CommunityWorks

1999

Trauma Theory *Abbreviated*

Authored By: Sandra L. Bloom, M.D.
PMB 138
12 West Willow Grove Avenue
Philadelphia, PA 19118-3952

TRAUMA THEORY ABBREVIATED

Sandra L. Bloom, M.D.
CommunityWorks®
www.sanctuaryweb.com

From the *Final Action Plan: A Coordinated Community-Based Response to Family Violence,* Attorney General of Pennsylvania's Family Violence Task Force, October, 1999.

Psychological Trauma Defined

To understand what trauma does we have to understand what it is. Lenore Terr, a child psychiatrist who did the first longitudinal study of traumatized children writes, "*psychic trauma occurs when a sudden, unexpected, overwhelming intense emotional blow or a series of blows assaults the person from outside. Traumatic events are external, but they quickly become incorporated into the mind*" (Terr, 1990, p.8). Van der Kolk makes a similar point about the complicated nature of trauma when he says, "*Traumatization occurs when both internal and external resources are inadequate to cope with external threat*" (Van der Kolk, 1989, p.393). Both clinicians make the point that it is not the trauma itself that does the damage. It is how the individual's mind and body reacts in its own unique way to the traumatic experience in combination with the unique response of the individual's social group.

Children are traumatized whenever they fear for their lives or for the lives of someone they love. A traumatic experience impacts the entire person - the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people, and the way we make sense of the world are all profoundly altered by traumatic experience.

Evolutions's Legacy

It is impossible to fully understand human behavior and the human response to trauma without grasping key insights about the way our evolution has affected us. The fight-or-flight response described below is a part of our mammalian heritage, and continues to profoundly impact, at a physiological level, our response to all stresses, even those caused by our sophisticated social environments. We are born with a number of innate emotions that are also part of our mammalian heritage and that produce patterned and predictable responses in all of our organs, including our brain. This means that overwhelming emotions can do damage to our bodies as well as our psyches. As a species we survived largely because we developed as social animals for mutual protection and this social nature of human beings is grounded in our need to attach to other human beings from cradle to grave. Children who suffer disrupted attachments may suffer from damage to all of their developmental systems, including their brains and we are particularly ill-suited to having the people we are attached to also be the people who are violating us. Our very complex brains and powerful memories distinguish us as the most intelligent of all animals, and yet as we will see, it is this very intelligence that leaves

us vulnerable to the effects of trauma such as flashbacks, body memories, post-traumatic nightmares and behavioral reenactments. The social nature of our species is guaranteed by an innate sense of reciprocity that can be observed even among primates. But this same sense of "fair play" leads not only to the evolution of justice systems, but also to the need for revenge. The result is that you cannot hurt anyone, most importantly children, without setting the stage for revenge that will be exacted either upon themselves, upon others, or both. Finally, we are physiologically designed to function best as an integrated whole, just like the computers that we now build. The fragmentation that accompanies traumatic experience degrades this integration and impedes maximum performance in a variety of ways. Human brains function best when they are adequately stimulated but simultaneously protected from overwhelming stress. This explains our need for order, for safety, for adequate protection. Let's look more closely now at what trauma does to the minds and bodies of those involved.

The Fight-or-Flight Response

We are animals and like other animals, we are biologically equipped to protect ourselves from harm as best we can. The basic internal protective mechanism is called the *fight-or-flight* reaction. Whenever we perceive that we are in danger our bodies make a massive response that affects all of our organ systems. This change in every area of basic function is so dramatic that in many ways, we are not the same people when we are terrified as when we are calm.

Each episode of danger connects to every other episode of danger in our minds, so that the more danger we are exposed to, the more sensitive we are to danger. With each experience of fight-or-flight, our mind forms a network of connections that get triggered with every new threatening experience. If children are exposed to danger repeatedly, their bodies become unusually sensitive so that even minor threats can trigger off this sequence of physical, emotional, and cognitive responses. They can do nothing to control this reaction - it is a biological, built-in response, a protective device that only goes wrong if we are exposed to too much danger and too little protection in childhood or as adults.

The real nature of the fight-or-flight response means that if we hope to help traumatized people, then we must create safe environments to help counteract the long-term effects of chronic stress.

Learned Helplessness

If a person is able to master the situation of danger by successfully running away, winning the fight or getting help, the risk of long-term physical changes are lessened. But in many situations considered to be traumatic, the victim is helpless and it is this helplessness that is such a problem for human beings. As a species, we cannot tolerate helplessness - it goes against our instinct for survival. We know from animal experiments, that helplessness can cause changes in the animals' ability to recognize and escape from danger so that once the animal becomes accustomed to trauma, it fails to try and escape from danger. This has been called "learned helplessness".

Apparently, there are detrimental changes in the basic neurochemistry that allows the animal to self-motivate out of dangerous situations. Change only occurs when the experimenter actively intervenes and pulls the animal out of the cage. At first, the animal runs back in, but after sufficient trials, it finally catches on and

learns how to escape from the terror once again. The animals' behavior improves significantly, but they remain vulnerable to stress. As in human experience, animals show individual variation in their responses. Some animals are very resistant to developing "learned helplessness" and others are very vulnerable. (Seligman, 1992).

We know that people can learn to be helpless too, that if a person is subjected to a sufficient number of experiences teaching him or her that nothing they do will effect the outcome, people give up trying. This means that interventions designed to help people overcome traumatizing experiences must focus on mastery and empowerment while avoiding further experiences of helplessness.

Loss of "Volume Control"

The experience of overwhelming terror destabilizes our internal system of arousal - the internal "volume control" dial that we normally have over all our emotions, especially fear. Usually, we respond to a stimulus based on the level of threat that the stimulus represents. People who have been traumatized lose this capacity to "modulate arousal". They tend to stay irritable, jumpy, and on-edge. Instead of being able to adjust their "volume control", the person is reduced to only an "on-or-off" switch, losing all control over the amount of arousal they experience to any stimulus, even one as unthreatening as a crying child.

Children are born with only an on-or-off switch. Gradually, over the course of development and with the responsive and protective care of adults, the child's brain develops the ability to modulate the level of arousal based on the importance or relevance of the stimulus. This is part of the reason why the capacity of adults to soothe frightened children is so essential to their development. They cannot soothe themselves until they have been soothed by adults. Children who are exposed to repeated experiences of overwhelming arousal do not have the kind of safety and protection that they need for normal brain development. They may never develop normal modulation of arousal. As a result they are chronically irritable, angry, unable to manage aggression, impulsive, and anxious. Children – and the adults they become – who experience this level of anxiety will understandably do anything they can to establish some level of self-soothing and self-control.

Under such circumstances, people frequently turn to substances, like drugs or alcohol, or behaviors like sex or eating or even engagement in violence, all of which help them to calm down, at least temporarily. If you have never been able to really control your feelings, and you discover that alcohol gives you some sense of control over your internal states, it is only logical that you will turn to alcohol for comfort. The experience of control over helplessness will count for much more than anyone's warnings about the long-term consequences of alcohol abuse.

The implication of these findings for intervention strategies is that we need to understand that many of the behaviors that are socially objectionable and even destructive are also the individual's only method of coping with overwhelming and uncontrollable emotions. If they are to stop using these coping skills, then they must be offered better substitutes, most importantly, healthy and sustaining human relationships. Blaming and punishment is thus counterproductive to the goals that we hope to achieve – they just tend to make things worse.

Thinking Under Stress - Action Not Thought

Our capacity to think clearly is also severely impaired when we are under stress. When we perceive that we are in danger, we are physiologically geared to take action, not to ponder and deliberate. In many situations of acute danger it is better that we respond immediately without taking the time for complicated mental processing, that we respond almost reflexively to save our lives or to protect those we love. When stressed, we cannot think clearly, we cannot consider the long-range consequences of our behavior, we cannot weigh all of the possible options before making a decision, we cannot take the time to obtain all the necessary information that goes into making good decisions. Our decisions tend to be based on impulse and are based on an experienced need to self-protect. As a consequence these decisions are inflexible, oversimplified, directed towards action, and often are very poorly constructed (Janis, 1982). In such situations people demonstrate poor judgment and poor impulse control. The mind is geared towards action and often the action taken will be violent. Many victims have long-term problems with various aspects of thinking. An intolerance of mistakes, denial of personal difficulties, anger as a problem-solving strategy, hypervigilance, and absolutistic thinking are other problematic thought patterns that have been identified (Alford, Mahone, and Fielstein, 1988).

In formulating intervention strategies, this means that every effort should be made to reduce stress whenever good decisions are sought. It also means that we need to look at the growing sources of social stress that are inflicted on individuals and families at home, in the workplace, and in the community and evaluate what kinds of buffers can be put into place that help attenuate the effects of these stressors.

Remembering Under Stress

Our way of remembering things, processing new memories, and accessing old memories is also dramatically changed when we are under stress. Still, there is a growing body of evidence indicating that there are actually two different memory systems in the brain - one for normal learning and remembering that is based on words and another that is largely nonverbal (Van der Kolk, 1996). Our verbally based memory system is vulnerable to high levels of stress. Under normal conditions, the two kinds of memory function in an integrated way. Our verbal and nonverbal memories are thus usually intertwined and complexly interrelated.

What we consider our “normal” memory is based on words. From the time we are born we develop new categories of information, and all new information gets placed into an established category, like a filing cabinet in our minds. We talk in words, of course, but we also think with words. The person we identify as “me” is the person who thinks and has language. When we need to recall something, we go into the appropriate category and retrieve the information we need. But under conditions of extreme stress, our memory works in a different way.

When we are overwhelmed with fear, we lose the capacity for speech, we lose the capacity to put words to our experience. Without words, the mind shifts to a mode of thinking that is characterized by visual, auditory, olfactory, and kinesthetic images, physical sensations, and strong feelings. This system of processing information may be adequate under conditions of serious danger. But the powerful images, feelings, and sensations do not just “go away”. They are deeply imprinted, more strongly in fact, than normal everyday memories. The neuroscientist Joseph LeDoux (1992) has called this “emotional memory” and has shown that this kind of memory can be difficult or impossible to erase, although we can learn to override some of our

responses.

This "engraving" of trauma has been noted by many researchers studying various survivor groups (Van der Kolk, 1996). Problems may arise later because the memory of the events that occurred under severe stress are not put into words and are not remembered in the normal way we remember other things. Instead, the memories remain "frozen in time" in the form of images, body sensations like smells, touch, tastes, and even pain, and strong emotions.

A flashback is a sudden intrusive re-experiencing of a fragment of one of those traumatic, unverbalized memories. During a flashback, people become overwhelmed with the same emotions that they felt at the time of the trauma. Flashbacks are likely to occur when people are upset, stressed, frightened, or aroused or when triggered by any association to the traumatic event. Their minds can become flooded with the images, emotions, and physical sensations associated with the trauma and once again. But the verbal memory system may be turned off because of the arousal of fear, so they cannot articulate their experience and the nonverbal memory may be the only memory a person has of the traumatic event.

At the time of the trauma they had become trapped in "speechless terror" and their capacity for speech and memory were separated. As a result, they developed what has become known as "amnesia" for the traumatic event – the memory is there, but there are no words attached to it so it cannot be either talked about or even thought about. Instead, the memory presents itself as some form of nonverbal behavior and sometimes as a behavioral reenactment of a previous event. Even thinking of flashbacks as "memories" is inaccurate and misleading. When someone experiences a flashback, they do not *remember* the experience, they *relive* it. Often the flashback is forgotten as quickly as it is happens because the two memory systems are so disconnected from each other.

Over time, as people try to limit situations that promote hyperarousal and flashbacks, limit relationships which trigger emotions, and employ behaviors designed to control emotional responses, they may become progressively numb to all emotions, and feel depressed, alienated, empty, even dead. In this state, it takes greater and greater stimulation to feel a sense of being alive and they will often engage in all kinds of risk-taking behaviors since that is the only time they feel "inside" themselves once again.

If we cannot remember an experience we cannot learn from it. This is one of the most devastating aspects of prolonged stress. The implicit functioning of the brain, life-saving under the immediate conditions of danger, becomes life threatening when the internal fragmentation that is the normal response to overwhelming trauma, is not healed. The picture becomes even more complicated for children who are exposed to repeated experiences of unprotected stress. Their bodies, brains, and minds are still developing. We are only beginning to understand memory, traumatic memory, and how these memory systems develop and influence each other (Perry, 1993; Schwarz & Perry, 1994). We do know that children who are traumatized also experience flashbacks that have no words. For healing to occur, we know that people often need to put the experience into a narrative, give it words, and share it with themselves and others. Words allow us to put things into a time sequence - past, present, future.

Without words, the traumatic past is experienced as being in the ever present "Now". Words allow us to put the past more safely in the past where it belongs. Since a child's capacity for verbalization is just developing, their ability to put their traumatic experience into words is particularly difficult. In cases of childhood terror, language functions are often compromised. Instead, children frequently act-out their memories in behavior instead of words (James, 1994). They show us what happened even when they cannot tell

us. We call this automatic behavioral reliving of trauma, "traumatic reenactment".

The implications of this important information about memory and trauma are extensive. It means that environments designed to intervene in the lives of suffering people must provide an abundance of opportunities for people to talk, and talk and talk about their experiences, their past lives, their conflicts, their feelings. It means that programs that focus on nonverbal expression – a description that includes art, music, movement, and theatre programs as well as sports – are vital adjuncts to any community healing efforts and should be funded, not eliminated, in the schools. It means that the arts can play a central role in community healing, serving as a "bridge across the black hole of trauma" (Bloom, 1996).

Emotions and Trauma – Dissociation

We don't usually think about it, but it is possible to die of fright or to die of a broken heart. Every vital organ system is closely tied in through the autonomic nervous system, with our emotional system. In fact, however, people rarely die from emotional upsets. A fundamental reason for such rarity, despite the extent of fearful circumstances that children face, is the built-in "safety valve" that we call "dissociation".

Dissociation is defined as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment". Dissociation helps us do more than one thing at once. We can go on autopilot and automatically complete tasks that we have previously learned well, while we are focused on something else. This increase in efficiency may help explain why we evolved the ability.

Traumatized people make special use of this capacity. There are different ways that people dissociate. Fainting is an extreme form of simply stopping consciousness. Psychogenic fainting is the brain's way of saying, "I can't handle this". But we can also split off memories from consciousness awareness, as we have already discussed, and develop "amnesia". Rarely, someone can develop amnesia for their entire identity and begin a separate life – a fugue state. More commonly people develop amnesia for parts of their lives or just for parts of certain overwhelming experiences.

But there is another way we can dissociate that is so common that almost everyone does it – splitting off experience from our feelings about that experience. In its most extreme form, this is called "emotional numbing". So commonly do human beings cut off feelings about what happened to them while still remembering everything, that often we have to look closely at the person before we see something is wrong - they do not feel the emotions that would normally be expected under the circumstances. In such cases, instead of seeing the emotional numbing that has occurred to the person, we will make comments about "how well Sheila is coping with her loss" or "how extraordinary it is that John never seems to get ruffled, even if someone is yelling at him". But Sheila and John are not necessarily "coping well" - they may be dissociated from their feelings and their capacity for normal emotional interaction may be consequently diminished.

We are able to cut off all our emotions but that usually happens only in extreme cases of repetitive and almost unendurable trauma. More commonly we cut-off or diminish specific emotional responses, based on the danger the emotion may present to continued functioning. Our emotions are intimately tied to the expression of emotion through our facial expressions, our tone of voice, our gestures, so that we easily give away what we may be consciously trying to hide. If you grow up in a violent home, where every time you express anger you get beaten, it is best that you never show anger. If you grow up in a home – or a culture – that says that little boys who cry are wimps who should be taught a "lesson", then it is a good idea to learn to never feel sadness,

therefore minimizing the danger of tears. If any sign of pleasure or laughter is met with hostility and abuse, then it is best that you never feel joy. In this way, children from destructive situations learn how not to feel, they learn to dissociate their emotions from their conscious experience and their nonverbal expression of that emotion and in doing so, they can possibly stay safer than if they show what they feel. That does not mean that the emotion actually goes away. It does not. Emotions are built-in, part of our evolutionary, biological heritage and we cannot eliminate them, we can only transmute them. There is an abundance of evidence from various sources that unexpressed emotions may be very damaging to one's mental and physical health (Pennebaker, 1997).

It is certainly clear that emotional numbing is damaging to relationships. We need all of our emotions available to us if we are to create and sustain healthy relationships with other people. If we cannot feel anger, we cannot adequately protect others and ourselves. If we cannot feel sadness, we cannot complete the work of mourning that helps us recover from losses so that we can form new attachments. If we cannot feel joy, life becomes empty and meaningless leading to an increased potential for detachment, alienation, suicide and homicide. This is yet another example of how a coping skill that is useful for survival under conditions of traumatic stress, can become a serious liability over time.

As this process continues over time, we gradually may shut-off more and more of our normal functioning. We may dampen down any emotional experience that could lead back to the traumatic memory. We may withdraw from relationships that could trigger off memories. We may curtail sensory and physical experiences that could remind us of the trauma. We may avoid engaging in any situations that could lead to remembering the trauma. At the same time, we may be compelled, completely outside of our awareness, to reenact the traumatic experience through our behavior. This increases the likelihood that instead of managing to avoid repeated trauma, we are likely to become traumatized again. As this process happens, our sense of who we are, how we fit into the world, how we relate to other people, and what the point of it all is, can become significantly limited in scope. As this occurs, we are likely to become increasingly depressed. These *avoidance* symptoms, along with the *intrusive* symptoms, like flashbacks and nightmares, comprise two of the interacting and escalating aspects of post-traumatic stress syndrome, set in the context of a more generalized physical hyperarousal. As these alternating symptoms come to dominate traumatized people's lives, they feel more and more alienated from everything that gives our lives meaning - themselves, other people, a sense of direction and purpose, a sense of spirituality, a sense of community. It is not surprising, then, that slow self-destruction through addictions, or fast self-destruction through suicide, is often the final outcome of these syndromes. For other people, rage at others comes to dominate the picture and these are the ones who end up becoming significant threats to the well being of others.

Children who are traumatized do not have developed coping skills, a developed sense of self, or self in relation to others. Their schemas for meaning, hope, faith, and purpose are not yet fully formed. They are in the process of developing a sense of right and wrong, of mercy balanced against justice. All of their cognitive processes, like their ability to make decisions, their problem-solving capacities, and learning skills are all still being acquired. As a consequence, the responses to trauma are amplified because they interfere with the processes of normal development. For many children, in fact, traumatic experience becomes the norm rather than the exception and they fail to develop a concept of what is normal or healthy. They do not learn how to think in a careful, quiet, and deliberate way. They do not learn how to have mutual, compassionate, and satisfying relationships. They do not learn how to listen carefully to the messages of their body and their

senses. Their sense of self becomes determined by the experiences they have had with caretaking adults and the trauma they have experienced teaches them that they are bad, worthless, a nuisance, or worse. Living in a system of contradictory and hypocritical values impairs the development of conscious, of a faith in justice, of a belief in the pursuit of truth. It should come as no surprise then, that these children so often end up as the maladjusted troublemakers that pose so many problems for teachers, schools, other children, and ultimately all of us.

Again, the implications of this knowledge for intervention techniques and strategies are significant. We must create systems that build and reinforce the acquisition of what Goleman has termed "emotional intelligence". We need to recognize that many of the maladaptive symptoms that plague our social environment are the result of the individual's attempt to manage overwhelming emotions, effective in the short-run, detrimental long-term. If we fail to protect children from overwhelming stress, then we can count on creating life-long adjustment problems that take a toll on the individual, the family, and society as a whole.

Endorphins and Stress - Addiction to Trauma

These magical substances called endorphins are a part of normal, everyday functioning, but they are especially important during times of stress. Again, if we look at evolution, this makes sense. Not only do endorphins calm anxiety, improve our mood, and decrease aggression, but they also are great analgesics since they are related to morphine and heroin. Therefore, in times of stress, they provide enough pain relief that we are not disabled by injuries that would otherwise prevent us from escaping the danger. If people are only exposed to rare episodes of overwhelming stress, then they are less likely to show alterations in this biochemical system. Far more problematic are those people who are exposed to repeated experiences of prolonged stress. These people, often children, are exposed to repeatedly high levels of circulating endorphins. One hypothesis is that people can become "addicted" to their own internal endorphins and as a result only feel calm when they are under stress while feeling fearful, irritable and hyperaroused when the stress is relieved, much like someone who is withdrawing from heroin. This has been called "addiction to trauma" (Van der Kolk & Greenberg, 1987).

If this cycle is in place, then it helps us to understand many of the perplexing symptoms that have been incomprehensible without this information. Stress-addicted children will be those children in the classroom who cannot tolerate a calm atmosphere but must keep antagonizing everyone else until the stress level is high enough for them to achieve some degree of internal equilibrium again. Violence is exciting and stressful and repeated violent acting-out, gang behavior, fighting, bullying, and many forms of criminal activity have the additional side effect of producing high levels of stress in people who have grown addicted to such risk-taking behavior. This also helps to explain self-mutilation in its many forms - these children and adults have learned that inflicting harm on the body will induce the release of endorphins that will provide some comfort, at least temporarily. These are children, who grow to be adults, unable to trust or be comforted by other people - in fact other people have been the fundamental source of the stress. Instead, they must fall back on whatever resources they can muster within themselves, resources that they can control, to achieve any kind of equilibrium. As adults, under stress, people who have been brutalized as children may again resort to behaviors that help induce some kind of alteration in the opioid system. These behaviors can include self-mutilation, risk-taking behavior, compulsive sexuality, involvement in violent activity, bingeing and purging, and of course,

drug addiction.

This recognition of the importance of addiction to trauma implies that intervention strategies must focus on helping people to "detox" from this behavioral form of addiction by providing environments that insist on the establishment and maintenance of safety. Physiological stability cannot be achieved as long as the person is on an emotional roller coaster of stimulus and response.

Trauma-Bonding

Even more ominous for repeatedly traumatized people is their pronounced tendency to use highly abnormal and dangerous relationships as their normative idea of what relationships are supposed to be (Herman, 1992; James, 1994). Trauma-bonding is a relationship based on terror and the twisting of normal attachment behavior into something perverse and cruel. People who are terrorized, whether as adult victims of torture, or domestic violence or child victims of family abuse, experience their abuser as being in total control of life and death. The perpetrator is the source of the pain and terror, but he is also the source of relief from that pain. He is the source of threat but he is also the source of hope.

This means that people who have been traumatized need to learn to create relationships that are not based on terror and the abuse of power, even though abusive power feels normal and right. In such cases, people often need direct relationship coaching and the direct experience of engaging in relationships that are not abusive and do not permit abusive and punitive behavior.

Traumatic Reenactment

It has long been recognized that "history repeats itself", but never before have we so clearly understood *why* history does so. People who have been traumatized cannot heal themselves alone. It is one of the tragedies of human existence, that what begin as life-saving coping skills, end up delivering us into the hands of compulsive repetition. We are destined to reenact what we cannot remember. Freud called it the *repetition compulsion* and he said, "*He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating... He cannot escape from this compulsion to repeat; and in the end we understand that this is his way of remembering.*" (Van der Kolk & Ducey , p. 271, 1989).

It has become clear that the very nature of traumatic information processing determines the reenactment behavior. We must assume that as human beings, we are meant to function at our maximum level of integration and that any barrier to this integration will produce some innate compensatory mechanism that allows us to overcome it. Splitting traumatic memories and feelings off into nonverbal images and sensations is life-saving in the short-term, but prevents full integration in the long-term.

Based on what we know about the split between verbal and nonverbal thought, it may be that the most useful way of understanding traumatic reenactment is through the language of drama. Shakespeare told us that the whole world is our stage, and with behavioral reenactments we see this in action. We reenact our past everywhere – at home, at school, at the workplace, on the playground, in the streets. We cue each other to play roles in our own personal dramas, secretly hoping that someone will give us a different script, a different outcome to the drama, depending on how damaging our experiences have been. The cure is in the disease.

The only way that the nonverbal brain can "speak" is through behavior, since it has no words. If we look at reenactment behavior we can see that traumatized people are trying to repeatedly "tell their story" in very overt, or highly disguised ways. If only we could still interpret nonverbal messages, perhaps we could respond more adequately to this " call for help". For healing to occur, we must give words and meaning to our overwhelming experiences. In "Macbeth", Shakespeare urges us to *"Give sorrow words; the grief that does not speak whispers the o'er fraught heart and bids it break".* But we cannot find the words by ourselves. That is the whole point - the traumatized person is cut off from language, deprived of the power of words, trapped in speechless terror.

We need the help, the words, the signals, of caring others, but to get their attention we must find some way to signal them about our distress in a language that has no words. This is the language of behavior, the language of the mime, of the stage. It is the language of symptoms, of pathology, of deviant behavior in all its forms. Unfortunately, we have largely lost the capacity for nonverbal interpretation, and so most of these "cries for help" fall on deaf ears. Instead, we judge, condemn, exclude and alienate the person who is behaving in an asocial, self-destructive, or antisocial way without hearing the meaning in the message. To counter these long standing habits, we need to develop systems of compassionate regard, translate the nonverbal message into a verbal understanding that can be shared, while still insisting on healthy change and behavior that is socialized, responsible, and nonviolent.

Trauma and the Body

Victims of chronic trauma, abuse and neglect often suffer from a multitude of physical disorders not directly related to whatever injuries they have suffered. There is now a science of stress-related disorders that details how stress impacts negatively on the body in a number of ways, producing short-term and long-term physical consequences (Sarno, 1998). A recent study by the Center for Disease Control (Felitti et al, 1998) surveyed almost 14,000 adults in a health maintenance organization, asking participants about their adverse childhood experiences divided into categories that included physical, sexual and emotional abuse, witnessing violence against one's mother, living as a child with a household member who was either imprisoned, mentally ill, suicidal, or a substance abuser. There was a direct relationship between the number of categories of adverse childhood experience and adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

Victim to Victimizer

When we understand the effects of trauma it is easier to grasp how someone could be victimized and turn away from the victim role and towards the victimizer role instead. A victim is both helpless and powerless, and as we have seen, helplessness is a noxious human experience. Human beings will do anything to avoid feeling powerless. If you have been victimized, one of the possible outcomes is to assume the power of the one who has hurt you by becoming someone who terrorizes and abuses others. Such behavior can reduce anxiety while providing a certain excitement and the combination of these two effects can become habit-forming. These

effects can also be profoundly culturally influenced. The traditional definition of masculinity does not allow for helplessness – you cannot be a victim and be masculine. In contrast, the traditional definition of femininity not only allows for but encourages, powerlessness and therefore the open possibility of victimization. It should come as no surprise, therefore, that more men would accommodate to the victimizer role and women the victim role (Real, 1997).

Issues of Meaning and Spirituality

As Ronnie Janoff-Bulman has shown (1992), the experience of trauma shatters - often irrevocably - some very basic assumptions about our world, our relationship to others, and our basic sense of identity and place in the world. A sense of meaning and purpose for being alive are shaken. Making sense out of violence, transcending its effects, and transforming the energy of violence into something powerfully good for oneself and the community describes what Judith Herman has called "a survivor mission" (1992). It is often a mission that encompasses the remainder of one's life. Confrontation with the spiritual, philosophical, and/or religious context – and conflicts – of human experience is impossible to avoid if recovery is to be assured.

Creating Sanctuary

Creating Sanctuary refers to the process involved in creating safe environments that promote healing and sustain human growth, learning, and health (Bloom, 1997). One fundamental attribute of Creating Sanctuary is changing the presenting question with which we verbally or implicitly confront another human being whose behavior we do not understand from *"What's wrong with you?"* to *"What's happened to you?"* Changing our position vis-à-vis other people in this way radically shifts our perspective on ourselves and others, moving us toward a position of compassion and understanding and away from blame and criticism. When people receive understanding from others it enables them to begin their way down the long road of understanding – and changing – themselves.

We have come to believe that in order to create safe, living-learning environments, any group of people must come to share the same basic assumptions, goals, and practice utilizing a shared language. A large part of the dilemmas currently facing us in all our communities is that we have not defined what – if anything – we share in common. We have not yet hammered out agreements, resolved conflicts, or untangled contradictions about even the most fundamental rules of how we are supposed to behave towards each other, what is allowed and what is forbidden. Without such basic structure, we cannot expect that our problem solving will be effective – it is set on too unstable a ground.

The first and most essential assumption must be the human need for safety. Our definition of safety, however includes not just physical safety, but psychological, social and moral safety as well. Psychological safety is the ability to be safe with oneself. Social safety is the ability to be safe in groups and with other people. Moral safety involves the maintenance of a value system that does not contradict itself and is consistent with healthy human development as well as physical, psychological and social safety. An environment cannot be truly safe unless all of these levels of safety are addressed. As we can see all around us, a focus on physical safety alone results in us living in an armed fortress, paranoid and alienated from others.

Safety involves not just prohibitions against violence to others but also prohibitions against the short and long forms of self-destruction, i.e. suicide and substance abuse. In a connected community, the violence you do to yourself and your own body also affects me. Violence is violence even if it takes the form of cutting one's own wrists, or abusing one's own body in other ways. Sexism, racism, poverty, homelessness, and hate speech can all be seen as forms of injustice and violence against the heart and soul of a people and a community. The real challenge is how to establish and maintain safety without invoking punitive, violent, and restrictive measures that add to the problem.

In the material above I have already drawn out some of the implications of trauma theory as they relate to what we now understand about the complex effects of trauma on the mind and body. We also assume that social influence is a powerful force in human organization and can be used for both positive and negative purposes. Any healthy human group will make an effort to maximize the positive aspects of social influence and group pressure and minimize the negative. Since every community organization must share assumptions, goals and practices, every group must make it a priority to create its own "constitution", establishing its mission, its goals, and the way it intends to go about achieving those goals. Since order and law is the basis of all civilization, a basic tenet of such a constitution must be nonviolence – and that tenet is not negotiable. No form of violence is acceptable, regardless of whether it is verbal, physical, sexual, social or economic. Violence must be viewed not as an individual problem, but a symptom of the breakdown of the social order and therefore a problem for the group. Therefore every act of violence must be analyzed, understood, and addressed as a problem of and for the entire community to resolve – nonviolently.

Bibliography

Alford, J. D., Mahone, C. and Fielstein, E. M. (1988). Cognitive and behavioral sequelae of combat: conceptualization and implications for treatment. Journal of Traumatic Stress, 1 (4), 489-501.

Bloom, SL (1996). Bridging the black hole of trauma: Victims, artists and society. Unpublished manuscript.

Bloom, SL (1997). Creating Sanctuary: Toward the Evolution of Sane Societies. New York: Routledge.

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine 14 (4):245-58.

Herman, J. L. (1992). Trauma and Recovery. New York: Basic Books.

James, B. (1994). Handbook for treatment of attachment-trauma problems in children. New York: Lexington Books.

Janis, I. L. (1982). Decision making under stress. In L. Goldberger & S. Breznitz (Eds.), Handbook Of Stress: Theoretical And Clinical Aspects (pp.69-87). New York: Free Press.

Janoff-Bulman, R. (1992). Shattered Assumptions: Towards a New Psychology of Trauma. New York: Free Press.

LeDoux, J. E. (1994). Emotion, memory, and the brain. Scientific American 270, 50-57.

Pennebaker, J. W. (1997b). Opening Up: The Healing Power of Expressing Emotions. New York: Guilford Press.

Perry, B. D. (1993). Neurodevelopment and the neurophysiology of trauma I: Conceptual considerations for clinical work with maltreated children. The Advisor: American Professional Society on the Abuse of Children, 6, 14-18.

Real, T. (1997). I Don't Want To Talk About It: Overcoming the Secret Legacy of Male Depression. New York: Simon and Schuster.

Sarno, J.E. (1998). The Mindbody Prescription: Healing the Body, Healing the Pain. New York: Warner Books.

Schwarz, E. D., & Perry, B. D. (1994). The post-traumatic response in children and adolescents. In D. A. Tomb (Ed.), Psychiatric Clinics of North America, Vol. 17, No. 2, Post-Traumatic Stress Disorder (pp. 311-326). Philadelphia: W. B. Saunders.

Seligman, M. E. P. (1992). Helplessness: on development, depression, and death. New York: W. H. Freeman.

Terr, L. (1990). Too Scared To Cry: Psychic Trauma in Childhood. New York: Harper & Row.

Van der Kolk, B. A. (1989). The compulsion to repeat the trauma: reenactment, revictimization, and masochism. Psychiatric Clinics Of North America, Vol. 12. Treatment of Victims of Sexual Abuse, (pp. 389-411). Philadelphia: W. B. Saunders.

Van der Kolk, B. A. (1996) Trauma and memory. In B. A. Van der Kolk, C. McFarlane & L. Weisaeth (Eds.), Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society. New York: Guilford Press.

Van der Kolk, B. A., & Ducey, C. P. (1989). The psychological processing of traumatic experience: Rorschach patterns in PTSD. Journal of Traumatic Stress, 2, 259-274.

Van der Kolk, B. A., & Greenberg, M. S. (1987). The psychobiology of the trauma response: Hyperarousal, constriction, and addiction to traumatic reexposure. In B. A. Van der Kolk (Ed.), Psychological trauma. (pp.63-88) Washington, DC: American Psychiatric Press.

Dr. Sandra L. Bloom, is a psychiatrist who specializes in the treatment of psychological trauma. She is currently CEO of CommunityWorks, a systems consulting firm and served as Founder and Executive Director of the Sanctuary programs from 1980-2001. She is a Past-President of the International Society for Traumatic Stress Studies and Past-President of the Philadelphia chapter of Physicians for Social Responsibility. She is the author of ***Creating Sanctuary: Toward the Evolution of Sane Societies****, and co-author of* ***Bearing Witness: Violence and Collective Responsibility.***