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SICK, CRAZY, OR TRAUMATIZED? DOES IT MATTER?

by Anonymous, M.D.

Back to Basics: Sick, crazy, or traumatized? Does it matter?

When I was in medical school in the British Isles, one of the hospitals where I spent a three-month rotation was a beautiful, old, and well-restored building constructed out of stone in the 1700s. It looked out over a lovely park with magnificent trees, tended flower beds, and a variety of colorful birds. Inside there were impressive hallways with tall windows, early landscape paintings that had been donated to the facility, and a number of doors that opened off the hallways leading to different clinics. Because the hospital building was an architectural treasure, as much as possible of the early flavor of the place had been maintained, including some of the gilt lettering on the original clinic doors.

During my stay there as a medical student, I noticed a door with a quaintly lettered sign that read, "Hysteria Theatre." Since I was busy and preoccupied, I didn't think a lot about it. I knew in that part of the world 'theatre' sometimes meant 'operating room,' but all my mind conjured up was some kind of stage musical, even though that didn't make much sense in a psychiatric hospital. But my thoughts were filled with other concerns, and I just let it go unexplored, especially since one of the maintenance men told me that these days, it was just used for storage. It took me a while longer to fully absorb what the sign meant and what had happened in that room a couple of centuries earlier.

Look up hysteria in the dictionary and among other things, you will find that the word derives from the former notion that hysterical women were suffering from disturbances of the womb…(1801).

So that room behind the quaint, gold-lettered sign was the place where troubled women went to have hysterectomies to 'cure' them of their emotional illness. Apparently, ordering a hysterectomy was part of accepted and standard practice at one low point in the history of the psychiatric profession. [Alas, there are several low points in the history of the psychiatric profession. See *Trauma and Recovery*, by Judith Herman, M.D., Chapter 1, "A Forgotten History."]

It was a blow to realize what I had been pushing out of my consciousness for that first month or two of my student psychiatric rotation, and it took a long time to get over the shock of it. When I questioned my supervisors about the former practice, most of them pleaded ignorance. One teacher, however, was familiar with the history of the hospital and shook his head with embarrassment and disgust about the remedies of his predecessors.

Not that things had improved greatly in all those years, especially in a country that approached emotional problems very much according to the 'medical model.' While I listened dutifully with a small group of students, one senior psychiatrist had a standard little talk he delivered to his (mostly female) outpatients, whom he often interrupted when they tried to tell him about their distress: "Now, now, dear, it will be all right. I promise you…Listen to me now! I promise you that this medication will take care of everything. You have a chemical imbalance, and we can treat that very well. I know it's hard to believe, given the way you're feeling at the moment, but I promise that if you take the pills as I have instructed, in four to six weeks you'll be a new woman, and the world will be rosy again…trust me. Off you go, now…" As a student observer, I watched him do that over and over again, week after week, as his patients left the clinic fighting back tears, prescriptions in hand. If some of them didn't return, I doubt that he noticed. He had a team of nurses, aides, and secretaries to handle appointments and cancellations.

I didn't ask that particular professor about his thoughts regarding the hysterectomies they did in the old days. He was too 'busy and important,' according to his assistants, to do anything but teach his students and minister to his patients. In fact, one of them told me that if I asked fewer questions in general and listened more to what the professor had to say, I might actually learn something. As I thought about

those unfortunate women back in the late 1800s, it occurred to me that some of them might have improved, if only temporarily. Think about it – if you take a woman out of a stressful, traumatic, or overwhelming situation or environment; tell her she is going to be cured by this simple operation; anesthetize her, perform the surgery, then recommend bed rest in a relatively comfortable hospital room with a view of the park outside; let her convalesce for a few weeks before going home, what do you know? By the time she leaves this impressive building with its beautiful grounds, she just might be quieter, more compliant, and grateful to the medical profession for helping her recover from her 'illness.'

This may seem an extreme example to make a point, perhaps, but I think it matters very much whether trauma survivors, their significant others, and members of the mental health profession regard their symptoms as 'illness' or 'injury.' Illness generally suggests a disease process, whereas injury has to do with hurt or trauma. While they sometimes overlap, these two avenues of approach involve different perspectives, different attitudes, and different paths to healing and recovery. And the balance of power is usually quite different in the relationship between client and caregiver in the medical model versus injury model.

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I want to say a word about the notions of 'crazy.' 'Crazy' is a label trauma survivors often apply to themselves before they come to understand that it was the early childhood situations in which they found themselves that were crazy and chaotic, not the children who had to find a way to survive those circumstances. Usually when people refer to themselves or others as crazy, they mean that certain ways of being and behaving make no rational sense and are sometimes extreme, violent, or alarming. The individual has lost touch with 'reality,' may hallucinate, and harbor some very strange ways of thinking and expressing him/herself…

Is this person psychotic?

A trauma survivor having a flashback or dissociative episode?

Someone on drugs, suffering from a high fever or toxic delirium?

Or maybe a tortured artist like Vincent van Gogh?

These states of being are not necessarily mutually exclusive. In other words, you can have more than one (hey, you could have them all, if you're supremely unlucky!).

But for clarity and the purposes of discussion, let's assume they are separate and don't overlap. And we will also assume that correct diagnoses are made by treating professionals (which I can categorically state is not always the case).

A little more about 'crazy.' The classic psychotic disorders are the schizophrenias and the major mood disorders, such as manic-depressive (or bipolar) disorder, though sometimes there are temporary psychoses brought about by other factors. These brief, temporary psychoses usually resolve when the circumstances that caused them are removed or clarified. Unfortunately, this is not the case with the 'classical' psychotic disorders. Without going into the details of the schizophrenias or major mood disorders, most medical professionals would agree that they are diseases. Research has demonstrated genetic vulnerabilities and biochemical imbalances that can sometimes be measured by laboratory studies and which account for the disabling symptoms suffered over a long period of time. Often there is a fairly predictable course, though there are individual variations and degrees of intensity. Both groups of psychotic disorders may respond favorably to medications, but so far neither can be cured. Supportive therapy and structure may help to some degree, but without medication, very little improvement has been reported.

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On the other hand, people who have been traumatized often dramatically improve and/or fully recover with the right kind of therapy and sometimes without medication. There are many kinds of trauma: abuse, torture, war, medical experimentation, natural disasters, crime, and other forms of significant injury. The ways in which many individuals respond to and cope with trauma is a tribute to the resilience of the human spirit, psyche, and body.

Obviously, not everyone makes it. Some die, some remain in a place of private despair and isolation. Most survivors know only too well of others who have

succumbed in one way or another to what happened. People are different, situations are different. But the fact remains that many traumatized individuals survive and survive very, very well, in spite of the hurts they have endured, in spite of an impressive range of painful, confusing, and often overwhelming symptoms, and in spite of the difficulties of finding kind and knowledgeable caregivers.

Survivors can be tenacious, once they have decided to heal. I'm not sure what the present statistics are, but not too long ago, it was the case that it took dissociative clients an average of 7 years(!) of working their way through the system to find a mental health professional who knew anything about trauma and abuse and was prepared to listen to them with respect, then discuss the possibilities of a collaborative effort to address the issues. Seven years of…

...frequent misunderstanding, misdiagnosis, and mismanagement;
...often ignorant and/or ineffective caregivers;
...too many highly credentialed professionals with indifferent, condescending, or downright contemptuous attitudes; and
...a whole smorgasbord of frequently inappropriate and sometimes dangerous prescription medications.

Seven years of searching through a minefield: that's tenacious!

It also indicates that there is probably something survivors are looking for, something they will recognize when they come upon it in a therapist or consultant. Perhaps they know intuitively that there is little to be gained from the medical model where there is often a large imbalance of power between them and the treating professionals. In the 'disease model,' something critical is missing when one person has the attitude, "I know what is wrong with you, and this is how I'm going to fix it." Respectful listening on an equal playing field by a thoughtful care provider who knows something about the way people respond to trauma seems to be an important key to recovery.

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From what survivors have told me, **the something they are looking for often has to do with an attitude of openness and non-judgmental acceptance, a kind of caring that is rooted in an understanding of a fundamental shared humanity, and a willingness by the care provider to learn a few things from his/her clients.** Healing from trauma and abuse must be a partnership rooted in trust and respect, which can and should take a little time to develop. A spirit of inquiry and a particular kind of

humor in a therapist helps, as well. If I were to say that survivors have taught me more than I ever wanted to know about what's been going on in the world, I'm sure a few readers would smile with recognition.

Posttraumatic stress disorder (PTSD) is the pivot around which many trauma symptoms revolve. It is a common and natural response to serious injury and/or threatened death. When the experts who determine and periodically update the diagnoses for the DSM (Diagnostic and Statistical Manual of Mental Disorders) got together to discuss the last edition (Fourth Edition) of the manual, a few of them wanted to call multiple personality disorder "chronic, complex posttraumatic stress disorder." In their deliberations, this PTSD group of consultants lost the vote, and instead, the majority voted that multiple personality disorder be renamed "dissociative identity disorder (DID)." As far as labels go, it's probably fair to say that both of these have some merit, but labels go only just so far, when it comes to human experience.

In order to survive overwhelming trauma and not die – or become psychotic – many people are able to dissociate the horrific experience(s). They learn to keep the components of the trauma separate from conscious awareness, while they struggle to carry on as best they can in their given environments. If the trauma/abuse/atrocities continue over a period of time, the gift of dissociation evolves into a sometimes complex means of quick rescue - it can become a literal lifesaver over and over again. Of course, there is a down side to dissociation, and survivors struggle with difficult symptoms, including 'loss of time,' a certain amount of chaos and confusion, and the emergence of PTSD symptoms (emotional or physical flooding, hypervigilance, flashbacks, nightmares, behavioral reenactments and 'body memories,' intense fear, dread, horror — and/or the opposite, numbness, avoidance, withdrawal, and shutting down). These symptoms can occur without warning, sometimes at inconvenient times and can be both distressing and embarrassing. Sometimes survivors are able to identify external or internal triggers for these symptoms and sometimes not.

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The good news is that with patience and perseverance, it is possible to learn how to honor and handle these symptoms when they emerge. In a structured therapeutic setting where there is a fundamental understanding of trauma and its aftermath, a survivor and his/her care provider establish the parameters for healing from the injury

he/she has sustained. The survivor learns, perhaps for the first time, how to develop a sense of internal safety and self-care that will be the foundation for solid recovery. After horrific, often life-threatening experiences, safety and self-care have to be practiced for a while, before they feel real to someone who may never have previously known such feelings. But as a sense of security and self-soothing techniques are established, the work of processing the trauma can begin – at a pace set by the survivor. Out of this painful and important work, the survivor is not only able to 'own' her/his own history, she/he eventually feels a sense of growing autonomy, inner strength, and connection.

Many, many survivors have healed, against sizeable odds. They have recovered from their injuries to a point where they can reflect on what has happened and ask what it means to them and where they will go from here. The answer to that question is different for each individual. Some find joy in being 'present' in the 'now' and living lives of relatively quiet contentment. Some feel a need to write or paint or creatively express themselves in other ways, often incorporating part of their life experience into their art. Still others are compelled to do what they can to connect with other survivors and do what they can to offer hope and support in recovery. Whatever the choice, survivors come to understand that they can look around freely, raise their own questions, think their own thoughts, and seek their own paths. "The best revenge is to live well," is a message many survivors have taken to heart.

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It is important for survivors and their significant others to appreciate that their challenge is to recover from serious injury. In most instances, they are not suffering from a disease. Posttraumatic stress disorder and dissociation were the means by which they survived terrible events in the past.

Although coming to terms with the trauma is difficult and heart-wrenching work, it is essential to realize that you have already survived the worst. All you're doing in a good therapeutic setting is healing the wounds and honoring the battle scars.

And in more ways than survivors may realize,
you're leading the way for the rest of us…

HEARTLAND TRAUMA INSTITUTE*: 2009 SCHEDULE OF ONLINE SEMINARS

Featuring the Core Integrity Model©:
Applying consciousness phenomenology from neurocognitive research to trauma recovery.

Fri . July 17 . 2-3:30 pm (CST)	**Recovering from injury to one's CORE SELF:** the neurocognitive rationale for including identity in trauma recovery.
Fri . July 31 . 2-3:30 pm (CST)	**Healing the CORE SELF through the Nexus of Consciousness:** finding the communication bridge between therapist, trauma survivor, and the injured mind.
Fri . Aug 7 . 2-3:30 pm (CST)	**Establishing safety with the Quintessential Safe Place©:** neurocognitive phenomenology applied to Stage One in the standard of care.
Fri . Aug 21. 2-3:30 pm (CST)	**The Core Integrity Model©:** applying the concepts of **CORE SELF**, the Nexus, and the Quintessential Safe Place to Stage Two of trauma recovery.
Fri . Sept 4 . 2-3:30 pm (CST)	**Differentiating fixed ideas from implanted beliefs:** case examples applying the neurocognitive phenomenology and symptom intervention.
Fri . Sept 18 . 2-3:30 pm (CST)	**Trauma Context No. 1. Acts of nature, unfortunate events, and "normal" deviance:** a summary of context-related phenomenology and relevant interventions.
Fri . Oct 2 . 2-3:30 pm (CST)	**Trauma Context No. 2. Social organizations, religious institutions, and "fringe" deviants:** a summary of context-related phenomenology and relevant interventions.
Fri . Oct 16 . 2-3:30 pm (CST)	**Trauma Context No. 3. Unethical research, human trafficking, and "conspiracy theory":** a summary of context-related phenomenology and relevant interventions.

Each 90-minute unit consists of: **(1) a brief introduction of participants, (2) definition of terms, (3) review of scientific foundation, and (4) the application to therapeutic intervention.**
*(**1.5 CEUs per seminar**; NBCC-approved.)*

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To register, email: heartland.trauma.institute@coreintegrity.org ***or visit:*** www.ehope.org

Presenter:
Lowell Routley, PhD, LMHC. Founder and Executive Director, Heartland Initiative.

Dr. Routley encountered his first case of multiple personality disorder in 1982. This introduction to the dissociative mindset initiated a personal and professional quest to

understand and treat the abused and traumatized. As he counseled clients and observed their progress, he incorporated the most effective principles and methods, developing the Core Integrity Model© over the course of several decades.

After tens of thousands of hours of client interactions, twenty-some years of education and study, Heartland Initiative was established in 2002 ***to transform lives impacted by trauma***. Today, Dr. Routley senses a keen obligation to pass on this vital information through the development of a network of therapists who, in their own spheres of influence, can help heal the mentally wounded to live happier and healthier lives.

* **HEARTLAND TRAUMA INSTITUTE**, a division of Heartland Initiative, Inc. (a 501c3 organization) is dedicated to ***transforming lives impacted by trauma*** by developing a network of trained professionals.
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