

6. Tri-Phasic Model (Herman, 1992)

Judith Herman is a psychiatrist in the Boston area. She has worked extensively with trauma expert Bessel van der Kolk. Herman is the author of two books, *Father Daughter Incest* (1981) and *Trauma and Recovery* (1992), and numerous articles on the enduring effects of chronic trauma. *Trauma and Recovery* is considered a seminal work on the history and treatment of chronic Type II trauma. Herman conceives trauma recovery to proceed in three stages:

- Safety and Stabilization
- Remembrance and Mourning
- Reconnection

Safety and Stabilization

The central task of recovery is safety. Victims of chronic trauma are betrayed both by their experiences as well as their own bodies. Their symptoms become the source of triggers that result in retraumatization. The clinician's primary goal is to help the client regain internal and external control. This is accomplished through careful diagnosis and education. If flashbacks are the chief symptom, the clinician helps the client to learn skills to reduce their frequency and duration. Similarly, if the client is living in an abusive environment, the therapist discusses alternatives, including the availability of shelters for battered women and other abuse victims. The overriding goal is to enable the client to make a gradual shift from "unpredictable danger to reliable safety" (p. 155) both in their environment and within themselves. Accomplishing this goal depends on the circumstances and may take days, weeks, or months to achieve.

Remembrance and Mourning

In the second phase of recovery the client reconstructs the trauma story in minute detail. Because of the nature of traumatic memories, this process is rarely linear. Bits and pieces of the story emerge and can be told. The objective is to create a space in which the client can relive and begin to make sense of the devastating experiences that have shaped his or her life. The clinician's role is to "bear witness" to the client's experiences, and help her or him find the fortitude to heal.

There are many excellent Cognitive Behavioral Therapy techniques that fit well within the rubric of

this stage of trauma recovery. In addition, there are newer approaches such as Eye Movement Desensitization and Reprocessing (EMDR), Time-Limited Trauma Therapy (TLTT), and Traumatic Incident Reduction (TIR) that warrant further exploration.

Reconnection

The final stage of recovery involves redefining oneself in the context of meaningful relationships. Trauma survivors gain closure on their experiences when they are able to see the things that happened to them with the knowledge that these events do not determine who they are. Trauma survivors are liberated by the conviction that, regardless of what else happens to them, they always have themselves. Most survivors are also sustained by an abiding faith in a higher power that they believe delivered them from oppressive terror. In many instances survivors find a "mission" through which they can continue to heal and to grow. They may even end up helping others with similar histories of abuse and neglect. Successful resolution of the effects of trauma is a powerful testament to the indomitability of the human spirit.

7. Necessary Ingredients for Trauma Recovery

We believe there are three active and necessary ingredients for the effective treatment of trauma. These include relaxation and exposure (reciprocal inhibition) and cognitive restructuring. Note, however, that none of the ingredients by itself is sufficient to accomplish the task of recovery. Each of the techniques included in this book is intended to provide at least one of the three ingredients. Since the timing of the interventions is important as well, some of the techniques are most appropriate during the Safety and Stabilization Phase, while others are more appropriate to the Remembrance and Mourning or Reconnection Phases. We will indicate which techniques provide which of the three ingredients by placing an R (relaxation, self-soothing), RE (relaxation and exposure) and/or CR (cognitive restructuring) by each technique title.

We chose to include a broad variety of interventions because it is the case that different interventions will work more effectively with different clients depending on their background and/or mode of experiencing. It is by no means an exhaustive list of interventions.

The type of intervention selected for which client is left to the creative discretion of the therapist. It is our hope that with experience and an understanding of the necessary ingredients and process for trauma recovery, good therapists will be able to adjust and create interventions of their own to meet the specific needs of each client.

8. Body, Cognition, Behavior, and Emotion/Relation

Throughout this book you will notice that sections are broken down into Body, Cognition, Behavior, and Emotion/Relation. The reason for this is that we process events on many channels and sometimes it is necessary to recover both our ability to live peacefully in our Bodies (i.e., psychophysiology, heart rate, breathing); our Minds/Cognitions (i.e., thoughts, perceptions and beliefs); our Behaviors (i.e., proactive vs. restricted); and our Emotions/Relations (i.e., range, depth, rationality, support level). With these elements in mind, we have made it our mission to seek out interventions that address recovery on all channels. By addressing different channels as needed we gear our treatment to the client and thereby avoid “cookie cutter” methodology that limits our ability to truly treat the complexities so often common among those suffering from Post Trauma syndromes.

9. Post-Trauma Response

Based on the DSM-IV (APA, 1994) diagnostic features, the most salient post-trauma elements result in the development of particular symptoms as a result of exposure to massive trauma in which one's personal health and well-being is threatened. The stressor is often identified as one that may lead to one's death or injury or that of a person close to the individual (i.e., friend, family, colleague). There are six criteria that

need to be met in part or whole in order to establish Post-Traumatic Stress Disorder (PTSD) as a diagnosis. The PTSD diagnosis is based on the following criteria: A1, personal involvement in a life or death event that is a threat to personal safety or that of friends, associates, or family; A2, the person responds to the stressor with horror, helplessness, or great fear; B, recurrent, intrusive mental re-experiencing of the trauma; C, avoidance of trauma related cues and emotional numbing; D, hyperarousal; E, PTSD must be present for longer than 1 month; and F, the symptoms must be significant enough to impair functioning of life skills (APA, 1994). Other possible diagnoses to consider might include: Acute Stress Disorder; Generalized Anxiety Disorder; Major Depressive Disorder; Panic Disorder; Adjustment Disorder, Dissociative Disorders or Dysthymia.

The wording of the diagnostic criterion for PTSD in the DSM-IV recognizes that the individual's response to a traumatic event is equal in importance as the objective evaluation of the event itself and degree to which it might be determined to be traumatic. By taking into account individual responses, we are able to begin to make sense of why some individuals become debilitated after experiencing a seemingly innocuous event while others can spend long periods of time in the midst of heinous trauma without developing negative effects.

To recap, key post-trauma symptoms include:

- Feelings of horror, helplessness or fear
- Recurrent, intrusive re-experiencing of the traumatic event (i.e., nightmares, flashbacks, intrusive memory replay)
- Avoidance of any trauma-related cues (i.e., places, people or activities associated with the trauma or resulting in reminders of the trauma)
- Anxious arousal (i.e., increase in heart rate and breathing, nervousness, fearfulness, agitation, easily ignited startle response)
- Impairment of life skills (i.e., ability to socialize, work, attend school or manage family responsibilities)

Alexithymia	Sadness and depression
Guilt over acts of commission or omission	Feelings of being overwhelmed
Survival guilt	Loss of assumptive world
Suicidal/homicidal ideation/behaviors	Behavioral reenactments
Disillusionment with authority	Self-destructive soothing behaviors
Feelings of hopelessness/helplessness	Somatization
Memory impairment and forgetfulness	Relationship problems

In addition, there are two types of trauma that the traumatologist would benefit from differentiating at the beginning stage of treatment to assist in treatment planning.

Type I Trauma: An unexpected and discreet experience that overwhelms the individual's ability to cope with the stress, fear, threat and/or horror of this event leading to PTSD (i.e., motor vehicle accident, natural disaster). Can be the witnessing of an event (secondary traumatic stress). Treatment outcome tends to be

achieved more rapidly than in Type II trauma if services are offered within a reasonable time (months rather than years) after onset of post-trauma symptoms.

Type II Trauma: Expected, but unavoidable, ongoing experience(s) that overwhelm the individual's ability to metabolize the event (i.e., childhood sexual abuse, combat trauma). This type of trauma is the origin of DESNOS (Disorders of Extreme Stress Not Otherwise Specified) and Dissociative Disorders.