

# *Thirty Years of Trauma Work: Clarifying and Broadening the Consequences of Trauma*

ROB GORDON

What is a trauma? The focus on trauma over the past thirty years has moved from a failure to acknowledge it as a formative influence in personality and behaviour to its present recognition as a primary influence. The field has moved also from a view that exposure to traumatic experiences would result inevitably in 'traumatisation' and a need for clinical help—which led to overenthusiastic counsellors forcing themselves on people who just needed time, space and security. We now know that only a proportion of those exposed to traumatic events develop symptoms of PTSD and associated clinical conditions, although this figure is higher in terrorist attacks. ROB GORDON highlights the problems for the field with a focus of most research and literature almost exclusively on PTSD. As a result many discussions of trauma are underpinned by a simplistic or fragmentary psychology, and techniques are developed that only focus on part of the person. Gordon explores the implications of this trend for treatment and argues for an approach that relies on a comprehensive psychology of the person and emphasises the importance of the social dimension. The notions of 'sensory' and 'informational' trauma are introduced, and helpful and hindering styles of social support are identified.

**I**n the 1970's trauma had barely penetrated clinical mental health work. The focus was on family interactions, early development and personal constructs.

As a young clinician in a large hospital, I remember being chastised by a supervisor when I asked an adolescent about her experience of abuse; I wanted to understand how it might be shaping her behaviour; she also seemed to want to talk about it. My supervisor expressed the consensus I found all about me: the details of the trauma were not important, her early experiences with parents shaped her responses and needed to be the focus of intervention. I could not help feeling it must be important to understand what had happened.

Trauma had been talked about for a long time before this—Carcot, early Freud, other psychoanalytic pioneers,

the First and Second World War psychiatrists, and other clinicians of many persuasions. But the object relations and system revolutions were dominating the scene.

Thirty years later, we find the opposite view expressed: trauma is the important formative influence of many patients. Now, clinicians who specialise in trauma often do not attend to the whole fabric of the client's family, interpersonal relationships and early experiences. The mental health field as a whole (by which I mean its collective manifestations) often seems like a child with learning difficulties—poor short-term memory and limited attention span. By focusing on the trauma we are in danger of losing the person.

The literature has moved on from the 1980's when trauma was discovered as a pathogenic influence in itself and seemed to explain a lot.

The main dimensions of traumatic experience were identified; threat to life and welfare, helplessness, isolation, witnessing horror, identification with victims. Trauma tended to be found wherever these characteristics were present and everybody subject to them was expected to be 'traumatised' and need clinical help. The fact that they did not ask for or rejected it was considered a mistake on their part. This view (and I have been subject to all the views I mention at some overenthusiastic point in my career) led to the development of trauma treatments.

When competent clinicians put their mind to a problem they come up with something that works—even if they are not sure why. It was concluded that all people involved in traumatic events were at risk for being traumatised and so should have treatment. This led to

overenthusiastic counsellors forcing themselves on people who just needed time, space and security. Then followed the rebound view that we should leave people to establish their defence mechanisms before interfering.

Now we know that some 95 per cent of people exposed to a traumatic experience in natural disasters report distress and some symptoms in the early aftermath, but for most, they subside steadily over the next month or two and recovery continues for a year or so. Only about 10–25 per cent of those affected develop symptoms that can be diagnosed as posttraumatic stress disorder (PTSD) and associated clinical conditions (Friedman, Ritchie & Watson, 2006).

In terrorist attacks, the proportion may be 45 per cent because of the higher levels of death and injury (North, Nixon, Shariat, Mallonee, McMillen, Spitznagel & Smith, 1999). Journals such as the *Journal of Traumatic Stress* publish numerous articles that investigate the proportion of people affected by all manner of traumatic events. The relatively small proportion traumatised has resulted in a search for screening instruments that can provide for early identification of those with vulnerable, predisposing risk factors, and trials to determine the most effective treatments.

### What is a trauma?

The bias in favour of rigorous research methods and psychiatric nosology makes the focus of the literature to be almost exclusively on PTSD—whether in natural or human caused disaster, criminal events, medical trauma or accidents. Apart from a few notable exceptions (e.g., Janoff-Bulman, 1992) the question of what a trauma is seems to have slipped away.

PTSD is included in DSM-IV to define an agreed condition for research and medico-legal purposes. It has enabled many sufferers to gain recognition and recompense, and established it as a genuine health problem. It has also enabled requirements for adequate treatment to be defined in relation to its symptom clusters (persisting intrusive recollections, persisting high arousal, numbing and detachment

and disruption of work or social life). Various forms of cognitive behaviour therapy have targeted these symptoms and the literature shows they are more effective at reducing the symptoms than doing nothing, supportive, non-directive or crisis counselling (Bryant & Litz, 2006).

PTSD is based on the idea that the traumatic experience places the person under stress. It imposes

demands that outstrip resources. The imbalance causes an inability to integrate the experience—or is it the failure to integrate the experience that causes the stress? Either way, recovery is disrupted and the condition can emerge after a delay, become chronic and associated with comorbid conditions (depression, anxiety disorders, substance abuse, gambling).

Stress defines trauma as a non-pathological process—an adaptation that eventually becomes maladaptive

to environmental demands. The concept of stress liberated the field from the assumptions of underlying psychopathology that were applied to trauma. The 19th century saw trauma as attributed to ‘weak character’, and in the 20th century to ‘neurotic character’ (Moorhead, 1944). We can now think of trauma as ‘a normal reaction to abnormal experiences’, although research has shown those most vulnerable

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are likely to have had prior evidence of psychopathology (McFarlane & Girolomo, 1996).

However, the question of what trauma is has faded in proportion to the domination of PTSD, leaving gaps in the literature and collective consensus about trauma. If only a small proportion of people affected by trauma sustain PTSD does this mean the others are unaffected? Or have they been affected, but normal recovery processes enable them to



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restore normal functioning and avoid developing a diagnosable condition? If they have no diagnosable condition, do they not need assistance?

The emphasis on screening and identifying those at risk for PTSD is illness-oriented and may be justifiable for provision of public resources, but if we accept human suffering as our reference point, much suffering does not qualify as PTSD. Having one criterion of intrusive recollections, heightened arousal, numbing and detachment, or disrupted work and

The central construct of stress refers to the *consequences of the damage*—how the whole system is compromised by the injury—rather than referring to the injury itself. By analogy, PTSD is like measuring and treating the stress caused by someone having a broken leg. The injury affects many aspects of their life. Pain, preoccupation with the leg, change in activities and reactions to ongoing disruption could all be identified as stress responses, without examining the leg. Pain management, social support, lifestyle advice and

The idea of an injury to the psychic apparatus allows us to identify the sites of injury, damaged structures or processes. In this instance, nothing replaces a comprehensive psychology of the human being. A theory of normal human functioning reveals the site of injury. We observe this by listening to what the affected person says and considering what they reveal. They show us the damage repeatedly by reporting the site of the pain or disruption.

To use a metaphor, the task with a traumatic experience is to repair the damaged structures and to 'digest' the experience. Symptoms resolve into two groups: *structural damage* and *disrupted functions*. The damage prevents normal integrative processes from occurring and memories are not transformed into different forms. As a consequence they do not fade and instead remain in present experience, or affect remains in spite of the event being over.

Technique depends on a simple formula: *language is the digestive juice of the psyche*. What is present as image or memory of a perception, action, or feeling remains exactly what it was until converted into a linguistic representation and verbally expressed. The integrity of the initial form of the experience is disrupted by words, which, in due course (upon repetition) convert raw sensory impressions into a narrative and the story is retained. Sensory qualities must be reconstructed from memory rather than intruding spontaneously in their original intensity. This means not just talking, but *talking about the right things*. For intrusive memories, it means finding what has *not* been said that allows them to be integrated.

Taking an idea with a long pedigree, we can examine the damage. To do this we need to observe rather than infer. The idea that enables us to do this, is that mind comes into being and is maintained through communication with other minds (Mead, 1962; Harbermas, 1982, 1989) and the act of communication (in all its forms) manifests mind to observation (Sigman, 1987). We can move beyond the ideology that interprets communication as encoding and transmitting information that is decoded by the other. We recognise

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social life is enough to spoil a person's happiness. Here we come to the epistemological assumptions that underpin a rationalist, empiricist, scientific worldview and the danger is that it frames our experience in such a way that we do not see what is missed.

The word trauma derives from the Greek meaning '*wound*'. Trauma medicine refers to conditions resulting from externally caused injuries. We can define psychic trauma as an experience with such intensity or meaning as to injure the psychic apparatus—the mental, physical and social systems that provide the framework for psychic life.

The idea of injury means that regardless of previous pathology, there is damage that prevents the apparatus from functioning properly. It does not mean prior pathology is not present. Physically injured people are deemed to be in need of care and are entitled to it ethically, even if the injury is minor. Yet there has to be evidence of significant pathology to be entitled to psychological assistance. If the apparatus is not damaged, a trauma has not occurred, but there can be different degrees of damage resulting from injuries to different sites of the apparatus. Trauma phenomena include the damage to the apparatus and to the meaning the experience has for the person.

strategies for managing the emotional sequelae would all be relevant. But the leg would remain broken. While good trauma treatment (whether CBT, dynamic or other) does attend to the injury and works with it, it is possible to follow good practice guidelines without attending to the psychic injury.

### **Trauma treatment**

This brings us to the essence of technique in trauma treatment. The consensus reviews, and presentations emphasise, the relative effectiveness of CBT treatments, usually based on a structured and manualised program aimed at addressing identified symptoms. A number of findings emerge that indicate essentials of treatment independent of method or therapeutic school. They are:

- confrontation of traumatic memories to reduce the intensity and distress associated with them (exposure);
- development of new meanings of the experience that do not allow simplified, fragmentary meanings to be imposed by dominant elements of the experience (cognitive restructuring);
- reduction of the arousal level and reactivity; and
- learning to understand the intense, unfamiliar emotions generated by the trauma and developing methods to manage them (affect regulation).

communication as a mingling of minds (albeit incompletely and with uncertainty) and internal representation is at the same time enacted presentation of the mental world of the other (Toulmin, 1972).

Such an epistemology is intuitive for effective therapists, whether their philosophy permits it or not, and for ordinary people. Listening to a traumatised client and observing the whole act of communication, we observe structures and functions in their psychic apparatus. While the content remains mysterious, structures are revealed in discourse and we can analyse communication in fine detail to reveal more and more, provided we recognise what we see.

The first manifestation of damage is evident when the traumatised person tells their story spontaneously. If we do not interfere, their account is fragmentary. They begin at some point of significance and narrate a sequence that suddenly halts. They pause, often looking to us for a response (if we give it, we obscure what is to be seen in the communicational gap), they may express emotion (perhaps cry with sadness, horror, rage or helplessness). Often they do not resume their narrative for some moments and it is tempting to rescue them, comfort, ask a question or talk to them. While these actions are important, they are most effective when we have completed our examination. If they resume spontaneously, it is often to go on another track, talking about their emotions, questioning something or speculating about what they do not know. The pause indicates a point in the narrative of intense threat—they pause at a peak of arousal.

The gap shows that whatever should follow is not linked to the preceding experience; instead of anchoring emotion in a sequence coming to a natural conclusion, they are suspended in the moment of threat. This fragment will repeat as an intrusive memory since what modifies it is disconnected from it. Often, the worst possibility does not occur, but is threatened and so instead of concentrating on the survival, they remain attached to the terrible possibility. Detecting these gaps and asking, 'what happened then?' makes them connect across the break,

to form a mental/cognitive/linguistic/neurological link to the following memory. We can consolidate this by repeating to them the sequence they have given or asking them to go over it again. In this way we can work to integrate memory structures and distribute their emotional energies.

We can also consider whether they communicate sensory images, fantasy pictures, thoughts, memories, judgements or speculations. If someone tells us about a memory image in their mind we do not see it. When they describe the image in words we see it represented in words. If it remains a sensory image it is a 'hot cognition' carrying affect and liable to reactivation. A person who says, 'when I saw his face I knew he was dead' and weeps, shows us they are remembering specific sensory features of the face which showed the person was dead, but have not allowed us to see it. We need to ask, 'what was it about the face that showed you he was dead?' They say, 'it was the awful purple colour around the lips and mouth, I just knew that was not right.'

We need to encourage them to convert image into language as part of a narrative. The test for this is whether we can see it too. If we can, they have put the details into words as an act

of communication. When they are distressed by a memory, we need to find out which details carry the affect. When they convert the memory into verbal representation for us it invariably shifts and affect reduces. The memory does not intrude so much or is not so powerful. In this way we can work with precision in listening to what is represented. Of course, there is no assumption that we can do this with a highly traumatised person on the first session, or that once is enough. The technique must be inserted into a secure, therapeutic relationship.

## Sensory and informational trauma

We can identify two different forms of impact. One is defined by the sensory impressions the person receives at the time of the traumatic experience. The threatening, horrific or painful quality of these impressions damages the capacity to put them into words, integrate them into past experience and consign them to memory. For this person the site of damage is what is called in philosophy, *the sensorium*—the system of receiving, making sense of and integrating sensory impressions.

Accordingly, the sensorium has to be one focus of treatment. I call this a *sensory trauma*. The problem derives from the content of discrete sensory details, the cognitive struggle to make them meaningful and management of the affects evoked. There is fear, horror and insecurity, as though the event persists. Sensory trauma locks the person into the specifics of an experience and isolates them from others who do not understand it, even if present. No two people have the same sensory impressions. They feel painful alienation and the emotions are evoked by the sensory impressions. Survivors of shootings or criminal events are often preoccupied with images of pain and suffering and have

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little concern with the perpetrator.

The other site of impact is for those who are not present at a traumatic event. They are told about it by others, often that loved ones are dead. The impact is not in the sensorium. The traumatic content takes the form of the information provided and its meaning. I call this an *informational trauma*. The specific sensory details can never be provided; they only have the facts of what happened and the consequences.

The site of impact is the cognitive systems related to their involvement in the situation (affect-memory systems of loved ones, etc.). The problem is to give information a concrete, sensory form (or perhaps avoid it). The

lack stimulates two complementary functions to fill the gap. On one hand, fantasy is stimulated to make it real, but is uncertain, cannot be stabilised and leads to restless preoccupation with more information. On the other, emotions become focused on the social environment from which the traumatising information came.

Informationally traumatised people are usually concerned with social systems around the event, angry at the perpetrator, those held responsible, emergency services, helping agencies, legal or government authorities and become involved in post-event processes. Blame, resentment and the search for justice often interfere with their recovery.

Informational trauma is characterised by symptomatology in social connectedness, causing repercussions in the social environment, where they encounter those not traumatised or traumatised in different ways with tension and conflicts. The work has to be with the damaged affect-memory systems and stabilising the restless search for what is unavailable.

While sensory events tend to isolate the person with their own unique experience that they feel others will never understand, informational events lead to heightened sensitivity to what others do and distress is transferred to the social context and other people involved. *Table 1* outlines the main differences between these two types of impact.

*Table 1*

Sensory	Informational
Sensory traces	Information
Immediate arousal	Retrospective arousal of memory
Personal and isolating	Social and connecting
Avoidance and numbing	Interpersonal tensions
Hot cognitions	Uncertainties
Distorted perceptions	Need for judgments
Re-experiencing of aroused memories	Retrospective interpretation of non-aroused memories
Fear and horror	Guilt and Remorse

### Contrasting characteristics of sensory and informational trauma

Sensory and informational discriminates between different domains of the psychic apparatus affected by the circumstances of the person's involvement. Our task is to have enough understanding of the mind, its bodily supports and social context to hear what has been damaged and use undamaged functions to

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heal them. My concern is that the application of empirically validated treatment packages is like applying a shotgun antibiotic instead of working out the pathogen and giving the appropriate agent.

Learning how to treat injuries to the psychic apparatus requires something different from randomised control trials that test methods already developed. We are still in the early stages of the psychology of trauma. Consider how burgeoning knowledge in the neuropsychological field has changed our thinking in the last ten years (Schore, 1994; Bremner, 2002; Cozolino, 2002).

Analysis of cases in the context of a comprehensive psychology of the person teaches us about the injuries. Many discussions of trauma are underpinned by a simplistic or fragmentary psychology and develop treatment techniques with a catchy title known by acronyms. They seem to focus only on part of the person.

The best thing we can give a traumatised person is sensitivity to

their whole being. After all, nothing works for everyone. But there is little room for non-prescriptive approaches in current authoritative trauma texts.

### Helpful and hindering styles of social support interactions

The narrowness of psychological theory is nowhere more evident than in the dearth of social psychology in trauma discussions. While not entirely absent (Kaniasty & Norris, 1999), it is encompassed in concepts such as 'social support' which are often not analysed. Support is not just the availability of people, but the person's embeddedness in social relationships (van den Eynde & Veno, 1999). Embeddedness refers to the sense of being part of a group, belonging, feeling entitlement about using relationships. This support enables the person to communicate the trauma experience and their needs in an empathic and constructive social environment and is the medium for recovery. Recent research into social support in grief has shown supportive relationships need to provide something positive and constructive as opposed to simplistic affirming, normalising or sympathy.

Repeatedly, I come across the failure of those supporting a traumatised person to respond in helpful ways. This results in the withdrawal and isolation of the traumatised person

Table 2

Helpful	Hindering
Active communication	Passive communication
Organizing	Saying the same things
Cognitive work increasing understanding and meaning	Reiterating or ruminating on losses
Revealing more, adding new details, making new connections	Going over the same ground Expressing emotions without adding meaning
Accepting emotions as part of work	Avoiding discussing emotions
Represent emotions in language	Emotional expression, catharsis, "getting it out" without adding words
Empathy—offering them something different	Sympathy—offering them more of the same
Generate positive emotions	Exhibit negative emotions
Selective focus on some aspects, rather than the whole	Reassurance, platitudes
Aiding control	Indiscriminate, unregulated meandering

from helpers, or worse, the traumatised person attempts to make helpers feel good by pretending they are helping. Trauma is not a normal experience and, on this basis, most people would not understand an experience so intense that it causes a psychic wound. It is qualitatively different from sub-traumatic crises; therefore the methods of supporters for dealing with it are unlikely to be appropriate. The education of supporters needs to be included in recovery activity; or where supporters are not receptive, help the person understand they may not get what they need and why.

Table 2 above gives a schematic contrast between constructive and unconstructive support styles, adapted from research into grief support styles (Stroebe & Schut, 2001) with observations from my practice. Supporters (and even clinicians) often become anxious and avoid expressed emotions, fearing further damage and so prevent the person from sharing their explorations. Although some people do not want to do this, many need to have their pain understood by those important to them.

### The social injury of trauma

The social dimension of trauma starts with the proposition that

every functional person is part of a community. Involvement in large and small communities with the intimate and distant relationships that constitute them form the social fabric as the medium for personal psychic life. Social fabric is the continuity of connectedness with people, institutions, place, traditions, culture and rituals. It provides the assumptions and reference points for cognitive function, supports personal identity and routines within which intentional action is undertaken. This social fabric is maintained by communicative interactions that carry affective energy and a repertoire of emotional responses. Emotions are inherently social in their form and expressions (Harré, 1988) and the psychic apparatus is an extension of social processes within the individual, while social fabric is continuation of the psyche into a collective space through communication. The person's connectedness with the social world is therefore implicated in the wounding. Recognition, understanding and treatment of social wounds is central to the traumatised person's experience and vital for establishing recovery.

Social consequences of high arousal are stimulated by confronting an immediate threat. Arousal

mechanisms are activated in sub-cortical brain regions and produce wide-ranging changes that activate physiological, cognitive and behavioural survival mechanisms (Bremner, 2002). For evolution, survival of the species is via survival of individuals. So arousal mechanisms narrow individual attention onto the immediate situation, perceptually focus on the threat and means of survival, cognitively estimate solutions, behaviourally enact them, or prepare for the worst. The intense centredness of this state involves the temporary setting aside, or drastic modification, of social connectedness. The more we revert to biological survival, the more we fall out of social fabric into a state of survival specialisation. Since these changes happen in very high arousal, they involve the holistic quality of 'hot cognitions' and become an alternative programming for survival, and weld all modalities of experience into one function. Perception, cognition, emotion and action function as a single threat-oriented unit.

In this state, all that is not relevant immediately drops out of play, the system reorganises around individual survival, and the social world is irrelevant to the moment and the situation. When people talk about their trauma, they often mention a sense of disconnection from loved ones and the general social fabric. They show an injury, where they have become *debonded* from the social attachments (intimate and distant) that constitute the social fabric (Gordon, 2004). This is why simple social interaction and interpersonal care are such an important component of psychological first aid (Gordon, 1997, Young, 2006). Without restoration of social connectedness ('embeddedness') the individual has difficulty recovering, and people with severe PTSD talk at length about how insensitive events after the trauma disrupted social attachments and prevented recovery. The treatment of returning Vietnam Veterans is one example of this.

Traumatic debonding is an inevitable consequence of survival specialisation and high arousal in response to threat. Bonds are swept aside as temporarily irrelevant. This reorganisation can be reversed readily

by empathic social interactions from caring strangers, followed by reunion with loved ones who have been briefed to understand and respond supportively. But if this is not achieved and subsequent events involve social isolation, uncaring, unfamiliar or unhelpful interactions, the restoration of their insertion into social fabric is disrupted and the injury compounded.

Debonding is complicated if the state of arousal does not come down. Arousal is maintained as much by unfamiliar social systems (police, medical, legal, insurance, relocation etc.) and misguided or voyeuristic interactions from supporters, as by continuing threat. As long as arousal is high, debonding is not properly reversed. The best way to reduce

sense of isolation and detachment can underlie the excitable, intense social interaction of the aftermath. Victims cannot explain this and loved ones do not understand this state of mind.

The momentum of familiar pre-trauma relations carries them along, but if not reversed, debonding persists, causing personal and social problems, that often form the germ of serious psychopathology.

It is essential for clinicians to pay close attention to what clients say about their social experience and social connectedness. If there was high arousal, we must look for debonding phenomena, help subjects to give expression to them and reverse them by reconnecting to what was there before the event.

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arousal is through caring social interactions. The connection to the social world is part of every aspect of trauma and its consequences.

Even when loved ones are present at the trauma, individual perceptions and estimations of what will happen are welded into the particular configuration of traumatic experience that constitutes the wound. These are no more the same for individuals in the same place at the same time than are the physical injuries received by casualties injured together. We understand passengers in a bus crash all have different injuries accounted for by the movements of their body, but somehow we do not expect equally different psychic injuries determined by their unique perceptions and expectations during the event. It is not unusual for those with the worst psychic injuries not to have physical injuries. Unless details are communicated to each other, they separate rather than connect, although this is not recognised at the time. They think they were in it together, but this does not identify and reverse the process of debonding. A confusing

Disruption of social life is the last PTSD criterion to be considered, but is often a painful first in the victim's experience and felt as the impediment to recovery. Physiological, cognitive or emotional processes all exist in a social environment, which means communications with people. If the social fabric remains damaged, personal functions do not recover.

An extreme form of debonding occurs in the encounter with imminent death (Gordon, 2005), when the person in high arousal accepts the inevitability of their (or loved one's) death and prepares for it. The reorganisation of high arousal focuses on transition to whatever they think death involves instead of survival. It involves debonding from life, past, future, loved ones, plans, body and any other domain of life that comes into it. The holistic reorganisation in high arousal redirects attention, energy and meaning away from familiar attachments of life towards preparing for death. The moment may be conscious or not; it may be represented as a verbal thought or a blank spot in memory, covering deeper, nonverbal representations.

It becomes evident in the aftermath as inability to take up the threads of their previous life, feeling emotionally detached and disconnected as though looking on at their life from outside. Former interests, plans and ambitions no longer have any hold and people engage in distracting activities with no long-term significance, or perform responsibilities as empty routines.

They are usually unable to articulate the problem and preoccupied with morbid thoughts and a sense of futility. It often leads to suicidal thoughts with a different quality to suicidal thoughts in more familiar pathologies. Instead of the unbearable anguish of meaninglessness and longing for death as relief of pain, they exhibit a sense of remoteness and detachment that suggests since they cannot connect to the world of the living and the future, they rather belong to the world of the dead. One person said, *'I belong dead'*. It is present as inchoate feelings and behavioural disorientation.

With help, they find words for what has not, as yet, been represented in linguistic form (so presumably has not been connected to left frontal brain regions where affect regulation and broader integration emanate) (Schoore, 1994) or they grasp words offered that give form to experience and allow them to take control of their fate. The earlier it is recognised and explained, the sooner they intercept the progressive traumatic reorganisation of their world and re-enter the common flow of shared life that is society. Recovery often involves a far-reaching revaluation of their earlier lives and values, which cannot be rushed.

These are some phenomena associated with psychic injuries that point to the structures. We only discover them by examining the injury. That means encouraging those suffering to speak freely, listening patiently and giving meaning to their words, metaphors and struggles to express themselves. These are not just stress problems, they are the causes of stress. Familiar categories of PTSD symptoms are just the start. We need to encourage people to communicate their experience in the richest way possible, help them find words for what is unique, while we bring our knowledge to bear on what they are saying.

Trauma has arrived as a problem, but we are still in early stages of understanding its effects. Every client teaches us something further. Stress effects are the most obvious and general features of the damage, however it has occurred. But the pain and struggle to recover is caused by the specific injuries; the damaged structures and functions are daily obstacles to recovery and present simultaneously in physiological, psychic and social forms. By careful observation of the psychic structures and processes revealed in communication, we can intervene to assist the healing. Here our skills and capacity are only restricted by the scope of our understanding of the human being.

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## AUTHOR NOTES

ROB GORDON is a clinical psychologist with a private psychotherapy practice in Box Hill, Victoria. He has been a psychological consultant to the Victorian State Emergency Recovery Plan since 1986. A clinical psychologist in private practice, Rob has worked in disasters since the 1983 Ash Wednesday bushfires and has been involved in most major Victorian emergencies since then. He treats adults and children affected by trauma and disaster as part of a general psychotherapy practice.

Comments: [rob@robgordon.com.au](mailto:rob@robgordon.com.au)