in the treatment of traumatized patients.[14] The patient enters the therapeutic relationship prey to every sort of doubt and suspicion. She generally assumes that the therapist is either unable or unwilling to help. Until proven otherwise, she assumes that the therapist cannot bear to hear the true story of the trauma. Combat veterans will not form a trusting relationship until they are convinced that the therapist can stand to hear the details of the war story.[15] Rape survivors, hostages, political prisoners, battered women, and Holocaust survivors feel a similar mistrust of the therapist's ability to listen. In the words of one incest survivor, "These therapists sound like they have all the answers, but they back away from the real shitty stuff."

At the same time, however, the patient mistrusts the motives of any therapist who does not back away. She may attribute to the therapist many of the same motives as the perpetrator. She often suspects the therapist of exploitative or voyeuristic intentions.[16] Where the trauma has been repeated and prolonged, the patient's expectations of perverse or malevolent intent can prove especially resistant to change. Patients who have been subjected to chronic trauma and therefore

suffer from a complex post-traumatic syndrome also have complex transference reactions. The protracted involvement with the perpetrator has altered the patient's relational style, so that she not only fears repeated victimization but also seems unable to protect herself from it, or even appears to invite it. The dynamics of dominance and submission are reenacted in all subsequent relationships, including the therapy.

Chronically traumatized patients have an exquisite attunement to unconscious and nonverbal communication. Accustomed over a long time to reading their captors' emotional and cognitive states, survivors bring this ability into the therapy relationship. Kernberg notes the borderline patient's "uncanny" ability to read the therapist and respond to the therapist's vulnerability.[17] Emmanuel Tanay notes the "sensitivity and intense perceptiveness" of survivors of the Nazi Holocaust, adding that "fluctuations in attention of the therapist are picked up by these patients with readiness and pathological hypersensitivity."[18]

The patient scrutinizes the therapist's every word and gesture, in an attempt to protect herself from the hostile reactions she expects. Because she has no confidence in the therapist's benign

CHAPTER 8

Safety

RECOVERY UNFOLDS in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central task of the third stage is reconnection with ordinary life. Like any abstract concept, these stages of recovery are a convenient fiction, not to be taken too literally. They are an attempt to impose simplicity and order upon a process that is inherently tur-

bulent and complex. But the same basic concept of recovery stages has emerged repeatedly, from Janet's classic work on hysteria to recent descriptions of work with combat trauma, dissociative disorders, and multiple personality disorder.[1] Not all observers divide their stages into three; some discern five, others as many as eight stages in the recovery process.[2] Nevertheless, there is a rough congruence in these formulations. A similar progression of recovery can be found across the spectrum of the traumatic syndromes (see table). No single course of recovery follows these stages through a straightforward linear sequence. Oscillating and dialectical in nature, the traumatic syndromes defy any attempt to impose such simpleminded order. In fact, patients and therapists alike frequently become discouraged when issues that have supposedly been put to rest stubbornly reappear. One therapist describes the progression through the stages of recovery as a spiral, in which earlier issues are continually revisited on a higher level of integration.[3] However, in the course of a successful recovery, it should be possible to recognize a gradual shift from unpredictable danger to reliable safety, from dissociated

trauma to acknowledged memory, and from stigmatized isolation to restored social connection.

The traumatic syndromes are complex disorders, requiring complex treatment. Because trauma affects every aspect of human functioning, from the biological to the social, treatment must be comprehensive.[4] Because recovery occurs in stages, treatment must be appropriate at each stage. A form of therapy that may be useful for a patient at one stage may be of little use or even harmful to the same patient at another stage. Furthermore, even a well-timed therapy intervention may fail if the other necessary components of treatment appropriate to each stage are absent. At each stage of recovery, comprehensive treatment must address the characteristic biological, psychological, and social components of the disorder. There is no single, efficacious "magic bullet" for the traumatic syndromes.

Stages of Recovery

Syndrome	Stage One	Stage Two	Stage Three
Hysteria (Janet 1889)	Stabilization, symptom-oriented treatment	Exploration of traumatic memories	Personality reintegration, rehabilitation
Combat trauma (Scurfield 1985)	Trust, stress-management, education	Reexperiencing trauma	Integration of trauma
Complicated post-traumatic stress disorder (Brown & Fromm 1986)	Stabilization	Integration of memories	Development of self, drive integration
Multiple personality disorder (Putnam 1989)	Diagnosis, stabilization, communication, cooperation	Metabolism of trauma	Resolution, integration, development of postresolution coping skills
Traumatic disorders (Herman 1992)	Safety	Remembrance and mourning	Reconnection

NAMING THE PROBLEM

Traumatic syndromes cannot be properly treated if they are not diagnosed. The therapist's first task is to conduct a thorough and informed diagnostic evaluation, with full awareness of the many disguises in which a traumatic disorder may appear. With patients who have suffered a recent acute trauma, the diagnosis is usually fairly

straightforward. In these situations clear, detailed information regarding post-traumatic reactions is often invaluable to the patient and her family or friends. If the patient is prepared for the symptoms of hyperarousal, intrusion, and numbing, she will be far less frightened when they occur. If she and those closest to her are prepared for the disruptions in relationship that follow upon traumatic experience, they will be far more able to tolerate them and take them in stride. Furthermore, if the patient is offered advice on adaptive coping strategies and warned against common mistakes, her sense of competence and efficacy will be immediately enhanced. Working with survivors of a recent acute trauma offers therapists an excellent opportunity for effective preventive education.

With patients who have suffered prolonged, repeated trauma, the matter of diagnosis is not nearly so straightforward. Disguised presentations are common in complex post-traumatic stress disorder. Initially the patient may complain only of physical symptoms, or of chronic insomnia or anxiety, or of intractable depression, or of problematic relationships. Explicit questioning is often required to determine whether the patient

is presently living in fear of someone's violence or has lived in fear at some time in the past. Traditionally these questions have not been asked. They should be a routine part of every diagnostic evaluation.

When the patient has been subjected to prolonged abuse in childhood, the task of diagnosis becomes even more complicated. The patient may not have full recall of the traumatic history and may initially deny such a history, even with careful, direct questioning. More commonly, the patient remembers at least some part of her traumatic history but does not make any connection between the abuse in the past and her psychological problems in the present. Arriving at a clear diagnosis is most difficult of all in cases of severe dissociative disorder. The average delay between the patient's first encounter with the mental health system and an accurate diagnosis of multiple personality disorder is six years.[5] Here both parties to the therapeutic relationship may conspire to avoid the diagnosis—the therapist through ignorance or denial, the patient through shame or fear. Though a small minority of patients with multiple personality disorder seem to enjoy and flaunt the dramatic features of