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Recovery from psychological trauma

[JUDITH L. HERMAN MD](#)

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Judith L.Herman MD Department of Psychiatry, The Cambridge Hospital, 1493 Cambridge St, Cambridge, MA 02139, USA.

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Abstract

Trauma destroys the social systems of care, protection, and meaning that support human life. The recovery process requires the reconstruction of these systems. The essential features of psychological trauma are disempowerment and disconnection from others. The recovery process therefore is based upon empowerment of the survivor and restoration of relationships. The recovery process may be conceptualized in three stages: establishing safety, retelling the story of the traumatic event, and reconnecting with others. Treatment of posttraumatic disorders must be appropriate to the survivor's stage of recovery. Caregivers require a strong professional support system to manage the psychological consequences of working with survivors.

The core experiences of psychological trauma are disempowerment and disconnection from others.¹ Recovery therefore is based upon empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation. In renewed connections with other people, the survivor recreates the psychological faculties that were damaged or deformed by the traumatic experience. These include the basic capacities for trust, autonomy, initiative, competence, identity, and intimacy.² Just as these capabilities are originally formed, they must be re-formed in relationships with other people.

Trauma robs the victim of a sense of power and control over her own life; therefore, the guiding principle of recovery is to restore power and control to the survivor.³ She must be the author and arbiter of her own recovery. Others may offer advice, support, assistance, affection, and care, but not cure. Many benevolent and well-intentioned attempts to assist the survivor founder because this fundamental principle of empowerment is not observed. No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest. Caregivers schooled in a medical model of treatment often have difficulty grasping this fundamental principle and putting it into practice.

With trauma survivors, the therapeutic alliance cannot be taken for granted but must be painstakingly built.⁴ Psychotherapy requires a collaborative working relationship in which both partners act on the basis of their implicit confidence in the value and efficacy of persuasion rather than coercion, ideas rather force, mutual cooperation rather than authoritarian control. These are precisely the beliefs that have been shattered by the traumatic experience.⁵ Trauma damages the patient's ability to enter into a trusting relationship; it also has an indirect but very powerful impact on the therapist. As a result, both patient and therapist will have predictable difficulties coming to a working alliance. These difficulties must be understood and anticipated from the outset.

Trauma is contagious. In the role of witness to disaster or atrocity, the therapist at times is emotionally overwhelmed. She experiences, to a lesser degree, the same terror, rage, and despair as the patient. This phenomenon is known as 'vicarious traumatization'.⁶ The therapist may begin to experience intrusive, numbing, or hyperarousal symptoms. Hearing the patient's trauma story is also likely to revive strong feelings connected with any personal traumatic experiences that the therapist may have suffered in the past.

The therapist, like the patient, may defend against overwhelming feelings by withdrawal or by impulsive, intrusive action. The most common forms of action are rescue attempts, boundary violations, or attempts to control the patient. The most common constrictive responses are doubting or denial of the patient's reality, dissociation or numbing, minimization or avoidance of the traumatic material, professional distancing, or frank abandonment of the patient.⁷ The therapist should expect to lose balance from time to time. She is not infallible. The guarantee of her integrity is not her omnipotence but her capacity to trust others. Therapists who work with traumatized people require an ongoing support system. Just as no survivor can recover alone, no therapist can work with trauma alone.

Ideally, the therapist's support system should include a safe, structured, and regular forum for reviewing her clinical work. This might be a supervisory relationship or a peer support group, preferably both. The setting must offer permission to express emotional reactions as well as technical or intellectual concerns related to the treatment of patients with histories of trauma. In addition to professional support, the therapist must attend to the balance in her own professional and personal life, paying respectful attention to her own needs. Confronted with the daily reality of patients in need of care, the therapist is in constant danger of professional overcommitment. The role of professional support is not simply to focus on the tasks of

treatment but also to remind the therapist of her own realistic limits and to insist that she take as good care of herself as she does of others.

The therapist who commits herself to working with survivors commits herself to an ongoing contention with herself, in which she must rely on the help of others and call upon her most mature coping abilities. Sublimation, altruism, and humor are the therapist's saving graces. In the words of one disaster relief worker, 'To tell the truth, the only way me and my friends found to keep sane was to joke around and keep laughing. The grosser the joke the better'.⁸ The reward of engagement is the sense of an enriched life. Therapists who work with survivors report appreciating life more fully, taking life more seriously, having a greater scope of understanding of others and themselves, forming new friendships and deeper intimate relationships, and feeling inspired by the daily examples of their patients' courage, determination, and hope.⁹

The traumatic syndromes are complex disorders, requiring complex treatment. Because trauma affects every aspect of human functioning, treatment must be comprehensive. At each stage of recovery, treatment must address the characteristic biological, psychological, and social components of the disorder. Well-designed biological treatments, for example, may be unsuccessful if the social dimensions of the patient's traumatic experience are not addressed. Conversely, even excellent social support may be ineffective if the patient's psychophysiologic disturbance remains untreated. There is no single, efficacious 'magic bullet' for the traumatic syndromes.

The therapist's first task is to conduct a thorough and informed diagnostic evaluation, with full awareness of the many disguises in which a traumatic disorder may appear. With patients who have suffered a recent acute trauma, the diagnosis is usually fairly straightforward. In these situations clear, detailed information regarding posttraumatic reactions is often invaluable to the patient and her family or friends. If the patient is prepared for the symptoms, she will be far less frightened when they occur. If she and those closest to her are prepared for the disruptions in relationship that follow upon traumatic experience, they will be far more able to take them in their stride. Furthermore, if the patient is offered advice on adaptive coping strategies and warned against common mistakes, her sense of competence and efficacy will be immediately enhanced. Working with survivors of a recent acute trauma offers therapists an excellent opportunity for preventive education.

With patients who have suffered prolonged, repeated trauma, the matter of diagnosis is not nearly so straightforward. Disguised presentations are common in complex posttraumatic stress disorder (PTSD).¹⁰ Initially the patient may complain only of physical symptoms, or of chronic insomnia or anxiety, or of intractable depression, or of problematic relationships. Explicit questioning is often required to determine whether the patient is presently living in fear of someone's violence or has lived in fear in the past. Traditionally these questions have rarely been asked. They should be a routine part of every diagnostic evaluation.

If the therapist believes the patient is suffering from a traumatic syndrome, she should share this information fully with the patient. Knowledge is power. The traumatized person is often

relieved simply to learn the true name of her condition. By ascertaining her diagnosis, she begins the process of mastery. No longer imprisoned in the wordlessness of the trauma, she discovers that there is a language for her experience. She discovers that she is not alone; others have suffered in similar ways. She discovers further that she is not crazy; the traumatic syndromes are normal human responses to extreme circumstances. And she discovers, finally, that she is not doomed to suffer this condition indefinitely; she can expect to recover, as others have recovered.

Recovery unfolds in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central task of the the third stage is reconnection with ordinary life. Treatment must be appropriate to the patient's stage of recovery. A form of therapy that may be useful at one stage may be of little use or even harmful to the same patient at another stage.

The first task of recovery is to establish the survivor's safety. This task takes precedence over all others, for no other therapeutic work can possibly succeed if safety has not been adequately secured. No other therapeutic work should even be attempted until a reasonable degree of safety has been achieved. This initial stage may last days to weeks with acutely traumatized people or months to years with survivors of chronic abuse. The work of the first stage of recovery becomes increasingly complicated in proportion to the severity, duration, and early onset of abuse.

Establishing safety begins by focusing on control of the body and gradually moves outward toward control of the environment. Survivors often feel unsafe in their bodies. Their emotions and their thinking feel out of control. Issues of bodily integrity include attention to basic health needs, regulation of bodily functions such as sleep, eating, and exercise, management of posttraumatic symptoms, and abstinence from substance abuse.

Environmental issues include the establishment of a safe living situation, financial security, mobility, and a plan for self-protection that encompasses the full range of the patient's daily life. Securing a safe environment requires strategic attention to the patient's economic and social ecosystem. The patient must become aware of her own resources for practical and emotional support as well as the realistic dangers and vulnerabilities in her social situation. Many patients are unable to move forward in their recovery because of their present involvement in unsafe or oppressive relationships. In order to gain their autonomy and their peace of mind, survivors may have to make difficult and painful life choices. Battered women may lose their homes, their friends, and their livelihood. Survivors of childhood abuse may lose their families. Political refugees may lose their homes and their homeland. The social obstacles to recovery are not generally recognized, but they must be identified and adequately addressed in order for recovery to proceed.

With survivors of prolonged, repeated trauma, the initial stage of recovery may be protracted and difficult because of the degree to which the traumatized person has become a danger to herself. The sources of danger may include active self-harm, passive failures of self-protection, and pathological dependency on the abuser. Self-care is almost always severely disrupted.

Self-harming behavior may take numerous forms, including chronic suicidality, self-mutilation, eating disorders, substance abuse, impulsive risk-taking, and repetitive involvement in exploitative or dangerous relationships. Many self-destructive behaviors can be understood as symbolic or literal re-enactments of the initial abuse. They serve the function of regulating intolerable feeling states, in the absence of more adaptive self-soothing strategies. The patient's capacities for self-care and self-soothing must be painstakingly reconstructed in the course of long-term individual and/or group treatment. Biologic, behavioral, cognitive, interpersonal, and social therapeutic modalities have all shown promise with some patients; each patient should be encouraged to develop a personal repertoire of coping strategies.

When safety and a secure therapeutic alliance are established, the second stage of recovery has been reached. The survivor is now ready to tell the story of the trauma, in depth and in detail. This work of reconstruction actually transforms the traumatic memory, so that it can be integrated into the survivor's life story.¹¹ The basic principle of empowerment continues to apply during the second stage of recovery. The choice to confront the horrors of the past rests with the survivor. The therapist plays the role of a witness and ally, in whose presence the survivor can speak of the unspeakable. Out of the fragmented components of frozen imagery and sensation, patient and therapist slowly reassemble an organized, detailed, verbal account, oriented in time and in its historical context. The narrative includes not only the event itself but also the survivor's emotional response to it and the responses of the important people in her life.

As the survivor summons her memories, the need to preserve safety must be balanced constantly against the need to face the past. The patient and therapist together must learn to negotiate a safe passage between the twin dangers of constriction and intrusion. Avoiding the traumatic memories leads to stagnation in the recovery process, while approaching them too precipitously leads to a fruitless and damaging reliving of the trauma. Decisions regarding pacing and timing need meticulous attention and frequent review by patient and therapist in concert. The patient's intrusive symptoms should be monitored carefully so that the uncovering work remains bearable.

Because the truth is so difficult to face, survivors often vacillate in reconstructing their stories. Denial of reality makes them feel crazy, but acceptance of the full reality seems beyond what any human being can bear. Both patient and therapist must develop tolerance for some degree of uncertainty, even regarding the basic facts of the story. In the course of reconstruction, the story may change as missing pieces are recovered. This is particularly true in situations where the patient has had significant gaps in memory. Thus both patient and therapist must accept the fact that they do not have complete knowledge, and they must learn to live with ambiguity while exploring at a tolerable pace.

In order to develop a full understanding of the trauma story, the survivor must examine the moral questions of guilt and responsibility and reconstruct a system of belief that makes sense of her undeserved suffering. The moral stance of the therapist is therefore of enormous importance. It is not enough for the therapist to be 'neutral' or 'non-judgmental'. The patient challenges the therapist to share her own struggles with these immense philosophical

questions. The therapist's role is not to provide ready-made answers, which would be impossible in any case, but rather to affirm a position of moral solidarity with the survivor.¹²

The telling of the trauma story inevitably plunges the survivor into profound grief. The descent into mourning is a necessary but dreaded part of the recovery process. Patients often fear that the task is insurmountable, that once they allow themselves to start grieving, they will never stop. Survivors of prolonged childhood trauma face the task of grieving not only for what was lost but also for what was never theirs to lose. The childhood that was stolen from them is irreplaceable. They must mourn the loss of the foundation of basic trust, the belief in a good parent. As they come to recognize that they were not responsible for their fate, they confront the existential despair that they could not face in childhood.¹³

Grieving has an additional meaning for survivors who have themselves harmed or abandoned others. The combat veteran who has committed atrocities may feel he no longer belongs in a civilized community. The political prisoner who has betrayed others under duress or the battered woman who has failed to protect her children may feel she has committed a worse crime than the perpetrator. Although the survivor may come to understand that these violations of relationship were committed under extreme circumstances, this understanding by itself does not fully resolve her profound feelings of guilt and shame. The survivor needs to mourn for the loss of her moral integrity and to find her own way to atone for what cannot be undone. This restitution in no way exonerates the perpetrator of his crimes; rather, it reaffirms the survivor's claim to moral choice in the present.¹⁴

The confrontation with despair brings with it, at least transiently, an increased risk of suicide. In contrast to the impulsive self-destructiveness of the first stage of recovery, the patient's suicidality during this second stage may evolve from a calm, flat, apparently rational decision to reject a world where such horrors are possible. Patients may engage in sterile philosophical discussions about their right to choose suicide. It is imperative to get beyond this intellectual defense and engage the feelings and fantasies that fuel the patient's despair. Commonly, the patient has the fantasy that she is already among the dead, because her capacity for love has been destroyed. What sustains the patient through this descent into despair is the smallest evidence of an ability to form loving connections.

The second stage of recovery has a timeless quality that is very frightening. The reconstruction of the trauma requires immersion in a past experience of frozen time; the descent into mourning feels like a surrender to endless tears. Patients often ask how long this painful process will last. There is no fixed answer to the question, only the assurance that the process cannot be bypassed or hurried. It will almost surely take longer than the patient wishes, but that it will not go on forever. After many repetitions, the moment comes when the telling of the trauma story no longer arouses quite such intense feeling. It has become a part of the survivor's experience, but only one part of it. It is a memory like other memories, and it begins to fade as other memories do. Her grief, too, begins to lose its vividness. It occurs to the survivor that perhaps the trauma is only one part, and perhaps not even the most important part, of her life story.

The reconstruction of the trauma is never entirely completed; new conflicts and challenges at each new stage of the lifecycle will inevitably reawaken the trauma and bring some new aspect of the experience to light. The major work of the second stage is accomplished, however, when the patient reclaims her own history and feels renewed hope and energy for engagement with life. Time starts to move again. When the second stage has come to its conclusion, the traumatic experience belongs to the past.

At this point, the survivor faces the tasks of rebuilding her life in the present and pursuing her aspirations for the future. She has mourned the old self which the trauma destroyed; now she must develop a new self. Her relationships have been tested and forever changed by the trauma; now she must develop new relationships. The old beliefs that gave meaning to her life have been challenged; now she must find anew a sustaining faith. These are the tasks of the third stage of recovery.

The issues of the first stage of recovery are often revisited at this time. Once again the survivor devotes attention to the care of her body, her immediate environment, her material needs, and her relationships with others. But while in the first stage the goal was simply to secure a defensive position of basic safety, by the third stage the survivor is ready to engage more actively in the world. She can establish an agenda. She can recover some of her aspirations from the time before the trauma, or perhaps for the first time she can discover her own ambitions.

By the third stage of recovery, the survivor has regained some capacity for appropriate trust. She can once again feel trust in others when that trust is warranted, she can withhold her trust when it is not warranted, and she knows how to distinguish between the two situations. She has also regained the ability to feel autonomous while remaining connected to others; she can maintain her own point of view and her own boundaries while respecting those of others. She has begun to take more initiative in her life and is in the process of creating a new identity. With others, she is now ready to risk deepening her relationships. With peers, she can now seek mutual friendships that are not based on performance, image, or maintenance of a false self.¹⁵ With lovers and family, she is now ready for greater intimacy.

At this point, the survivor may be ready to devote her energy more fully to a relationship with a partner. If she has not been involved in an intimate relationship, she may begin to consider the possibility without feeling either dread or desperate need. If she has been involved with a partner during the recovery process, she often becomes much more aware of the ways in which her partner suffered from her preoccupation with the trauma. At this point she can express her gratitude more freely and make amends when necessary. The survivor may also become more open to new forms of engagement with children. If the survivor is a parent, she may come to recognize the ways in which the trauma experience has indirectly affected her children, and she may take steps to rectify the situation. If she does not have children, she may begin to take a new and broader interest in young people.

Most survivors seek the resolution of their traumatic experience within the confines of their personal lives. But a significant minority, as a result of the trauma, feel called upon to engage in

a wider world. These survivors recognize a political or religious dimension in their misfortune, and discover that they can transform the meaning of their personal tragedy by making it the basis for social action. While there is no way to compensate for an atrocity, there is a way to transcend it, by making it a gift to others. The trauma is redeemed only when it becomes the source of a survivor mission.¹⁶

Social action offers the survivor a source of power that draws upon her own initiative, energy, and resourcefulness, but which magnifies these qualities far beyond her own capacities. It offers her an alliance with others based on cooperation and shared purpose. Participation in organized, demanding social efforts calls upon the survivor's most mature and adaptive coping strategies of patience, anticipation, altruism, and humor. It brings out the best in her; in return, the survivor gains the sense of connection with the best in other people. In this sense of reciprocal connection, the survivor can transcend the boundaries of her particular time and place.¹⁷

Social action can take many forms, from concrete engagement with particular individuals, to the abstract intellectual pursuits. Survivors may focus their energies on helping others who have been similarly victimized, on educational, legal, or political efforts to prevent others from being victimized in the future. Common to all these efforts is a dedication to raising public awareness. Survivors understand that the natural human response to horrible events is to put them out of mind. They also understand that those who forget the past are often condemned to repeat it. It is for this reason that public truth-telling is the common denominator of all social action.¹⁸

The survivor mission may also take the form of pursuing justice. In the third stage of recovery, the survivor recognizes that the trauma cannot be undone, and that personal wishes for compensation or revenge cannot be fulfilled. She also recognizes, however, that holding the perpetrator accountable for his crimes is important not only for her personal well-being but also for the health of the larger society.

The survivor who undertakes public action also needs to come to terms with the fact that not every battle will be won. Her particular battle becomes part of a larger, ongoing struggle to uphold the rule of law and the principles of non-violence against the rule of force. She must be secure in the knowledge that simply in her willingness to tell the truth in public, she has taken the action that perpetrators fear the most. Her recovery is not based on the illusion that evil has been overcome, but rather on the knowledge that it has not prevailed, and on the hope that restorative love may still be found in the world.