

Trauma and Recovery

A literature study of Dr. Judith Herman's research and
treatment methodology

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C/D Master thesis

Psychology

Department of Human Work Sciences

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Abstract

American psychiatrist Judith Herman is one of the pioneers within the modern trauma studies and has contributed to the improvement of diagnosis, clarifying the definition and symptoms of Post Traumatic Stress Disorder (PTSD), and treatment methodology. In the revised edition of Herman's book, *Trauma and Recovery* (2001) she presented her theory and treatment methodology for trauma. The aim of this thesis is to evaluate the validity of Herman's theory and the effectiveness of her treatment methodology. An extensive account of Herman's work, as it is reported in *Trauma and Recovery*, is presented and the validity of Herman's statements is evaluated through a literature review of other researchers' and clinicians' ratings of Herman's work. The results show that Herman's theory has been accepted by clinicians and researchers as a foundation for the development of contemporary treatments for trauma.

Keywords: Trauma, Stages of Recovery, Diagnosis, Treatment, Isolation, Social and Political involvement

Sammanfattning

Den amerikanske psykiatrikern Judith Herman är en av pionjärerna inom moderna studier av trauma. Hon har bidragit till en förbättring av diagnostik, förtydligande av definition och symptom samt behandlingsmetodik rörande Posttraumatisk stress. I den reviderade upplagan av Hermans bok, *Trauma and Recovery* (2001), presenterade hon sin teori och sina behandlingsmetod för trauma. Syftet med detta examensarbete är att utvärdera giltigheten hos Hermans teori och effektiviteten av hennes behandlingsmetoder. En grundlig genomgång av Hermans arbete, som det redovisas i *Trauma and Recovery*, presenteras och giltigheten hos Hermans påståenden utvärderas genom en litteraturstudie av andra forskares och klinikers omdömen om Hermans arbete. Resultaten visar att Hermans teori har godtagits av kliniker och forskare som en grund för utveckling av moderna behandlingar av trauma.

Nyckelord: Trauma, Stadier hos Tillfrisknande, Diagnos, Behandling, Isolering, Socialt och Politiskt engagemang

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1. Introduction

Judith Herman MD, a psychiatrist and author from America, has spent the last three decades compiling research on, and studying the effects of, trauma on the human condition. Through working with discussion groups on women's and children's issues in society far from war torn countries, she found that information given by those was a clear sign of hidden traumas. This led her to investigate historical records of studies done within this area and she found that there was in fact documentation proving the existence of trauma. Herman's book, *Trauma and Recovery* (2001), is a compilation of her research findings and treatment methodology. The main issues dealt with in the book are the social and political acts of denial regarding legitimacy of trauma as a human disorder that plagues the young as well as the old, defining trauma and diagnosis, and, finally, treatment of this complex disorder.

1.1 Background

According to Herman's (2001) findings, the study of psychological trauma has "a curious history— one of episodic amnesia" (p. 9). This periodic amnesia is not due to the lack of interest, but rather that the issue provokes controversy that sometimes it is easier to avoid the subject and deny its existence. Herman's (2001) historical research has shown that three times in the last century, "psychological trauma has surfaced into public consciousness, and each time flourishing in affiliation with a political movement" (p. 9). The first to come forward was, according to Herman (2001), Hysteria or the Seduction Theory, the fashionable psychological disorder of women introduced by Sigmund Freud and later researched by Pierre Janet. Herman found that these studies resulted from the "republican, anticlerical political movement of the late 19th century in France" (p. 9). In the late 19th century Freud's attention of women's hysterical symptoms showed that they had a connection to sexual abuse, which was pushed to the unconscious and forgotten. According to Herman (2001) Freud believed he solved the issue of women hysteria, but his research was not accepted. The reason being that at this point in time society was not structured politically, or socially, to see women or children as entities in their own, they were the property of men and therefore their suffering was not of importance. Therefore, to accept Freud's research would mean that the society would have to change their view of women and children and admit abusive actions against them. Herman (2001) also contends that Freud's theories were never proven scientifically, adding to the prejudice against his findings. Due to social pressure, Freud, according to Herman (2001), succumbed to the popular social and political views of the time and changed his theory to suit the general opinion, from the Seduction Theory to

Fantasy, and women's hysteria was now seen as the result of women's own hidden desire to be abused and raped. Herman (2001) states that Janet (1891) did not fall to political or social pressures and kept the belief that abuse induces traumatic symptoms. Unfortunately his work on this matter was forgotten until Herman reintroduced the subject some 60 years later.

Herman (2001) found that psychological trauma became an issue again with the First World War. It was at this time the diagnosis of shell shock, or combat neurosis, developed. Studies on soldiers began in "England and the United States after the First World War and reached a peak after the Vietnam War" (p. 9). Being confined in the trenches amidst constant violence and threat of death resulted in soldiers behaving like Freud's hysterical women. They screamed, cried, and lost senses and memory at uncontrollable rates. These patients were labelled as being "moral invalids" (p. 21) and their hysterical symptoms were treated with electric chock therapy. Some of the psychiatrists treating these soldiers noted at this time that the soldiers suffering had nothing to do with their lack of courage but more with circumstances, which resulted in the label of "moral invalid" being changed to "combat neurosis" (p. 23). During the Second World War this issue became of interest again but with little progress. She ascertains that it wasn't until the Vietnam War that trauma was revisited and found that its "political context had to do with the collapse of pro-war sentiments to the growth of an anti-war movement" (p. 9). In the trenches there was an illusion of male heroism from society, but actually men were breaking down psychologically and speaking out about their experiences. For the first time in the history the anti-war movement became socially popular. Veterans were no longer keeping silent about the degree of violence they faced and started creating "rap groups" (p. 9) discussing these experiences upon returning home. In 1980 Post Traumatic Stress Disorder (PTSD) was made official, but solely in regards to war experiences.

The latest trauma to get awareness is that of sexual and domestic violence. Herman (2001) states that "its political context is due to the feminist movement in Western Europe and North America" (p. 9). In 1970-80 studying trauma was only legitimate with reference to "the sacrifice of young men in war" (p. 9). At this time through the increased interest in women's liberation issues, feminist organisations were fighting for recognition of the traumatic effects of rape, abuse, and captivity. When the PTSD diagnosis was established and made legitimate in 1980, researchers studied the symptoms of PTSD and soon found that the anxiety and stress experienced by soldiers were exactly the same as those experienced by women and children who have been placed in care facilities (hospitals/asylums/group homes). This lead to further investigation of what kind of trauma exists in everyday society that could induce these symptoms in women and children.

When, in 1980, Post Traumatic Stress Disorder first was made legitimate and included in the diagnostic manual of the American Psychiatric Association

Comprehensive Textbook of Psychiatry trauma was described “as the experience of an event outside the range of usual human experience (occurring only in one out of a million people)” (p. 33). Herman viewed this as a grossly inaccurate definition. She states “rape, battery, and other forms of sexual and domestic violence” (p. 33) were, and still are, very common especially in women’s lives, and, when taken into account the high statistics of those that die in war, it was, and is, wrong to declare that trauma is “outside the range of ordinary human experience” (p. 33). She concluded that only the very fortunate in life can really say that trauma is outside their range of ordinary experiences. She further states that what is extraordinary about the subject of trauma is not that they rarely occur, but how extensively they affect the human condition. She explains that “unlike commonplace misfortunes, traumatic events can generally be described as involving threats to life or bodily integrity, or a close personal encounter with violence and death” (p. 33).

Herman (2001) attends that the most significant determining factor of psychological injury has to do with the character of the traumatic event and not the level of a person’s vulnerability, or resilience, as commonly believed. According to her the personality characteristics are of no consequence when facing overwhelming odds. In her professional experience and research there is a “direct relationship between the severity of the trauma and its psychological impact, whether that impact is measured in terms of the number of people affected or the intensity and duration of harm” (p. 57). Herman (2001) attributes some of the most recent advances in the field of trauma to modern technical laboratory studies in which the biological factors of PTSD has been studied. According to her, what these studies show are lasting modifications in the central nervous systems, autonomic and endocrine from traumatic exposure.

New lines of investigation are delineating complex exchanges in the regulation of stress hormones, and in the function and even the structure of specific areas of the brain. Abnormalities have been found particularly in the amygdale and the hippocampus, brain structures that create a link between fear and memory. (p. 237)

She adds that more proof of the pathogenic role of dissociation has come from a “large-scale clinical and community study of traumatized people conducted by a task force of the American Psychiatric Association” (p. 239) and explains that in this study dissociate symptoms were experienced by people for which there could not be found any physical cause. These same people also engaged regularly in self harm or self destructive behaviour. These studies validated “the century-old insight that traumatized people relive in their bodies the moments of terror that they can not describe in words”, as well as indicating that “the mechanism by which intense sensory and emotional experiences are disconnected from the social domain of language and memory, the internal mechanism by which terrorized people are silenced” (p. 239).

Herman (2001) has concluded, through her research and clinical experience, that due to immense complexity of this disorder and its varied effects on grades of emotions, regulation, social interaction, and disconnection both psychologically and physically the most progressive and successful treatment methodology for trauma survivors should reflect that of the disorder. It should therefore be multi phased using of various therapeutic techniques in accordance to the tolerance and abilities of the individual trauma survivor and most definitely should not be done in isolation, but within the context of a social network. Hence, the first stage deals with physiological symptoms that must be managed before any investigative work (anxiety, phobias, self-harm, addictions etc.), the second with managing the intrusive effects of investigative work, and the third has to do with empowering the survivor to gain control over their intrusive feelings from the trauma. In the fourth stage a complete narrative of the trauma should be done linked with emotion. The fifth stage deals with reconnecting with oneself and others, self esteem and tolerance and the seventh, the final, stage deals with integrating the trauma into a life story, a system of meaning is established.

1.2 Problem Formulation

Herman's (2001) work is considered as one of the most important since Freud, influencing and developing not only the contemporary theory on trauma but also treatment methodology for this complex disorder. When one source, like this, becomes so influential in one field of research (like trauma) there is a necessity for evaluating the validity of such a work. Are there other researchers that confirm, or refute, this work?

1.3 Aim

The aim of this thesis is to evaluate the validity of Herman's theory and treatment methodology in the context of how other researchers judge Herman's work.

1.4 Research Questions

- Are Herman's theoretical findings valid according to other researchers?
- Is Herman's treatment methodology practical, valid, and reliable according to other researchers?

2. Theories, diagnoses, and treatments of trauma

2.1 The Trauma Theory

According to the study by Auerbach, Salick, and Fine (2006) the trauma theory begins with the classic work of Janet, Freud, and Breuer & Freud. Taking also into account Charcot's observations on the affects of trauma on the mind, there were two different concepts formulated. For instance, Freud hypothesizes that trauma induces extreme stimulus, which proves overwhelming to the mind resulting in the person being unable to deal with the experience and as a defence mechanism against such overwhelming mental anguish, the tool of repression is used. However, Janet (as cited in Auerbach et al., 2006) preferred the hypothesis that the experience of trauma actually disturbs a person's ability to connect or hold various experiences together, resulting in dissociation and fragmentation in the mind. Auerbach et al. (2006) also found, through their historical research, that trauma research came to a temporary stop following Freud changing his seduction theory to fantasy. Thereafter trauma was investigated again in conjunction with the World Wars, when soldiers developed shell shock, and then given up again until the Vietnam War, when both veterans and rape victims push forward political recognition of trauma by health professionals and their communities (Herman, 1992 cited by Auerbach et al., 2006).

The current understanding of what is recognized as PTSD can be found in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, (4th ed., text rev. (DSM-IV-TR) (American Psychiatric Association, 2000, p. 463).

DSM – IV Diagnostic features: 309.81 Posttraumatic Stress Disorder

The essential feature of Posttraumatic Stress Disorder is the: development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response to the event must involve disorganized or agitated behaviour) (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).

2.1.1 Development of diagnostic criteria and concepts for PTSD.

In reflection to the struggle of getting trauma more in the fore front many researchers have also found that, though, the disorder was made legitimate and included in the Diagnostic manual for mental disorders, the diagnosis criteria for the full spectrum of the disorder is in need of attention. For instance, the study by Goff, Bole, Scheer, Hayes, Archuleta, Blalock-Henry, et al. (2006) shows that the diagnostic criteria for trauma defined in the DSM-IV-TR (APA, 2000) make the trauma, in itself, still primarily synonymous with PTSD. The issues surrounding this limited reference stems from several researchers' clinical experiences demanding a description that goes beyond the current DSM-IV-TR of trauma, Goff et al. (2006) refer here to Brewin, Carlson, Creamer, and Shalev, 2005. Goff et al. (2006) also found that many researchers wanted the scope of the definition to include the effects of secondary trauma as experienced by those working with, or closest to, the victim. For instance, Goff et al. (2006) found that in the research of Shalev (2005) it was indicated that an event goes from stressful to traumatic on the bases of emotion, meaning (to the person), cognitively incongruous, affecting the connections and relations of the person involved, trauma is not individually based but context based. Goff et al. (2006) also found that many other researchers have come up with various names for what they considered to be the secondary effects of trauma such as Figley's compassion fatigue or burnout, McCann and Pearlman's and Pearlman and Saakvitne's vicarious traumatisation, Barnowsky, Young, Johnson-Douglas, Williams, Keeler, and McCarrey's trauma transmission, as well as Weingarten's witnessing. Goff et al. (2006) have also found in their study that secondary effects of trauma can be found in children, spouses, medical professionals, and in direct or indirect witnesses. Goff et al. (2006) refer here to the work of Barnes (1998), Steinberg (1998), Arzi et al. (2000), Bramsen et al. (2002), Lev-Wiesel and Amir (2001), McCann and Pearlman (1990), Pearlman and Saakvitne (1995), McCammon and Allison (1995), and Weingarten (2003-2004).

Cabizuca, Mendlowics, Marques-Partella, Coutinho, and Figueria (2009) also found inadequacy in the classification for PTSD in the DSM-IV (APA, 2000). Taking for example anxiety disorders, development in people who have a loved one with a potentially fatal illness. In this study it was indicated that the anxiety disorder develops due to the trauma of threat of death and has the symptomology of avoidance, re-experiencing, and numbing (emotionally) as well as hyper-arousal. They also found that epidemiological studies show rates of 1.3% to 9.2% in the general population suffering from this disorder and 60% have a strong likelihood of becoming chronic. Cabizuca et al. (2009) also found that the majority of studies regarding PTSD in the past 30 years has been limited to war veterans, indicating that the current diagnosis criteria has been based on this limited sample group. Diagnosis of PTSD therefore could only be given when the trauma experienced was unusually cruel like that of combat, natural disaster or rape. However, other studies have found

that people who had a son or daughter diagnosed with a terminal, or potential fatal, illness experience trauma symptoms. Cabizuca et al. (2009) report that it was not until the early 1990s that the assessment of parents with chronically ill children started to be systematic. The Cabizuca et al. (2009) study also found that one out of four parents with chronically ill children fill the PTSD criteria. This research also emphasizes that this number is an underestimation due to the fact that parents suffering deeply of the disorder were less likely to participate in the study due to their avoidance symptoms. One of the most productive means for assessing these parents was through the use of in-depth questioning, structured interviews, which the researchers state is now the standard for researching this disorder. The trigger for developing PTSD is described in the DSM-IV as being when the parents get the information from clinicians that their child has a chronic illness and thereby a threat of death. The meaning with this is that a key element of inducing trauma under such circumstances is due to how information is delivered from healthcare professionals to patients and/or their loved ones. Taking into account the DSM-IV description, as well as their own findings, Cabizuca et al. (2009) concluded that an improved understanding of trauma and trauma inducing situations should be initiated for care professional dealing with health and welfare of people.

Chaiken and Prout (2004) also found fault with the current definition of PTSD, namely that the post traumatic stress diagnosis does not represent the complete nature of complex trauma adequately. Moreover, that several other researchers have proposed an alternative diagnosis concept of “disorders of extreme stress (DES), sometimes referred to as disorders of extreme stress not otherwise specified (DESNOS)”, and refer to Herman (1992a), Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, and Resick (1997), Roth, Newman, Pelcovitz, van der Kolk, and Mandel (1997) and van der Kolk (1996). Chaiken and Prout (2004) report that the consequences of unexplored, or unacknowledged, complex trauma leads directly to misdiagnosis and miss-application of treatment, preventing recovery and increasing suffering. “Nearly 3 million reports of alleged child abuse and neglect are made each year, and the long-term effects include the development of affective disorders, sexual dysfunction, eating disorders, personality disorders, posttraumatic stress disorder (PTSD), substance abuse, dissociative disorders, and susceptibility to suicide” (p. 160), here Chaiken and Prout (2004) refer to studies done by American Academy of Child and Adolescent Psychiatry (1998), Emery and Laumann-Billings (1998), Franklin and Zimmerman (2001), Gorey, Richter, and Snider (2001), Read (1997), Read, Agar, Barker-Collo, Davies, and Moskowitz (2001, and Ruscio (2001). Chaiken and Prout (2004) have also shown that clinical samples made up of adult women suffering from “psychotic disorders, affective disorders, and personality disorders (particularly borderline personality) (p. 161), proved significant results indicating a past experience of trauma in childhood and refer to Cohen, Mannarino, and Rogal (2001), Darves-Bornoz, Lempérière, Degiovanni, and Gaillard (1995), Herder and Redner (1991), Marley and Buila (2001), Mullen, Martin, Anderson, Romans, and

Herbison (1993), and Read (1997). Chaiken and Prout (2004) conclude that the current DSM-IV definition and its criteria must be broadened.

This struggle for getting the full spectrum of the dialectics of trauma legitimated, socially and politically, has also been investigated in a review by Piper, Lillevik, and Kritzer (2008) with an emphasis on repressed trauma. This study found that it was not until 1985, a century after Freud and Janet lived that repression of trauma first appeared. Their study brings to light how recent the recognition of trauma is and the importance of revising the criteria for diagnosis in accordance with new research findings.

In that year, Judith Herman delivered a speech to the American Psychiatric Association, describing this new mental mechanism (Ofshe & Singer, 1994; Pendergrast, 1995; Webster, 1995). No record exists of anyone ever having mentioned such a concept before this speech, and nothing previously published in the scientific literature on memory had indicated that such a mechanism's existence was ever suspected. (p. 223)

2.1.2 Society's role.

As previously stated by Cabizuca et al. (2009) the majority of studies in the past 30 years on PTSD were based on war veterans as the sample group, which limited the scope of recognizing trauma experienced on the home front. For example traumas like rape, battery, abuse, chronic illness, and secondary traumatization experienced by those closest to the trauma survivor, are all areas that have been researched and proven a like symptomology, but have received little recognition from society. One of the most controversial of these traumas has been that of rape. In society far from war the reality of women and rape and the reaction from society has been shrouded in the understanding that it is not based on the woman's experience, but subject to interpretation. This theory has in fact been studied and proven in more than one country. For instance, Swedish sociologist Stina Jeffner's (1998) research of heterosexual sex within the Swedish youth culture and British sociologist Liz Kelly's (1988) research analyses, who both found that rape in itself is subject to interpretation from society and not dependant on the females' experience. Both researchers found that there exists a middle ground to good or bad sex, this middle ground consists of the factors that society considers before determining if a female has been raped, for instance, intoxication, actions before and after the incident, reputation of the girl and how and when the "no" word was stated, etc., for rape to actually be considered rape. Not unlike war veterans, victims of crimes search for meaning and recognition from society. When that is denied or ignored trauma symptoms increase and the victim's themselves are isolated.

2.1.3 Working with trauma survivor's.

Adams, Boscarino, and Figley (2006) found that the psychological side effects of providing care and social support to trauma survivors have been researched in the last two decades but very few of these studies focused on professionals in the field like that of nurses, therapists, rescue workers, child protection workers etc. and their reactions to their patients/clients suffering from trauma. Adams et al. (2006) found that there are various researchers who have indicated a strong connection between trauma patients and the therapists that work with them showing signs of psychological distress as a result of these interactions. In Adams et al. (2006) research it is also stated that when physicians, social workers therapists and nurses start to experience these secondary trauma stress the consequence becomes that they themselves can re-experience the trauma of the patient, which in turn triggers the human defence tactic of avoiding or arousal (or counter-transference).

Chaiken and Prout (2004) have also investigated this issue and came to similar conclusions emphasizing the importance of education regarding the impact on themselves as therapists working with trauma patients.

Barnowsky, Gentry, and Schultz (2005) have presented a study of their work with the Oklahoma bombing victims. In working with PTSD victims they developed a compassion fatigue concept as well a recovery program for rescuers and psychological helpers called "Accelerated Recovery Program for Compassion Fatigue", which, in turn, became an aid after the terror attack of the World Trade Centre (Sept. 11 2001). The method consists of a prescribed and formalized cognitive-behavioural process, emphasizing that other CBT techniques can be applicable according to the situation and client.

2.1.4 Treatment methodology for trauma victims.

Whether trauma is experienced in childhood, or as an adult, some of the common practices for treating this diverse and highly complex disorder vary. For instance, in the work of Cloitre, Stovall-McClough, Miranda, and Chemtob (2004) the methodology is based on the understanding that one of the biggest problems with abuse in childhood has to do with self regulation. In ideal circumstances the skill of self regulating emotions, for example, is aided by supportive and loving caregivers, learning the importance of defining emotions (labelling), interpreting experiences, soothing, and witnessing mood regulation through stable role models. These are essential socializing skills that unfortunately are gravely disturbed in a situation wherein caregivers exposed a person in their childhood to sexual or physical abuse. Extensive research has shown that abused children in comparison to non-abused children have increased difficulty regulating their emotions in childhood following them to adulthood with the added immense struggle of adaptation, interpersonal relationships, work, home, anxiety, anger, and depression. The Cloitre et al. (2004)

treatment methodology is a multi phase/step plan (Therapeutic Alliance Method) involving various therapeutic techniques in accordance to the client's needs and progression. The sequence of the treatment is used to permit education and practice of regulating emotions for application during "a modified version of prolonged exposure (MPE)" (p. 411), involving exposure to traumatic memories (imaginal) for improving of resolving PTSD symptoms. The Therapeutic Alliance, as described by Cloitre et al. (2004), have proven the prediction of treatment results of various treatment models including short-term cognitive-behavioural treatment, interpersonal therapy, psychodynamic therapy, gestalt therapy, and cognitive therapy. Auerbach et al. (2006) have also developed a treatment model, but this is focused on strategies for those suffering from multi-contextual trauma and based on their own historical research.

Chaiken and Prout (2004) developed their multivariant model with a special emphasis on the consequences that fall on the trauma survivor if clinicians are not better informed about the full complexity of this disorder. Chaiken and Prout's (2004) multivariant model is referred to as OPAL, a tri-phase treatment structure in order to meet the needs of the individual (woman) and promoting the reduction or resolution of symptoms. They conclude that a long-term multilevel model is vital for treating trauma patients. In the treatment model of Everett and Gallop (2001), the method is instead of phases based on ten steps emphasizing information, context, and relationships. They also emphasize the importance of the therapists own skills in interpreting where the client is in the recovery process and what work can be done, or not, according to their current status. Their treatment incorporates cognitive-behavioural therapy, with some Dialectical Behaviour Therapy, treatments for dissociative identity disorder, eye-movement desensitization, reprocessing, group approaches, solution-focused therapy, self help and, finally, what to do when there doesn't seem to be anything that works.

2.1.5 Trauma and children.

Feeny, Foa, Treadwell, and March (2004) have found that several studies, e.g. Giaconia et al. (1995) and Jenkins & Bell (1994), regarding trauma and children have been based on school samples indicating that reported trauma exposure rates in these samples were between 40% and 70%. Moreover, in regards to youths 25% have been found to have experienced severe trauma by the age of 16 (Costello, Erkanli, Fairbank, & Angold cited in Feeny et al., 2004). While a meta-analyses of the effects of sexual abuse in childhood has an average PTSD rate of 32% (Kendall-Tackett, Williams & Finkelhor cited in Feeny et al., 2004), not to mention that about one third of hospitalized youth with psychiatric problems meet the criteria for PTSD (Lipschitz et al. cited in Feeny et al., 2004). Feeny et al. (2004) have also found that the most common method for measuring PTSD symptoms is by following the Child Post-

Traumatic Stress Disorder Reaction Index (CPTSD-RI). Even though this method of using CPTSD-RI is satisfactory with its psychometric properties, there are weaknesses. Most prevalent of these weaknesses is that not all PTSD symptoms are assessed and, therefore, diagnosis of the severity in an individual is not possible and the consequence of this is that the child, or youth, does not receive the treatment that would most aid to full recovery. Feeny et al. (2004) also found that the CPTSD-RI does not include the assessment of functional impairment (trauma related) like that of impaired relationships at home, work, school and friends. Feeny et al. (2004) propose that an alternative is to use a measure for assessment of PTSD (CPSS) that is used for assessing the severity and diagnosis of adults who have experienced various traumas. They also found that CPSS has good convergence, high reliability, discriminant validity as well as internal consistency.

2.1.6 Treating a child in trauma.

Feeny et al. (2004) proposes several aids in the assessment and treatment of a child, or youth, in trauma. In order to determine the best course of treatment for the traumatized client, a youth for example, they recommend psychologists starting with the PTSD assessment and noting the probability, or possibility, of PTSD, then following that up with a clearer comprehensive diagnostic tool, the Clinician-Administrated PTSD and PTSD Scale for Children and Adolescents (CAPS-CA), the Anxiety Disorders Interview Schedule for Children (ADIS), or the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS). After a clear assessment the treatment can include the following, due to empirical evidence for psychosocial therapies of PTSD the strongest approach is CBT. Therefore this treatment is preferred, there is however other treatments like that of individually delivered exposure treatment, eye-movement desensitization and reprocessing (EMDR), and anxiety-management training (AMT), group delivered treatments and child-parent treatments, which have been studied exclusively for sexual abuse-related PTSD. Feeny et al. (2004) describe their treatment plan as four 30-min sessions and two individual sessions in a school setting taking place over a period of three weeks. These sessions would consist of reprocessing the trauma, clarification of cognitive distortions, coping strategies, grief resolution, problem solving, aggression management, and relaxation. The child/youth are encouraged to discuss the trauma, draw pictures, and to identify how the most traumatic moment is associated with current trauma-related distress. The elements of the treatment consist of psycho education, exposure to trauma narratives, AMT (muscle relaxation, diaphragmatic breathing, and training to gauge distress levels), interpersonal problem solving for anger control, development of positive self-talk, and relapse prevention. For further understanding of how a treatment plan for youth, or children, can be Feeny et al. (2004) use a similar method to their own as an example, the treatment spans 18 weeks of group sessions at school in conjunction to one week private session in the

10th week, activities including pictorial exposure to the abuse, modifying self-blame attributions, psycho education about sexual maturation and sexual behaviours, and teaching coping self statements and anxiety-management strategies. Along with the guidelines of the treatment procedure “it has been found by other researchers that the techniques of reaching children in trauma successfully is highly based on the adults ability to understand the mind set of how a child in trauma sees the world” (p. 474). This theory of how a child interprets their environment is clarified by Haldor Ovreide (2007), a clinical Psychologist from Norway, who has studied how to communicate with damaged children for over thirty years. Understanding the reasons why children place blame on themselves when abused and traumatized is fundamental to being able to help and communicate with them.

2.2 Herman’s Trauma and Recovery

2.2.1 Trauma theory.

Herman (2001) states that traumatic reactions within the body and mind are developed as the direct result of being restricted, or unattainable, in action, when “neither resistance nor escape is possible (fight or flight), the human system of self-defence becomes overwhelmed and disorganised” (p. 34) resulting further in deep and lasting modifications in physiological arousal, memory, cognition, and emotion. Traumatic events can also undo from one another various normally integrated functions, “the traumatized person may experience intense emotion without a clear memory of the event, or they may remember everything in detail but with no emotion” (p. 34). To support her findings she refers to the work of Janet, who identified the critical pathology in Hysteria as Dissociation as well as Abram Kardiner’s work some fifty years later. Kardiner states (as cited in Herman, 2001):

When a person is overwhelmed by terror helplessness, the perceptions become inaccurate and pervaded with terror, the coordinative functions of judgement and discrimination fail...the sense organs may even cease to function... The aggressive impulses become disorganised and unrelated to the situation in hand... The functions of the autonomic nervous system may also become dissociated with the rest of the organism. (p. 35)

2.2.2 In trauma.

The common pathology in traumatic symptoms, as Herman (2001) views it, is divided up into three parts; hyper arousal, intrusion, and constriction. She describes the symptom of hyper arousal in survivors of trauma as “the human system of self-preservation going into permanent alert, as if danger might return at any moment” (p. 35). She explains that in this state of hyper arousal, which is the first symptom of PTSD, “the traumatized person startles easily, reacts irritably to small provocations,

and sleeps poorly” (p. 35) and supports her findings by referring to other researchers one of whom is Kardiner who proposed that:

The nucleus of the traumatic neurosis is a psychoneurosis. He believed that many of the symptoms observed in combat veterans of the First World War – (startle reactions, hyper alertness, vigilance for the return of danger, nightmares and psychosomatic complaints) - could be understood as resulting from chronic arousal of the autonomic nervous system. The irritability and explosively, aggressive behaviour of traumatized men as disorganised fragments of a shattered fight or flight response to over whelming danger (p. 36).

In regards to intrusion (the second symptom of PTSD) Herman (2001) states that it can be experienced long after the actual trauma or the initial danger has past, in other words trauma survivors relive the trauma as if it was repeatedly happening in the present and prevents survivors from being able to resume any “normal course of their lives” (p. 37), a finding which is also supported as far back as the work done by Janet, Kardiner, Freud and many more (as cited in Herman, 2001). Herman (2001) found that Janet described his hysterical patients as being steered by an “*idée fixe*” (p. 37) (intrusion) and Freud, after struggling with the enormous proof of combat neurosis accumulated from the First World War, stated (as cited in Herman, 2001) “The patient is, one might say, fixated to the trauma...”(p. 37). Kardiner (as cited in Herman, 2001) also described the existence of this intrusion factor in traumatized soldiers as fixation being one of the critical elements of the combat neurosis (now PTSD) and that nightmares of the trauma recur unchanged for years due to the discovery that traumatic memories (or intrusion symptom) “are not encoded like the ordinary memories of adults in verbal or linear narratives” (p. 37).

Herman (2001) describes the aspect of constriction (third symptom of PTSD) as that of involving a person becoming completely powerless and going into a “state of surrender” (p. 42) and explains that the individual’s self-defence system shuts down, for instance, a person who cannot escape physically escapes instead by shifting her state of consciousness. This point in her research is further explained through the findings of observing the analogous states of animals that sometimes freeze when attacked. These responses of defeat, or helplessness, in a person are often present in the testimonies of rape survivor “I couldn’t scream, I couldn’t move, I was paralyzed...like a rag doll.” (p. 42). She adds that these modifications of consciousness are at the core of constriction, or numbing reiterating, and in traumatic circumstances the situation is still registered cognitively, but elements are detached from their usual meaning making the perceptions of the event numbed or distorted, and sometimes altering the sense of time often described by survivors as being in slow motion. She also found with regards to constrictions that a person can experience that they are outside that traumatic event, that it is not happening to

them, like an observer outside their body. She notes that this modification of consciousness, or disassociate (constriction), could be seen as “one of nature’s small mercies, a protection against unbearable pain” (p. 43).

2.2.3 After trauma.

After a person experiences overwhelming danger, Herman (2001) states that there are usually two conflicting reactions of intrusion and constriction which fluctuate within the survivor. Over time this dialectic slowly progresses and changes. Herman (2001) points out that even if certain trauma symptoms fade they are never eliminated and can be revived by reminders, or triggers, even years after the event. Due to this altered state of consciousness after trauma social and personal disconnection is inevitably developed. In working with trauma survivors for nearly three decades, she has found that those who have experienced trauma find themselves questioning human relationships on a basic level of love, friendship, family, and community leaving the survivor to recede into isolation.

Due to the fact that trauma damages the ability survivors have to relate to others it is here we see how the people in the survivor’s social world influence the degree of the effect of the trauma. Herman (2001) explains that a “supportive response from other people towards the survivor may alleviate the impact of the event, while a hostile or negative response may enforce the damage and aggravate the traumatic syndrome” (p. 61). The survivor’s struggle to overcome shame and come to a just assessment of themselves during the traumatic event requires the assistance and intervention from others. Here she declares that the mindset of the people surrounding the survivor becomes significant. If those around the survivor give either harsh criticism or unsighted acceptance the survivors’ self isolation and blame will be reinforced and recovery unattainable.

Herman (2001) has also found that re-establishment of the break between the community and the traumatized person is firstly dependent “upon public acknowledgement of the traumatic event, and second, upon some form of community action” (p. 70). This is seen most evidently in the study of returning soldiers “after every war, soldiers have expressed resentment at the general lack of public awareness, interest, and attention; they fear their sacrifices in killing and death will be quickly forgotten” (p. 70). Soldiers need, and search for, a moral meaning to their experience with killing and death from their community. Herman (2001) states, that they need for their own sense of self to know from others if their actions in war are seen as “heroic or dishonourable, brave or cowardly, necessary and purposeful or meaningless. A realistically accepting climate of community opinion fosters the reintegration of soldiers into civilian life; a rejecting climate of opinion compounds their isolation” (p. 70). The importance of community response is also often seen with regards to women’s issues and specifically that of rape. Herman’s (2001)

research indicates that “woman quickly learn that rape is a crime only in theory; in practice the standard for what constitutes rape is set not at the level of women’s experience of violation but just above the level of coercion acceptable to men” (p. 72), i.e. a woman’s lifestyle, age, and the circumstances under which the rape took place are all questioned in accordance to if the sexual act can be called rape from the man’s point of view. She has found that when survivors seek justice the result is further trauma since the majority, if not all survivors that have been studied, found the legal system as being openly hostile to rape victims. Herman (2001) states that “women who have sought justice in the legal system commonly compare this experience to being raped a second time” (p. 72). According to her findings the result is that “most rape victims view the formal social mechanisms of justice as closed to them” (p. 72). According to her research, only one rape out of ten actually gets reported to the police.

2.2.4 The syndrome of chronic trauma.

Herman (2001) states: “that prolonged, repeated trauma, which by contrast to the single trauma, occurs only in circumstances of captivity” (p. 74). These conditions of imprisonment exist obviously in “prisons, concentration camps, and slave labour camps” (p. 74). However, she adds that these conditions also exist, but are not as recognised in “religious cults, brothels and other institutions of organized sexual exploitation and in families” (p. 74). Here she explains the process involved in a successful captivity starting with the most predominant aspect of psychological domination. Psychological domination deals with inducement of fear and the perpetrator destroy the victim’s independence physically and psychologically. This is done by inspection and control of every function of victim’s body.

The perpetrator surmises what the victim eats, when she sleeps, when she goes to the toilet, what she wears. When the victim is deprived of; food, sleep, or exercise, this control results in physical debilitation. But when the victim’s basic physical needs are adequately met, this assault on bodily autonomy shames and demoralizes her. (p. 76)

Similar to victims of single traumas, Herman (2001), states that those that are held captive become skilled in the “arts of altered consciousness” (p. 87). This refers to the exercise of dissociation, meaning, suppressing ones thoughts voluntarily, and sometimes denying thoughts outright, which is how captive people withstand and alter unbearable situations. She explains further that this altered state can be described as doublethink. George Orwell (as cited in Herman, 2001) defined doublethink:

Doublethink means the power of holding two contradictory beliefs in one's mind simultaneously, and accepting both of them. The person knows in which direction his memories must be altered; he therefore knows that he is playing tricks with reality; but by the exercise of doublethink he also satisfies himself that reality is not violated. (p. 87)

According to Herman (2001) there is also often, if not always, an extreme narrowing in the cognitive and behavioural range of scheme that becomes "habitual with prolonged captivity and in turn it must be unlearned after the prisoner is liberated" (p. 90). She explains that here prisoners are no longer thinking of escape but more of how to survive, make their present situation bearable. For instance:

A concentration camp inmate schemes to obtain a pair of shoes, a spoon, or a blanket; a group of political prisoners conspire to grow a few vegetables; a prostitute manoeuvres to hide some money from her pimp; a battered woman teaches her children to hide when an attack is imminent.(p. 90)

Another common survival skill of those who are isolated and held captive, is referred to as pair bonding with the captor, commonly known as the Stockholm Syndrome, and this connection becomes the basic component of survival. Herman (2001) states that this traumatic bonding occurs when prisoners are psychologically defeated and now "view their captors as their saviours and therefore fearing and hating their rescuers" (p. 92). Herman (2001) has also found that prisoners intentionally practice calling to mind mental images of loved ones to preserve their connection to the outside world. She adds that it is also common that prisoners "fight to preserve physical tokens of devotion. "They may even risk their lives for the sake of a wedding ring, a letter, a photograph, or some other small memento of attachment" (p. 81). Herman (2001) explains that to those on the outside, such risks, may seem foolish from the outside, but adds that these risks are in fact based on practical reasons. "Under conditions of prolonged isolation, prisoners need transitional objects to preserve their sense of connection to others. They understand that to lose these symbols of attachment is to lose themselves" (p. 81).

This aspect of psychological defeat is, according to Herman (2001), the act of total surrender by the prisoner. In regards to total surrender "terror, intermittent reward, isolation, and enforced dependency create a submissive and compliant prisoner, which is the final step in psychological control of the victim" (p. 83). This final step is not done until the prisoner is forced to act against their own morality and betray their fundamental human connection. According to Herman (2001) "psychologically, this is the most destructive of all coercive techniques" (p. 83) for once the victim has violated their own moral principles he/she will despise him/herself completely which results in such an intense level of self hatred that the

victim (now truly broken) is willing (under threat) to participate in the harm of others. A prime example of this is sometimes seen in families wherein children are sexually abused but also assist their care givers in the abuse of others (Pornographic rings) (Herman, 2001).

2.2.5 Child abuse.

In Herman's (2001) research recurring trauma in adulthood corrodes the structure of a formed personality, but what about repeated trauma in childhood? She has found that repeated trauma experienced in childhood not only warp personality, but forms it. She explains that "when a child is trapped in an abusive environment the child is faced with terrifying tasks of adaptation" (p. 96). Unlike the adult victim who has the resources to perhaps manipulate their situations consciously for survival, the child has no other frame of reference to life and people other than that to which they are born in. She states that doublethink is also found to be used by children as a survival technique. In this environment of overwhelmingly disturbed relationships the child has to find a way to attach to their caretakers for survival, despite the caretakers being dangerous or neglectful. This is done through learning signals and rules of reward and punishment. "Unlike the adult victim, the child has yet to develop any sense of self having no previous experience of being able to self-regulate their body, (because the child's body is at the disposal of the abuser) normal biological cycles of sleep and wakefulness, feeding, and elimination are chaotically disrupted or over controlled" (p. 108). When the child has never or seldom experienced having basic biological regulation consistently, comfortably and safely they often develop "chronic sleep disturbances, eating disorders, gastrointestinal complaints, and numerous other bodily distress symptoms" (p. 108). The child must also be able to self sooth in a situation or environment demanding complete conformity from the abuser. She adds that the child is also forced with developing on their own, a "capacity for intimacy out of an environment which defines them as a whore, a slave or evil" (p. 101). Due to the fact that self soothing, or comfort, for many abused children can only be found within their own imagination, inducing disassociate or trance states, is high, especially with regards to abused children in school-age. She states that documented studies have shown that the relationship between the harshness of childhood abuse and the fluency level of disassociate states, "children may learn to ignore severe pain, to hide their memories in complex amnesias, to alter their sense of time, place, or person, and to induce hallucinations or possession states" (p. 102). Another self-preserving technique used by abused children is that of the development of a double self. Herman (2001) states that not all children who have been abused change, or vary, their reality by dissociation and this is where a double self is formed. In environments that render avoiding abuse and its reality as impossible, the child "constructs a system of meaning that justifies it" (p. 103). This means that a conclusion is made in the child's mind that it is their own inborn

wickedness which causes others to abuse them and this conclusion is due to the fact that a child has no other frame of reference. The child clutches to this explanation in the earliest stage of abuse because it gives them meaning, a way of understanding their life and it gives them hope because; “If the child is bad, then the parents are good. If the child is bad then they themselves can try to be good” (p. 103). She adds that even after the abuse has stopped either by intervention or the child becoming an adult this contaminated identity is not easily given up due to the fact that it is this view of them that has allowed them to form attachments and therefore is a steadfast part of the personality structure of the child. The result of this is that the abused child cannot develop a solid self image with fair virtues and reasonable faults. In other words, child abuse survivors like that of adult trauma victims live by rule of an all, or none interaction or a quick condemnation of others, after even the slightest disappointments. Herman (2001) adds that many abused children hold on to an idea “that growing up will bring escape and freedom” (p. 113). However, due to the fact that their personality was formed under coercive control, growing up does not lead to freedom because their personality doesn’t adapt well to adult life having fundamental problems regarding, trust, initiative, and independence/autonomy. The adult finds that just as in childhood; they approach the tasks of intimacy and establishing independence plagued by immense “impairments in self-care, in cognition and memory, in identity, and in the capacity to form stable relationships” (p. 113).

2.2.5.1 Need for a new concept.

Herman (2001) has found through her research that the psychological alterations of captivity are mostly unacknowledged or misunderstood. Therefore social judgement of people chronically traumatized has had a tendency to be particularly unkind. She explains this point with reference to Patricia Hearst, a hostage of kidnappers for several months, who in the end participated in robberies. In the notorious case of Patricia Hearst, “the hostage, she was convicted for crimes committed under duress and received a longer prison sentence than her captors” (p. 115). The harsh judgement on trauma survivors according to Herman (2001) is partly, if not mostly, due to the field being too specialised and lack of correct and complete diagnostic concepts. She notes that because the link between the symptoms experienced by patients and the trauma is often lost, the patient is frequently “forced into a mould of existing diagnostic constructs which results in a partial understanding of the problem and a patchy approach to treatment” (p. 118). According to Herman (2001) the current diagnostic criteria reflects symptoms of survivors from restricted traumatic events, the diagnoses are based on the model of rape, disaster and combat. In survivors of long-lasting, repeated trauma, the symptoms are often “far more complex” (p. 119). She states that the existing diagnosis of PTSD falls short of capturing the “erratic symptomatic materialization of prolonged, repeated trauma or the intense deformations of personality that occur in

captivity” (p. 119). Herman (2001) has found that many veteran clinicians have appealed to the necessity of a new diagnostic formulation of PTSD that extends beyond the current simplified description. For instance she references Nederland (1968), who worked with survivors of the concentration camps of the Nazi Holocaust and who also found that the perception of traumatic neurosis (now PTSD) as not adequate to cover “the multitude and severity of clinical materializations of the syndrome observed in his patients” (p. 120). According to Herman (2001), suggestions have been made to make PTSD one diagnosis and Complex PTSD as another. In 2001 Complex PTSD was being considered for the diagnostic manual of the American Psychiatric Association 4th edition, with seven criteria as the bases for diagnoses. She states that there are Empirical field trials in progress to verify whether diagnoses of chronically traumatized people can be done reliably. She adds that while the concept of complex traumatic syndrome has increased it has also been given various names such as “disorder of extreme stress not otherwise specified (DESNOS), and personality changes from catastrophic experience” (p. 121). According to Herman (2001) it is vital that not only the diagnosis of PTSD is improved but that a broader concept including that of Complex Trauma is made legitimate. Herman (2001) states, that “when survivors of abuse seek treatment, they have what the Psychologist Denise Gelinis calls a disguised presentation” (p. 123). They seek help/advice due to various difficulties they have coping with their symptoms or relationship and that all too often the connection between present problems/symptoms and a history of chronic trauma are seldom made neither by patient nor doctor. Herman (2001) explains that survivors of abuse in childhood, similar to that of other traumatized people, commonly receive misdiagnoses and thereafter mistreatment. Due to the volume and complexity of a patient’s symptoms, in conjunction to misdiagnoses, leads to their treatment being fragmented and deficient. The three predominantly worrying diagnoses frequently applied to survivors of abuse in childhood are: “somatic disorder, borderline personality disorder, and multiple personality disorder” (p. 123) and symptoms dealt with through medication. Incidentally these diagnoses were all found as part of the obsolete diagnoses of Hysteria. Credibility of the patients (usually women) was, and is frequently suspect, which resulted in their treatment being incorrectly applied. In her research patients diagnosed with any one of these three diagnoses commonly also qualify for numerous other disorders. For example, “the majority of patients with somatic disorder also have major depression, agoraphobia, panic, and in addition to their various physical complaints, over half are given additional diagnoses of histrionic, antisocial, or borderline personality disorder” (p. 124). Her research has also uncovered that, similarly, people diagnosed with borderline personality disorder frequently also have “major depression, substance abuse, agoraphobia/panic, and somatic disorder” (p. 124). Furthermore She states that the bulk of patients diagnosed as having multiple personality disorder also experience harsh depression and fit the diagnostic criteria for borderline personality disorder not to mention having various psychosomatic complaints, including

“headache, unexplained pains, gastrointestinal disturbances, and hysterical conversion symptoms” (p. 124). Similarly, patients with somatic disorder have also “difficulties in intimate relationships, including sexual, marital, and parenting problems” (p. 125). In Herman’s (2001) professional experience she has found that “the earlier the start of abuse is in conjunction with the severity of the abuse the greater the likelihood of the survivor developing symptoms of borderline personality disorder” (p. 126). She explains that with accurate diagnosis survivors can recognize the birth of their psychological difficulties as the result of an abusive environment in childhood instead of some sort of inborn deficiency. She explains that every time a misdiagnosis is given there is also further suffering that survivor experiences while undergoing failed treatment, which in turn can only result in compounding the survivor’s feelings of despair, and isolation.

2.2.6 Treatment - working with trauma survivors.

According to Herman (2001) it is important that the therapist is aware of the side effects of therapeutic relationships both for the survivor and the therapist. She explains that one side effect is known as traumatic transference. Traumatic transference reactions occur due to the fact that the survivor has an idealized view of the therapist and in time it becomes evident that the therapist cannot live up to this perfect standard. As previously stated, the trauma survivor deals mostly with an all, or nothing, thought process, where one is either all good (no faults, perfect) or all evil (faults). As no human is perfect the therapist will “fail in the patient’s eyes resulting in the patient becoming overcome with fury” (p. 137). This life or death or all or nothing thinking is due to the patient feeling as though life (recovery) is based upon the rescuer (therapist): “the survivor cannot afford to be tolerant, there is no room for human error” (p. 137). It is therefore vital, according to Herman (2001), that the skills of the therapists are enough to see the patient through these moments of flight or fight in therapy by understanding these possible responses from a survivor permits the therapist to plan sessions and stay committed to the patient regardless of any outburst, therefore establishing trust.

Herman (2001) states that traumatic counter-transference on the other hand deals with the therapist’s reactions. She states that commitment to this kind of work with survivors of trauma “poses some risk to the therapist’s own psychological health” (p. 141). It is not unusual that the exposure of the therapist to various accounts of human cruelty unavoidably challenges the therapist’s faith in humanity. She warns that if this counter-transference reaction occurs, and is left unanalysed by the therapist, it can result in an interaction with the patient that inevitably leaves them disempowered instead of empowered because the therapist themselves cannot handle hearing the details of human cruelty. She explains that unless there is sufficient support for the therapists to fulfill their commitment to “bear witness to the

survivor's testimony is not possible and will therefore inevitably lead to the therapist withdrawing emotionally from the therapeutic alliance" (p. 144). She adds that it is also possible for the therapist to experience feelings of disgust towards the patient and their behaviour, or the therapist may become exceedingly judgemental and censor the patient's testimony due to the fact that the patient hasn't filled some preconceived notion of what "good victims" (p. 145) should be. She states that the therapist may even begin to feel disrespect for the helplessness of the patient, they may fear the patient's rage, or have intense periods of hate desperate to get free of the patient. Furthermore, she states that it is not unusual that the therapist experiences "voyeuristic excitement, fascination, and even sexual arousal" (p. 145). She describes this as sexualized counter-transference occurring "particularly for male therapists working with female patients that have experienced sexual violence" (p. 145). All of these factors should never be denied by the therapist, they are natural, however they must be handled through the aid of a support network for the therapist themselves (Herman, 2001).

2.2.7 Stages in recovery.

Herman (2001) outlines the three stages of recovery. The first stage's primary task is the "establishment of safety, the central task of the second stage is remembrance and mourning and finally the central risk of the third stage is reconnection with ordinary life" (p. 155). She emphasises that these stages of recovery should not be seen as set in stone, but as an attempt to simplify and organise an extremely complex and chaotic process. She has found that the "same basic concept of recovery stages is also seen in Janet's classic work on Hysteria as well as recent descriptions of combat trauma, dissociate disorders, and multiple personality disorder" (p. 155). She adds that dividing the recovery stages by three is not adhered to by all researchers; some have five stages and others eight. However, she states that what ever the sequence is, that "no single course of recovery follows a straightforward linear order" (p. 155). She has found that it is in fact very common that patients and therapists alike become discouraged when issues that were thought to be dealt with reappear. She adds that it is also essential that the treatment applied at each stage of recovery is appropriate, for instance "one form of therapy may be useful for a patient at one stage but of little use or even harmful to the same patient at another stage" (p. 156). She also states that in regards to diagnosing patients it is important to remember that in most cases there are masked formulations of the true underlying problem of PTSD or Complex PTSD. She explains that the patient at first "may complain only of physical symptoms, or of chronic insomnia or anxiety, or of intractable depression, or of problematic relationships" (p. 157). She contends that it is only through precise questioning that a determination of the patient living presently in fear of violence, or if the present symptoms are the result of a past experience. She adds that traditionally this type of in-depth questioning with the

patient has not been done, only surface general questions have been asked by general practitioners leading thereafter to misdiagnosis.

2.2.7.1. Restoring control – establishing safety.

As previously stated Herman (2001) outlines that the first task of recovery work with a survivor is to establish the survivor's safety. She emphasises that this task takes precedence over all others, for "no other therapeutic work can succeed if safety has not been adequately secured and that no other therapeutic work should even be attempted until a reasonable degree of safety has been achieved" (p. 159). In her professional experience this stage lasts days for some and weeks for others like that of acutely traumatized people, and for chronic traumatic abuse survivors this stage may take years. The establishment of safety, according to Herman (2001), refers to the patient having a stable living situation, financial aid, "mobility, and a plan for self-protection in daily life"(p. 160). Without anyone of these elements securely in place it will be difficult for the patient to commit themselves and concentrate fully in therapy due to outside insecurities and distractions. Herman (2001) points to the cardinal rule of medicine as a reference and reminder to therapist thinking of working with trauma patients that "Above all do no harm..." (p. 161). Anyone coming into contact with these survivors must at all times make it certain to include them in all decision making procedures, which aids in establishing security. For instance, she references an ER doctor explaining the protocol he uses when faced with a rape survivor: "I spend a lot of time preparing the victim; every step along the way I try to give back control to the victim. I might say, we would like to do this and how we do it is your decision" (Anonym, p. 161).

Herman (2001) states that with regards to chronic childhood abuse survivors, the establishment of safety is even more time consuming and intricate. She notes that it is often the element of "self-care which is almost always severely disrupted due to survivors' tendency towards self-harming behaviour, such as chronic suicidal, self-mutilation, eating disorders, substance abuse, impulsive risk-taking, and repetitive involvement in exploitative and dangerous relationships" (p. 166), which need to be managed before and during exploratory work. Though the most common error in therapy to occur is that traumatic material is avoided, and, perhaps, the second most common is impulsive exploratory work having neither safety nor a secure therapeutic agreement established (Herman, 2001).

2.2.7.2 Remembrance and mourning.

The second stage of recovery deals with two factors; remembrance and mourning, According to Herman (2001) remembrance is about the survivor telling in detail the story of their trauma, this reconstruction of the experience from the past

changes the memory of the trauma integrating it into the present, as is also indicated by both Freud's and Janet's work. Herman (2001) emphasises that the therapist must keep a careful eye on the intensity of the intrusive symptoms experienced by the patient and that the work of uncovering the trauma story is kept on a tolerable level. She warns that if there is a drastic increase in symptoms during exploratory work, such as self harm, anxiety etc. this should be a signal to the therapist to re-examine the structure of the therapeutic process, as well as the pace, in other words slow down. She explains that in attempting to reconstruct the trauma story it should begin with a reassessment of the patient's life prior to the trauma. She refers to therapist Yael Danieli regarding the significance of being able to reclaim an earlier history and restore a connection with the past for recovery. Herman (2001) warns that at this stage the therapists can find themselves searching for some sort of certainty, eager certainty easily replaces an open mind and attitude, remembering that therapists should not be fact-finders or criminal detectives, but instead their role is to be open-minded and bear witness to what the survivor has to say. Herman (2001) describes techniques that are commonly used for transforming a trauma story. The Direct Exposure or Flooding method is often used in treatment of veterans as well as the formalized testimony method in treatment of those who have survived torture. This is described as a behavioural therapeutic method exposing the patient to reliving the trauma in a controlled environment in conjunction with a written script of the experience by the patient including emotions relived weekly fulfilling twelve to fourteen sessions. According to Herman (2001) studies have shown that veterans "suffered fewer nightmares and flashbacks, and they experienced a general improvement in anxiety, depression, concentration problems, and psychosomatic symptoms" (p. 183).

In regards to the testimony method, Herman (2001) refers to the first practised case of this method reported by two Chilean psychologists in 1983, which had their findings published using pseudonyms to protect their identities. She explains that the project's focus of treatment dealt with creating an extensive and detailed account of the experiences of trauma patients through the recorded transcript from the patient and then revised the fragmented recollections into, eventually, a full testimony. She states that even though (through flooding and testimony) symptoms of hyper arousal and intrusion seem to improve, "the constrictive symptoms of numbing and social withdrawal do not change, and marital, social, and work problems do not necessarily improve" (p. 183). Here she refers to another method, that of Trance, which is a method used by the patient as an aid to self soothing, planning and relaxation before progressing into uncovering the trauma in therapeutic work. She refers to the work of the psychiatric nurse and hypnosis-therapist Shirley Moore, who described her method in uncovering work with trauma patients as follows:

We might use an age regression technique like holding a ribbon or a rope that goes to the past. For some survivors you can't use ropes. There are a lot of standard techniques that you have to change the language for. Another technique that works well for a lot of people is imaging they are watching a portable TV. When we use this, they become accustomed to having a safe channel, and that's always where we tune in first. The working channel is a VCR channel. It has a tape that covers the traumatic experience, and we can use it in slow-motion, we can fast-forward it, we can reverse it. They also know how to use the volume control to modulate the intensity of their feelings. (p. 186)

Herman (2001) adds that in this stage of remembrance of those who have survived prolonged repeated trauma it is not practical to approach every single memory separately, since there are too many, and usually these memories overlap each other. However, she adds that there usually exist some distinct and principally meaningful aspects of the various memories which stick out and, therefore, reconstructing the trauma story is usually formed from these specific aspects. In other words, one traumatic incident is representative of the many that occurred.

The second factor of the second stage is as mentioned mourning. According to Herman (2001), this is commonly misunderstood as learning how to forgive, an act that she deems unnecessary for recovery unless, of course, it is the survivors forgiving themselves. Generally speaking, she states that "folk wisdom recognizes that to forgive is divine" (p. 190). She warns, however, that this statement should not be trusted. For survivors divine forgiveness is unattainable until "the perpetrator has sought and earned it through confession, repentance, and restitution" (p. 190). In reality this is an exceptional miracle. According to her experience waiting for restitution from the perpetrator is not necessary for a survivor's recovery. The survivor's healing depends solely on concentrating their thoughts and feelings towards themselves and she explains:

...it does not require that this love be extended to the perpetrator. Once the survivor has mourned the traumatic event, she may be surprised to discover how uninteresting the perpetrator has become to her and how little concern she feels for his fate. She may even feel sorrow and compassion for him, but this disengaged feeling is not the same as forgiveness. (p. 190)

2.2.7.3 Reconnection.

Herman (2001) states that after a patient has come to terms with trauma experienced in the past they can now start reconnecting or relearning the various grades of tolerance and emotion in everyday life. An activity which aids in the reconnection process is what she refers to as learning to fight. Here, the survivor learns how to take "power in real-life situations through a conscious choice to face

danger out” (p. 197) in the real world. She explains that at this point in recovery, survivors have come to the understanding that their post traumatic symptoms are a “pathological exaggeration” (p. 197) of what a normal reaction to danger is, in conjunction with being conscious of their ever present feeling of vulnerability regarding even the smallest of threats or reminders of their trauma. She states that in these instances the survivor might choose to face their fears instead of being passive to them. This choice, however, must be a conscious choice made by the survivor without influence and undertaken through a structured and highly methodical situation. She refers here to the words of Jean Goodwin, a therapist who has participated in various wilderness trips with childhood abuse survivors:

Magical or neurotic means of ensuring safety do not work in this setting. Being sweet, not making demands, disappearing, and making excessive and narcissistic demands, waiting for a rescuer: none of these manoeuvres puts breakfast on the table. On the other hand victims are surprised and delighted at the effectiveness of their coping. In reality, they are able to learn to rappel down a cliff; their adult skills...outweigh the fears and low estimation of themselves that initially made them judge this impossible. (p. 198)

Herman (2001) explains that by the survivor putting herself in a situation of flight or fight to experience her responses to danger she does so with the frame of thought to fight to control being with her choices. This behavioural/physical exposure is the relearning process of regulating emotional responses, “not all danger is overwhelming; not all fear is terror” (p.199), that there are of various grades of emotion and how to live and use them.

The survivor’s ability to interact socially with others is another aspect which must be learnt. Here she recommends that the first step towards that is through the involvement of family members or significant others in therapy when the survivor is strong enough. She explains that due to the fact that so many interactions that occur within a family are automatic or habitual, meaning that the interaction itself is taken for granted, the dynamics of the roles taken in a family regarding dominance and submission are often overlooked. She explains that “just like self-defence training, direct involvement in family conflicts often requires a series of graded exercises, in which the survivor masters one level of fear before choosing to proceed to higher levels of exposure” (p. 201). Finally, special attention should also be paid to help the survivor plan, and, perhaps, anticipate, a range of possible reactions that family members can have upon disclosure. It is common to be faced with disbelief by family members and to minimize the hurt this will cause to the patient the therapists should plan carefully their course of action in dealing with these possible outcomes.

2.2.7.4 Reconciling with oneself.

Herman (2001) states, that the survivors, when ready, also must go through reconciliation with themselves. At this stage in recovery the survivor has to relearn how to have hopes and dreams for themselves. She explains that just as the survivor must have the courage to face their fears, they must also have the courage to identify their hopes or wishes. She warns that this process in recovery is easily defined as a time of trial and error. Survivors at this stage learn how to be tolerate, excepting of mistakes and how to celebrate success, and again learn the various levels of these emotions at a moderate pace. For many survivors thinking, planning, or even hoping for the future is terrifying, since the survivor has overcome their trauma by restricting their hopes, dreams and expectations for a better life. She adds that while the survivor takes more chances at this stage, this is also a time wherein their life becomes ordinary. Life without constant intense traumatic symptoms, high medication, to a calm daily existence, feels strange: "I am an intensity junkie. I feel a letdown whenever I come to the end of particular cycle of intensity. I became addicted to my own sense of drama and adrenaline. Letting go of the need for intensity has been a process of slowly weaning myself" (Anonym, p. 203).

2.2.7.5 Commonality and Group therapy.

In Herman's (2001) research survivors of trauma have learnt that their entire being, self worth, and humanity is determined by others. This is where, according to Herman (2001), group therapy can be of assistance. She explains that with the isolating effect that trauma produces "the group can re-create a sense of belonging, where trauma shames and stigmatizes - the group bears witness and affirms, wherein trauma degrades the victim - the group praises them, and finally wherein trauma dehumanizes the victim - the group restores humanity" (p. 214). The abilities to all these restorative elements are due to what she describes as the mirrored actions of others. Social bonds are restored, according to Herman (2001), through the discovery that we are not alone and various types of therapeutic groups for aiding in the reconnection process are used; first, second and third stage groups. Generally speaking, she has found that in the first stage the group work should be decidedly cognitive and instructive instead of investigative or explorative for the most part modelled after the Alcoholics Anonymous structure. She states that these groups work from a cognitive framework dealing predominantly with the symptoms that have developed due to trauma, like self-harm, drug and alcohol abuse, overeating/starving etc. These groups are not structured to deal in depth with trauma, they are meant to aid in the daily self care of individuals.

In regards to second stage groups (or trauma focused) Herman (2001) emphasises that these groups should also be extremely structured and here it should be understood that these groups are for uncovering work. Trauma focused groups

are for survivors that have already secured safety and self-care with some control over self-harm/somatic symptoms. She states that most of the work surrounding integration in these groups is in fact done towards the end because they are time limited in structure. To further explain the various techniques in the second stage groups, Herman (2001) refers to psychologists Yael Fischman and Jaime Ross explaining their termination session with a group for exiled torture survivors. Here the written testimony methods are used and group members narrate each other's testimony aloud and in detail. Fischman and Ross (as cited in Herman, 2001) have found that through listening to someone else tell one's own story of trauma the participants get a new view of their experience, which, in turn, gives them some emotional control. Herman (2001) emphasises that groups, or group, therapy are hardly ever, and should rarely be seen as, the resource first undertaken after a trauma. She states that the survivor of recently experienced trauma is in a state of extreme fear, overwhelmed by intrusive symptoms such as flashbacks, and she recommends waiting weeks to months after the trauma before attempting to enter a group.

3. Method

3.1 Literature Search

Articles and books were attained using the library catalogue database Education Psychology Sociology, followed by the database PsycINFO (CSA) and PsycARTICLES (CSA) at Luleå University of Technology. The keywords used were Trauma, Herman, Judith Herman, A.P.A + Trauma, trauma and recovery, recover from trauma, trauma treatment, and trauma studies. Searches were also made with the Internet search engines www.google.com and www.yahoo.com using the keywords Trauma critic, Critic of Judith Herman, Review of Judith Herman, Judith Herman + Trauma, and Recovery + Analyses. A total of 15 sources were selected (Appendix).

3.2 Demarcation

Since no clinical trials with the primary aim to test Herman's theory and treatment method were found, articles and books on trauma were selected if they contained statements that could be used for evaluation of Herman's work.

3.3 Analysis

The analysis of the material was structured according to the themes in Herman's theory and treatment methodology. For each theme, relevant information was gathered from each of the sources.

4 Result

4.1 Trauma Theory and History

Herman (2001) has shown through referencing the historical research on trauma (Charcot, Freud, Janet, Kardiner etc.) that Freud's first theory of the origins of hysteria (being due to past trauma), was in fact a valid theory and worthy of further investigation. The validity in Herman's historical findings on the origins of trauma as a theory and its development, is found in other contemporary studies like that of Auerbach et al. (2006) who came to the same conclusion in their study published some fifteen years after the first publication of Herman's (2001) book.

Herman's (2001) research and findings regarding the "episodic amnesia of trauma as a disorder" (p. 7) in society is also shared by Auerbach et al. (2006). They found through their historical research that trauma research came to a temporary stop following Freud changing his seduction theory to fantasy. Thereafter trauma was investigated again in conjunction with the World Wars, when soldiers developed shell shock and then given up again until the Vietnam War, when both veterans and rape victims pushed forward political recognition of trauma by health professionals and their communities.

4.2 Limited Diagnostic Criteria and its Consequences

Herman's (2001) view of the diagnostic criteria for those suffering from trauma as lacking and in grave need of revision due to her clinical experience is also an opinion shared by other researchers based on their research and experience. For instance, Goff et al. (2006) found that the diagnostic criteria for trauma defined in APA (2000) in, itself, still was primarily synonymous with PTSD. The issues surrounding this limited reference stems from several researchers clinical experiences demanding a description that goes beyond the current DSM-IV-TR of trauma. Goff et al. (2006) also found that many other contemporary researchers in various fields regarding trauma share their opinion, e.g. Brewin, Carlson, Creamer, and Shalev (2005), Figley (1995, 1998, 2002), McCann and Pearlman (1990), Pearlman and Saakvitne (1995), Barnowsky, Young, Johnson-Douglas, Williams.Keeler and McCarrey (1998), Weingarten (2003; 2004), Barnes (1998), Steinberg (1998), Arzi et al. (2000), Bramsen et al. (2002), Lev-Wiesel and Amir (2001), and McCammon and Allison (1995).

Cabizuca et al. (2009) also share Herman's (2001) view of inadequate diagnostic criteria citing several more researchers from her study with similar results of inadequacy in the classification for PTSD in the DSM-IV. For instance, they cite

Breslau et al. (1998), Davidson, Hughes, Blazer, and George (1991), and Kessler, Sonnega, Bromet, Hughes, and Nelson (1995).

Chaiken and Prout (2004) also find fault with the current definition of PTSD similar to that of Herman (2001). Aside from the results of their study they also reference other researchers who have come to the same conclusion that the consequences of unexplored or unacknowledged complex trauma leads directly to misdiagnosis and miss-application of treatment, preventing recovery and increasing suffering. For instance, Chaiken and Prout (2004) cite Herman (1992a), Pelcovitz, van der Kolk, Roth, Mandel, Kaplan and Resick (1997), Roth, Newman, Pelcovitz, van der Kolk and Mandel (1997), van der Kolk (1996), Emery and Laumann-Billings (1998), Franklin and Zimmerman (2001), Gorey, Richter and Snider (2001), Read (1997), Read, Agar, Barker-Collo, Davies and Moskowitz (2001), Ruscio (2001), Cohen, Mannarino and Rogal (2001), Darves-Bornoz, Lempérière, Degiovanni, and Gaillard (1995), Herder & Redner (1991), Marley and Buila (2001), and Mullen, Martin, Anderson, Romans, and Herbison (1993).

4.3 The Importance of Understanding the Dialectics of trauma

Herman's (2001) findings of the need for more general acknowledgement and understanding of trauma is shared by researchers Piper et al. (2008) and by Cabizuca et al. (2009) in their study of parents with chronically ill children, who suffer from PTSD symptoms due to the lack of knowledge of the impact of life threatening information being given by general practitioners. Cabizuca et al. (2009) also found other researchers with the same findings such as Farell, Ryan, and Langrick (2001), and Fallowfield and Jenkins (2004) emphasizing the importance of the Dialectics of Trauma becoming less specialised and more generalised knowledge within the health care sectors.

4.4 Working with trauma survivor's

Herman (2001) places great emphasis on the therapist's own self analysis and self care as being one of the key features of a trauma survivor succeeding in treatment once properly diagnosed. This is an important element as seen by many other researchers such as Adams, Boscarino, and Figley (2006) who uncovered many more researchers with similar results with emphasis on the acknowledgement and support resources that must be improved upon for those working with trauma survivors. For instance, they cite Figley (1995; 2002a; 2002b), Nelson-Gardell and Harris (2003), Schauben and Frazier (1995), Jenkins and Baird (2002), Gentry, Baranowsky and Dunning (2002), Salsten and Figley (2003), Stamm (2002), Sabin-Farell and Turpin (2003), Pearlin (1989), Thoits (1995), Boscarino (1997), and Francis (1997).

The importance of professional support for trauma workers is reiterated in the studies of Tummala-Narra (2005) and Barnowsky et al. (2005). The study by Chaiken and Prout (2004) has also shown similar conclusions emphasizing the importance of education regarding the impact on themselves as therapists working with trauma patients. They cite the research of Courtois (1999), Treppa (1998), Wade (1998), and Saakvitne et al. (2000) for validation.

4.5 Treatment methodology for trauma victims

Herman's (2001) research also showed as previously stated that "traumatic events have primary effects not only on the psychological structures of the self but also on the systems of attachment and meaning that link individual and community" (p. 51). Fighting to avoid trauma burdened memories the survivors isolate themselves, struggle with self regulation, and intense emotional extremes. Herman (2001) bases her recovery methodology on the interactions of society and support networks. As she stated "survivors need support to put their experience in words, retrieve and work through hidden aspects, no one person can truly see themselves accurately" (p. 68). This theory of Herman's process for recovery being dependant on the intervention of others, as well as involving various therapeutic methods in phases, is shared by Cloitre et al. (2004), Barnowsky et al. (2005), Feeny et al. (2004), and Chaikin and Prout (2004).

Although these other researchers' methodology is not a linear copy of Herman's (2001) the bases or foundation of the treatment methodology reflects her theory for progressive trauma treatment requiring a varied and phased methodology. Everett and Gallup (2001) in fact cite their borrowing the model for treatment and recovery directly from Herman (2001) in their own care plan for patients who were abused, both sexually and physically, as children as well as Auerbach, et al. (2006), who also reference Herman's (2001) methodology directly.

Whether trauma is experienced in childhood, or as an adult, some of the common practices for treating this diverse and highly complex disorder vary. Although the models vary in content due to the fact that they are specified in accordance to the specific field of trauma they work in and the treatment methodology most recommended is based on the multilevel model introduced by Herman (2001). The difference that can be seen between the treatment methodology that Herman (2001) proposes with that of these other researchers is mainly on the bases that she never pinpoints Cognitive Behavioural Therapy (CBT) directly in her methodology (emphasis placed on psychodynamic therapy techniques) as opposed to the other researchers. However, many of the levels she describes for the phases of recovery can be seen as CBT, for instance, reprocessing the regulation of emotions, skills and interaction deals with the process of relearning which is now know as CBT.

4.6 Trauma and Children

Herman's (2001) findings on the psychological process for children in trauma are shared by other researchers. For instance recently by Ovreeide (2007), although not referring directly to Herman's (2001) research he too has come to the same conclusion. Understanding the reasons why children place blame on themselves, when abused is fundamental to being able to help and communicate with them. Another study that has come to the same conclusion as Herman (2001) on children in trauma and the consequences of inadequate care of them is the study by Chaikin and Prout (2004), who found that "Nearly 3 million reports of alleged child abuse and neglect are made each year, and the long-term effects include the development of affective disorders, sexual dysfunction, eating disorders, personality disorders, posttraumatic stress disorder (PTSD), substance abuse, dissociative disorders, and susceptibility to suicide" validated by American Academy of Child and Adolescent Psychiatry (1998), Emery and Laumann-Billings (1998), Franklin and Zimmerman (2001), Gorey, Richter and Snider (2001), Read (1997), Read, Agar, Barker-Collo, Davies and Moskowitz (2001), and Ruscio (2001).

Herman's (2001) research findings of the importance of the child's perspective is also shared by Feeny et al. (2004), who cites further several other studies validating their studies regarding trauma and children, e. g. Giaconia et al. (1995), Jenkins and Bell (1994), Costello, Erkanli, Fairbank and Angold (2002), and Kendall-Tackett, Williams and Finkelhor (1993), emphasizing that along with the guidelines of treatment procedure it has been found by other researchers that the techniques of reaching children in trauma successfully is highly based on the adults ability to understand the mind set of how a child in trauma sees the world.

4.7 Society's Role

Herman (2001) found as Cabizuca et al. (2009), that the majority of studies in the past 30 years on PTSD were based on war veterans as the sample group, which limited the scope of recognizing trauma experienced on the home front. One of the most controversial of these traumas has been that of rape. In society far from war the reality of women and rape and the reaction from society has been shrouded in the understanding that it is not based on the woman's experience, but subject to interpretation. Swedish sociologist Stina Jeffner (1998) and British sociologist Liz Kelly (1988) have come to the same conclusion. In both studies it was found that rape in itself is subject to interpretation from society and not dependant on the females' experience. Both studies report that there exists a middle ground to good or bad sex and that this middle ground consists of the factors that society considers before determining if a female has been raped. As with war veterans also victims of crimes

search for meaning and recognition from society and when that is denied, or ignored, trauma symptoms increase and the victim's themselves are isolated.

4.8 Summary

In Herman's book (2001) the development of psychological trauma during the last two centuries is explored and a multi variant treatment methodology is offered. Herman has spent the last three decades compiling research on, and studying the effects of, trauma on the human condition. In evaluating the validity of her theories and the practicality of her treatment methods, comparisons with respect to theory/history of trauma, diagnostic criteria, society's role, therapist role, single and multi trauma as well as treatment methodologies were made in the works by Auerbach et al. (2006), Piper et al. (2008), Cloitre et al. (2004), Goff et al. (2006), Cabizuca et al. (2009), Adams et al. (2006), Tummala-Narra (2005), Barnowsky et al. (2005), Feeny et al. (2004), Everett & Gallop (2001), Appelbaum and Stein (2009), Jeffner (1998), Kelly (1988), Ovreeide (2007) and Chaiken and Prout (2004). The findings of this thesis indicate a strong confirmation that Herman's (2001) findings are reliable as proven by a multitude of independent studies in various fields of trauma by the aforementioned researchers. The empirical work that Herman (2001) bases her theoretical findings on are found to be reliable and valid having been referenced by the comparative researchers and the structure of Herman's methodology has been validated as practical, valid, and reliable due to the multi phase/variant methodology being recognised and practised in various fields of trauma. Although differing in contents, the confirmations of the other researchers validate the significance of Herman's (2001) theory for treatment of single and acute trauma. Both theoretically, and practically, Herman's (2001) work has been the foundation and inspiration for further development of treatment methods in this vast field.

5. Discussion

5.1 Result discussion

5.1.1 Trauma theory and history.

An interesting aspect of this study has been the findings of contemporary researchers citing Herman (2001) directly in regards to laying the foundation of modern trauma studies. For instance Auerbach et al. (2006) cited the significance of her work in their studies stating: “One of the theorists most responsible for reinvigorating the study of trauma was Judith Herman, particularly with the publication of her landmark book *Trauma and Recovery* (Herman, 1992)”. Sharing the view of the importance of Herman’s (2001) work researchers like Piper et al. (2008), who, in their study, go as far as describing the immense contribution of her work in opening up the field of trauma back into society.

5.1.2 Treatment methodology.

An aspect of Herman’s (2001) research, which could be seen as missing to some extent is in regards to the treatment methods for children in trauma. She places most emphasis on explaining the importance of understanding a traumatized child’s perspective, e. g. understanding that children use doublethink and double self in a situation of overpoweringly troubled relationships. However, since Herman (2001) never describes in her book the treatment methodology for children in detail, it is assumed that the methodology would be similar to that used for adults after a trauma. This study has only been able to validate Herman’s (2001) theories of the psychological effects of trauma on children and the treatment methodology was never addressed except that it too should be multi phased. It would have been beneficial to this study to have compared Herman’s (2001) treatment methods for children against the methodology proposed by Feeny et al. (2004), which is solely Cognitive Behavioural.

Another particular aspect of Herman’s (2001) methodology, which provoked great interest, was that of the involvement of survivors (adults) testing the levels of emotions through physical challenges for re-learning and re-integration of balanced emotional reaction. The detailed description that the survivors have to relearn the levels of danger and fear, meaning that not all fear or danger is life threatening or even overwhelming, gives a graphic glimpse into the state of mind in which survivors live. The question of why Herman (2001) doesn’t outright name CBT as an aspect of the stages for recovery is not understood. CBT is one of the preferred therapeutic methods used in the USA and as researchers Feeny et al. (2004), Auerbach et al. (2006), and Adams et al. (2006) have developed their treatment methodology from

Herman's (2001) basic concept, they all cite that within their treatment methodology CBT is an active component. It could be argued that by 2001, when the latest revision of her book was publicized, she should have been aware of CBT and have acknowledged it accordingly as a tool she in fact uses in her treatment methodology.

A rather new take on the essence of healing was found in Herman's (2001) statement that "despite folk wisdom (to forgive is divine) forgiveness given to the perpetrator is not in fact essential to individual healing" (p. 190). This is a most interesting theory, she concludes that in reality the victim should not be concerned with forgiving the assailant, but through focusing on themselves the assailant will automatically become less meaningful. It can be argued that the more secure a person feels in their selves the less important others negative actions affect them. This is a refreshing take on what healing can mean. It can be argued that in today's world survivors struggle with the idea that they must spend time on the thought of the perpetrator, in terms of understanding them, and therefore achieving forgiveness thinking as the way to feel healed, but in fact forgiving the perpetrator never alleviates the survivor's symptoms of the trauma.

None of the other researchers touch this subject in their work, so validity of this theory for healing has not been found, however it does provoke the question of, why this concept is not better known and studied? Or perhaps it is, but in another form, for instance, it could be argued that this technique of focussing on the here and now and self is again closely connected to CBT's mindfulness techniques. The difference is that Herman (2001) states specifically that concentrating on forgiving or coming to terms with perpetrator is fruitless, whereas CBT techniques addressed by the other researchers in this study dealt mostly with general information such as the act of reconnecting for the individual. It could be argued that one of Herman's (2001) strengths is that she is so detailed (sometimes graphically) in the issues/elements/thoughts/ feelings that those in trauma and those working with trauma deal with. By not simply giving general explanation of the disorder allows for anyone to get an in-depth view of trauma and its effects on the human condition.

Even though there seems to be a lot of indications towards CBT as a beneficial technique in recovery from trauma, using only CBT as a treatment method can be argued as risky, just as risky as only referring to psychodynamic therapy as Herman (2001) does. The risk is that by following just one school of thought or theory can be argued as limiting the ability for development and improvement in any given area of interest. Combining CBT with the psychodynamic method can, perhaps, give the best assurance for recovering, for instance, by having the support of a psychodynamic therapist for discussing the effects of traumatic memories and their emotional weight (which come up while using CBT techniques) provides the survivor not only with the tools they need for relearning and reprocessing, but also the social and emotional support they need to overcome the aspect of isolation and alienation they live in.

Clearly, depending on the field of trauma researchers have adapted their treatment methods accordingly, based on the needs of the individual. From the examples in this study researchers seem to be open to further developments and willing to use not only multi phase therapy but also multi variant types and to continue to fight for broadening the definition of this disorder, all of which are seen as promising steps to further improvement and understanding of trauma.

5.2 Method Discussion

5.2.1 Reliability, validity and critic.

Reliability in scientific research deals with the ability to measure findings quantitatively through the use of instruments such as scales, calculations, and response mechanisms (Ejvegård, 2003). In such a field as the study of trauma it would be inhumane to subject any survivor to experiments and therefore almost always research of trauma is done through qualitative studies (observations, interviews). It could be argued that this poses a question of reliability upon this study, due to the fact it was solely based on accumulating published material and not attempting any field study. However, having found studies by other researchers independent of Herman (2001) acquiring the same results increases this study's reliability factor.

Validity in scientific research deals with the research findings directly reflecting the research data (Wolming, 2000). This thesis dealt with Herman's (2001) theories on trauma and treatment methodology, a detailed account of her work was presented as well as various other studies by other researchers in order to investigate the validity of Herman's (2001) claims in the field of trauma. There was no critic against her theories, or methodology, only confirmations. This could decrease the validity factor of this thesis having no conflicting research, however, due to the immense nature of the confirming data from various researchers, the validity factor of the information presented in this thesis increases.

This literature study is of a qualitative nature based solely on Herman's (2001) theories and treatment methodology. The advantage of investigating existing research is that it increases resources and education. The disadvantage is that it is difficult to refute her research findings without doing an actual experiment. In this instance, validity could only be attained through referencing other researchers. Although there exist no critique against Herman's (2001) work itself, it shouldn't be understood as perfect. Another disadvantage in regards to doing a qualitative study is that there is a bias factor that can easily come into play. Objectivity was difficult to sustain due to the intense nature of the subject and other researchers' confirmation of her theories and methodology. Another difficulty with sustaining objectivity was in regards to the actual act of writing an overview of Herman's (2001) work. Not all of

her work was included in this thesis, the choice of what would be used, or not, became very difficult due to the vastness of information that her book provides. The final choice of what to use was based on personal opinion and subject to interpretation of what the important points of her theories and treatment methodology are. It is for this reason reading Herman's (2001) book is highly recommended for attaining full understanding of her work and this subject matter.

5.2.2 Future research.

This thesis concentrates solely on Herman's (2001) work compiled in the book *Trauma and Recovery*. The reason for this concentration on one source of research is based on that this book has been described as one of the most important psychological works since Freud. The field of trauma is vast with many literature references and researchers expanding the general knowledge of this complex disorder. That being said, future research on this matter can in fact be looked at locally. Herman (2001) has shown that trauma is not just restricted to war, or natural disaster experiences, but there are incest, rape, battery, child abuse, prostitution, and crime of all scales that occur and also causes trauma. It would therefore be highly interesting to investigate the methodology used in the social care sectors here in Sweden when faced with those who have been raped, abused, robbed etc. What procedures and treatment methodology do the police, social services, judicial systems, and local physicians have when faced with patients in the middle, or aftermath, of a traumatic event like rape or abuse? Lastly, when we consider the statistics revealing the vastness of addiction and suicide problems in Sweden, what is the likelihood that physicians in Sweden see the connections of somatic symptoms like anxiety, phobias, and addiction in connection with a trauma experience, perhaps, early in life?

Another research area to investigate within the field of trauma is in regards to the gender issue. It would be interesting to do a comparative study of survivors long after their trauma to find out through careful interviews and questionnaires how common it is that men experience trauma in their life compared with that of women, and in what time frame? Is it more common for a man to experience trauma as a child or adult or is it more common for a woman to experience trauma as a child or adult? Another aspect of this question could be whether social constraints toward what is accepted within society for the behaviour of men and women make them more susceptible to trauma or less? Whatever the topic, trauma is clearly a part of the human condition and further research can only add to our understanding of the coping and survival skills of individuals at any age.

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Appendix: Literature overview

	<u>Perspective Scientific or other Theoretical Views</u>	<u>Problem and Aim</u>	<u>Method/ Analysis</u>	<u>Result</u>	<u>Discussion</u>
<p>Title: Compassion Fatigue and Psychological Distress Among Social Workers: A validation study</p> <p>Author: Adams, R. E., Boscarino, J. H., Figley, C. R.</p> <p>Publication: American Journal of Orthopsychiatry</p> <p>Year: 2006 Vol 76, nr 1</p>	<p>There exists a psychological affect to those that work with traumatized people known as Compassion Fatigue.</p>	<p>Very few studies have been done on the affects of working with traumatized people...using the psychometric scale asses CF and examine the scales validity</p>	<p>Data was collected using a survey distributed amongst social workers following the terror attack in New York City Sept. 11 2001,</p>	<p>By means of Factor Analyses the scale of CF indicated multiple dimensions, after eliminating overlapping dimensions there were 2 key dimensions indicated, secondary trauma and job burn out.</p>	<p>How to increase care givers abilities to meet the needs of traumatized people without experiencing CF.</p>
<p>Title: The impact of shame on the psychoanalysis of a borderline child.</p> <p>Author: Appelbaum, A. H., & Stein, H.</p> <p>Publication: American Psychological Association Journal</p> <p>Year: 2009 Vol 26, nr 1</p>	<p>Lewis (1987) developed the hypothesis that shame experienced in the patient – therapist relationship that is not analysed results in deeply effecting the patient and therefore recovery.</p>	<p>They deal with noting the issues surrounding misdiagnosis of children suffering from trauma like that of ADHD, this categorizing leads to deep shame for the child.</p>	<p>The methodology is the observation of patients returning to treatment after previous analyses (so called successful)</p>	<p>Practitioner’s observations and analysis of practitioners often result in the patient feeling overexposed as well as shamed.</p>	<p>Lewis drew awareness to the infectious character of shame as an explanation for the neglect of this topic by analysts.</p>
<p>Title: Using grounded theory to develop treatment strategies for multicontextual trauma.</p> <p>Author: Auerbach, C. F., Salick, E., & Fine, J.</p>	<p>Building on the earlier work of Janet (1889) and others, Herman developed two ideas which have influenced how we read</p>	<p>The importance of a graded progression in treating trauma</p>	<p>Research participants moved through these stages, although not always in a linear progression.</p>	<p>Consistent with the work of Janet (1889), Herman (1992), and others, found evidence for three distinct stages in the process of</p>	<p>Because of the uniqueness in every individual following a linear line is impossible, but the process of</p>

<p>Publication: American Psychological Association Journal</p> <p>Year: 2006 Vol 37, nr 4</p>	data.			recovery.	recovery must be graded as practical stages for relearning basic trust, safety and human interaction
<p>Title: Trauma practice. Tools for stabilization and recovery.</p> <p>Author: Baranowsky, A.B., Gentry, J.E., & Schultz, D.F.</p> <p>Publication: Hogrefe & Huber</p> <p>Year: 2005</p>	Warm, personal, and supporting interaction should always be the framework in which treatment or therapy is done. Also a sensitivity to the effects of exposure to Trauma memories is also and important.	The book is written as a guideline for practitioners	The methodology incorporates a cognitive behavioural intervention process, CBT all in an individualized way.	Valuable methods, tasks, and exercises suggested in the book combined with strategic plans of the recommended treatment algorithms	This is a academic book for practitioners
<p>Title: Posttraumatic Stress Disorder in Parents of Children with chronic illnesses: A meta-analysis</p> <p>Author: Cabizuca, M., Mendlowics, M., Marques-Partella, C., Coutinho, E., & Figueria, I.,</p> <p>Publication: Health Psychology Journal</p> <p>Year: 2009 Vol 28, nr 3</p>	The prevalence of PTSD amongst parents of chronically ill children	Assess the prevalence of parents reactions to their chronically ill children and how this effects their behaviour towards their child	Sixteen studies were used showing prevalence to PTSD in parents ratios pooled and compared with parents with healthy children	19.6% of mothers and 11.9% of fathers and 22.8% of parents in general	The high prevalence of parents suffering from PTSD indicates the necessity for prompt and correct care for the parents in order to prevent the consequence of incompetence as caregivers
<p>Title: Treating Complex Trauma in women within community mental health</p> <p>Author: Chaikin, N. D., & Prout, M. F.</p> <p>Publication:</p>	Propose a tri-phase model for treating women with complex trauma which is as yet not recognised adequately by health care officials	In response to there being no comprehensive treatment for trauma survivors in the community health care	OPAL treatment method permotes Reduction or resolution of PTSD symptoms, treatment structure is multi level and is suited to assessment of	There is a tremendous opportunity to develop health centres where trauma is also treated	If health centres provide the necessary expertise and resources to trauma survivors it is also a tremendous training

<p>American Journal of Orthopsychiatry</p> <p>Year: 2004 Vol 74, nr 2</p>		system....	each individual		ground for students who often work first in health centres
<p>Title: Therapeutic Alliance, Negative Mood Regulation, and Treatment outcome in child abuse – related Posttraumatic stress disorder</p> <p>Author: Cloitre, M.K., Stovall-McClough, C., Miranda, R., & Chemtob, C.,</p> <p>Publication: Journal of Consulting and Clinical Psychology</p> <p>Year: 2004 Vol 72, nr 3</p>	An examination of 2 phase treatment of child abuse PTSD under Therapeutic Alliance and negative mood regulation	One of the largest difficulties facing those that suffer from or have suffered abuse as children is their ability to self regulate their emotions	Guided activities, labelling and interpretation of emotional responses, and imaginal exposure to traumatic memories	Reliably predicted improvement of PTSD symptoms in post treatment	Exposure treatments for PTSD are argued to be effective because they force the survivor to overcome their avoidance of their memories.
<p>Title: The link between childhood trauma and mental illness</p> <p>Author: Everett, B., & Gallop, R.</p> <p>Publication: Sage Publications</p> <p>Year: 2001</p>	Borrowing from Judith Herman’s model for recovery, they expand this framework into 10 steps.	The book is for new practitioners and front line workers that have little to no experience with trauma survivors	A practical guide for caring for individuals who were abuse (both sexual and physical) as Children seeking help as adults	Understanding the power a practitioner has with trauma patients is essential for the patients process of recovery	Emphasis lies on the therapists ability to pace the patient as to how much is to much and when to push, what they can endure.
<p>Title: Posttraumatic Stress Disorder in Youth: A critical review of the cognitive and behavioural treatment outcome literature</p> <p>Author: Feeny, N.C., Foa, E., Treadwell, K., & March, J.,</p> <p>Publication: Professional Psychology: Research and Practice, 35(5)</p> <p>Year: 2004</p>	CBT although effective is not completely effective in itself,	What are the treatments that work for children suffering from PTSD? Or more importantly what do clinicians need to learn?	To high light the clinical implications of treatment methods used on youth with PTSD and indicate the areas where further research is needed.	For single trauma experience CBT involving the child/youth provide a solid bases for treating PTSD but must include the parents/caregivers, those suffering from child abuse or long term traumatization	There needs to be a large scale investigation RCT’s comparing all treatment methods in order to assess efficacy and therefore come closer to a formalized method

Vol 35, nr 5				a more complex and varied treatment plan is required	strategy for treating youth properly.
<p>Title: The effects of trauma relationships: A qualitative study with clinical couples</p> <p>Author: Goff, B.S.N., Bole, A., Reisberg, A.M.J., Scheer, T., Hayes, E., Archuleta, K.L., Blalock Henry, S., Hoheisel, C., Nye, B., Osby, J., Sanders-Hohs, E., Schwerdtfeger, K.L., & Smith, D.B.,</p> <p>Publication: American Journal of Orthopsychiatry, 76(4)</p> <p>Year: 2006 Vol 76, nr 4</p>	Individual exposure to trauma affects also the child of the victim, the spouse, parents, etc.	Research into trauma has focused on those directly effected but little is known of the effects on those around the victim, caregivers and partners,	Examining interview data from 17 individuals using a retroductive methodology to determine how intimate relationships are affected.	Both increased and decreased communication, increased and decreased connection, increased and decreased understanding, sexual problems, relationship distress,	Treating trauma survivors in isolation of their families overlooks many consequences which could prove limiting the victim's recovery rate due to exclusion from their community and their communities exclusion of them only results in misunderstanding and further isolation.
<p>Title: Liksom Våldtakt, Typ – Ungdoms förståelse av våldtakt.</p> <p>Author: Jeffner, S.</p> <p>Publication: Uppsala University/Riksorganisationen för kvinnojourer i Sverige</p> <p>Year: 1998</p>	Jeffner refers mostly to the work of Liz Kelly (1988) who developed the theory of a "continuum of violence" in regards to rape which is prevalent in society.	Understanding the view of good and bad sex according to the youth culture	Compilation of data was done through interviewing youth of both sexes and collection of questionnaires on the subject.	Between good (romantic love) and bad (rape) sex, the youth culture experiences and reflects the views often seen in society, there is a middle ground that contends that a girl isn't raped if she is i.e. intoxicated, flirty, bad reputation, etc... boys are boys mentality.	In the course of Jeffner's study she found that only female principles were open to having her at their school and that in some cases of rape wherein the principle was male the punishment if any was light, this view of a middle ground that allows for coerced sex is reflected in adults which influences the youth.

<p>Title: Surviving sexual violence</p> <p>Author: Kelly, L.</p> <p>Publication: Polity Press</p> <p>Year: 1988</p>	<p>Developed the theory of the concept of a 'continuum of violence' in regards to rape which is prevalent in society.</p>	<p>Major goals of the project were to integrate theoretical and empirical research for policy makers.</p>	<p>This study deals with women's experiences over a lifetime having survived sexual violence</p>	<p>The result was that it was found that women defined how they cope with, and survive sexual violence.</p>	<p>The issue of human rights violations in the context of interpersonal relationships is key.</p>
<p>Title: Samtal med Barn – metodiske samtaler med barn I svåra situationer</p> <p>Author: Ovreeide, H.</p> <p>Publication: Lund.</p> <p>Year: 2007 2.rev.</p>	<p>Ovreeide bases his methodology on the psychological development of children, cognitive research in their capacity to not only take in information but process it and understand it.</p>	<p>Improving communication with children in difficult situations for social services and other professionals that come in contact with these children.</p>	<p>Through Ovreeide work as a clinical psychologist, researcher and court ordered investigator He has developed a method of communication with children that deals less with the time limits and pressure of adults but more with attaining viable information in a non threatening form from the child's perspective.</p>	<p>Through meeting the child using identity marker, roll presentation, and here and now focus, information that comes from children is not only freer but truthful, which in abuse cases is essential.</p>	<p>Social services and other professionals that come in contact with children in difficult situation may believe they are acting in accordance with the UN children's perspective initiative, but in actuality they fail communicating with the child and a dialogue of yes or no answers are the result.</p>
<p>Title: What's wrong with believing in repression? A review for legal professionals.</p> <p>Author: Piper, A., Lillevik, L., & Kritzer, R.</p> <p>Publication: American Psychological</p>	<p>Rather than being a concept introduced by Janet or Freud, repression of today was never anticipated until a century after these men lived in 1985 when Judith Herman delivered a speech to the</p>	<p>Addressing the issue of cases involving repressed trauma within the judicial system</p>	<p>The type of repression– called <i>robust repression</i> by Ofshe and Watters seen in today's court cases - this kind of repression is seen as a product of the late 20th century and should be further investigated</p>	<p>The concept of massive repression being brought to light by Herman into society, the only contemporary researcher to have recognized the need for understanding trauma and</p>	<p>Evaluating what evidence if any there is against the existence of repression.</p>

<p>Association Journal</p> <p>Year: 2008 Vol 14, nr 3</p>	<p>American Psychiatric Association, describing this new mental mechanism (Ofshe & Singer, 1994; Pendergrast, 1995; Webster, 1995).</p>		<p>according to this significance</p>	<p>societies denial of it</p>	
<p>Title: Addressing Political and Racial terror in the therapeutic relationship.</p> <p>Author: Tummala-Narra, P.,</p> <p>Publication: Harvard Medical school American Journal of Orthopsychiatry</p> <p>Year: 2005 Vol 75, nr 1</p>	<p>Judith Herman (1992) theory on the roll of traumatic counter transference. <i>and other researchers results on the consequences of that phenomenon.</i></p>	<p>If a practitioner is detached, taking a neutral stance it can prevent the therapist from going deeper into the patient's experiences</p>	<p>It is critical for recovery that patients are not censor or dictated for in therapy due to the therapist own reactions in baring witness to hearing a trauma story</p>	<p>Since 9/11 it is becoming more familiar to discuss issues of terror and trauma.</p>	<p>Society is not still however not used to analysing social or political positions regarding trauma and this is a hindrance to the field.</p>