



Considering trauma and recovery

'We'll never be the same' Learning with children, parents and communities through ongoing political conflict and trauma: *a resource.* Rosie Burrows and Bríd Keenan



Barnardo's

NORTHERN IRELAND

GIVING CHILDREN BACK THEIR FUTURE

Contents

Considering trauma and recovery

Definitions: what is trauma?	03
Trauma and recovery	05
Working in groups	12
<i>(see also Considering groups and leadership)</i>	
Inter-generational trauma	13
Safety and leadership	21
Further information	22
Bibliography and websites	24



Definitions: what is trauma?

Definitions are necessary in order to name our experience and to know how to respond. However, standard definitions of post-traumatic stress disorder (PTSD),¹ and even more appropriate definitions of complex PTSD need to be held lightly for several reasons.

Each person needs to be met in his or her uniqueness, with symptoms as a symbol of adaptation and creative adjustment in the face of harsh circumstances, and not as a series of symptoms, deficits or personal weakness. They were not developed with our specific context in mind – a context of prolonged war and unresolved conflict. We are taking a social and not a medical approach, so that individual cure is not possible, as the individual is not sick. Instead, recovery from injury, integration of traumatic and other experience and, therefore, further growth is possible in the context of relative safety, personal choice and a more supportive environment.

Stress is a part of everyday life and helps us to feel alive. Too much stress, where we feel overwhelmed by the expectations of others (and ourselves), leads to a general sense of distress. Trauma is different: trauma is a severe shock that results in:

- a deep sense of being overwhelmed
- feelings of intense fear and terror
- helplessness
- loss of safety, loss of control and fear of annihilation.

When a person is in a life-threatening situation, the natural response is to be extremely alert and to forget about everything else in order to either fight or flee to get away from danger. When people cannot do either of these, they freeze.

Sometimes people may resolve and integrate their experience with the support of trusted others. Often they will not, and the trauma remains locked inside; this is called 'unresolved' trauma. The result of unresolved trauma is some or all of the aspects detailed below.

Hyperarousal, intrusion and interruption to everyday living:

- always on the alert
- disturbed sleep
- explosive behaviour
- flashbacks.

¹ See 'Further information' for definitions of post-traumatic stress disorder and complex traumatic stress disorder or syndrome.

- nightmares
- frozen, wordless memories, full of sensations and images
- going over and over what happened, trying to find a different ending
- risky, dangerous actions.

Disconnection / dissociation:

- going numb
- very calm, as if in slow motion, and a sense of being outside the body
- emotional detachment
- profound passivity, almost like a hypnotic trance.

A restricted life:

- not wanting to go out or going out less
- not being able to plan for the future
- feeling lifeless, without energy, sometimes more connected to the dead than the living.

Self-medication to kill the pain or fear through:

- drugs, alcohol, prescription medication, forgetting / amnesia or partial amnesia, and busying.

Trauma and recovery

Those models of trauma recovery support that focused on individuals or that were based on the impact of a single event or combat experience did not reflect the conditions of the programme.

Herman's model supported the work in a number of important ways:

- by introducing the idea of complex post-traumatic stress disorder (syndrome)
- through the model for trauma support based on safety, remembrance and mourning and reconnection
- by emphasising the central role of the community in trauma recovery
- by stressing the importance of the group in supporting recovery
- by highlighting the impact of the experience of the worker in the process
- by recognising that there is no recovery from traumatic experience in the sense of being restored to how a person was before the event occurred; the process of recovery is really one of integration
- through a political and social framework for understanding trauma and trauma recovery.

Remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims (Herman, 1992).



Herman argues that individual people do not experience trauma as a result of some inherent instability within themselves; for example, hysterical women, cowardly soldiers who develop symptoms to avoid combat, or children with wild imaginations. Rather at the level of society, she argues, some things are too terrible to be spoken about; they are unspeakable.

There is a powerful urge to deny these terrible events by straight denial, keeping secrets, threats, deflection, blaming the injured, self-imposed ignorance or the maintenance of social norms that isolate the injured. However, it is the conflict between the need to speak out and the need to deny that is central to the experience of trauma. Herman (1992) states: 'The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma.'

People need to say what happened to them and to have witnesses who give recognition to the terrible experience. However, often the fragmented, emotional and confusing way that traumatised people recall events undermines credibility. Their symptoms call attention to the terrible things that happened, and at the same time deflect the attention they desperately need.

Furthermore, those who witness the telling are also involved in the dialectic. It is often impossible to obtain a clear picture of events and experiences. In addition, because of the difficulty of finding a language to describe terrible events, compounded by the urge – at an individual and societal level – to deny them, witnesses risk losing credibility.

As with the victim, they risk being stigmatised and dismissed if they speak publicly. This enables the perpetrator and accomplices to remain unknown and unchallenged, and for bystanders to feel justified in their feelings of helplessness and disconnection, and for society as a whole to deny, repress and eventually forget events that affect the life of the community.

Where the traumatised person copes alone with the trauma through a range of actions, symptoms, distortions and painful adjustments, this is mirrored at the level of society that pathologises and isolates the individual and reorganises around the silence and secret. Herman (1992) states: 'In the absence of strong political movements for human rights, the active process of bearing witness inevitably gives way to the active process of forgetting. Repression, dissociation and denial are phenomena of social as well as individual consciousness.'

The implication for us as a society is to reappraise our responses to the individualising and pathologising of the presentation of trauma and to look at the emergence of the symptoms of trauma as information about how our society works. While providing understanding and therapeutic technique, such approaches decontextualise the individual from their social context.

As workers in the field of trauma, we need to begin to understand the presentation of trauma as a response in the individual to the events in the wider society and to look at the connections as well as the isolation inherent in responses to trauma.

Complex post-traumatic stress syndrome

We needed a model for working that would take account of the complexity of the experience of trauma in our context. Herman's model of complex post-traumatic stress offered a way in describing the immediate impact of the events and their continued outworking over time and through generations. 'The current formulation of post-traumatic stress disorder fails to capture... the protean symptomatic manifestations of prolonged, repeated trauma... Prolonged repeated trauma needs its own name. I propose to call it complex post-traumatic stress disorder.'

Herman argues that responses to trauma are best understood as a spectrum of conditions, the spectrum ranging from post-traumatic stress disorder to complex PTSD is contained in 'Further information'.

Three-stage model

Herman has a three-stage model for supporting trauma recovery:

- safety
- remembering and mourning
- reconnection.

These are not three discrete phases of recovery but rather aspects of the recovery process to be recognised and supported by the leader and the group members when evidence of their presence in the work emerges.

In our work with the groups, the issue of safety was ever present and was constantly being supported. We returned to the story of the events, identifying losses and developing individual and group versions of what happened. From an early stage, the process of reconnection was ongoing as an integral part of the work. Indeed the desire to reconnect was the impetus for some people to become part of the group.

Safety (feeling safe and protected)

Safety involves feeling safe and also feeling protected. Survivors need:

- to talk – which means that they need a language to describe what has happened – time, space, safety, protection and a witness
- to know that they are not alone
- to know that they are not crazy
- to understand that their responses are normal in abnormal circumstances
- to realise that recovery is possible as others have recovered
- to accept support as an act of courage and commitment to life and the future rather than as a sign of weakness (James, 1989).

It bears repeating that the survivor is free to examine aspects of her own personality or behaviour that rendered her vulnerable to exploitation only after it has been clearly established that the perpetrator alone is responsible for the crime (Herman, 1992).



A vital part of creating safety, which pre-echoes mourning and recovery, is for injured people to witness the events and to hear that there is no direct correlation between their actions and what happened to them. The responsibility for what happened rests with the other. They had a choice and took a decision regardless of how far out of awareness and reactive their choices and decisions appeared at the time.

In the experience of one group, this realisation had a profound effect in supporting the members to reposition themselves in relation to what had subsequently occurred.

PHYSICAL / BODY: Safety begins by focusing on control of the body and moves outwards towards the environment. Control of the body includes basic health needs, regulation of the bodily functions such as sleeping, eating and exercise, management of symptoms such as hyper-alertness and control of self-destructive behaviours including misuse of stimulants and drugs. Early on in the programme, we provided basic information.

ENVIRONMENT: The second aspect of safety is a safe environment and a safe living situation. As leaders, our job is to create a climate of protection at the level of organisation, interpersonal contact, individual support and programme content. This means considering all environments that make up the living space of the members – the group, the room in which the groups met, the larger building, the immediate external environment and the journey to the meeting. Coming from the other direction, the group members might bring issues of safety from further afield in the city and issues of safety in their own homes. All the safety issues were discussed in relation to supporting the children to feel safe.

Herman's model echoes the approach taken by Beverly James (1989) when she describes the need for children to regain mastery as part of the process of feeling safe and in control again. For James, people need to feel safe at every level and therefore have to regain their sense of being in control in four key ways.

PHYSICAL MASTERY: They need to feel in control of their environment and not controlled or restricted by their experience of trauma. They also need to regain control of their bodies and bodily function.

EMOTIONAL MASTERY: They need to explore all their emotional responses and in particular those that may culturally be seen as bad or wrong: revenge, hatred, despair, rage or fear as well as the more acceptable or softer emotions such as grief, longing, pity or compassion. Part of the impact of trauma on the emotional life is the destruction of attachments. Recovery strategies involve supporting the re-emergence of the range of normal interpersonal relationships.

COGNITIVE MASTERY: A traumatised person has a fragmented, contradictory memory of events, made more disturbing by the need to speak out and the shame of the trauma. In order to feel in control of the memory and personal experience of what happened, they need to be able to tell what happened and to build as complete a picture as possible. They need to find their own version of events even when that departs from the security of an official or group version.

VALUE / BELIEF SYSTEM: Trauma shakes a person's understanding of the purpose of existence or sense of justice and that there is a rational intrinsic order to the universe. They need to be supported to explore their loss of faith in their value system and to find ways of reconnecting and integrating their experience of trauma. The specific difficulty in working in this environment is that the situation is unresolved and for many people, including the members of these groups, various forms of attack continued even during the life of the groups.

When people talked of returning to normal, this was the normality of being within an environment of acclimatised or normalised levels of trauma – in other words the way things had been before this specific event that had been a peak in the already traumatising climate.

The reality of the general environment was that it was not safe. Creating a safe environment meant supporting the women to find levels of personal safety within the existing context and to rediscover that many things are dangerous but not everything is traumatising.

In developing sufficient safety to move deeper into an exploration of the events, the person will find a sense of predictability in her life and can rely more on others. She will not feel so completely isolated and will have a confidence in her ability to protect and care for herself and to deserve no less. Herman draws attention to the fact that people may be mistaken in thinking that by simply plunging into the graphic detail of the experience, a cathartic cure may occur that will remove the trauma once and for all. Herman (1992) states: 'The... desire for this kind of quick and magical cure is fuelled by images of early, cathartic treatments of traumatic syndromes which by now pervade popular culture as well as the much older religious metaphor of exorcism.'

Both of these deny the person's agency in her own recovery and repeat the feeling of helplessness. Although expertise is vital, Herman states that 'in the end it is the survivor who determines her recovery through her own actions'.

Remembering and mourning

When the truth is finally recognised, survivors can begin their recovery (Herman, 1992).



The work of reconstructing the story of the trauma transforms the traumatic memory so that the survivor can integrate it. Traumatic memory is wordless, frozen and static. The worker's role is to hear and bear the witnessing of the telling and retelling of the story. This takes courage on the part of all engaged in the work.

Providing a context for the actual trauma story is vital. Engaging in activities that tell the person's history up to the time of the events gives a sense of the continuity and a context for understanding what happened.

The next step is to tell the story of the trauma and to encourage the person to bring him or herself gradually into the story. At each point of the story the person can also say what he / she felt. In the process of this work the traumatised person also begins to seek answers to 'why?' and 'why me?' Here he / she will explore the dialectic of culpability and innocence, vulnerability and influence as outlined in the work of Philip Lichtenberg.

The worker must stand in solidarity with the person's struggle. The worker contributes to a new interpretation of events that affirms the dignity of the teller. Herman states: 'The fundamental premise... is a belief in the restorative power of truth telling... Testimony has both a private dimension which is confessional and spiritual and a public aspect which is political and judicial.'

The mourning part of this stage is vital and as mourning is so difficult, it often emerges as 'a fantasy of a magical solution usually through revenge, forgiveness or compensation' (Herman, 1992). The revenge fantasy is a mirror image of the trauma in which the victim becomes the perpetrator and the person imagines that she can restore her power in this way. Paradoxically, revenge fantasies arouse horror and loss of self-image and exacerbate the feelings experienced during the traumatic event. Nonetheless, it is important that these be explored in order to support the person to handle the feeling of revenge and understand its role in mourning. Similarly, fantasies that involve 'a willed act of love' may also contribute to the loss of self-image as such acts are beyond the reach of most human beings. It may deflect self-empowerment away from what is possible.

The process of mourning is the only way to truly honour what has been lost. So it is important that the person learns how to mourn and to recognise mourning. The injured person may also seek compensation and, being unable to obtain this from the perpetrator, may seek it from society – the bystanders. Again, the danger is that this, if prolonged, may be a defence against the pain of loss and the act of mourning.

One of the impacts of trauma is that the person may feel more connection with the dead than the living and may think about suicide. Here the smallest evidence of the ability to form a loving connection may sustain the person through the worst stages of despair. Soothing imagery, a supportive or loving memory and an opportunity for compassion all support the feeling that it is possible to form attachments again and begin the journey towards self-compassion.

When the retelling of the story begins to lose its intense feelings, it has begun to be integrated into memory, like other memories. Gradually the person begins to see other parts of her life as more interesting than the trauma story and lifts her focus to the wider environment.

Throughout life there will be new challenges, and at each new stage, the events will reawaken differently. However, the person now can draw upon the experience, putting the new and the old together and move through to the future.

Reconnection



Helplessness and isolation are the core experiences of psychological trauma. Empowerment and reconnection are the core experiences of recovery (Herman, 1992).

In the third stage of recovery, the traumatised person recognises that she has been a victim and is ready to bring these experiences into her life and to use what she has learned. One of the first realisations is that not all danger is overwhelming and not all fear is terror. Gradually she can begin to appraise concretely life's daily occurrences and develop a way of not being overwhelmed by fear or pretending that the world is utterly safe.

Having the experience of trauma changes the person and her relationships and during this phase the person may need help to renegotiate how she now is in these relationships. This comes with the recognition and acceptance that no one can be restored to how they were before the trauma, and this is who they are now in the world. Herman states: 'Compassion and respect for the traumatised, victim self join with a celebration of the survivor self.'

Appreciation of the self takes the place of the grandiose feeling of being special, which victimised people sometimes feel and that goes with distance and isolation. Reconnecting is reconnecting with ordinariness and the sense of being like others. Herman views recovery as happening when:

- the physiological symptoms of post-traumatic stress disorder have been brought within manageable limits
- the person is able to bear the feelings associated with traumatic memories
- the person has authority over her memories
- the memory of the traumatic event is a coherent narrative, linked with feeling
- damaged self-esteem has been restored
- important relationships have been re-established
- the person has reconstructed a coherent system of meaning and belief that encompasses the story of the trauma.

In practice, all of these issues are interconnected, and all are addressed at every stage of recovery. The course of recovery does not follow a simple progression but often detours and doubles back, reviewing issues that have already been addressed many times in order to deepen and expand the survivor's integration of the meaning of her experience (Herman, 1992).

Community and trauma recovery

The role of the community is vital in trauma recovery and is a central theme of Herman's model.

To hold traumatic reality in consciousness requires a social context that affirms and protects the victim and joins victim and witness in a common alliance. For the individual victim, this social context is created by relationships with friends, lovers and family... For the larger society, the social context is created by political movements that give voice to the disempowered (Herman, 1992).



The acknowledgement by the community of terrible events is vital in supporting the injured person to feel safe, to mourn and to reconnect with the present. A central issue for both groups is either feeling abandoned by the wider community and / or rejected by their own.

There was certainly a sense in which the community as a whole needed to acknowledge the horror of the events and to recognise their connection with the women and their families and the whole of society. In this sense, the traumatised person carried the manifestation of what is happening in the field of wider society.

A vital component of the community involvement is addressed to some extent by Herman, but more so by Bloom in her reference to trauma-bonding; it was the inter-generational aspect of the continuation of trauma effects

within families and communities. Not only is the community present in the experience of the individual, but historical and inter-generational aspects are also present. One group had grandmothers who lived the early part of their lives before the onset of the conflict and who now expected little to change. Both groups contained those who had been born into the conflict, and this event was the most recent and personally experienced of the entire ongoing trauma. Furthermore, it was reported that earlier traumas experienced by other family members were reawakened with the current events and had led to mental and physical deterioration in some cases.

The work with individuals as members of communities needs to hold in awareness the role that the individual plays on behalf of the community and to support the exploration of this relationship.

Working in groups

Working in groups is an important way of exploring the relationship between the individual and community. From our training we were aware of the power of the group in relation to women speaking out and also because of the importance of reconnecting with family, friends and community – the practising of being in the community of the group. Herman states: 'The restoration of social bonds begins with the discovery that one is not alone. Nowhere is this experience more immediate, powerful or convincing than in a group... because traumatised people feel so alienated by their experience, survivor groups have a special place in the recovery process.'

Group acceptance encourages self-esteem and each member also becomes more accepting of the others. For individual survivors it is recommended to wait some months before joining a group and to initially take the support of family or friends or individual work. However, given the political context of many years of conflict and traumatic experience, this may be less relevant. Herman describes three types of groups in trauma recovery processes linked to the three stages of recovery of safety, remembering and reconnecting (see *Considering groups and leadership*).

Inter-generational trauma

In the past, multigenerational transmission [of trauma] has been treated as a secondary phenomenon, perhaps because it is not as obviously dramatic as the horrific images of traumatised people. The mind recoils when viewing such images; and it does not take in that children not yet born could inherit a legacy and memories not of their own but that, nevertheless, will shape their lives. It is bad enough to see images of children victimised today; that the same images may shape the lives of generations to come, sometimes unconsciously, often by design, is even harder to comprehend, and accept (Danieli, 1998).



When we began talking about the possibility of working with parents we were interested in what we, as adults, were teaching (transmitting / passing to) our children, as a result of our growing up in the midst of armed conflict.

The 1994 ceasefires had produced a different environment and space for people to reflect on the effects of the preceding thirty years (and for some, longer). There was a sense for many people of having survived. At the same time, there was a coming-to-terms with the fact that many had not survived, or had done so with physical and psychological injuries.

As adults, we were slow to adjust to this new situation and concerned about what was happening with the children and how parents were handling this situation with their children. Certainly the dangers had not disappeared. However, there was a greatly reduced need for most people to behave as if at any moment a life-threatening situation could develop. What was intruding from the previous ways of living that was no longer needed in the new situation?

The recognition that people had survived was important, had coped with daily life and in some cases transformed the experience of trauma through art and culture, community responses and activities. People were both resilient and malleable, therefore, pathologising² individual people, families and communities did not recognise this resilience, a powerful resource for recovery.

At the same time there was an alarming increase in suicide among young people; car theft and other forms of serious risk-taking seemed to be increasing among a younger age group. Many of the ways of coping with traumatised living – heavy use of alcohol, prescription and over-the-counter drugs – were still prevalent.

The growth of interest in and provision of early years environments outside the family seemed to be directing social attention towards the importance of early years development. We wanted to know how the traumatic experiences of this specific context were moving from one generation and appearing in the next through the parent / child relationships, family and extended family structures and in and between communities, and to know what parents needed to support themselves and their families.

² Pathologising stems from a medical approach focusing on the individual as sick and in need of a cure. A primarily individualistic medical culture may work

against recovery and 'resilience', and maximise the dynamics of victimisation (see *Considering victims and workers*).

What is inter-generational trauma?

Inter-generational trauma describes the emergence in subsequent generations of the unresolved traumas of previous generations, in other words, the way that children experience the traumas of their parents, grandparents and other relatives. We often hear about the effects of directly experienced trauma and of the impact on witnesses. Research also shows the impact of secondary trauma experienced by the support services working with people in the aftermath of life-threatening events.

What is less understood is the way in which children are exposed to the traumatic experiences of their parents, experiences that could have occurred before they were born. There is cause for concern when this happens in one family. However, we each live in relationship, and the experiences of one impacts on the life of the other(s). Where there is war or armed conflict, the community in which the child lives has also experienced trauma and therefore the 'life space' of the child is structured in trauma. Furthermore, what the child learns to expect, and indeed meets, are trauma-related ways of living, and these form the developmental experiences of the child.

A brief recap on the impact of trauma

Trauma overwhelms the person beyond the capacity to cope. Where the natural responses of fight and flight are not possible, freezing is the only other defensive action available. Disconnection or dissociation follow. Some life energy is lost in this process as the person becomes stuck in time. They lose connection to a part of themselves and therefore a sense of self-continuity is lost (Levine and Heller, 2003).

However, dissociation or disconnection are not pathology. Rather they form 'the life-saving capacity to help deal with situations which were at that time beyond their capacity to survive' (Levine and Heller, 2003). The range of resilience (the capacity to cope with and to re-engage in the events of living) is circumscribed by the effects of the trauma.

Resilience is influenced by:

- genetic capacity (the capacity to develop our abilities that is genetically encoded)
- attachment experiences in infancy, childhood and adolescence (our sense of security and self-worth and value in the world)
- inter-generational trauma (Hellinger, 1999)
- the experience of other traumas and, vitally, how we have handled previous traumas (Levine and Heller, 2003)
- how parents and the wider community respond.

Supporting resilience in this context, therefore, means supporting individuals, families and communities to integrate and transform their traumatic experiences, and to resource themselves to live more satisfactorily in the aftermath of political conflict.

In order to develop resources, people need to feel safe, to remember and mourn and to reconnect with life (Herman, 1992) and also to develop cognitive, emotional, physical mastery and to reconnect with their belief / value system (James, 1996).

The inter-generational perspective highlights how trauma is repeated in the patterns of family and community life and may help to explain certain behaviour patterns, values and ways of being adopted by family members, the family as a group and the community as a whole (Danieli, 1998). These would include both the sources of vulnerability that remain present through the generations as a result of unresolved trauma as well as the resilience and strength that develop.

All those who inhabit the environment of the child need to be aware of how children are (a) developmentally affected by trauma and (b) the mechanisms by which inter-generational trauma moves through and emerges in subsequent generations. Paying attention to the indicators of unresolved trauma needs to be part of our everyday relationships with children. Danieli states: 'Intergenerational trauma is not yet officially recognized as victimization-related pathology... Until it is... the behaviour of some children of survivors may be misdiagnosed, its etiology misunderstood, and its treatment, at best, incomplete.'

Much of the initial research on inter-generational trauma was carried out in relation to the children of Jewish survivors of Nazi persecution and more recently the families of US veterans of the Vietnam war. The work and research has now begun to widen out to look at other forms of conflict such as civil war (Rwanda), and the former Yugoslavia.

Significant work is being done with German and Jewish Israeli children and young people. Understanding the impact of colonisation is in the very early stages (in relation to the first peoples in North America, to Aboriginal peoples in Australia and the Maori peoples in New Zealand). There appears to be a need to consider other children of colonial wars including Palestinian and Vietnamese children.

At present, there does not appear to be any large-scale government-initiated research to identify how inter-generational trauma is currently appearing in the population of this region or how it may appear in the future, information which would support an effective strategic intervention.

How does inter-generational trauma happen?

Inter-generational trauma happens primarily through the processes of:



re-enactment and mimesis
the family, attachment, memory and the mind
wider social structures and culture.

Re-enactment of traumatic events at the level of the family and community creates the general context (the subsoil) for inter-generational trauma to emerge. The process of attachment seems to be the main mechanism that makes it possible for trauma to travel through the generations. Social structures that develop and represent the experience of traumatic events also help to freeze and fix the experience and thus support the development of a culture of trauma. What follows is a description of how trauma travels beyond the person.

Re-enactment

Re-enactment occurs when those who have been exposed to trauma have not had the opportunity to integrate the experience. Integration of experiences is a vital aspect of the development of human beings. Any barrier to integration will produce some 'innate compensatory mechanism that allows us to overcome it' (Bloom, 1997).

People who have had traumatic experiences sometimes re-enact these events overtly but more usually do so in a disguised and highly symbolised way which can come to dominate a person's entire life, often out of their awareness. The integration process may not happen for a number of reasons.

- The event is experienced at every level of being, from the central nervous system to cognition, and needs to be addressed at every level, not just the cognitive. Knowing the story of the event does not necessarily support the resolution of the trauma frozen in the central nervous system (Levine, 1997).
- Memories of the event(s) are not necessarily the coherent, linear story of explicit memory as outlined in 'Considering the model' (pages 57–77) (Siegel, 1999) and therefore may leave a person feeling that they cannot tell the story or if they try to do so, they become more frightened and frustrated.
- Splitting traumatic memories and feelings off into non-verbal images and sensations (dissociation) is life-saving in the short term but prevents full integration in the long term. Because we are human, we have a need to convert our overwhelming experiences into meaningful words.

Over and over, people find themselves in situations that reinvolve their earlier trauma either because they lack awareness or a clear memory about the event or because they do not know how to prevent it from happening again. Consequently, as the rational part of their mind struggles to make sense of the situation, they will try to find an explanation for their behaviour (Bloom, 1997): 'But without access to the dissociated material, the rational mind flounders helplessly, interpreting behavior in a simplistic... way while the person helplessly re-exposes himself or herself to further trauma.' In addition, people feel compelled to repeat the trauma even when they know it is wrong or harmful to do so. They are seeking a resolution of the trauma and the unfinished (unintegrated) experience is trying to find expression.

Mimesis

Mimesis is 'the ability to produce conscious, self-initiated representational acts that are intentional but not linguistic' (Donald, 1991) and is how traumatised people re-enact or represent an event or relationship. These acts are both repetitive and ritualised in an attempt to gain recognition from the social group (Bloom, 1997).

Mimesis is also clearly a part of cultural life where rituals and symbols, art and music are ways of representing our experiences without language and can be seen as an expression of resilience as well as the restrictive effects of trauma. The dialectic of trauma (the pressure to deny and to speak out) is experienced at the level of the individual as well as the family and the wider community.

In our context we need to consider how the non-verbalised dissociated residue of trauma is expressed at all levels. Therefore, it is necessary, in the light of this, to reconsider aspects of our social and family life such as joyriding, suicide, child neglect, alcoholism and substance abuse, and attention and concentration difficulties in young children and adults. Equally we need to reconsider social withdrawal and forgetting or creating narratives about events as if they are truth. Appreciating our resilience in the expression of art, cultural creativity, community structures and cohesion is vital if we are to support empowerment and resilience at all levels.

The family

Each traumatised generation has done its best to guarantee minimum survival. The intergenerational problems begin when the emergency measures that have been activated to protect family survival operate long past the time when they are necessary. Separated from their original purposes, these emergency measures become family styles of interacting, family belief systems that rapidly become impermeable to change (Bloom, 1997).



Where the family has sought to 'forget' the experience of trauma in the interests of family survival, it becomes very difficult to 'open up old wounds' and yet this is the only way that the family can heal. Bloom states: 'By ignoring traumatic affect and memory, we do not make it disappear.'

The process of not talking about or not remembering the event within the family means that the felt experience of the event gets passed on to the next generation without a cognitive, verbalised framework to make sense of their experiences of the world (Bloom, 1997). In addition, the power of emotion between parents and children is underestimated as a means of conveying experience. The result is that the emotional and psychological responses developed in the initial generation are passed on, leaving the next generation unable to make sense of their feelings or place them in context. Bloom states: 'Emotion gets conveyed to the people we are close to in an inevitable and uncontrolled way if we do not take responsibility for it and talk about what we feel.'

Therefore, when the children and grandchildren act out or re-enact the traumas of previous generations, the child is often seen as having a problem, and we want to find ways to help the child. To see the child's actions as part of an inter-generational response to the experience of trauma would lead to the necessary exploration of unresolved and painful experiences. It is the responsibility of the current generation to work with the unresolved traumas of the past to ensure a firmer ground of support for the next. By helping themselves, adults in one generation support a secure relationship with not only their own children but their children's children.

Attachment, memory and the mind

Siegel (1999) states: 'Attachment at its core is based on parental sensitivity and responsivity to the child's signals, which allow for collaborative parent-child communication.' The process of attachment has been identified as a major way in which children experience the trauma of the parent (Bloom, 1997). Where trauma is unresolved for the parent, the dissociation giving rise to re-enactment is present in and structures the relationship between the infant and the parent.

Children initially learn about the world and relationships with others through the process of attachment with the parent. It is in this relationship that the child develops a sense of self-worth and self-esteem through the experience of being loved. Attachment is 'an inborn system in the brain' (Siegel, 1999). The region of the brain most central to attachment, the right orbitofrontal region, also serves 'the vital integrative function of coordinating social communication, empathic attunement, emotional regulation, registration of bodily state, stimulus appraisal (the establishment of value and meaning of representations), and autoegetic consciousness'³ (Siegel, 1999).

Attachment provides the framework for adaptation to life's experiences.

- It motivates the child to seek proximity to parents and establish communication. In a basic evolutionary sense, this increases the possibility of survival.
- It allows the child to use the mature functioning of the adult brain to support the development of the immature brain. In other words, the child relies on the adult's experiences to support him / her to make sense of the world. This relates both to the meaning a child makes out of its experiences and also the physical development of the brain.
- It encourages the organisation of an emotional framework needed by the child to engage in relationships throughout life. Secure attachment, involving a parent's emotionally sensitive responses, amplifies the child's positive emotional states and modulates the negative states by soothing the child and giving him / her a safe place to be when they are upset. Repeated experience becomes encoded in the brain as expectation and helps the child to develop a secure base in the world (Siegel, 1999).

This secure base includes a sense of self-worth, of being loved and so being capable of loving. Caregivers are the 'architects' (Siegel, 1999) of the way in which the brain develops in the relationship between genetic predisposition and social experience. A significant aspect of the process of attachment in this regard is the parents' own experiences of attachment to their parents as well as their own experiences of trauma.

Recent research on parents' attitudes to attachment has been carried out through the Adult Attachment Interview. Where adults have had a positive attachment experience with their own parents, they are more likely to value the experience with their own children, and so promote 'emotional well being, social competence, cognitive functioning and resilience in the face of adversity... even in the face of trauma and loss' (Siegel, 1999).

Where the adult has had insecure attachments, it follows that in their relationships with their children there is a greater risk of rigidity, uncertainty or disorganisation and disorientation. Where there is unresolved trauma or grief, parents may behave in a fear-inducing way with their children (difficulty in regulating their own emotions

3 Autoegetic consciousness relies on self-knowing and allows the mind to 'mental time travel', that is, have a sense of recollection of the self at a particular time in the past,

awareness of the self in the present and project the self into the imagined future (Siegel, 1999).

or those of their children, intrusive memories, and confusion and internal conflict [Siegel, 1999]). Therefore, the children may develop 'a marked inability to regulate emotional responses and the flow of states of mind establishing a tendency towards dissociation, disruptive behaviours, impairments in attention and cognition and compromised coping capacities as well as a vulnerability towards post-traumatic stress disorder' (Siegel, 1999).

In the context of situations such as community violence, children may develop an understanding of the world as a hostile place, not just currently but in the future. As a consequence:

Significant figures such as children's caregivers may come to be viewed as incapable of keeping children safe from the dangers present in their environment. Likewise, children may feel that they are not worthy of being kept safe. If such beliefs persist, then they may contribute to the development of insecure relationships with caregivers among children who live in threatening and violent environments (Lynch and Cicchetti, 1998, in Siegel, 1999).



Recent developments in neuroscience have increased our understanding of the attachment process by extending our understanding of the nature and function of memory ('how these early reciprocal communication experiences are remembered and how they allow a child's brain to develop a balanced capacity to regulate emotions, to feel connected to other people, to establish an autobiographical story, and to move out into the world with a sense of vitality' [Siegel, 1999]).

Memory

Memory can be understood as implicit or explicit memory.

Implicit memory relies on brain structures already intact at birth. With repeated experiences the infant's brain is able to detect similarities and difference across experiences, thus enabling generalised representations of their experiences in the world to be made. These help us to interpret present experiences and anticipate future ones that help us to develop 'readiness to respond' (Siegel, 1999).

Implicit memory does not need a conscious effort either to encode or retrieve our experiences. This type of memory is held in the part of the brain that has to do with behaviours, emotions and images. Therefore, they are memories that mean that the child can act, feel and imagine without recognition of the influence of past experiences on our present reality. Siegel (1999) states:

By a child's first birthday, these repeated patterns of implicit learning are deeply encoded in the brain. By eighteen months, the maturation of various parts of the child's brain has allowed for the blossoming of her comprehension and expression of language. At about this time, frontal parts of the brain are developing rapidly and enable her to have evocative memory, in which it is believed she is able to bring forward in her mind a sensory image of a parent in order to help soothe herself and regulate her emotional state.



As the ability to use language develops, the child begins to experience other forms of memory. Explicit memory is a form of memory requiring conscious awareness for encoding and having the sense of recollection. With that comes factual recall, autobiographical and episodic memory (the child's sense of himself / herself over time).

By the age of two children can talk about their day and remember more distant experiences from the past. By three years of age, children and caregivers begin to weave mutual stories of their experiences together. The type of attachment experiences affects the child's ability to place themselves in different memories of the past and supports the development of self-cohesiveness and continuity. This is of vital importance in supporting the resilience in the child and the ability to engage with the world. When the parents' unresolved traumas are present in this early child / parent relationship, the child stores the experiences in implicit memory through its emotional experiences, the behaviour patterns of the relationship and images (Siegel, 1999).

This is clearly significant if we are to try to understand how inter-generational trauma affects the development of the brain itself and the relationship between this, the child's sense of self in the world and the capacity to develop into adulthood. Consequently, there are implications for strategic planning both in respect of the transition to peace and in the longer term of post-conflict development.

Social structures

Just as unresolved trauma forms patterns of relationships and ways of living within individuals and families, it also emerges at the level of the community and the society as a whole. The process of re-enactment structures the ground on which the family and the individuals develop.

Where unresolved trauma is re-enacted at the community or societal level, the structures of social organisation will reflect this. This can be seen in:

- the cultural organisation of the community (that is, what is spoken about and not spoken about, celebrated or denigrated, and how our intimate relationships are formed and maintained); the dialectic of trauma – denial and speaking out as well as the dissociation and the symbolic acting out of unresolved trauma – becomes part of the cultural representation of our lives
- the official level of societal organisation – that is, how victimhood and trauma are defined and given official recognition as well as patterns of response by the authorities (speaking / acting on behalf of the victim or blaming the victim for their experiences) and resourcing the needs of those who have been traumatised.

The interconnected and relational experiences of the individual, the family and the community provide us with the pathways of reconnection so vital in the aftermath of trauma. Certainly, working with one part of the system will affect all the other parts. However, there is an urgency in relation to organised and structured intervention which will have the greatest impact that needs to be embedded into our structures of living if we are to ensure a future environment for the healthy growth and development of children.

Safety and leadership

Honouring and learning from the past is the only way of guaranteeing safety in the present and ensuring that we have a future (Bloom, 1997).



Sandra Bloom (1997) has built on the work of Herman (1992) and others to provide an analysis of trauma as fundamentally a social and political issue which requires individual, community and societal solutions. Her work summarises over twenty years of research into post-traumatic stress. It provides a wake-up call, a call to action as she elaborates on the importance of the following.

- An integrative theoretical framework to enable us to even perceive certain information and experiences as well as to make sense of them. This integrative framework is necessary because trauma itself has such profound effects. Otherwise, major traumatic experience is forgotten, and the past is repeated, that is, unresolved traumatic experience is re-created in other relationships out of awareness, as trauma is literally physiologically hardwired or imprinted in the mind and body. 'Putting the past behind' is therefore impossible, and many situations may then trigger an emergency response. Her definition of 'traumatic re-enactment' has been used and applied in this text.
- An emphasis on the social and political context and on collective responsibility: Bloom explores the connections between the individual experience of the child and the wider society. She makes the case for a systemic approach requiring change at all levels in order to create safety, as part of the total traumatising process actually comes from social and institutional reactions towards those traumatised.

In the first three chapters of *Creating sanctuary*, she outlines research on what traumatic experience does to the body, mind and relationships, on children, attachments and the trans-generational transmission of trauma.

In chapter 4, she describes how her work and that of her colleagues changed as a result of what she and others learned about psychiatric disorder, which she argues is the 'failure of social systems to provide traumatised children with the protection and care to which they have a right'. The degree of health in our social systems is a critical factor, yet these same systems also resist change, so we require an understanding of how complex systems function. Finally, she calls for a paradigm shift, a 'new way of viewing the world that is far more personally demanding than the old'. This new way requires speaking out against tyranny in all its forms and reconnecting to each other and the natural world.

Leadership

Finally, the function of leadership is seen as critical in creating situations that promote learning as widely as possible. Those working with victims of trauma, who are responsible for co-creating safe enough settings, also need to have places in which to experience safety. These places need to nourish and sustain us, settings in which we can feel:

safe, cared for, trusted, free to express our deepest thoughts and feelings without censure, unafraid of being abandoned or misjudged, unfettered by the constant pressure of interpersonal competition, and yet stimulated to be thoughtful, solve problems, be creative, and be spontaneous... this is the kind of setting that human beings need to maximise their emotional and intellectual functioning in an integrated way (Bloom, 1997).



Further information

Post-traumatic stress disorder

The diagnostic criteria for post-traumatic stress disorder is defined in Diagnostic and Statistical Manual-IV as follows.

The person experiences a traumatic event in which both of the following were present:

the person experienced or witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

the person's response involved intense fear, helplessness, or horror.

The traumatic event is persistently re-experienced beyond three to six months in any of the following ways:

recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions

recurrent distressing dreams of the event

acting or feeling as if the traumatic event were recurring (for example, reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those on waking or when intoxicated)

intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

Complex post-traumatic stress disorder

The focus of PTSD is a single life-threatening event or threat to integrity. Where the symptoms are the result of a series of events, the term complex 'PTSD' (formerly referred to unofficially as 'prolonged duress stress disorder' or PDSO) may be more appropriate. It seems that complex PTSD can potentially arise from traumatic events and prolonged periods in which certain factors are present, which may include a sense of captivity, lack of means of escape, entrapment, repeated violation of boundaries, betrayal, rejection, bewilderment, confusion and, crucially, lack of control, loss of control and disempowerment. It is the overwhelming nature of the events that leads to the development of complex PTSD.

Alterations affect regulation, including:

persistent dysphoria (a state of anxiety, dissatisfaction, restlessness or fidgeting)

chronic suicidal preoccupation

self-injury

explosive or extremely inhibited anger (may alternate)

compulsive or extremely inhibited sexuality (may alternate).

Alterations in consciousness, including:

amnesia or hyperamnesia for traumatic events

transient dissociative episodes

depersonalisation / derealisation (depersonalisation: an alteration in the perception or experience of the self so that the usual sense of one's own reality is temporarily lost or changed; derealisation: an alteration in the perception of one's surroundings so that a sense of the reality of the external world is lost)

reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation.

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by at least three of:

- efforts to avoid thoughts, feelings or conversations associated with the trauma
- efforts to avoid activities, places or people that arouse recollections of this trauma
- inability to recall an important aspect of the trauma
- markedly diminished interest or participation in significant activities
- feeling of detachment or estrangement from others
- restricted range of affect (for example, unable to have loving feelings)
- sense of a foreshortened future (for example, does not expect to have a career, marriage, children or a normal life span).

Alterations in self-perception, including:

- sense of helplessness or paralysis of initiative
- shame, guilt and self-blame
- sense of defilement or stigma
- sense of complete difference from others (may include sense of Specialness, utter aloneness, belief no other person can understand, or non-human identity).

Persistent symptoms of increased arousal (not present before the trauma) as indicated by at least two of the following:

- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hyper-vigilance
- exaggerated startle response.

Alterations in perception of perpetrator, including:

- preoccupation with relationship with perpetrator (includes preoccupation with revenge)
- unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
- idealisation or paradoxical gratitude
- sense of special or supernatural relationship
- acceptance of belief system or rationalisations of perpetrator.

The symptoms last for more than three months.

Alterations in relations with others, including:

- isolation and withdrawal
- disruption in intimate relationships
- repeated search for rescuer (may alternate with isolation and withdrawal)
- persistent distrust
- repeated failures of self-protection.

The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Alterations in systems of meaning:

- loss of sustaining faith
- sense of hopelessness and despair.

Bibliography

Bloom, S (1997) *Creating sanctuary: toward the evolution of sane societies*. Routledge, New York and London.

Donald, M (1991) *Origins of the modern mind: three stages in the evolution of culture and cognition*. Harvard University Press, Cambridge, Massachusetts.

Family Trauma Centre – leaflets on trauma. Available from Family Trauma Centre (Tel. 028 9020 4700).

Hellinger, B (1999) *Acknowledging what is: conversations with Bert Hellinger*. Zeig, Tucker and Theisen, Phoenix, Arizona.

Herman, JL (1992) *Trauma and recovery: from domestic abuse to political terror*. Pandora, London.

James, B (1989) *Treating traumatised children: new insights and creative interventions*. Free Press, New York.

Levine, P (1997) *Waking the tiger: healing trauma – the innate capacity to transform overwhelming experiences*. North Atlantic Books, Berkeley.

Levine, P, Heller, D (2003) *Somatic experiencing: an introductory course handbook*. (see www.traumahealing.com).

NOVA project – leaflets on trauma. Available from Barnardo's NOVA project (Tel. 028 3833 5173).

Siegel, DJ (1999) *The developing mind: toward a neurobiology of interpersonal experience*. Guilford Press, New York.

TAP project – information leaflets for adults and parents / carers on traumatic grief in children, adults, parent information, schools, et cetera. Available from the Eastern Health and Social Services Board Trauma Advisory Panel, Belfast.

Wider Circle – booklets on trauma and anxiety. Available from the Wider Circle (Tel. 028 9045 6654).

Websites

www.berthellinger.com

www.sanctuaryweb.com

Creating sanctuary information

www.trauma-pages.com

International trauma information

www.traumahealing.com

Trauma healing

