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Another Baby Dies: Preventing Child Homicide

Patricia Crittenden

Words are very powerful. They can reveal meaning, obscure it, or change it. Recently, 'Baby P' died of injuries inflicted by his parents. The newspapers in England screamed "**torture**", "**deception!**", "**sadistic thug**" … With those evocative words, the adults' motivations were revealed as "**wicked**" and "**evil**" – beyond human comprehension. Powerful words like these stand in the way of understanding and preventing the next tragedy.

In the last issue, I wrote about Victoria Climbié. Have we learned nothing in the 8 years since her death? Did the workers who saw Baby P 60 times not know that children who are repeatedly hurt by their parents are very quiet, very good and, when they are old enough, very 'happy'? Baby P's nickname was 'Smiley': *His happy smile masked months of pain and terror inflicted by his mother and stepfather* (*Daily Mail*, Nov. 12, 2008).

Did the professionals not understand that such parents were themselves hurt as children and often were frightened and endangered now as adults? *Baby P's mother had grown up around social workers and had plenty of practice in how to manipulate them.* That line – and the word 'manipulate' - shape our understanding and hide the question of why she had needed social workers. Did the danger of abandonment – that she had experienced as a child – drive her both to dangerous lovers and to do whatever was necessary to keep her baby?

Did the professionals not know that adults, like Baby P's stepfather, who have been punished dangerously often punish their children hard – very hard – to teach them to avoid greater dangers? Adults from countries exposed systematically to danger know this. Do we, who live in safer countries, fail to appreciate the power of exposure to unprotected danger to shape the mind and organize behavior?

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What should we have learned from Victoria's death that might have prevented Baby P's death?

- To recognize the import of false positive affect, especially when it is discrepant with the situation;
- To avoid accusations and to ask parents about their fears and past trauma so we can help them to protect their children;
- To provide long-term 'supportive' services (see Nickel article on page 3)

How should we react? Shall we reorganize the services? Develop a new protocol? Fire everyone? Let's not treat the professionals like Baby P's parents treated him. Nor like their parents treated them. Let's recognize the good intentions of the well-meaning professionals and their distress at intentions gone bad – distress that Baby P's parents feel too. Let's not put anyone on the defensive – because that will change their behavior in undesirable ways. Instead, let's provide the needed information on affect, the effects of trauma, and the importance of compassion combined with safe practice at every stage of life.

We can't prevent every death, but we can stop repeating the same errors.

Patricia Crittenden, Ph.D. has written about child homicide in *Raising Parents* (2008).

The Canadian Residential School Experience: A Personal Perspective

Mary Courchene

"The treatment of children in Indian residential schools is a sad chapter in our history and will never be repeated." This statement was made by Prime Minister Steven Harper on June 11, 2008 in the Canadian House of Commons, when he officially apologized to many representatives of First Nations, Inuit and Métis Peoples of Canada for a devastating government assimilation policy. Residential school internment lasted a century and yielded multiple generations of children who were wrenched away from their families and forced to live in schools where their language and culture were banned and where many were abused physically and sexually.

I was one of those representatives on that historic day. I am also one of an estimated 87,000 residential school survivors and I am writing to share a personal perspective on the devastating legacy that this course of action has left on the lives of generations of First Nations, Inuit, and Métis peoples of Canada.

I recall my preschool years as being happy and loving, with much nurturing surrounded by family which included parents, grandparents, siblings and other extended family members. When I was 5 years old, my older brother and I were taken away to a residential school, which incidentally was a mere 5 minute walk from where we lived.

I remember looking forward to school because I could learn English and decipher what the bubbles said in the comic books that I looked at for hours!

Strangely, my parents did not prepare us for what to expect at school, and I soon found out why they couldn't. My mother still held onto the painful memories from the decade she had spent in the very school she was now forced by law to enroll her children in!

Life in residential school was one of misery, incredible loneliness and deprivation of nurturing and parental love. During the 13 years I was forced to stay, I was systematically stripped of dignity and pride and indoctrinated into believing my culture, customs and language were savage-like and primitive. As a result, I rapidly learned to hate my whole world including myself and my people. (I also hated my ancestors.) At home one summer, during our annual two month break, I recall looking at my parents with extreme resentment and outright hatred, simply because they were Indian and greeted me in our traditional language.

"From now on we will speak only English in this house," I proclaimed. My dad looked at me with sadness as my words stung him. "Well I guess we will never speak to this little girl again," he said in Ojibway, the language of our people. I was just 11 years old.

Already by then, my absence from home had caused irreparable damage. I was almost robot-like and unable to express positive emotions like love and joy. Instead I was driven by fear and hate at a crucial time of my childhood. I was a stranger in my own home, unable to relate to my parents, and, because boys and girls were prevented from interacting, I was not even able to relate to my brother at the same school.

I tell this part of my life story to make the point that the residential school system in Canada destroyed the family unit of a whole First Nations population. It was deliberate and systematic.

The First Nations, Inuit, and Métis populations of Canada are still reeling from this dark era of Canadian history. Our statistics in child welfare, prisons and our graduation rates corroborate this phenomenon. It is no wonder that Aboriginal people still struggle to find their identity. Alas, many of our youth today, especially in large urban centres, find that they are disconnected from their culture and language, and are lost in an unhealthy sub-culture.

This warfare on our spirit left generational scars and a history that the whole world should know about, given Canada's reputation as a free country.

How do we heal?

The solution is to reclaim our traditions, our customs and our languages by connecting with our own elders, who are our traditional knowledge-keepers. This movement of reclamation and revitalization is strong and we are a resilient people.

We will heal.

Photo: Duane Burnett, BC, Canada

Mary Courchene is the former Dean of Aboriginal Education at Red River College in Winnipeg, Canada.

Trauma & Victimization

Pat Crittenden

DMM News #5 is focused on trauma; issue #4 was about sex-and-violence. Put another way, we are discussing *perpetrators* and *victims*. This issue also refers to *resilience* and *transmission of attachment across generations*. These terms are common enough, but let's not slip too quickly and easily past meanings that are so troublesome that we'd rather avoid them.

Take, for example, the dichotomy between victims and perpetrators. Peder Nørbech and Val Hawes showed us that dangerous murderers are usually grown up victims. Jennie Noll, in this issue, describes how a girl victimized by her father's sexual abuse later neglects her own children so severely that one will die and two will be removed from her care. Is such a girl a victim or a perpetrator? Do these words refer to different people or only to our attitude to the same person at different points in their life? Do our terms reduce the complexity of their suffering and the completeness of our understanding to a single act - in order to make our selection of a response less stressful to us?

As I see it today, words like perpetrator, abuser, and offender define the person from the perspective of others and for the purposes of others. In so doing, the terms omit crucial aspects of the person, both in the present and in how they developed.

People who harm other people have almost always suffered very greatly at times when they could not protect themselves. Moreover, there was almost never someone to comfort them. As Sverre Varvin and Mary Heller point out, they did what they could, with the maturity and experience that they had at that time, to protect themselves. I agree. They make the best meaning they can, in childhood, of their situation and organize their behavior to protect themselves from danger and pain. Usually, that means (1) attending hypervigilantly to some information, (2) discarding distracting or misleading information, often information about safety and comfort, and (3) acting quickly, often before thoughtful integration can be initiated. When we observe their dangerous behavior, we find it difficult to see that they feel endangered and are acting to protect or comfort themselves. Understanding that could change our response in ways that might reduce both their threat to others and their suffering.

Victims face the opposite problem. Often we fail to predict how their efforts to protect themselves may someday endanger others, including their lovers and children – the very people whom they intend to protect. Our efforts to rescue victims often overlook their complex relationships with endangering family members.

This brings us to resilience. Many people who were victimized do not go on to harm others or, having harmed others, they, nevertheless, come to appreciate what they have done and to change. By calling them resilient, we may overlook the process by which their maturity was achieved. Resilience conjures up the notion that they were somehow, magically, untouched by the harm they experienced.

Not so! They suffered, they worked very hard to come to grips with both the experience and their role in it, and they continue to grieve for what was lost. Resilience is not a special gift; it is a hard won and costly achievement. It transforms the passivity of suffering into the action of repair. Moreover, as Mary Courchene suggests, it is earned again and again as one recovers personally across a lifetime and assists others to find the same possibility. Resilience is grit, undergirded by compassion, not luck.

Finally, transmission of attachment – or maltreatment. How exactly does one generation affect the next? 'Transmitted' suggests a package – or a message. Once again, it is not so. Each person must experience and perceive their own world, represent their perceptions, organize strategies and act – for themselves. These things cannot be transmitted as wholes and children may not organize similarly to their parents. Endangered children, in particular, display a wide range of outcomes that they organize for themselves.

My point is that our terminology omits processes, reduces complexity, and overlooks variability. If we really want to help, our job is to pause exactly where language slides quickly across complex meanings. At just that point, we should, in the words of American 'Indians', try walking in the other person's moccasins. Only then will we appreciate the experience of those who had no choice but to wear such shoes. Only then will we understand the psychological and behavioral strategies of threatened people, respect the effort that mental organization requires, and be prepared to celebrate the achievement of human potential that the word 'resilience' embodies.

Supporting Aboriginal Families

Irmie Nickel

Aboriginal people in Canada include First Nations peoples (who were here before Europeans arrived), Métis people (mixed First Nations and European ancestry) and Inuit people (Northern most regions). In Manitoba, they represent 10% of the population, approximately 50% of whom are under the age of 25. Many are at risk for developing difficult attachment relationships due to the century-long residential school experience.

After much debate, each aboriginal nation has been given the right to form its own child care agencies. The new agencies came into existence under much scrutiny, with little time to prepare and train staff, but with the opportunity to do something significant and different.

The DMM and aboriginal people

People in aboriginal cultures have a wide range of attachments based on family structures and responsibilities that reflect aboriginal values and traditions. Aboriginal parents are less likely to be directive with their children and more likely to prefer non-verbal teaching and learning styles, stressing the importance of observing their children in normal life contexts. The DMM, with its focus on observing and identifying patterns of relationship, is congruent with aboriginal peoples' desire to focus on the competence and skills of children who have unique adaptive "characteristics" which are observed, rather than labeled as "problem behaviours".

In line with the above thinking, some newly formed aboriginal agencies have accomplished great things in a short time. The Métis Child, Family and Community Services (*2008*) is one of them. This agency has developed programs suitable for all levels of service need, following DMM guidelines (*Crittenden, 1992*). **Their programs include:**

Levels of Family Functioning (Patricia Crittenden, Ph.D.)

Independent and adequate families

The *Young Mothers and Kookums Program* to connect young mothers with grandmothers for ongoing support, mentoring and teaching about parenting.

Vulnerable to crisis (6 months)

The *Family Support Program* which provides a range of prevention and early intervention services to strengthen families and reduce risk factors.

Restorable (1-5 years)

The *Family Enhancement Program* that places entire families in supported and supervised foster care settings when children are at risk for removal from the family.

Supportable (15-20 years)

The *Family Mentorship Program* which matches families with long term mentors, preferably from their own extended family.

Inadequate (remove children)

The *Kinship Care Program* employs extended family members as foster parents and seeks out community networks to support the family foster parents.

The significant emphasis on engaging the extended family and the community in these examples is something to watch carefully over the next few years. DMM principles of protection, provision of comfort and biological survival are at work here.

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Doctor, Can You Treat My Trauma?

Sverre Varvin

Patients rarely ask this question. They come instead with perplexing symptoms like sudden anxiety, intrusive thoughts and vengeful preoccupations with what "they did to me." They feel something has gone wrong inside them. They cannot manage their children, their partner seems threatening, they seek isolation.

The problem in attachment and information processing terms

Occasionally therapists just think about trauma from a 'what happened' perspective and even claim to be trauma or trauma-focused therapists.

I think the patients are right. In accord with research on traumatisation and memory, they feel something is wrong in their personality – their sense of who they are - and their way of relating to others.

Severe and traumatic injury committed by other people, such as childhood abuse, torture, and war, has a massive and often unpredictable influence. This implies activation of attachment strategies. For example, a common strategy is to become more distancing of negative affect and close attachment figures. The more avoidant one can be, the better the chances for survival in many contexts. This may be the reason why Type A strategies predominate among survivors of traumatic abuse.

Trauma operates through procedural and imaged memory, with many aspects preserved as imaged or sensory memories. Is there then a specific *traumatic* memory, a type of memory different from others, that etches into the brain like a photo, almost impossible to erase or change? The persistence of the traumatic imagery in many patients' dreams raises this speculation, but neither clinical experience, nor memory research, supports the idea. Memories are modified according to the context in which they are remembered and therapy may contextualise memories. When traumatic incidents are unresolved, there is no coherent and reliable narrative of the experience. A key aspect of the therapy, therefore, is to help the patient develop such a coherent narrative.

Traumatic experiences are embedded in incomplete symbolised scenarios dominated by implicit memory and structured by attachment patterns acquired during development. Traumatic experiences also remould earlier memories, making safe situations seem unsafe, and activate inhibitory attachment strategies that suppress more balanced ones.

Traumatisation often produces Type A strategies. As a result of incomplete memory processing, unrelated but similar stimuli may release extreme anxiety and avoidance. Use of forebrain and hippocampal regions may be diminished while amygdala and brainstem mediated acute responses (fight, flight, freeze) may dominate.

The effects of traumatic injury differ according to the age when the trauma

occurs. This is as true for the adolescent war victim as for the elderly victim of genocidal terror: a life course is broken. Not being able to marry the person you loved in adolescence (or maybe feeling unable to love again) or not being able to function as grandparents (or losing your grandchildren) are terrible blows to developmental expectations. From this, it may be clear that I see psychotherapy of traumatised patients as something more, and often something else, than treating 'the trauma."

Treatment

Most people exposed to extreme natural disasters do not develop post-traumatic disorders. Many experience strong grief reactions and passing trauma reactions that will subside and which do not require specialized treatment. One should, however, be aware of late onset conditions that may appear several decades after long-lasting danger and threat.

The combination of exposure to life-threatening danger, especially man-made, and/or loss of a loved one and a blow to one's self-esteem, seems to represent a massive risk for psychic traumatisation (*Weisaeth, 2006*). This type of combined exposure, which may be repeated or long-lasting, affects a substantial number of people following war, terror, persecution, or refugee experiences.

These experiences can affect peoples' belief - systems (i.e., semantic memory) and the underlying structures and dynamics of the mind. When traumatic, they may result in more permanent changes in personality and attachment functions. The person often feels endangered, and attachment patterns concerned with survival will dominate the person's relations to self and others.

The effects appear in relationships, including transference patterns with therapists, and are met at the very beginning of any therapeutic encounter. The 'treatment of the trauma,' therefore, starts from the very first contact with the treatment system.

If the treatment system is characterised by neglect, obsessive procedures, suspicion of foreigners (the fate for many refugees), an anti-therapeutic element is built into the treatment from the beginning. Both the expectation of being neglected and maladaptive attachment patterns are reinforced.

Therapists and those who organise treatment and care should be aware of an *expectational triad* characterising many traumatised people:

(1) Something bad can happen at any time

(2) There will be no help, and

(3) Nobody will care.

Sadly, experience shows this belief system can typify many first therapeutic encounters. If early attempts to obtain therapeutic help prove difficult or frustrating, the traumatised person is likely to activate mostly avoidant attachment patterns geared to detecting any signal of danger in the other person.

A patient had experienced incest from her father, and now feared men. In one session, she entered confused and watchful. She had pain in her eyes. It appeared that she was afraid she would not 'see' her effect on the therapist. As she said after some therapeutic work, "I was afraid I could not make you feel good. It's always like that. I have to watch out. If men don't feel good, things may suddenly change. Then I am trapped. I can't do anything. I must do as they say."

This had been the situation with her father. Her avoidant attachment strategy was a post-hoc reaction in order to prevent what had already happened.

The understanding and processing of such transference situations is at the heart of any trauma therapy. The therapist has to deal with several issues:

- Defensive and often extremely rigid relational patterns
- Beliefs that the worst may happen any time with no help
- Complex transferences and counter-transferences: idealized patterns may interchange with withdrawal and perpetrator victim enactments with the danger of therapist's withdrawal
- Massive projective identifications: the therapist has to contain both projected perpetrator and victim parts from the patient's inner world
- Awareness of avoidant attachment strategies is indispensable: The patient has difficulties in representing their own feelings, especially negative feelings. 'You always have to be aware,' is the traumatised patient's slogan
- Trauma scenarios may present as presently felt danger and may be meaningfully treated as mental representations related not only to the past, but also, and mainly, to the present

Treatment takes time; the patient is trying to change ways of being with others, and is also trying to create a more satisfying life. Inability to love is possibly the most devastating effect of man-made traumas.

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If You Feel Very Distressed

When you have experienced overwhelming situations, you may feel helpless, anxious, scared and angry. Sometimes this happens a long time after the dangerous experience. There are some things you can do that might help:

- **Find a place where it feels safe and give yourself quiet time there**
- **Seek out people you trust and contact your close ones if you can**
- **Ask them to stay with you and talk when you feel you can**
- **Eat, rest, and care for yourself or let others care for you**
- **Do not isolate yourself**
- **Be gentle with yourself – recovery takes time**

If anxiety and sleeplessness persist, seek professional help. Remember that you can be helped even a long time afterwards.

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Protecting the Next Generation: Children of Women Who Were Sexually Abused in Their Own Childhood

Jennie Noll

Wilma made a frantic call: her 10-month-old baby was drowning in the bathtub!! When emergency personnel arrived, they found Wilma intoxicated and her 4-year old son attempting to revive the already dead infant while her toddler screamed in his playpen.

Months later, depressed and suicidal in an inpatient drug unit, Wilma recounted the incident, admitting using drugs and alcohol to cope with severe depression and the painful reminders of her traumatic childhood. Wilma had been repeatedly raped by her father, until she was 12. She reflected on how the harmful effects of her abuse persisted and cropped up again and again throughout her life. She spoke of her inability to "keep a man" and her difficulty "connecting" with her own babies. "And now … the whole thing is spreading to my own children. When will this nightmare end?"

Wilma's story is true. It is a stark example of the compounded struggles facing many child sexual abuse survivors and of the potential danger to their children.

Our Research

We have followed 84 sexually abused girls from mid-childhood to early motherhood to find out how they and their children developed. Most longitudinal studies are *retrospective,* with the transmission assessed by self report. Our study is ***prospective***. We kept 96% of our sample of girls who had been sexually abused and 89 demographically similar girls who had not been abused for 20 years (*Noll, Trickett & Putnam, 2008*). We assessed all the girls six times while they were growing up. Now we have assessed almost all of their 135 known children.

Previous Research

Although about 30% of child abuse victims abuse their own children (*Kaufman & Zigler, 1987*), the potential for harm extends to their own physical and psychological problems in adulthood and may have devastating effects on their offspring.

Child sexual abuse involves early sexual boundary violations and can result in an association of sex with extreme violence and/or the conditional intimacy of caregivers. Crittenden theorizes that dispositional representations drawn from abusive relationships may contribute to continuity of maltreatment across generations (*Crittenden, 2008*). Others have reported that, compared to non-abused mothers, mothers with histories of sexual abuse pay less attention to their infants, respond differently to them, and draw conclusions about the babies based on their own (distorted) representations.

The experience of childhood sexual abuse places victims (girls and boys) at risk for continued emotional trauma and interpersonal difficulty, including cognitive and affective distortions around sex and intimacy (*Noll, Trickett, & Putnam, 2003*). Further, because incestuous abuse by fathers usually occurs without physical coercion or violence, its victims are more likely to consider themselves willing participants and to blame themselves more than other victims. Guilt and self-blame can lead to confusion regarding sexual arousal, interpersonal intimacy, and safety. Alexander (*1992*) identified several consequences of sexual abuse that are related to attachment, including mood disorders, ineffective or dangerous parenting practices, and adult attachment insecurity.

Our findings

The results of our study are dramatic and affect a wide range of developmental and adaptive outcomes. Sexually abused mothers were more likely to be high-school dropouts and to have experienced psychiatric problems, drug and alcohol abuse, and domestic violence than non-abused mothers. Their children were more likely to have a teenage mom, be born preterm, and receive child protective services than were the children of the comparison mothers (17% versus 1%). Children of sexually abused mothers performed worse cognitively and displayed more attachment disruptions (based on Ainsworth's Strange Situation for infants and Crittenden's Preschool Assessment of Attachment for 2-5 year olds) than children born to comparison mothers (*Kwako, 2007*).

Children of mothers who were sexually abused in their childhood are at risk for:

1) being abused or neglected, either at the hands of their own caregivers or by other violent or exploitive individuals who are allowed access to them;

2) various deleterious consequences of having a mother who suffers from emotional, psychiatric and interpersonal sequelae of her own childhood abuse

Attachment disruptions, both those that impair a victim's ability to form healthy adult attachments and those manifesting in insecure attachments with offspring, may contribute significantly to the intergenerational continuity of childhood maltreatment and continued adversity.

Nevertheless, not every abuse victim suffers as severely as Wilma did, and not every child born to victims will carry an adverse legacy forward. There are second chances. Many victims show resilience, take advantage of intensive treatments, seek opportunities for healing, or form healthy attachments with partners and children. There is hope and we can learn about recovery from such women.

Treating Child Sexual Abuse

Resolution of childhood trauma should extend through (or be revisited at) various developmental stages. At each period, different issues become salient and need attention. Moreover, as children mature, they are capable of more complex and complete resolutions. The precipitating issues might include romantic attachments and dating, initiation into sexual relationships, marriage, and having one's own baby. Professional help might be needed when the child's parent needs to move on, but the growing child needs to go over it again, differently.

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"I Feel As If I Am In A Terrible Nightmare That I Can't Wake Up From"

Mary Brownescombe Heller

Post-traumatic Stress Disorder (PTSD) has two opposing features:

Active physical avoidance, or emotional numbing to any situations, thoughts and images that act as reminders.

Intrusive 'flashback' recollections of the traumatic event, dread, hyper-vigilance and startle to triggers.

These give the typical see-sawing back and forth between an avoidant state (dissociation) and a re-experiencing state (flooding).

In *chronic* PTSD, these responses persist for years. Studies suggest that PTSD recovery depends on the nature, severity and perceived threat of the trauma, with personal factors being key to the development of chronic PTSD. These include lack of social support, adverse childhood experiences, previous exposure to trauma and pre-existing mental disorders. (Horowitz,1992; McFarlane, 1990). Early developmental trauma can undermine the neuro-physiological and psychological ability to moderate highly arousing and potentially traumatising situations, leading to a greater risk of developing PTSD in adulthood (Heller, 2001; Shin *et al,* 2005).

The research study

Using AAIs classified with the DMM method, I explored the relation between childhood trauma and chronic PTSD in a group of 22 adults referred for treatment (Heller, 2001). They came from all social groups and were mentally well before the onset of PTSD. Most had experienced significant unresolved losses and/or traumas in their childhood, but these earlier events were regarded as having little significance in their current lives. As one participant remarked, "*I must have developed PTSD because nothing bad has ever happened to me before, so I didn't know how to deal with something like this.*" At age five, this participant experienced the near death of her father in a terrible mining accident. He was left severely disabled and the family became destitute.

The childhood losses and traumas in this group frequently bore a striking resemblance to the event in adulthood that precipitated the PTSD. For example, a physical education teacher reacted with PTSD after a pupil collapsed and died during his class. This teacher's father disappeared shortly after his birth and, as a six-year-old, he had watched his much loved granddad die in front of him while they were out walking.

Such similarities led me to propose that the *real* trauma was the earlier one which had remained active, but dissociated. The *adulthood* trauma amplified the unexpressed feelings tied to the earlier trauma. These individuals, though mentally and physically well as adults, retained precarious mental states that broke down under the impact of equivalent endangering events.

When the AAI data from these 22 individuals were compared with matched groups of 'normative' and 'mixed diagnosis' AAIs (*Crittenden & Heller – unpublished paper*), the findings suggested that pre-existing attachment disturbances create a predisposition for developing PTSD in adulthood.

Three subgroups emerged within the PTSD group:

C+ attachment strategies: aggrieved and preoccupied, with thoughts of retaliation or revenge

A/C combinations: mixed dismissing and passive-aggressive attachment strategies.

Compulsive A+ strategies: with severe depressive features

Treatment

Because these groups use thoughts and feelings differently, a 'one-size-fits-all' approach to PTSD treatment is unlikely to be helpful, and could be harmful.

'Greg' was 50 and in the A+ cluster. Eight years earlier, he had been shifting crates on the dockside when a crane-load of steel bars swung around and knocked him down. He was convinced he would be crushed to death. The steel load was brought to a halt inches short of where Greg lay. Afterwards, Greg had nightmares and almost daily 'flashbacks.' Medication had not helped, nor had counselling and CBT. As the years continued with no improvement, Greg made several suicide attempts. When I met him, he was attending a day centre in a dejected and hopeless state.

"I'll open the door to the living room…and it's like I'm there…the whole thing happening again. Steel has a taste, you know. And I can see, taste, smell, hear, feel…that sling-load of steel as it comes towards me. Your heart starts racing and you're physically sick. It's there…and you can't get away from it."

All five senses were involved in this terrifying image. As the steel approached, his use of 'you' distanced the terror; it is not him but 'you' that can't get away. This is a typical speech pattern of 'distancing A's'. The AAI revealed a history of unresolved losses. He idealized his childhood: "*I was always the little blue-eyed boy.*" In reality, it appeared emotionally deprived and bleak. His only memory was of his father being brought home after a serious accident at work in the dockyard with blood-stained clothes.

Greg was offered a year of weekly individual psychotherapy focusing on safe expression of negative affect to enable him to acknowledge and express the shame, guilt, anger and humiliation he felt about what had happened to him. Gradually, he was able to make contact with workmates he had not seen for eight years. When therapy ended, no longer plagued by chronic PTSD, he was offered a job as caretaker in a block of flats. This suited his compulsive A strategy and placed him far from the dockside that defined danger for him.

TREATING PTSD

- Listen empathetically for words and feelings
- Let the person tell their story, their way
- Remain calm
- Let patients select behaviour management techniques that are right for them
- Be punctual and consistent

TRY TO AVOID

- Dismissing patients' thoughts and feelings – even when they seem bizarre
- Imposing one's own ideas on the patient
- Rushing the patient to 'get well'

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