute to the healing of the whole person, The clinician who promotes these aspects of healing serves as a teacher and a coach, offering concepts that might be new to the client, and shaping abilities that may be latent.

3. The third category includes methods that enhance social support and social integration. Family and group therapy could be included here. Exposure to self-help and support groups in the community are other examples. But most important is the sensitive assessment of social skills, the enhancement of these skills, the reduction of irrational fears, and the expert timing of encouragement to risk new relationships. Traditional analytical tools and traditional social work skills are employed to promote healing in supportive human groups.

4. Finally, there are clinical techniques that are best categorized as therapy. These include working through grief, extinguishing the fear response that accompanies traumatic imagery, judicious use of medication for target symptoms, the telling of the trauma story, role-play, hypnotherapy, and many individualized methods that are consistent with the principles of PTT.

These four clusters of techniques are not comprehensive. There are innovations that defy categorization, such as the Native American sweat lodge technique (and other techniques of healing and purification) discussed by Wilson (1988) and testimony of political repression, used as a therapeutic instrument (see Chapters 55 and 57, in this volume; Cienfuegos & Monelli, 1983).

But it is not my purpose here to prepare an exhaustive catalog of techniques. My intent is to explain those approaches that I have employed, in residential (Ochberg Br Fojtik, 1984) and in outpatient settings, with victimized, traumatized clients.

Education

Reading the DSM together

I will never forget the first time I brought out my green, hardbound copy of the DSM-III (American Psychiatric Association, 1980), moved my chair next to Mrs. M., and showed her the chapter on PTSD. Mrs. M. is a thin, soft-spoken woman in her thirties who was assaulted and raped in South Lansing, Michigan. She was referred by a colleague and had just finished telling me her symptoms, 8 or 9 weeks after the traumatic event. She was frightened, guarded, perplexed, and sad. She had no basis for trusting me. But after she saw the words in the book, as I read them aloud, she brightened, sat up tall, and said, "You mean, that's me, in that book! I never thought this could be real."

Seldom have I found such a reversal of mood and such a sudden establishment of trust and rapport since Mrs. M., but I have never missed an opportunity to read the criteria list with a client, when it seemed appropriate.

The responses vary, from satisfaction that the symptoms are officially recognized; to surprise that anybody else has a similar syndrome. Some patients take pride in making their own diagnosis, pointing out exactly which symptoms apply. Few show any interest in other sections of the book. Most seem to enjoy hearing my explanation of the trouble we (i.e., the members of the America can Psychiatric Association committee on PTSD criteria) had formulating the diagnostic category - how some of us argued for placing the description in the "V Code" section with other "normal" reactions, such as "uncomplicated bereavement," but others prevailed and the practical consequence of placing this normal reaction to abnormal events in the chapter on anxiety is that insurance companies pay their share of the bill!

Reading the DSM-III (American Psychiatric Association, 1980) or DSM-III-R (American Psychiatric Association, 1987) together begins the educative and collaborative process. It opens the door to further education about the physiology of stress and the range of human responses to adversity. The DSM-IV is scheduled for production in 1993, and the architects are considering a "Victim Sequelae Disorder," in addition to PTSD (R. L. Spitzer, S. 1. Kaplan, & D. Pelcovitz, personal communication, 1989). This should help clinicians and clients, since the list of potential criteria supplements the PTSD symptoms and includes those common features that affect victimized rather than traumatized individuals. I have long considered the distinction important (Ochberg, 1984, 1986, 1988, 1989) and am delighted to see it considered in the DSM-IV (see Appendixes 1 and 2 at the end of this chapter).

Introducing Civil and Criminal Law

A therapist need not be a lawyer to know about the law. When our clients face the criminal justice system for the first time, understandably they may be concerned, confused, and overwhelmed.

Mr. A. was shot in the abdomen at close range by an intruder and almost killed. After heroic surgery, he awoke to the hubbub of an intensive care unit. Between hallucinations, he learned what occurred, received family visits, and began looking at mug shots. His introduction to the world of detectives, prosecutors and judges was better than most. They appreciated his condition and worked slowly and sensitively, after realizing the futility of expecting a positive identification. He appreciated their professional responsibilities and their regard for him. Would it were always so!

Victims of violent crime are often treated like pawns in an impersonal bureaucracy (Young, 1988). President Ronald Reagan realized this in commissioning the President's Task Force on Crime Victims (1982), and the U.S. Congress followed suit by passing the Victims of Crime Act of 1984.

Usually, I offer clients who are victims of violent crime several articles and brochures that explain their rights under state law and the role of the victim-witness in the American judicial justice system. In the United States, Michigan is blessed with a model victims' rights law (Ochberg, 1988 Van Regenmorter, 1989), and a Crime Victim's Compensation Board that provides financial aid. Clinicians who counsel victims could easily find resources and references in their own states. I find that many clinicians, even in Michigan, are unaware of these resources, but are pleased to know that a portion of their bills can be paid by the state, if their clients report their victimization within a year of the crime.

A patient who is in the middle of a trial, cooperating fully with the prosecutor, may know nothing of his or her right to sue the assailant, to have a court injunction against harassment, to receive workers compensation, and, in some instances, to receive representation from the pro bono committee of the county bar association. Moreover, finding the right lawyer is as difficult as finding the right therapist, so I pay close attention to my patients' experiences with attorneys and maintain an up-to-date referral roster. Sharing information about legal resources is part of the education process.

Discussing Psychobiology

Few clients are interested in reading about autonomic nervous system activation, but some read voraciously. To understand the physiology of mammalian arousal during stress is to begin mobilizing the mind in pursuit of recovery. It is relatively easy to impart a basic understanding of the fight/flight mechanism (Cannon, 1939) and the General Adaptation Syndrome (Selye, 1956). Wilson (1989) and Merlin and Smith-Kurt (1988) explained the concepts clearly and Wroth (1988) and van deer Kola (1988) discuss more complex implications in the same volume

(Ochberg, 1988). Without turning therapy into a didactic exercise, without burdening the client with unsolicited instruction, one can convey the fact that lethal threat has a powerful impact on body chemistry; that our adrenal glands are stimulated; that we are prepared to fight or to flee as if we were facing a wild beast, millennia ago; that all this circuitry is out of date and usually destructive when we face threats in modern society- that PTSD is the predictable outcome in general after extraordinary stress; and that everyone's individual pattern is different.

Furthermore, vigorous use of the large muscles is the intended result of adrenal activation, and physical activity is an advisable measure to ameliorate the effects of PTSD. This point leads to the next educational objective.

Reviewing Concepts of Fitness and Holistic Health

In designing the milieu and program of the Dimondale Stress Reduction Center (Ochberg & Fojtik, 1984), I hoped for a blend of a health spa, a community college, and a hospital. For several years, we maintained this balance but eventually the hospital bureaucracy crowded out the other elements. I was disappointed, but not surprised. American medicine, particularly hospital-based medicine, places the patient in a passive role and ignores the power of health promotion. In elementary school, we used to call health promotion "hygiene." Gym teachers, not doctors, got the points across.

Now, in an office-based, part-time practice, I do what I can to educate patients about the benefits of exercise and nutrition. The syllabus is in the Merwin and Smith-Kurtz (1988) chapter of *Post-traumatic Therapy*. My approach includes nagging, begging, and heartfelt approval when interest is shown. Since the general category of holistic health promotion includes this educational goal, let us move there now.

Promoting Holistic Health

Physical Activity

Writing about the development of a healthy fitness routine for PIT clients, Merwin and Smith-Kurtz (1988) observed that

techniques of physical training have changed in recent years as the maxim "no pain, no gain" has been discarded. Exercising past the pain threshold risks injury to muscles, joints, or tendons. The watchwords today are "balance," "moderation," and "listen to your body."

They go on to describe the three elements of a balanced program: strength, cardiovascular efficiency, and flexibility, and they note the generally accepted activities that provide these elements. Nowadays, I find few clients who are unfamiliar with these principles, but many who lack the motivation to begin or to resume an interrupted routine. Some fear social interaction. Some have injuries that limit activity. Some are generally lacking in initiative, evidencing Criterion C. (4) of PTSD (American Psychiatric Association, 1987), "markedly diminished interest in significant activities." Relatively early in therapy, I will evaluate the client's potential for supervised physical activity. I want to know that a recent medical examination has been performed and there are no limitations or restrictions. If there are limitations, I may still promote allowable activity, but only after consultation with the examining physician.

Often, the client and I develop an exercise plan, with goals and methods listed in the record. Usually, this process occurs after a preliminary discussion of stress physiology and before agreement on overall treatment objectives. (The client may be ready to take daily walks, but not ready to discuss the details of victimization.) Agreeing on an exercise plan and fulfilling the agreement are separate issues.

When there is resistance to exercise, the resistance itself must be confronted. The therapist should not assume to know an individual's underlying motive for avoiding healthy activity. A gentle, collaborative search for the obstacles and the construction of a path around these obstacles comprise an important chapter of PTT. Having said this, I must admit that I find it very difficult to avoid the methods that ultimately motivated me to undertake a fitness routine: the unremitting urging of well-meaning friends.

Therapists are advised to become familiar with supervised, structured fitness programs in their communities. A referral to a specific YMCA, health dub, or aerobic instructor can assure that the milieu is appropriate, the regimen is reasonable, and the opportunity for reinforcement is available.

I am delighted when clients adopt a healthy exercise routine, and they know it.

Nutrition

We never learned much about nutrition in medical school (other than infant formulas in pediatrics). I am still baffled by conflicting professional and lay advice on the value of various "healthy" diets. But it makes sense to evaluate a client's eating habits and look for the common mistakes that contribute to anxiety, irritability, and depression. In general, this is part of good clinical work, but particularly important for posttraumatic (Stress Syndrome) patients who are vulnerable to mood swings and who may have neglected their nutrition.

Caffeine Intoxication

The DSM-III-R (American Psychiatric Association, 1987) requires 5 out of 12 signs, plus the presence of recent excessive caffeine ingestion and the absence of other causes, to make the diagnosis of caffeine intoxication (or "caffeinism"). The 12 signs overlap with the hallmarks of panic, generalized anxiety, and aspects of PTSD: restlessness, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. Clients who experience numbing may consciously or unconsciously increase their coffee consumption. A demoralized indifference to preparing and consuming adequate meals may result in excessive drinking of tea, or coffee, or alcohol. Also, caffeine is found in soft drinks, candy, and certain desserts as well as in coffee and tea. The incidence of true caffeine intoxication is relatively rare, but good clinical practice requires that we rule out the diagnosis when anxiety symptoms are present. Furthermore, a discussion of caffeine effects leads to the broader issues of diet, appetite, and meal rituals.

Meaning of Healthy Eating

Food gathering, preparation, and consumption have ritual significance in most cultures. Full participation in the family or tribe requires the equivalent of "bringing home the bacon" or "fixin' dinner" or "getting to the table on time." Food sharing is a critical aspect of nurturing and of family cohesion. When a traumatic event interferes with one's desire to eat, one's ability to face the ordeal of shopping, and one's participation in shared meals, more than nutrition is at stake. There is disruption of biochemistry, interpersonal relations, self-esteem, and connection to culture. PTT requires attention to all of these issues, agreement on desired objectives in the short-term and long-term future, and a collaborative search for remedies.

Mrs. A. developed agoraphobia in addition to PTSD after being held hostage and surviving a sexual assault. Her therapy was prolonged, involving residential and outpatient treatment. She read every book she could find about coping with stress, and understood the significance of reestablishing her role in her family and community. But a major obstacle was her fear of meeting

people who knew about her assault and who felt compelled to make well-intentioned remarks about her recovery. We discussed this situation at length. As she learned to respond to the sympathetic comments of friends and acquaintances without feeling invaded, she overcame her fear of the marketplace. The later phases of PTT were supportive and nondirective. She resumed her functions in the family, and meals became a source of pleasure rather than pain.

Referral to Nutrition Experts

My community has a state-supported university with a department of food science, four hospitals with dietitians, and a professional association of dietitians that holds regular educational conferences. It is relatively easy to identify competent colleagues. Several expressed interest in counseling clients on the fundamentals of food selection and diet. They are experienced in working with eating disorder patients, but not with victims of violence and extreme stress. In those few instances where I made referrals, the outcome was generally good. The clients learned new facts and experienced a feeling of mastery. Those therapists who do not have colleagues close by to assist with nutritional counseling are advised to review the basic facts and the supplementary reference list provided in Ochberg (1988), Chapter 4.

Humor

Following the advice of my colleagues who wrote the section on humor in the chapter just mentioned (Merwin & Smith-Kurtz, 1988), I asked Mrs. R., an adult survivor of incest, to tell me about her ability to laugh. "Do you think my life is funny?" she fumed, casting a look at me that could wither an oak tree. My timing was awful. But usually I can succeed in initiating a discussion about humor, its salutary effect, and ways that we can improve our ability to laugh at ourselves. Smith-Kurtz cites the remarkable example of Norman Cousins (1979), a genius in marshaling humor as a coping mechanism for critical illness. Furthermore, she provides techniques and references to enhance the therapist's sense of humor.

The goal in adding humor to PTT is not for the therapist to be witty, but for the client to have the capacity to laugh. A clinician can facilitate the recovery and the improvement of a client's sense of humor by setting an example, by searching for instances when the client used humor well, and by providing a good audience when spontaneous humor arises.

A week after Mrs. R. cut me down to size, I told her how clumsy a therapist can feel, trying to uncover humor and failing completely. She laughed. Now we can talk freely about her tendency toward sanctimoniousness and her neglect of humor as a healing art. She is interested in elevating her capacity for laughter, and that is a step in the right direction.

Spirituality

Long before psychology and psychiatry were invented, before medicine was a science, there were healers who treated the sick and the wounded. Sometimes they used remedies with a chemical basis for efficacy unknown at the time (e.g., belladonna for diarrhea). But, invariably, there was a sacred, ritual dimension to the treatment. The medicine man invoked spiritual assistance. Sacrifices were required to the gods. Prayers were said, individually and collectively. There is abundant evidence that healing was facilitated (see Wilson, 1989, for a review).

The power of prayer in surviving captivity and torture is well known (Fly, 1973; Jackson, 1973), although the mechanism of action is subject to debate.

Although I once felt that religion and spirituality had no place in the clinical sciences, I am now convinced that clinicians must evaluate their clients' spiritual potential. By this I mean their ability to benefit from their own beliefs, particularly a sense of participation in universal, timeless

events. For adherents to the major religions, this spiritual dimension may be conceptualized as feeling God's love. For others, spirituality may be described as a transcendent feeling of harmony and communion with humanity or Nature or the unknown reaches of space.

Merwin and Smith-Kurtz (1988) explained that
spirituality is a state of being fully alive and open to the moment. It includes a sense of belonging and of having a place in the universe. A deep appreciation of the natural world, an openness for surprise, a gratefulness for the gratuity of everything, joy and wonderment are all a part of spirituality. Although spiritual growth is a type of healing from which most of us could benefit, a victim's sense of spirit may be acutely dimmed for a period after the victimization.

Over time, however, as the victim heals in all areas, the potential for spiritual growth may become greater than ever before and greater than for many people who have not faced the reality of their individual death.

Usually, I avoid these issues early in therapy. Many patients have complained to me about clergy who focused on their own method of spiritual healing after a trauma, ignoring the feelings of the victimized individual. On the other hand, many clients have been helped by sensitive pastoral counselors, and continue seeing them while seeing me. My role is not to promote any specific spiritual approach. But after a relationship is established, after some progress has been made, I express interest in the client's experience of spirituality. Often I am surprised by the strength of religious conviction that coexists with pessimism and helplessness. In therapy, the issue then is not creating de nova a spiritual capacity, but identifying and overcoming the obstacles to feeling the embrace of one's faith.

An excellent example of personal triumph over childhood sexual assault, and the effects of racism and sexism, can be found in the autobiographical prose and poetry of Maya Angelou (1978). Her faith in her own indomitable spirit inspires others. I have referred her works to clients and students, when the spiritual dimension of overcoming adversity was relevant. Here is a powerful poem of hers (Angelou, 1978) that can reach the right client at the right time:

And Still I Rise

You may write me down in history
With your bitter, twisted lies,
You may trod me in the very dirt
But still, like dust, I'll rise.
Does my sassiness upset you?
Why are you beset with gloom?
Because I walk like I've got oil wells
Pumping in my living room.
lust like moons and like suns,
With the certainty of tides,
Just like hopes springing high,
Still I'll rise.
Did you want to see me broken?
Bowed head and lowered eyes?
Shoulders falling down like teardrops,
Weakened by my soulful cries.
Does my haughtiness offend you?
Don't you take it awful hard
'Cause I laugh like I've got gold mines
Diggin' in my own backyard.
You may shoot me with your words,
You may cut me with your eyes.

You may kill me with your hatefullness,
But still, like air, I'll rise . . .
Out of the huts of history's shame I rise.
Up from a past that's rooted in pain I rise . .
Leaving behind night of terror and fear
I rise
Into a daybreak that's wondrously dear
I rise.
Bringing the gifts that my ancestors gave
I am the dream and the hope of the slave.
I rise.
I rise.
I rise.

From Maya Angelou, And Still I Rise. New York: Random House. © 1978 by Maya Angelou. Reprinted with permission.

Holistic health recognizes that the healing process is more than chemical reequilibration. Attention to exercise, nutrition, humor, and spirituality are important elements of the holistic approach. Beyond these elements is the human group, whether it is a family, a support network, or a community. The individual who is victimized cannot recover in isolation. Therefore, the clinician must attend to the demands of social integration.

Social Integration

A supportive family is the ideal social group for healthy posttraumatic healing. Figley (1988) described how such families promote recovery by "(1) detecting traumatic stress; (2) confronting the trauma; (3) urging recapitulation of the catastrophe; and (4) facilitating resolution of the trauma inducing conflicts." After reviewing the first 50 admissions to the Dimondale victims' assistance program, a residential treatment facility with an average stay of 2 weeks, I was surprised to find that less than 10% of the patients had supportive families. My conclusion is that victimized individuals with loving, effective families would rather recover at home than be separated from their primary source of nourishment. However, even the ideal family can be sorely strained after one or more members are seriously traumatized. There is an important role for the posttraumatic therapist in assessing family strengths and weaknesses, and in assessing in the design and implementation of strategies for optimum recovery. Referral to support groups and self-help networks may complement or supplement the healing function of the family.

Posttraumatic Family Therapy

The formula for posttraumatic family therapy includes an assessment phase (Figley, 1988) and four distinct treatment phases. Before summarizing these, I must emphasize that family therapy is not necessarily the best approach, particularly when violation occurs within the family. For example, Herman (1988) cautioned that following the crisis of disclosure, the incestuous family is generally so divided and fragmented that family treatment is not the modality of choice. Experienced practitioners who have begun programs with a family therapy orientation have almost uniformly abandoned this method except in late stages of treatment (H. Giarretto, A. Giarretto, & Sgori, 1978). Stark and Flitcraft (1988) minimized family therapy and emphasized the shelter movement and individual, empowering therapy for battered women: "Assuming that violence has stopped, principal treatment objectives are to overcome the sense of physical and psychological violation and restore a sense of autonomy and separateness."

Family Assessment

Eleven criteria distinguish functional from dysfunctional families, according to McCubbin and Figley (1983): the traumatic stressor is clear, rather than denied; the problem is family-centered rather than assigned completely to the victim; the approach is solution-oriented rather than blame-oriented; there is tolerance; there is commitment to and affection among family members communication is open; cohesion is high; family roles are flexible rather than rigid; resources outside of the family are utilized; violence is absent; drug use is infrequent. Standardized protocols can supplement clinical judgment, but ultimately the clinician and client together must decide whether family therapy is feasible.

T*reatment Phase 1: Building Commitment to Therapeutic Objectives.* When the clinician and the client agree that family therapy is indicated, the first phase of treatment requires that as many family members as possible disclose their individual ordeals, and the therapist demonstrate recognition of their suffering. Figley (1988) suggested that the therapist's sense of respect for each family member's reaction, coupled with optimism and expertise, promotes trust and commitment to therapy. Highlighting differences in individual responses leads to the next phase.

Treatment Phase 11: Framing the Problem. Now each family member is encouraged to tell his or her view of the traumatic event, and to understand how each member was affected. The therapist reinforces discussion that shifts the focus away from the victimized individual, toward the impact on the family as a whole. This is the time to recognize, explore, and overcome feelings of 'victim blame." When positive consequences of the ordeal are mentioned (e.g., a greater appreciation of life after a close brush with death), they are duly noted.

Treatment Phase 111: Reframing the Problem. After individual experiences, assumptions, and reactions are expressed and understood, the critical work of melding these viewpoints into a coherent whole begins. "The therapist must help the family reframe the various family member experiences and insights to make them compatible in the process of constructing their healing theory," notes Figley (1988), illustrating this principle with an example from his work with Vietnam veterans. A combat veteran felt rejected by his wife who avoided talking with him. She felt like a failure as a spouse because she could not help him overcome PTSD symptoms. In this treatment phase, "he began to reframe his perception of her behavior from a sign of rejection to a sign of love." Eventually, the whole family rallied, seeing obstacles as challenges to be overcome.

Treatment Phase IV: Developing a Healing Theory. The goal of posttraumatic family therapy is consensus regarding what happened in the past, and optimism regarding future capacity to cope. An appraisal that is shared by all family members, that accounts for the reactions of each, and that contributes to a sense of family cohesion is a healing theory. Figley (1988) suggested a fifth phase that builds upon this consummation, emphasizing accomplishment and preparedness. However the therapist chooses to clarify the closure of successful therapy, the family will know that they have fulfilled their potential as a healing, nurturing human group.

Alternatives to Family Therapy

Self-Help Groups

Lieberman, Borman, and their colleagues (1979) described and evaluated self-help groups, noting how effective they are, particularly in those countries and cultures that do not rely upon the extended family for support. Self-help and mutual support groups tend to be specific, rather than generic. It is unusual to find a group for all victims of violent crime, but common to have groups for parents of murdered children, adult survivors of incest, and victims of domestic assault. Groups that endure tend to have extraordinary leaders, compatible members, and an optimum

blend of ritual and flexibility. Often, professionals are in the background, available for consultation and referrals, but not intruding upon the autonomy of the group.

Therapists, who work with victims of violence should become familiar with community groups that offer opportunities to share experiences, promote normalization, combat victim blame, and provide a nonthreatening social experience. Some groups will complement individual therapy. Some provide unique opportunities to help others, restoring a sense of purpose and potency. But some groups do more harm than good, encouraging premature ventilation, allowing self-styled "experts" to dominate, confusing and demoralizing the new participant.

Dyadic Support

I have found several ex-patients who were willing to meet with current clients to share experiences. Usually, this worked best one-on-one, at the ex-patient's home or at a restaurant. Since I knew both individuals, I could arrange the meeting, giving a bit of background information to each. I would choose the pairs carefully, thinking about compatible personalities, common traumatic events, and timing with respect to each. For example, Mrs. L., a 35-year-old mother of two children, a survivor of rape by a man eventually convicted of serial rape and murder, told me, after therapy, that she would be pleased to help other women with similar terrifying experiences. Mrs. L. was of considerable help to Mrs. A., the woman mentioned earlier who was held hostage and assaulted. Both were mothers, career women, and articulate and assertive. Mrs. A. did not want sympathy from strangers, had difficulty returning to work, feared entering a supermarket, but rallied as therapy and self-help efforts progressed.

Later, Mrs. L. assisted other clients. But when she went through a separation and divorce from an abusive husband, she was not available to help. I therefore recommend that any attempt to promote contact between ex-clients and current clients be made with caution, knowing the current status of each, and protecting confidentiality by withholding names and personal information until each has been consulted, each agrees, and the timing seems appropriate. However, a carefully screened dyadic "support group" can be extremely beneficial, and is well worth the effort on the part of the therapist. Most of my clients tell me they would appreciate an opportunity to assist others, and I believe them.

Support Services for Victims

Social integration refers to the use of sensitive, supportive companions in the course of recovery from traumatic events, and also to the goal of reentering society without fear. Victims of violent crime who participate in the criminal justice system have little choice about the timing of some stressful social experiences. They are questioned, cross-examined, brought to crowded courtrooms, and sometimes forced to share a waiting room with the perpetrator. For them, social integration can be sudden and traumatic. Fortunately. Efforts are underway in most states to provide specialized services for victims facing these stressful ordeals. Marlene Young, Director of the National Organization for Victim Assistance, describes these efforts and the generic model of ideal victim services in her chapter, "Support Services for Victims" (1988). Young points out the need for advocacy and assistance at every stage of the process, including the pre-court appearance, the trial, and the sentencing hearing.

There are victim-witness specialists, who are trained to support an individual throughout the criminal justice gauntlet, but caseloads are overcrowded, budgets are tight, and too often, the victim-witness specialist is ignored. I have not hesitated to meet with prosecutors and to attend court hearings when my clients felt it would help. PTT objectives are advanced, particularly the objective of sensitive facilitation of social contact. Moreover, court personnel take more interest in the client, and I learn about the wheels of justice in my hometown. Some colleagues argue that this type of intervention fosters dependency and interferes with the therapeutic relationship. They

would be correct if psychoanalysis were the modality. But PTT recognizes the reality of revictimization by busy bureaucrats and officious officials. Partnership between clinician and client in the pursuit of justice is both ethical and professional.

Psychotherapy

When I concluded a dozen years in federal and state government to return to full time practice of psychiatry, Perry Ottenberg congratulated me and said, "It's a great occupation. You've got your tools in your tuchas (Yiddish for backside)—right here!" And he pointed to his head. Wherever the tools of the trade are located, most therapists rely on their own stock of intervention methods, sharpened by years of use. Good therapists establish rapport easily, facilitate discussion of painful material gently, and help their clients or patients to make informed choices about critical decisions, such as use of medication. PTT requires and employs these basic skills. There are several additional psychotherapy tools, specialized tools, that deserve mention. These are the timing of the telling of the trauma story, symptom suppression, the search for meaning, and the handling of coexisting problems.

Telling the Trauma Story

PTT is never complete if the client has not told the details of traumatization. This does not mean that a person who has seen several therapists must tell every detail to every clinician. Nor does it mean that one unemotional synopsis will suffice. Persons who suffer PTSD and victimization symptoms are still captured by their trauma histories and often feel "trapped in the trauma" (Wilson, 1985, 1988, 1989). They are unable to recollect without fear of overpowering emotion. And they recollect what they do not want to recollect, recall, or remember, especially when they are least prepared to remember. As a therapist, the purpose of hearing the details of the trauma story is to revisit the scene of terror and horror and, in so doing, remove the grip of terror and horror. The client should feel your presence at that moment. The purpose is more than catharsis. It is partnership in survival. It is painful and it is necessary and unavoidable.

There is no sense in exploring these corridors before a bond of mutual trust is established. Usually, I know some details from a referral source before beginning my first session with a client, and I will mention them in a matter-of-fact manner, but I make it clear from the beginning that there will be a time for sharing the details, and that will come later.

I believe that highly charged events are filed in the brain's special filing system according to emotional tone, not chronologically, certainly not alphabetically. My objective with respect to the traumatic memory is to file a memory of the two of us, client and clinician, revisiting the trauma, right next to the original file. The co-location of this experience of controlled, shared recollection, with the original, terrifying event, allows mastery and respect to permeate the experience of lonely dehumanization.

Obviously, a mechanical retelling of events will not produce a memory file that ends up in that "special" drawer reserved for extreme emotion. And an uncontrolled, unanticipated abreaction lacks the healing quality of guided, collegial reexploration. There is an optimal emotional intensity, strong enough to assure association with the original trauma, but not so strong as to obliterate the recognition of mastery and respect.

I have employed hypnosis and guided imagery to facilitate recall of trauma scenes, but always with continual reassurance that we are proceeding together that safety is assured. With female sexual assault survivors I have always used a female co-therapist during hypnotic revisiting of trauma scenes.

Occasionally, the properly timed telling of the trauma story is the dramatic crux of therapy.

Mrs. M., a 60-year-old woman married to a man with advanced senile dementia, was driving with her lover on a snowy night. There was a crash and he died in her arms. She could not share her horror with her daughters and she had PTSD symptoms for over a year. My colleague Alice Williams, a social caseworker, worked with her on an outpatient basis, and I consulted once or twice. Symptoms remained. But after 3 days in a residential unit, we revisited the terrible snowy night together with Mrs. M., who was placed in a light hypnotic trance. She cried and screamed as she narrated the events, then blurted out, "Alice, why didn't I do this before?" then cried some more. But now they were clearly tears of relief. The lonely terror was welded to the reenactment experience with a respected therapist. Symptoms abated completely. Telephone follow-up 2 years later confirmed enduring relief.

More frequently, the telling of the trauma story is not curative. One re-enactment with a trusted clinician is not enough. Aspects of the trauma are still hidden. Implications of victimization are profound. Symptoms remain entrenched. PTT continues, with all applicable tools applied.

Symptom Suppression

Roth (1988) asked the pertinent question in his chapter on the role of medication in posttraumatic therapy: "Is the treatment of a psychological disorder by biological means a short-sighted suppression of symptoms that robs the patient of the motivation and resources to solve his or her true underlying psychological problems?" He then provided an "integrated psychobiological viewpoint" of posttraumatic stress, justifying the temporary suppression of symptoms that interfere with adaptation. Whether medication, biofeedback, or behavior modification are offered to suppress symptoms, the client should have the opportunity to make an informed choice among effective options. Common posttraumatic symptoms that can be suppressed at any stage of PTT include insomnia, panic, and generalized anxiety. Medication can help with each of these, but there are pitfalls and contraindications. Roth (1988) and van der Kolk (1988) discussed these issues well.

I have found that judicious use of sedatives (e.g., triazolam, 0.125 mg every other night) often restores a normal sleep pattern without creating dependency. The dosage may be increased, but the client avoids using medication nightly, and discontinues the drug within a month. Some sleep disorders are very difficult to treat, however, with or without drugs.

Similarly, moderate use of tricyclics for panic and benzodiazepines for anxiety have allowed many of my patients to accelerate recovery, reenter social groups, and restore self-esteem. Both of us know that symptoms are being suppressed to facilitate PTT, not to replace it.

Individualized Search for Meaning

By definition, catastrophic stress shakes one's equilibrium, breaks one's attachments, and removes a sense of security. Inevitably, confrontation with deliberate human cruelty strains one's sense of justice, shatters assumptions of civility, and evokes alien, sometimes bestial, instincts. Those clinicians who describe therapy with Holocaust victims and refugee survivors of violence and torture (Danieli, 1988; Mollica, 1988) recognize these profound effects, often transmitted to a second generation, cast in the shadow of cruelty.

Victor Frankl, the famous Viennese psychiatrist, pondered the profound questions about life's meaning as he endured the Nazi concentration camp and, afterward, as he provided therapy to fellow survivors. "Woe to him who saw no more sense in his life, no aim, no purpose, and therefore no point in carrying on," stated Frankl, recalling the death camp (1959).

What was really needed was a fundamental change in our attitude toward life. We had to learn ourselves and, furthermore, we had to teach the despairing men, *that it did not really*

***matter what we expected from life, but rather what life expected from us.* We needed to stop asking about the meaning of life, and instead to think of ourselves as those who were being questioned by life - daily and hourly. Life ultimately means taking the responsibility to find the right answer to its problems and to fulfill the tasks it constantly sets for each individual.**

It is a rare privilege to work with a client who reaches the philosophic stage of PTT, consciously formulating a new attitude toward life. But when patients are overwhelmed with symptoms, discussion of life's meaning has little relevance. However, as normalization restores a sense of dignity, as empowerment restores a will to endure, and as individuality restores a sense of self, clients do take responsibility to find the "right answer" for themselves. Their behavior demonstrates their fulfillment of Frankl's ideal, even if they lack the ability or inclination to formulate a philosophy of life.

The therapist, however, should have the aptitude to guide a search for meaning, to recognize existential despair, to confront self-pity, to reinforce recognition of one's responsibility for one's own life. A final phase of PTT includes articulation of the meaning of life in terms that are specific to the individual, not general or abstract.

Coexisting Problems

PTSD may mimic personality and anxiety disorders. It may precipitate physical and psychiatric conditions. It may exacerbate preexisting disorders. It may be confounded by coexisting problems, including normal stages of life adjustment (Mowbray, 1988; Wilson, 1988). To illustrate this point, Wilson (1988) cites the remarkable findings of Green, Lindy, and Grace (1984) who found "that only 13% of a treatment seeking population of Vietnam veterans manifest a single diagnosis of PTSD." Therefore, it is important for posttraumatic therapists to recognize coexisting problems and to clarify these in therapy.

Certain coexisting disorders, particularly borderline personality may be impossible for the posttraumatic therapist to manage according to the principles of PTT. Where borderline cases are at issue, for example, collegiality may be misinterpreted as intimate friendship, and a willingness to intervene with criminal justice officials may lead to insatiable requests for help with personal affairs. Unfortunately, abused children may evidence combinations of borderline personality, multiple personality and PTSD. This presents enormous challenges to the therapist. A treatment strategy must be individualized, and may involve several therapists, concurrently or in sequence.

Recently, I served as a consultant to a therapist who was treating a client with borderline personality disorder and PTSD. I provided educational material to the client and his spouse, and shared my clinical hunches with the therapist. The client made several attempts to enlist my aid in undercutting therapy, calling me at home, complaining that his therapist never saw him after the therapy hour, citing previous papers of mine to "prove" how insensitive his therapist was to the needs of traumatized patients. His therapist confronted him respectfully, maintained appropriate therapeutic boundaries, and continued undeterred. I am grateful for therapists with the maturity and stamina to treat borderline patients, and I am thankful for lessons in the limitations of PTT.

It is not unusual for a traumatized patient to request help with psychological issues that antedate the trauma. Several clients have embarked upon long-term therapy for dysthymia, avoidant personality disorder, or dependent personality disorder, after achieving mastery of PTSD and victimization symptoms. In these cases, I continually clarified the contract and the objectives, to avoid self-blame when working with victimization issues, and to promote self-reliance when treating the preexisting condition. There is no way to untangle completely PTSD and a personality disorder, treating one first and then the other (see Wilson, 1988). But the therapist can maintain the fundamental principles of PTT and use tools in the general armamentarium of techniques, as long as there is no contraindication that is due to coexisting problems.

Conclusion

The clinician and the client have no difficulty realizing when posttraumatic therapy approaches its conclusion. Symptoms subside, although they may be present to some degree. There is an understanding of the causes and significance of autonomic echoes. There is a sense of mastery and control. But most significantly, there is a shift from victim status to survivor status. To clarify this change of self-perception, I wrote the Survivor Psalm and use it with clients to gauge progress and to mark termination: I have been victimized. I was in a fight that was not a fair fight. I did not ask for the fight. I lost. There is no shame in losing such fights, only in winning. I have reached the stage of survivor and am no longer a slave of victim status. I look back with sadness rather than hate. I look forward with hope rather than despair. I may never forget, but I need not constantly remember. I was a victim. I am a survivor. With every client who travels that painful path from victim to survivor, I feel a surge of hope for all of us who are engaged in the larger struggle for survival.

It is no accident that many of the same principles that guided the community mental health movement in the 1960s are rediscovered in the victims' rights movement of the 1980s. There is a vast, undeserved population. There is a need to mobilize help from separate disciplines. There is a crescendo of attention that cuts across ideology. There is a scientific basis for humanitarian aid. There are atavistic approaches that do more harm than good, and that beg for reform. Treating rape victims on the same psychiatric unit as chronic schizophrenics is the modern equivalent of institutionalizing the mentally ill. Removing sexually abused children from their mothers rather than removing the abusive father is reminiscent of persecuting psychotic individuals as demons. And denying that thousands of Vietnam veterans and millions of refugees can benefit from clinical attention is tragically similar to the national myopia that culminated in President Kennedy's call for Action for Mental Health (1963).

Participation in any aspect of the healing arts and sciences is a source of gratification and humility. The rewards are great; the problems are never-ending.

Appendix 1

Proposed Diagnostic Criteria for Victimization Sequelae Disorder

A. The experience, or witnessing, of one or more episodes of physical violence or psychological abuse or of being coerced into sexual activity by another person

The development of at least (number to be determined) of the following symptoms (not present before the victimization experiences):

1. A generalized sense of being ineffective in dealing with one's environment that is not limited to the victimization experience (e.g., generalized passivity, lack of assertiveness, or lack of confidence in one's own judgment)

2. The belief that one has been permanently damaged by the victimization experience (e.g., a sexually abused child or rape victim believing that he or she will never be attractive to others)

3. Feeling isolated or unable to trust or to be intimate with others

4. Overinhibition of anger or excessive expression of anger

5. Inappropriate minimizing of the injuries that were inflicted

6. Amnesia for the victimization experiences

7. Belief that one deserved to be victimized, rather than blaming the perpetrator

8. Vulnerability to being revictimized

9. Adopting the distorted beliefs of the perpetrator with regard to interpersonal behavior (e.g., believing that it is OK for parents to have sex with their children, or that it is OK for a husband to beat his wife to keep her obedient) 10. Inappropriate idealization of the perpetrator C. Duration of the disturbance of at least one month

Appendix 2

Victimization Symptoms: A Distinct Subcategory of Traumatic Stress

1. Shame: Deep embarrassment, often characterized as humiliation or mortification.

2. Self-blame: Exaggerated feelings of responsibility for the traumatic event, with guilt and remorse, despite obvious evidence of innocence.

3. Subjugation: Feeling belittled, dehumanized, lowered in dominance, and powerless as a direct result of the trauma.

4. Morbid hatred: Obsessions of vengeance and preoccupation with hurting or humiliating the perpetrator, with or without outbursts of anger or rage.

5. Paradoxical gratitude: Positive feelings toward the victimizer ranging from compassion to romantic love, including attachment but not necessarily identification. The feelings are usually experienced as ironic but profound gratitude for the gift of life from one who has demonstrated the will to kill. (Also known as pathological transference and "Stockholm syndrome.")

6. Defilement: Feeling dirty, disgusted, disgusting, tainted, "like spoiled goods," and in extreme cases, rotten and evil.

7. Sexual inhibition: Loss of libido, reduced capacity for intimacy, more frequently associated with sexual assault.

8. Resignation: A state of broken will or despair, often associated with repetitive victimization or prolonged exploitation, with markedly diminished interest in past or future.

9. Second injury or second wound: Revictimization through participation in the criminal justice, health, mental health, and other systems.

10. Socioeconomic status downward drift: Reduction of opportunity or life-style, and increased risk of repeat criminal victimization due to psychological, social, and vocational impairment.

Note. From Post-traumatic Therapy and Victims of Violence (Chapter 1) by F. M. Ochberg, 1988. New York: Brunner/Mazel. Copyright 1988 by Brunner/Mazel. Reprinted by permission.

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