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From Trauma to Transformation

Foreword by Daniel Araoz, EdD

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INTRODUCTION

America may never be the same. Before 9/11, wars had always been fought on foreign soil, never here at home. But all of that changed with the collapse of the World Trade Center on September 11, 2001. We are at war against terrorism by fanatics within our borders as well as throughout the world. It is virtually impossible to predict and prevent every possible terrorist attack, even in our own backyard. As a result, we must learn to live under the constant threat of disaster.

That threat can give rise to emotions ranging from mild anxiety to sheer terror. Most people (Bracken, 2002) manage to "push it aside to get ready for the hustle and bustle of our everyday lives", (pp. 1–2). However, some people just can't shed the anxiety and must live out their lives with a constant feeling of dread. Their lives are not shaped by a taken-for-granted order, but are endlessly threatened by the quicksand of meaninglessness.

No one escapes a disaster without some degree of impairment that flows like a wave over the family, work group, and the community. In its wake, it leaves the seeds of severe and debilitating physical and psychological disorders. In reaction to the emotional shock wave that spread from Ground Zero, many people slipped into altered states of consciousness. Hospital emergency rooms were jammed with frightened people suffering from a variety of somatic reactions. My physician tells me that later, after the first signs of the biochemical attack, patients were begging him for antibiotics in case of anthrax exposure. A male patient I treated for depression and suicidal ideations is still, to this day, hoarding medication to combat anthrax.

One of the most difficult problems of disaster is dealing with the death of a loved one. Jozefowski (1999), outlines the stages of coping with death in her book, *The Phoenix Phenomenon*. "The death of a loved one," she explains, "forever changes the normal flow and rhythm of life, dividing it into before and after" (p. 15). In this sense, 9/11 has changed the normal flow of life in the world.

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CHANGE AND THE PROCESS OF HEALING

CHANGE AND ANXIETY

Change is being forced on us, and the human psyche's protective response is to fight to avoid the anxiety that always accompanies change. Paraphrasing Kierkegaard, Becker (1974) points out that:

> Man [is] lulled by the daily routines of his society, content with the satisfactions that it [life] offers him. In today's world, the car, the shopping center, the two-week summer vacation. Man is protected by the secure and limited alternatives his society offers him, and if he does not look up from his path, he can live out his life in a certain dull security (p. 74).

For Kierkegaard, there were three kinds of people: "Normal" man (or woman), who lives a life of quiet desperation to avoid or deny death anxiety; "Schizophrenic" man, who is crazy; and "Creative" man, who lives in a garden of anxiety. Becker explains, "As long as man is an ambiguous creature, he can never banish anxiety. What he can do instead is to use anxiety as an internal spring for growth into new dimensions of thought and trust" (p. 92).

The years since the 2001 terrorist attacks have presented us with new challenges. Man can no longer be lulled into a life of quiet desperation while terrorists confront us daily. We must learn to live with death anxiety. In this way, catastrophe can be used as a garden for growth.

Recently, I asked myself how I have changed since 9/11. I found myself working exhaustingly long hours trying to help my patients work through their individual traumatic reactions to the terrorism. I felt like

I was really doing something to help others, and found the effort healing, not only for my patients, but also for myself. Many weeks later I also found that I had neglected certain parts of my practice that, in comparison, I considered less important under the circumstances. These include chart notes, a task required to meet the standards of the National Committee of Quality Assurance (NCQA).

I was trained as a psychoanalyst in the 1970s. In those days, therapists were taught not to keep chart notes because they would color the next session. A good psychoanalyst was advised to keep everything that was important in his or her head or else find another profession. When the NCQA was formed, chart notes became a must.

Trauma in any form (terrorism, the Twin Towers attack, auto accidents, sexual or emotional abuse, etc.) changes us biologically forever. It evokes a response that is both psychological and biological. If the response remains maladaptive and stuck, it can turn into dis-ease. As Peter Levine (1997) warns, "Psychology now becomes biology" (p. 99). It can feel like a mild anxiety attack or it can debilitate us. If a person's energies remain trapped in the trauma, it will become chronic, and over time the energy to heal and restore a person's equilibrium will dissipate. Drugs can be helpful for short periods of time, but basically we need to find new, creative ways to deal with our anxieties.

TRAUMA AND IMMOBILITY

Today, our survival depends on our ability to face our problems artfully rather than use our prehistoric defense resources: fight, flight, or freeze. Symptoms form in a spiraling response to the trauma. The human defense mechanism summons a response from the prehistoric part of our brain. The last option is freezing where the brain constricts the energy that would be discharged by either of the other options, fight (rage) or flight (helplessness). At this point psychology can turn freeze (immobility) into biology and people begin to go numb or lapse into altered states of being, (i.e., acute stress symptoms, post-traumatic stress disorder (PTSD), or depersonalization). The immobility is not easily resolved because what the brain gets used to it repeats over and over. A good example is the body's response to cold. When you go swimming in a cold ocean or lake, the water feels freezing at first but then slowly becomes comfortable as your body adjusts to the temperature. The brain works in much the same way.

Trauma victims are trapped in their own fear and cling to the frozen part of themselves. That old defense saves them. If they feel any activation toward thawing the numbness, they also feel the potential for violence again. They remain in a vicious cycle of immobility, terror, or rage. These reactions are not confined to physical disasters. One patient who

was sexually abused as a child became numb. Her father was a war veteran who medicated himself with alcohol to escape the horrors he experienced during World War II. When he was drunk he abused her. Although my patient is not an alcoholic like her father, she is terrified to get involved with a healthy man because (a) it is unfamiliar, and (b) she fears she will again feel the hurt she felt as a child. Thus, she remains inhibited by her fears. Meanwhile, the immobility often feels to her like a living death. Unconsciously, it becomes safer to remain in a cocoon guarded by her defenses than to face life.

The immobility of the freeze response often feels like death, and human beings will do just about anything to deny death. One of the ways to move through the immobility response is to gradually experience life in a safe environment (i.e., a therapist's office). If the freeze response is not treated, it becomes stronger, and with each freezing and refreezing the symptoms proliferate and become cumulative.

Some of the possible maladaptive patterns are: parasomnias, dyssomnias, sexual problems, eating disorders, substance abuse, acute stress disorder (ASD), depression, post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), depersonalization, behavior problems, and attention deficit/hyperactivity disorder (ADHD).

The physical reactions to trauma include rapid heart beat, perspiration, sensitivity to light and/or sound, muscle tension, chronic fatigue, hyperactivity, reduced immune function, breathing and digestive problems, and blood pressure and blood vessel constriction. Mental reactions include racing thoughts, increased paranoia and worry, obsessions, compulsions, mood swings, numbness, hypervigilance, guilt, and dissociation. These reactions are often combined. Dissociation is the psyche's way of protecting itself from the attack. Mild dissociation produces a general spaciness, while intense dissociation can generate multiple personality disorder (MPD), distortions in time and/or perception, and out-of-body experiences (see Table 1).

Another patient explains that he is "here, but not here." He lives in constant fear that he will faint, leave his body, and never return. This patient was emotionally abused as a child by his mother, and subsequently sent to live with his grandmother, who was extremely superstitious. The grandmother taught the child to always exit a room by the same door that he entered or else some catastrophe would certainly occur. She also taught him that stepping on a sidewalk crack would "break his mother's back." To this day, my patient always exits a room through the door by which he entered and carefully avoids stepping on sidewalk cracks, despite the fact that his mother died many years ago. Although he has only screen memories of the abuse, the dissociation interrupts the hyperarousal state and prevents him from effectively reacting to his symptoms. For instance, he blames himself for the World Trade Center disaster. The patient actually feels it might not have

Table 1: Response to Trauma

Response*	Action	Leads to	Result
FIGHT	Attempted retaliation; Energy is discharged	Anger Rage Frustration Aggression Determination to "get even"	Anxiety disorders Eating disorders Substance abuse Sleep disorders Impulse control disorders Behavioral problems Relational problems
FLIGHT	Escape; Self-preservation	Fear Guilt Shame Imploded anger Lowered self-esteem	Acute stress disorder Depression Sleep disorders Relational problems
FREEZE	None; Inability to act; Energy is bound up	Immobility Guilt Terror Rage Helplessness Shame Death-like feelings	Post-traumatic stress disorder Obsessive-compulsive disorder Amnesia Forgetfulness Dissociative disorders Depression leading to neurosis Relational problems

*In response to trauma, the limbic part of the brain kicks into one of three responses: fight, flight, or freeze. In our culture, men are commonly taught to fight (e.g., the military, police, firefighters, etc.), while women are expected to freeze, or stoically endure stressful situations. Although there are signs that this may be changing, the pattern dates back to the time when men went out to hunt food, while women stayed home to raise children and clean the house.

happened if he had said all of his prayers that morning. Consciously, he realizes that he is not really responsible for the destruction. Unconsciously, he suffers from unrelenting guilt. He cannot stop worrying, nor can he find a safe place for himself. He also experiences night terrors and sleeps with all the lights and the TV on. To make matters even worse, this patient is afraid to travel far from home. He found

TREATMENT PLAN

ACUTE STRESS DISORDER

SHORT-TERM BEHAVIORAL GOALS: FAMILY	THERAPIST'S INTERVENTIONS
Improve communications among family members to reduce familial anxiety.	Conduct family sessions to reduce alienation, improve communication skills, and enhance understanding of the impact of the trauma on the entire family.
Identify unsatisfied needs and attempt to get help.	Explore if and how basic needs are being met (i.e., food, clothing, shelter, safety, etc.) and, if necessary, refer to FEMA. Explain "second disaster" to family and teach them how to deal with overloaded agencies.
Identify outside resources that can provide temporary support during crisis.	Identify if there are members of the extended family who can provide temporary practical and emotional support.
Each family member shares his/her reaction to the trauma.	Explore individual reactions to the trauma. See how each family member felt before and after the critical incident.
Identify your response to disaster so proper interventions can be customized to help survivors. Family understands responses may vary.	Investigate the individual responses of family members to disaster: fight (get angry, seek vengeance), flight (run away), or freeze (which constricts energy and makes one feel helpless with imploded anger, depression, or post-traumatic stress disorder). (See appropriate treatment plan, Chapter 3.)

SHORT-TERM BEHAVIORAL GOALS: FAMILY	THERAPIST'S INTERVENTIONS
Explain how you feel internally in order to identify and reduce traumatic biological response.	Help family create a climate for healing. Have family members talk about how they feel "inside" (shaky, trembling, etc.).
If there has been a death in the family, understand the normal stages of grieving and what is expected of each other.	Teach the Stages of Grief using either the Kubler-Ross Model: Denial, Anger, Bargaining, Depression, and Acceptance (Kubler-Ross, 1997) or the Phoenix Model: Impact, Chaos, Adaptation, Equilibrium, and Transformation (Jozefowski, 1999).
Share your unique reactions to the critical incident and understand how other family members are reacting.	Have each family member explore his/her feelings and response to the incident to provide a chance to vent their sorrow, which can be cathartic.
Identify how each family member copes with the disaster.	Discuss individual methods of coping with traumatic stress.
Identify irrational thoughts related to trauma.	Explore irrational methods of coping with trauma with all family members.
Identify your unfinished business with the deceased and psychodynamically work through relevant issues that remain unresolved.	Use role-playing with an empty chair representing the deceased. Ask family members to express what they would like to have said to the deceased. Include any unfinished business they would like in order to have closure.
Discuss blame and guilt you feel, and vent your concerns.	Investigate for feelings of blame or guilt and provide the opportunity for family members to vent their feelings.

SHORT-TERM BEHAVIORAL GOALS: FAMILY	THERAPIST'S INTERVENTIONS
Learn to reduce stressors to the critical event.	Teach rational alternatives: 1. Help child structure time in a better way; keep busy. 2. Teach patient to realize he/she is not crazy. It's normal to feel that way under stress. 3. Talk to others about your feelings. 4. Understand that attempting to numb the pain with drugs, alcohol, or food just complicates the problem. 5. Reach out and connect with others. 6. Don't suppress your feelings. 7. Help friends by letting them help you. 8. Write your feelings in a journal, especially during sleepless hours. 9. Do things that feel good. 10. Do not begin hoarding out of fear. It will cause more trouble for everyone. 11. Do not make any life decisions at this time. They may seem foolish once the crisis is over. 12. Do not fight flashbacks. Use TRT after teaching self-help (see Chapter 6). 13. Do things that help you feel you have some control over your life. 14. Listen carefully to traumatized persons.

SHORT-TERM BEHAVIORAL GOALS: FAMILY	THERAPIST'S INTERVENTIONS
	15. Do not deny reality, but reduce the addictive listening to radio or watching TV. Avoid reinfecting yourself by watching video of the tragedy over and over.
Family members realize they can find hope through growth and adaptation.	Educate family about the phase of adaptation. Help them realize that they have a chance at a new way of life, which can be the birthplace of hope and transition.
Family members are empowered by realizing through trial and error they can take on new roles and grow.	Assist family to establish equilibrium by taking on new roles and planning a new life even in times of crisis.
Stay in the here and now to reduce stress.	Teach members to reduce stress by staying in the here and now.
Recognize the uselessness of worry.	Reassure family members that worry is useless since the things we worry about seldom happen and the things we do not worry about may well come to pass (see the Atom Bomb story in Chapter 1).
Strengthen yourself by developing a new, productive role.	Help each family member build self-confidence through actual realistic achievements.
Develop your individual SMART action plan to get through the crisis.	Develop a SMART action Plan: Small, Measurable, Achievable, Realistic, Timelined goals (see Change, Behavioral Techniques, Chapter 6).
Realize you have the power to make important changes, even if they seem small.	Help family members recognize they have an opportunity to do some things differently.

SHORT-TERM BEHAVIORAL GOALS: FAMILY	THERAPIST'S INTERVENTIONS
Recognize that major change is the result of small steps taken one at a time.	Help family members identify and prioritize achievable goals.
Identify your transformation.	Have each family member identify ways in which they have been transformed since the tragedy, or the progress they have made toward transformation.
Read and discuss these books to enhance your understanding of grief.	If a family member has died in the disaster, assign reading of *The Phoenix Phenomenon: Rising From the Ashes of Grief* and *Living Beyond Loss: Death in the Family* (see Resources, Chapter 8; also see bereavement plan, Chapter 3).
Make use of community resources.	Refer family to available community group.
Reduce negative communication.	Develop a system of positive reinforcement to help family members interact better and reduce scapegoating.
Work together to develop a treatment termination plan.	Discuss termination issues, and agree on a plan to terminate treatment.

In this post 9/11 world therapists need to expand their toolboxes to deal with trauma and its effects. This book provides a new way of dealing with the devastating emotional residue of a traumatic event. It centers on the innovative application of hypnotherapy to help trauma victims "self-actualize", regain their lives, and move forward again.

Many people are familiar with the famous "fight or flight" response to trauma, but few know about the "freeze" response. "Freeze" is the most dangerous of the trio since it inhibits any reaction and leaves the victim immobile. It can lead directly to Post-traumatic Stress Disorder. Also included is a brief survey of brain research and its implications. For clinicians, this volume outlines the effects of trauma on mind and body and provides comprehensive treatment plans for the mental disorders caused or exacerbated by trauma.

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"… a life-saving contribution to the field of trauma."

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"Written with professional wisdom and sensitivity, this groundbreaking volume offers a fresh and practical view of the connection between hypnosis and healing."

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