What does a trauma hide? From all that is indescribable to the process of recovery

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ABSTRACT: Going through a trauma, in any of its forms (child abuse, domestic violence, etc.), is a devastating experience for the victim, whose life is stigmatized forever. The process of recovery depends on the victim's own cognitive, emotional, motivational and behavioural resources, as well as on the degree, scope and depth of the physical, sexual and psychological sequelae caused by the trauma, all of which will be dealt with herein.

Key words: trauma, recovery process, victim, perpetrator, violence.

INTRODUCTION

Throughout this research, in addition to carrying out an analysis of trauma, we attempt to prove some of the problems that emerged during the research of this disorder given the inextricable link existing between violence and victimization in this condition. It is worth mentioning the clash dividing those who put a premium on scientific objectivity and those who put individual/social acknowledgement before the rights of those affected.

On a different level, the difference between the DSM-III-TR (APA, 1987) and its last edition, the DSM-IV-TR (APA, 2000), does not clarify what the term *direct exposure* means either, and reopens the debate it dealt with, according to which since the DSM-IV (APA, 1994) was published, the emphasis had to be placed on the individual's reaction, and not on the kind of traumatic event, when it comes to approaching/treating this disorder, whether as a victim or as a witness. Likewise, the normal course or natural record of human reactions to stress is still unknown, so many of the psychological reactions considered symptoms, according to lists of diagnostic classifications, are actually recovery and adaptation responses whose vital meaning and temporary course still need to be better specified (Vazquez, 2005).

Disregarding these issues, it is worth mentioning that the central dialectics underlying every trauma results from the internal conflict the victim has to face,

which involves denying such horrible events and their willingness to reveal them, so that if the first option prevails, silence will be accompanied by the psychic damage and emotional sequelae the victim suffers, and if the second one wins through, the victim will be able to begin the painful path towards the cure.

In any case, whichever the choice is, this will inevitably imply a high cost for the victims, whose credibility will be questioned, which will in turn encourage their stigmatization, given the strong alternative ingredient involved in researching the trauma, both in the individual and social sphere, of which denial, depression and dissociation are faithful images in reacting to such atrocities (Herman, 1997).

In addition, we should mention the complete lack of conceptual distinction found on the current diagnostic systems among the traumas caused by humans (e.g. theft, rape, etc.) and the rest of traumas (e.g. natural disasters) (Vazquez, 2005), which in spite of having a vast and rich scientific tradition, would make it possible that trauma research could be compared to the clinical manifestations of an episodic amnesia, given the alternation periods of intense research with others of blatant oblivion. Backing these arguments there is the nature itself of its purpose of research, which results in the difficult situation in which researchers find themselves since they must face human vulnerability, on the one hand, and the ability to do evil, on the other. In turn, researchers' work could also be marred by accusations that cast doubt on their supposed impartiality and objectivity, when their research is considered biased and influenced by the terrible events described by the victims, which sometimes lead them to isolate professionally from their colleagues (Baranowsky,

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Gentry and Schultz, 2005).

In the same way, although situated somewhere else, is the witness (neighbours, relatives, etc.) who will have to face the dilemma of remaining deaf, blind and dumb as regards what happened, or telling what happened, thus standing next to the victim, and not the perpetrator (Alberdi, 2005), whose main purpose is to silence the victims or undermine their credibility using arguments of all kinds, so the greater his/her radius of influence, the firmer his/her belief, according to which he/she can name and define reality his/her own way.

FROM WHAT IS UNUSUAL TO WHAT HAPPENS EVERYDAY: THE CLINICAL FEATURES OF TRAUMA

Among the critical factors that had an influence on the research of trauma are the two World Wars that ravaged humanity in the 20th century, as well as other military conflicts such as the Vietnam War, through which trauma became known as a lasting and inevitable legacy for their survivors, even though it was not formally acknowledged until 1980, when for the first time the diagnostic category called Posttraumatic Stress Disorder (PTSD) was included in the DSM-III. The fact is that just after the date mentioned, due to the initiatives implemented by war veterans, the PTSD was legitimized, which helped corroborate that the psychological syndrome the victims of rape, domestic violence and incest were showing was inherently similar to what war survivors were going through (Herman, 1997).

That is how it came as obvious that such atrocities are part of everyday life, and not of the extraordinary and unusual, as some lay people and experts believed, so the various symptoms of PTSD could be divided into three main categories: hyperactivation or constant on guard state, intrusion or indelible impression left by the traumatic experience, and finally, constriction, through which the emotional dullness and failure attitude the victim suffers due to the trauma experience are objectified.

And the truth is that bringing back a traumatic experience, whether through the irruption of intrusive memories or dreams and other behaviour, always carries the emotional intensity of the original situation, which survivors have to face, because, if they choose to avoid it, they will aggravate the posttraumatic syndrome. Likewise, although such intrusive memories, like *flashbacks,* a dissociative paradigm for some authors and a simple memory component for others (Perez Sales, 2006), can be part of the trauma, both are made of different ingredients, since whereas the first ones constitute recurring memories of what happened before and during the traumatic event, the second ones push the individual to relive the traumatic experience as it were happening right now (Echeburúa, 2004). We should also take into account that, if *flashbacks* are the main symptom, the therapist's task will involve training the patient in the set of suitable cognitive and behavioural techniques to reduce their frequency and duration.

In any case, both responses, intrusion and symptom avoidance, will take turns, as the individual aims at finding a nonexistent balance, emphasizing at first the intrusive reliving of the traumatic event, which will plunge the victim into a state of restlessness and alertness when faced with new threats. The intrusive symptoms will reach their climax during the first days or weeks following the event, and they will be reduced to a certain extent between the following 3 to 6 months, tempering slowly as time goes by. However, the specific symptoms linked to the trauma could even be reproduced after many years, stimulated by different circumstances, such as the date when the tragic event took place.

At any rate, once the intrusive symptoms are reduced, the avoidance symptoms increase, and victims pretend not to feel afraid, which would place them, at least ideally, in a suitable position to resume their life, watching everyday events from outside, with a huge affective distance, and a dullness and gulf feeling, which will help avoid experiencing the horror moment again only temporarily. And even if such affective dullness disappears, and victims are aware of the suitable way to express their emotions, this could negatively affect their perception of themselves and of their confrontation strategies since it makes them feel more vulnerable to traumatic memories (Echeburúa, 2004). Another task trauma survivors will have to undertake is the reliving of all their inner struggles to achieve autonomy, initiative, competence, identity and intimacy. Still, social support, whether through the family, through friends or through social/institutional networks, is necessary, since it exudes the victim's primitive emotional bonds, as the community's initiatives aimed at healing the deep wounds the traumatic experience inflicted on the victim, who longs to recover the trust on others and to know they are not alone on the difficult return to everyday life (Duque, Mallo and Álvarez, 2007). However, serious research endorse that those related to the victim must be flexible and tolerant, given the changing need they have as regards closeness and distance, as well as regards recovering their autonomy and self control. On the other hand, the victim's uncontrolled aggressive episodes should not be tolerated, as these increase their guilt and shame load, as well as their social isolation; thus, together with high doses of patience, tenderness and understanding when treating the victim, those interested in them will be able to show some firmness.

TOWARDS THE "CURE": PHASES IN THE PROCESS OF RECOVERY

It seems obvious to think that if the abuse situations took place in certain family and social contexts, the victim's recovery could happen in different contexts. What they long for, above all, is the feeling of power and autonomy they had before the trauma, the first one being the convergence of mutual support and individual autonomy, and the second one, the individual's feeling of being able to stay alone and take important decisions on their own.

Having said this, so that the patient's recovery process can be considered successful, it would be

necessary that a gradual change took place, from an unpredictable feeling of danger to one of reliable safety, as well as a transition from dissociated trauma to recognized memories, and from the stigmatized isolation to the restoration of social contact. Of these phases, the first one, restoring safety, is a top priority. Its length can go from days to weeks in traumatized people, and from months to years in survivors of chronic abuse, depending on the severity, duration and early start of the abuse.

In any case, restoring lost safety begins with treating body control, and gradually starts going outwards, to treat context control. Thus, in order to reduce the victim's reactivity and hyperactivation, medication could be applied, and relaxation and hard physical work out are useful to manage stress. Mental dullness can be treated keeping journals to record symptoms and adaptation responses, as well as to set tasks and develop specific safety plans. In turn, therapy can help increase the genuine trust on others, while social alienation can be confronted through natural support systems (family, partner, friends, etc.), self-help organizations or mental health, social well-being and justice institutions.

Once the body has been controlled, the victim's security within the context should be increased. The danger or safety potential must be carefully examined, since if a family member happens to be producing the trauma, the most suitable urgent measure could be staying temporarily in a shelter. While victims recover that feeling of being safe, some surround themselves with other people all the time, whereas others choose to isolate themselves. And since it is possible for them to choose people that instead of helping them recover, get in the way of recovery, the patient's initial evaluation must include a review of their most significant social relationships, because although some can be their source of protection, emotional support and practical help, others can be a source of potential danger.

Even so, relatives or close friends protecting the victim must accept that, during a while, their lives will be altered more drastically when the victim demands almost constant support and care, and must also consider implementing a protection plan for the future.

The next phase, of remembering and mourning, happens gradually, and a valid indicator of belonging to it is the victim's perception that they are no longer vulnerable or isolated. Then, this is the time when they have to fit into the traumatic experience, which some victims try to avoid, claiming that they are now able to protect themselves, control their most disturbing symptoms and know who to turn to for support.

However, one has to be cautious when reconstructing traumatic memories, since if the individual faces them too suddenly, they will relive them unsuccessfully. Thus, therapist and patient must pay careful attention and agree widely. Monitoring intrusive symptoms will also be very useful, since it will unblock traumatic memories within bearable boundaries. In the event that symptoms dramatically worsen, therapy must be slowed down and redirected.

Reconstructing the trauma, in any case, demands reviewing the patient's life before the event, as well as the circumstances preceding it, all of which provides context where to start to grasp the special meaning of the trauma, so that if an unsuitable psychological performance prior to the traumatic experience is detected, one should analyze what aspects of the current problem can be attributed to situations that took place before the trauma, such as which victimization profiles have been fostered due to the occurrence of these events before the traumatic experience, or if they are associated to personality traits the victim already had (Anglin, 1998). At any rate, and as the patient's traumatic story comes closer to the most unbearable moments, they can spontaneously turn to other non-verbal communication methods (e.g. drawings), which can be the closest approach to these indelible memories. But for this to be really effective, it is also necessary that the victim physically expresses and feels all the emotions associated with such a fact, since memory without emotion hardly ever produces results (Duque, Mallo y Álvarez, 2007). In such a task, fantasies of revenge, as well as of compensation and forgiveness, burst in, with more or less affective intensity in the individual's conscience, which once they achieved certain safety in the context can turn their vulnerable rage into justified indignation; thus, regaining control of their own life. But if they chose to forgive the aggressor or compensation, whether expected from a particular person or from society, the feeling of controlling their own life would depend on others' actions, and the path towards recovery would be interrupted.

Likewise, the social and relational dimensions of the traumatic experience must be included, because although direct exposure techniques, such as flooding, seem to improve intrusion and hyperactivation symptoms, the constrictive symptoms of mental dullness and social seclusion do not necessarily improve, as it happens with marital, social and work problems. Similarly efficient has been flooding when used to alleviate the intense reactions to the memories of only one traumatic event, but its therapeutic efficiency diminishes when used to treat prolonged and repeated traumatic experiences (Herman, 1997).

Despite what has been said, the trauma reconstruction process will never be completed altogether because there will be new conflicts and challenges that will reawaken the trauma, disclosing other aspects of this terrible experience. But if the patient is able to come to terms with their own story and feel hopeful, they will be able to look backwards from a different perspective, working in the present to gradually start consolidating the future. Then, traumatized people will have entered the third phase, the one about the restitution of their own power and social reconnection, through which they will already feel ready to incorporate into their life the hard lessons derived from the traumatic experience, recognizing themselves as victims, and grasping the terrible impacts produced by their victimization.

As a result, victims will start learning to live with fear, and even to use it as a source of impetus or energy, turning the anticipatory physical danger or

mental distress in potentially dangerous situations into something regular in their lives. Now, their task will consist of becoming who they want to be, turning to the most outstanding personality traits they had before the traumatic experience, such as the ones built up during the experience and incorporated in the recovery process, whose integration will result in a new self, both at an ideal and at a real level.

From such identity signs, the most prominent ones are those built up in the traumatic context, since only the victims recognize them and are able to give them up, when they show more willingness to forgive themselves realizing that the terrible damage inflicted on them is not permanent. Thus stimulated, some victims embark on social actions, whose main aim is to help others that, like them, have gone through traumatic experiences. Their private life and different social networks are also affected when they resume their old love relationship or start a new one, like it happens if they decide to have children, as all of them are concentrated on establishing a relational dynamics different from the previously existing one.

Rounding off, despite the time gone by from their original formulation, we find it useful to make reference to the seven criteria pointed by Harvey (1990) to evaluate the degree of resolution of a trauma: First, PTSD symptoms must be within manageable boundaries. Then, the individual must be able to endure feelings associated with traumatic memories; third, the individual must have authority over such memories, so that they are able to choose between remembering the trauma or leaving it behind. Next, the traumatic event must be told as a coherent description associated with the feeling; fifth, the individual must have recovered their self-esteem. Last, the sixth criterion makes reference to the necessary restoration of the person's most significant affective and social relationships, and the seventh criterion, to the person's reconstruction of a coherent meaning and value system that embraces the trauma story.

The achievement of such criteria can be made through individual or group therapy. The second therapeutic method is recommended once between six months and one year has gone by after the traumatic experience. And if, as we have mentioned, the first phase of the recovery process pursues the search for security, group work in the last phase should be highly cognitive and educational, and it should never deal with a deep exploration of the trauma, because if we did not try provide strategies for the individual's own care and protection, we would increase group members' distress. Therefore, the group structure is centred on symptom relief, problem resolution, and basic care daily tasks.

On the other hand, exploring the trauma is appropriate in the second phase, of remembering and mourning, since it is through group action that the trauma grows, releasing the victim from the isolation they have been subjected to. Sharing the story of the trauma in a group means not only relief or catharsis, but it is also the step prior to the active control of the trauma. And since initially there is no group member more trained than others to take on the group's

leadership, we generally recommend a shared leadership, based on cooperation among equals, in order to avoid reproducing a dominance and subordination dynamics. In this way, the emotional weakness is distributed among several leaders, who are witnesses of the group members' stories, and it is not taken on by just one of them (Anglin, 1998). Although we often see how the anxiety symptoms worsen at the beginning, group members have a feeling of euphoria for having met others, and for the first time, they feel they are recognized and understood.

Given the limited duration of group therapy, a great deal of the integration work must be carried out towards the end, taking into account that it is a complement of the intensive, individual exploration of the trauma, and that, under no circumstances, does it replace individual therapy.

CONCLUSION

In tune with previous research that has already been published (Rodriguez Vega, Fernandez Liria and Bayón Perez, 2005), we believe that every effective and efficient intervention model when coming to grips with and treating PTSD must include the self psycho-physical experience –in relation to, and not exclusively the physical experience- in order to integrate the cognitive experience into the somatosensory emotional experience. Likewise, it is necessary to increase the number of studies that stress people's psycho-social performance, which is a key criterion to determine whether a disorder affects individuals' everyday life, to what extent, how, etc., something rarely dealt with in current epidemiologic research. In addition, we must examine measure methods used (clinic interviews, standardized tools, self-evaluations) into greater detail, since serious studies endorse that the kind and extent of reactions depends on such methods, as well as on the more or less strict criteria employed. The most predominant studies are those based on a dimensional approach that includes symptom scales that reflect different reaction degrees, but there others that have been centred on some of the most extreme responses, such as the development of a complete posttraumatic stress disorder (Vazquez, 2005).

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