

Shallow Affect, No Remorse: The Shadow of Trauma in the Inner City

Christopher B. Roach
Alliant International University

This article looks at a psychotherapist's lessons learned at the intersection of trauma and antisocial behavior in 20 years of working in American prisons, forensic hospitals, and trauma centers. Typically, posttraumatic stress disorder (PTSD) presents as an anxiety disorder with the symptom triad of avoidance, reexperiencing, and hyperarousal. Therapy can proceed once some level of safety has been achieved. But many potential patients do not have a safe space for the work to proceed. Instead, they are living in conditions of ongoing exposure to trauma that has been variously described as complex PTSD and continuous traumatic stress. Anxiety would hardly be adaptive for survival in this environment and, in fact, the symptom picture is often dominated by anger, aggression, and callousness. When these potential patients are found in jails, prisons, and hospital emergency rooms, their outward presentation, instead of centering on anxiety, can appear more like conduct disorder or even criminal psychopathy. They may have been victims, but they frequently have also been perpetrators of violence. These patients need and deserve a trauma-centered treatment, but exposure therapy is hardly appropriate for someone who is experiencing ongoing traumatic conditions. Therapy can proceed, however, and be successful, but the techniques that the therapist uses may be quite different from those found in other settings. A theory of how trauma connects to antisocial presentations will be described, and some of the lessons learned in working with this population will be shared.

Keywords: trauma, inner city, anger, PTSD, conduct disorder

That was what I was thinking, about what was in my heart and what that made me. I'm just not a bad person. I know that in my heart I am *not* a bad person.

Walter Dean Myers (1999, p. 92)

A soldier leaves Iraq or Afghanistan, arrives home, and commits a murder. In 2008, *The New York Times* documented 121 murders that were committed in the United States by service mem-

bers who had returned from an overseas combat zone (Sontag & Alvarez, 2008). The reaction from law enforcement, communities, and families to these acts by servicemen is often sympathetic. War, they reason, had changed a decent, moral man and driven him to murder; exposure to violence has changed him.

A young man leaves prison, arrives home, and murders another young man. In 2008, 124 murders were committed in the city of Oakland, California, alone (Spiker, Garvey, Arnold, & Williams, 2009). Like the soldier in a combat zone, this young man has been exposed to lethal violence, but the violence he was exposed to was not overseas, it was in his own neighborhood (Schwartz, Bradley, Sexton, Sherry, & Ressler, 2005). The reaction from some in the community may be sympathetic, but, from the larger society, law enforcement, and the courts, it is often not.

This article looks at one American therapist's experience with the world of violence and trauma in the context of work done in prisons,

CHRISTOPHER B. ROACH, PsyD, has focused his clinical work on the treatment of the seriously mentally ill and on treating both the victims and the perpetrators of violence. He teaches a graduate course in the assessment and treatment of family violence. Prior to his undergraduate and graduate studies, he spent 12 years as a member of the United States Marine Corps. He is currently affiliated with Alliant International University, Clinical Psychology PsyD Program.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Christopher B. Roach, Alliant International University, Clinical Psychology PsyD Program, One Beach Street, Suite 100, San Francisco, CA 94133-1221. E-mail: croachpsyd@earthlink.net

victim-support programs, and forensic hospitals for mentally disordered offenders. The violence discussed in this article does not come from the delusions and hallucinations of major mental illness (Farrington, 2007). Instead, it comes from men who do not look “sick” and who may have never been diagnosed with a mental illness. They have, however, often been exposed to trauma, though they may not appear to be traumatized. My question is: How do we understand and help them?

My investigation, carried out in the spirit of Bowen Paille (2007) and Philippe Bourgois (1995), seeks to integrate aspects of clinical practice, qualitative and quantitative research, sociology, psychology, public health, anthropology, criminology, literature, and medicine. This may be an ambitious goal, but the roots of violence, the care of the traumatized, and the treatment of the perpetrator are aspects of the human condition that exceed the scope of any single discipline or perspective. In fact, one of the difficulties in the field of treating and understanding violence is this multiplicity of perspectives, each with their own language, methods, and ways of understanding. Integrating multiple disciplines and perspectives is a necessary task for the therapist who encounters the wounded in the world of prisons, hospitals, and communities, and who seeks to alleviate the cycle of victimization and violence.

Describing the Population

The average perpetrator of a “simple” violent assault in the United States is male, between the ages of 12 and 20 years old, not under the influence of alcohol or drugs, and is disproportionately Black. His victim is a male, below the age of 25, also disproportionately Black, with an equal probability of being an acquaintance or a stranger (Hart & Rennison, 2003; Truman & Rand, 2010; U.S. Bureau of Justice Statistics, 2006). Although overall crime has fallen in the United States, the rate of serious, violent victimizations has remained relatively steady (Truman, 2011; Truman & Rand, 2010). The group most impacted by serious violent crime in the United States is comprised of these young males who both assault and are the victims of assault—a blended perpetrator—victim (Roach, 2008; Truman & Planty, 2012). Unlike the soldier who returns home from the war zone and

who comes home to a space relatively free of violence, these victims do not leave the war zone; they remain at the scene of the crime, in the center of their own “war zones,” neither emotionally nor physically safe. A large percentage of these young men are criminals. Unlike the traumatized soldier who receives treatment at the Veteran’s Administration, these young males receive their treatment, if they receive treatment at all, within the prison system.

Various authors have expanded on the original concept of posttraumatic stress disorder (PTSD) to address the reality that people cannot only suffer multiple traumas at different stages of their life, but that their exposure can be ongoing or “continuous.” Judith Herman’s (1992) concept of complex PTSD (C-PTSD) involves repeated traumas, such as sexual abuse, from which the victim is unable, or perceives an inability, to escape. Gillian Straker et al. (Straker & Sanctuaries Counseling Team, 1987; Straker & Moosa, 1994) developed the concept of continuous traumatic stress (CTS) in the context of work with South African township youth. These youth had endured ongoing trauma under apartheid, as well as in postapartheid South Africa in the violent aftermath of the systemic change the country underwent. For these youth, there was no safe haven in which the reparative work of therapy could be conducted. CTS brings the political and sociological elements of institutionalized racism to the discussion of the effects of living in the midst of trauma. Developmental trauma disorder focuses attention on the impact of trauma on children and the diagnostic problems that result when there is no trauma-specific diagnosis for this age group (van der Kolk, 2005). All of these concepts highlight the social, medical, biological, and psychological complexity of trauma as a holistic interactive phenomenon that does not exist in diagnostic isolation.

In the United States, there also exist areas where historical racial trauma interacts with ongoing high levels of violent crime. In the areas where there is extremely high, ongoing exposure to violence through crime and social disorganization, there is a situation analogous to that experienced in some parts of apartheid-era South Africa. These are communities that cannot solve their own problems, and where political, economic, and social forces result in

sustained disorder and the isolation of these communities from the economic mainstream (Kurbin & Weitzer, 2003). In some of these communities, there are now multiple generations who have grown up in an environment that has many of the characteristics of what might be considered CTS.

Although overall crime in America has gone through a steady decrease from its peak in the 1990s (U.S. Department of Justice, 2010), in specific crime “hot spots” there have actually been increases in the number of homicides (Police Executive Research Forum, 2008). In 2012, while killings held steady or dropped in Los Angeles and New York City, Chicago’s murder rate has climbed 38% from 2011 (Davey, 2012). What distinguishes these areas from others is not merely the volume, but the concentration, of crime that occurs in them. In New York City, about 4% of the population lives in public housing, but 20% of all the city’s violent crime occurs there (Moynihan, 2012). These hot spots are predominantly urban, poor, and centered in areas with high concentrations of minority populations (Weisburd, Lum, & Yang, 2004). Growing up in these areas exposes children, adolescents, and adults to significantly elevated lifetime rates of viewing traumatic events, knowing someone who has been a victim, and being a victim oneself (Kiser, 2007). Studies have shown that over three quarters of children in these areas have had direct exposure to community violence (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009; Thomas et al., 2012). This is not just an American phenomenon: a recent United Nations study showed that 60% of urban dwellers in developing countries and countries undergoing transition have been victims of crime over a 5-year period, with victimization rates reaching 70% in Latin American countries and Africa (United Nations Human Settlements Programme, 2007).

It is clear that exposure to traumatic events causes distress in children and adults. Responses linked to trauma run the gamut of physical symptoms, including gastric upset, insomnia and headaches, and psychological symptoms and syndromes such as anxiety disorders, depression, personality disorders, social isolation, decreased focus and concentration, anger and irritability, loss of intimacy, distrust, an increase in risk-taking behaviors, and substance abuse (Gill, Page, Sharps, &

Campbell, 2008; Gomez-Beneyto, Salazar-Fraile, Marti-Sanjuan, & Gonzalez-Lujan, 2006; Löwe et al., 2011; McQuaid, Pedrelli, McCahill, & Stein, 2001).

Outside of the clinical realm, images of post-trauma suffering and PTSD have permeated American culture from *Rambo* (Feitshans & Kotcheff, 1982), to Oprah Winfrey (Morgan, 1986), to director Tim Burton’s (Guber & Burton, 1989) *Batman* movie franchise. The patient with symptoms of reexperiencing, avoidance and numbing, and hyperarousal, the classic triad of PTSD (American Psychiatric Association [APA], 2000), has a presentation that is easily recognized in both clinical presentation and popular American culture. The patient is haunted, wounded, isolated, and anxious, with a psyche scarred by the experiences he or she has been through. In media representations, the psychologically wounded warrior can be angry, but in the description of PTSD in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000)* there is scant mention of “hostility”; it is found only once in the Associated Features and Disorders section (p. 465) and in diagnostic criteria D2 as “irritability or outbursts of anger” (p. 468). In trauma-focused writings and conceptualizations, descriptions of anger and hostility are also present, but they are largely viewed as secondary to the core diagnostic triad (van der Kolk, McFarlane, & Weisaeth, 1996).

However, for the trauma survivors of crime “hot spots,” who have spent a good deal of their lives in contact with violence, there may be a different diagnostic picture for trauma responses, one that is frequently far less sympathetic than the diagnostic picture that gives primacy to anxiety. Anger and hostility may be the most prominent feature of their presentation. These patients might be found not only in clinics and hospitals, but also in jail holding tanks, solitary confinement cell blocks, and prison exercise yards. Their experience with mental health practitioners, from childhood referrals for behavioral problems, to adult referrals for crime victim services, are frequently transitory, and the interventions they receive frequently do not change the downward trajectory of their lives. When assessing this population, the therapist can find no shortage of childhood, adolescent, and adult trauma.

Although some therapists may choose to work with violent or underserved populations, they seldom come from this world or live in it. But in trying to understand violence, I agree with Paille (2007) that, “when it comes to studying violent encounters and the transformative processes associated with them, being there—or getting as close as possible is crucial” (p. 761). Direct encounters with violent individuals, however, can be not just instructive but also unsettling. I was doing a therapy group in a prison setting when six young men simultaneously began to show their scars: multiple gunshot wounds that were described as “the first time I got shot,” “the second time I got shot,” and so on. They were engaged and gregarious as they told their stories to one another. I did not see any signs of anxiety, numbing, avoidance, or painful reexperiencing in this lively group. When I looked at their medical records and saw the occasional diagnosis of PTSD, I thought, “Where are the symptoms?” I easily saw the trauma, but not the posttraumatic outcome commonly associated with PTSD.

When these patients arrive at therapy, they are easy to dismiss as poor prospects for treatment. The rise of the “nothing works doctrine” in American criminology, and the departure of psychology from the field of rehabilitation (Ward & Maruna, 2007), has been well documented in the literature, in which predicting violence and the “untreatable” psychopath became the focus (Harris & Rice, 2006). Over the last decade, there appears to have been a reversal, and there is again psychological interest in what works in treating violent offenders (Cullen, 2005). However, the fascination with the “psychopath” in forensic psychology continues (Seabrook, 2008). The traits that characterize the psychopath, including glibness, superficial charm, shallow affect, callousness, and a lack of empathy (Hare, 2003), have become a lens through which young offenders are frequently seen and evaluated. Anxiety and psychopathy are not commonly placed together. In fact, a low resting heart rate in a child and adolescent is felt to be one of the biological precursors of adult violence (Ortiz & Raine, 2004). This raises the question: Can someone who is aggressive, callous, and glib even have PTSD, or is criminality a prophylaxis for the development of posttraumatic symptoms?

Recent research has shown that the occurrence of major depressive and generalized anxiety disorders is significantly reduced in men who have antisocial personality disorder (Goldstein, Compton, & Grant, 2010). Similarly, the findings of one study showed that children and adolescents who had experienced or witnessed significant trauma and met the *DSM-IV-TR* criteria for conduct disorder and oppositional defiant disorder were less likely to develop full PTSD (Silva et al., 2000).

This research raises more questions about the presentation and treatment of traumatized individuals: Can the experience of trauma have—an endpoint—both a sympathetic suffering patient who comes to therapy seeking relief from acute distress *and* a callous, narcissistic criminal who is coerced into treatment and feels that the problem is “the system,” not any internal suffering he is experiencing? Does one have PTSD and the other a difficult, if not impossible to treat, “personality disorder”?

Sitting with a patient recently, I felt the issue was more complex than what is currently encompassed under the diagnostic compartments of the *DSM-IV*. A young, African American male, facing an 11-year sentence for a violent offense, spoke with an upbeat affect and a smile on his face about how his primary therapist did not seem to want to spend time with him and told him that he was “adjusting well” to his new circumstances. There was no anger as he said this, but then he began to talk about his one prior suicide attempt as an adolescent. His emotions could be construed as superficial or “shallow,” and he did not evidence obvious emotional pain. I listened closely as he talked more about the event, while rubbing one hand over the scars on his wrist. He remained smiling and upbeat. He had experienced extensive, repeated exposure to trauma as child, as an adolescent, and as a young man within the prison system. When we were done, he got up and casually walked out of the room, his step jaunty and mood apparently unconcerned. He easily joined a group of fellow prisoners in the waiting room. I saw no avoidance, no startle response, no hyperarousal, and yet I felt, as I believe many therapists would, that I had been in the presence of PTSD. But would it make sense to diagnose him with PTSD and have the next therapist wonder, “Where are the symptoms?”

A Different Conceptualization

There is no specifier in the *DSM-IV-TR* (APA, 2000) for PTSD, such as *callous type*, *secondary to continuous trauma exposure*, but I would contend that PTSD is exactly what the therapist is seeing, and that, in criminal populations, PTSD does not manifest primarily as an anxiety disorder, but as what is essentially a conduct disorder. This is because survival in situations of continuous danger demands an action-oriented adaptation instead of anxious withdrawal. Particular to the diagnostic picture I am examining here is witnessing or participating in interpersonal violence as victim, perpetrator, or both, within an environment permeated by violence and where safety, justice, and social reciprocity are rare or transitory (Sampson & Bean, 2006; Sampson & Wilson, 1995). In this form of PTSD, secondary to repeated or continuous trauma, there are three dimensions that run counter to the traditional conceptualization of PTSD as an anxiety disorder: anger replaces fear, emotions are “muted” or “shallow,” and approach to danger replaces avoidance.

Anxiety is exhausting. For those in continuous danger, there is a preoccupation with threat and an anxious apprehension of the next danger accompanied by muscle tension, restlessness, and fatigue (Nitschke, Heller, & Miller, 2000). Anxiety is a wide-spectrum emotional state promoting *hypervigilance*, the constant searching of the environment for threats. Anxiety is protective; it is an emotion that is designed to discourage the organism from engaging in potentially harmful behaviors. But constant anxiety cannot provide protection in these areas of continuous danger, and cognitively, emotionally, and somatically a person pays a price for maintaining a forced alertness (Rosen & Schulkin, 1998). Both police officers and civilians in high-crime, high-violence areas can become engaged in a cycle of anxiety, stress, and fatigue, which results in the individual being even less able to cope with the situation in an effective manner. In these “hot spots,” the end result of this anxiety-driven coping can be serious injury or death (Vila & Kenney, 2002). At the end of his or her shift, a police officer can leave these areas and try to decompress, but the resident is stuck there, with the only escape frequently being the relief of sub-

stance use and abuse. However, there is another way out, and that is through the emotion of anger.

The 17th-century English churchman and historian, Thomas Fuller (1864/2012) called anger “one of the sinews of the soul” (p. 205). Anger strengthens and empowers, it creates possibilities. Among the most important of these is the possibility of eliminating the threat. Anger can improve conflict resolution, but not in a creative way; anger is a blunt instrument (Geddes & Callister, 2007; Glomb & Hullin, 1997). Anger narrows the focus but conveys benefits: the narrowed attentional scope created by simply observing another’s anger can illuminate the most important information relevant to a simple task (De Dreu & Nijstad, 2008). As closely as anxiety is related to self-preservation, so is anger. Despite their place far down on most lists of the sequelae of trauma, anger, aggression, and violence have a robust relationship to both experiencing and witnessing trauma. Singer, Anglin, Song, and Lunghofer (1995), investigating the relationship between adolescents’ exposure to violence, symptoms of psychological trauma, violent behavior, and coping strategies, found that being a witness or victim of violence was reliably associated with symptoms of psychological trauma, including depression, anxiety, PTSD, dissociation, and anger. Flannery, Singer, van Dulmen, Kretschmer, and Belliston (2007) noted: “There is a strong association between violence exposure and increased risk for the perpetration of aggression and violence, even after controlling for demographic and contextual factors” (p. 315).

The relationship between trauma and anger/aggression extends beyond adolescence into adulthood. In their study that followed substantiated cases of childhood abuse and neglect into adulthood, Widom and Maxfield (2001) found that there was a 28% increase in the chances of the adult with prior abuse having been arrested, and a 30% increase in the chances that the arrest was for a violent offense. Residing in areas of high social disorganization increases exposure to multiple and ongoing traumatic situations, including witnessing violence both inside and outside the home, experiencing physical discipline, being a victim of violence, perpetrating violence, and being subject to both educational and physical neglect (Drake, Jolley, Lanier, Barth, & Jonson-Reid, 2011; Foster, Brooks-

Gunn, & Martin, 2007; Kiser, 2007). Exposure to violence in children, adolescents, adults, and combat veterans (Chemtob, Novaco, Gross, & Smith, 1997) has been found to result in problems with anger regulation, including the behavioral expressions of aggression and anger. In communities subject to CTS, it is almost as though anger and aggression have become “indigenous coping strategies” that replace the disempowerment of fear with the much more adaptive empowerment of anger (Hamber & Lewis, 1997).

Anger replaces fear in this model of posttraumatic stress, and the other emotions have a particular quality in that they are muted or “shallow.” The criminal psychopath is “callous” (Hare, 2003), lacks the capacity for empathy, and has “emotional poverty or a limited range or depth of feeling” (Widiger & Lynam, 1998, p. 174). The survivor of trauma shares this quality, but with trauma it becomes “psychic numbing” and a “markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness and sexuality)” (APA, 2000, p. 464). However, the psychopath is a “callous monster,” while the trauma survivor is a “numb victim.” In therapy groups with violent inmates, many awaiting transfer to prisons where they would face long sentences, for some life without parole, the therapist sees the visible scars from their prior battles. Despite limps and lingering pain, the mood is often light and conversational; it is as though the wounds had been physically painful but emotionally painless. I have sometimes wondered at the lack of emotional suffering in some of these men who so easily resort to anger and aggression, sometimes at the slightest provocation. The difference between “numbness” and “callousness” may, however, rest more with the countertransference of the observer than with any objective measure.

With repeated exposure to violence, there can come an “emotional desensitization,” a gradual and increasing lack of response to the fear and shock of seeing human victimization occur again and again (Aizer, 2009; Huesmann, & Kirwil, 2007). Across their life span, residents of high-crime, poverty-stricken areas witness and experience a high occurrence of violence (Agnew, 2007; Margolin & Gordis, 2000). There are both short-term and long-lasting effects following violence exposure, including a

lack of appreciation for the pain of others that comes when violence is a routine event. In this environment, deep feeling is not adaptive. In fact, a lessening of the capacity to experience painful emotions becomes a successful coping strategy in both the combat soldier and the inner city adolescent (Huesmann & Kirwil, 2007; Vitzthum, Mache, Joachim, Quarcoo, & Groneberg, 2009).

Another quality that distinguishes these patients is a history of aggressive violence; these patients have not just been a repeated victim, they have also been a repeated perpetrator. On the face of it, seeking out traumatic situations does not seem to be congruent with the diagnostic criteria of PTSD; the obvious reaction would be to avoid these situations. Freud (1920/1955) himself saw this failure to avoid or learn from trauma, and coined the phrase “repetition compulsion,” in part to describe those who act out their trauma instead of remembering it. Otto Fenichel (1946) saw “repetitions of traumatic events for the purpose of achieving a belated mastery” (p. 542), and the idea of the need to achieve “mastery” of the trauma is frequently seen in contemporary accounts of PTSD (van der Kolk, 1987). However, there may be another explanation for those who live in the presence of CTS. For a soldier out on patrol, the quickest way out of danger may be to go over the top of it. In an ambush, a soldier strives to get out of the “kill zone” as quickly as possible. Running away can keep the soldier in the enemy’s field of fire, whereas going through the enemy gets one out of the kill zone and helps the soldier to regain the initiative in the fight. For someone in continuous danger, a similar response of closing the gap and going through an imminent or possible danger may be an adaptive conditioned response. However, whereas the soldier can (one hopes) return from patrol to the relative safety of his base, for these victims/perpetrators going home to a cell block or a troubled community does not provide safety. A readiness for quick aggression is a valued quality in both of these places.

Thinking About Treatment

Now we have our patient: angry, with shallow affect, and a history of violence. He has endured repeated traumas, and he has been the perpetrator of potentially traumatic acts as well.

He remains in a dangerous situation in which a readiness to be violent is to his apparent advantage. He is social, he can be quite gregarious, and much of his behavior is the opposite of avoidant. He thinks and talks about his traumatic experiences and carries their scars, but he does not appear to have PTSD. Instead, his presentation is more in line with a diagnosis of antisocial personality or conduct disorder. In contending that PTSD in criminal populations sometimes does not manifest primarily as an anxiety disorder, but rather as closer to a conduct disorder, it is necessary to separate muted affects and lack of emotional expression as an artifact of PTSD from the “cool pose” of the inner city male (Anderson, 2000; Major & Bilson, 1993). Violence is traditionally a male-dominated phenomenon, but lately, in the United States, violence perpetrated by adolescent and adult women has been increasing (Substance Abuse and Mental Health Services Administration, 2009; Zahn et al., 2008). The greatest increases in women’s violence are again among minority, low-income, inner-city populations and, again, similar factors of exposure to violence, victimization, and poverty seem to be correlated with the actions of women perpetrators (Rosich, 2007; Bottos, 2007). Although this article is primarily concerned with male victims and perpetrators, an implication is that angry, violent expression of traumatic stress is not an exclusively gender-specific phenomenon, or a cultural expression, but a human reaction to certain conditions, and that it is a posttraumatic stress response.

I am arguing that PTSD has both an internalizing and an externalizing expression, and both are legitimate targets of treatment. We know that exposure is the evidence-based treatment for PTSD, but what about when PTSD manifests as an externalizing disorder? How is treatment conducted in situations in which safety is elusive and the expression of affect or vulnerability can result in even more victimization? One basic medium in working with cases of repeated traumatization is the story or narrative. Cyrulnik (2005), in his study of resilience, has a chapter entitled, “Storytelling Enables Us to Sew Up the Pieces of a Torn Self” (p. 37), and he delves into the way the stories of the traumatized—spoken, written, autobiographical, and fictional—contain the “images, actions and words” (p. 39) that are the key to resilience.

Because sustained traumas contain stories that span very different developmental periods within the adult’s telling, the therapist may find the structures of narrative from the perspectives of the child, the adolescent, and the adult (Hunt, 1994). It is the therapist’s job to help the patient find a way to weave these narratives together and to find the common coherent themes and meanings: “By giving a theme to the wounded person’s life, trauma changes the meaning of that life, becoming a means of struggle and not a weakening” (Cyrulnik, 2005, p. 160).

When one considers the history of forensic treatment in America, working with narratives becomes even more compelling. Concluding their article on the therapeutic treatment of violent aggression, Heyman and Selp’s (2007) recommended the following to treatment providers: “First do no harm” (p. 612). They cite findings that group cognitive-behavioral treatments for high-risk adolescents actually increase rather than decrease delinquent behavior (Poulin, Dishion, & Burraston, 2001). Similarly, so-called boot camps for young offenders, once a popular alternative to incarceration, have been found to have no significant effect on recidivism (Wilson, MacKenzie, & Mitchell, 2003), and common juvenile justice therapeutic interventions are not just inefficient but also exert iatrogenic effects on their recipients (Gatti, Tremblay, & Vitaro, 2009). There is even the concern that therapy can weaken the survival skills necessary to navigate and survive in a dangerous environment (Brown, Shear, Schulberg, & Madonia, 1999; Meeks, 2011). Glancy and Saini (2005) note that “There remains no clear consensus among therapists and researchers on the best way to treat angry clients and little information exists to guide therapists in their work with specific angry populations” (p. 229). Given the cautions and lack of consensus on how to best proceed, narrative can be chosen as a therapeutic medium, because it is less invasive and more flexible than more structured interventions, and thus potentially less harmful. This is not a call for therapeutic nihilism, but an acknowledgment that the therapist needs to proceed with a judicious sense of humility and respect when undertaking to treat this population.

The metaphor for working with patients who remain in danger is as old as humanity. It is the story told at campfire’s light. Although outside

the circle the danger remains, inside that light is safety and a place to find strength. Knowing that danger awaits the patient, the therapist treats the patient's narrative like a gift, one that is unfolded and shared and then packed away in a hard protective case until it is again revealed. What follows are some ideas and reflections on how to listen to these stories. We know that trauma has its effect on both the survivor and the person who listens to the survivor's tale (Straker & Moosa, 1994), and that how one listens, and what one listens for, makes all the difference.

Locate the Affect

The therapist listens for parts of the narrative in which affect connects to human interactions and works to form a scene from what the patient is saying, complete with characters, light, and color (Cyrulnik, 2005). "Flashbacks" derive some of their power by involving the whole spectrum of senses: touch, smell, hearing, and vision (Nemeroff et al., 2006). The more sense modalities the therapist and patient bring to these voluntarily elucidated scenes, the more potential potency they will have when contrasted to distressing involuntary memories. Compared to the drama of flashbacks, this work can be quite pedestrian (Lion, 2008). These new scenes will become touch points in constructing a narrative that contains a past, a present, and a future. Of necessity, some scenes will evoke depression and pain, and because the scenes are linked and explicated, depression may become more prominent for the patient. The affects of the blended victim-perpetrator, however, involve more than the pain of victimization. When the patient relates scenes in which he has been violent, he may be filled with the power and excitement of acting out and retaliating against his enemies and his environment, even at the cost of pain and imprisonment (Katz, 1988). These emotion-filled scenes may come easily into the narrative. Competing with these actively powerful but violence-sustaining scenes are the more subtle emotions of the silent, passive scenes formerly associated with loneliness and victimization. Made salient by the therapist, these scenes form the basis for thought and reflection in contrast to the formally dominant value of action. This is the start of the

patient examining his life for different forms of meaning and constructing a new narrative.

Use of Humor

The importance of humor in working with trauma cannot be underplayed. In Freud's view, humor or jokes happen when the conscious allows the expression of thoughts that society usually suppresses or forbids. The superego allows the ego to generate humor as a compensation for life's pain (Freud, 1920/1955). The particular form of humor that underlies repeated trauma is *irony*. This is the "battlefield humor" of the soldier, the cop, and the emergency room nurse. For Freud, and for the person who remains in danger, humor and, in particular, irony is a gift. It allows the truth of a situation to be acknowledged, but protects the person voicing it from being overwhelmed by fear or despair. The lives of those who live with the constant possibility of death or injury are tragedies in the fullest sense. Irony stands here at the juxtaposition of humor and tragedy, and it is a gift to those who live in the face of CTS. The enemy of irony is *cynicism*, the loss of belief that goodness is possible in human nature and in human interactions. Accompanying cynicism the therapist may find sadism: the pleasure taken in the suffering of others. The therapist needs to be prepared to find sadism in these violent patients (Lion, 2008), and the task as one listens to these narratives becomes finding and nurturing irony, to see with the patient that there is a way to live with tragedy that allows for the humanity of all the players caught up in the drama, both the victims and the perpetrators.

Slowly Deconstruct the Myth of Self-Creation

Often, patients who come from a background of repeated traumatic exposure have survived by being members of male-dominated street and prison gangs. These gangs, which create a structure with their own hierarchy, laws, punishments, and rewards, bring order and, sometimes, safety into dangerous environments. These groups frequently embrace a mythology of self-creation, the myth of "I grew up alone on the street." This is essentially a fascist world in which women are either idealized or demeaned. In this creation story, men make themselves;

they are born into the gang. Women become either a Madonna or a whore in this world in which feelings are dangerous, womanly, and associated with victimization (Theweleit, 1987). In listening to the narratives that accompany C-PTSD and CTS, the therapist can find figures—men and woman—who provided nurturance. But frequently the nurturance is mixed with abuse, or it exists as a seemingly futile gesture in a world of trauma. These figures may even appear as persecutors. But if the therapist listens carefully to the narrative, he or she will see which of these persons gave more than abuse. It is important to make these figures salient, and to preserve them in the developing story, because, however flawed, they are the connections to humanity (Cyrulnik, 2005).

Find the Child in the Narrative and Pair Him With the Adolescent or Adult

Steve Harmon, the 16-year-old hero of Myers's (1999) novel *Monster*, sits in his jail cell and struggles to reconcile the "monster" the prosecutor has portrayed him as in court with the person he conceives himself to be. "I know that in my heart I am not a bad person" (p. 92), he thinks to himself. There is often this nascent "good self" in violent patients, but it exists in rotation with the "bad man" the patient has become. It seems untenable that these two versions of the self can occupy the same space in the narrative. Violence tends to obviate complexity and subtlety, and a self-narrative that involves blended perspectives is an act of creative complexity.

One therapeutic technique to promote complexity is to look for the child to appear in the narrative and then to pair him with the strengths of the adolescent or man. The task is for the adult perpetrator to assume responsibility for protecting the child in their own narrative. In this way, there is both vulnerability and strength within the same scene, a way to go through the trauma narrative in a protected and more complex manner. The story of trauma and violence can potentially become an act of self-rescue. This allows for an inner pride to grow that gradually eclipses the outer show of strength necessary to ward off danger. In his study of how ex-convicts reformed and rebuilt their lives, Shadd Maruna (2001) noted that the narratives of "desisters," those who desist from

crime, "begin by establishing the goodness and conventionality of the narrator" (p. 87). The child begins in innocence and falls into evil ways. The child represents the "true" or "core" self, who the violent young man *really* is. For those violent young men who find and sustain within their narratives this "original" good self, leaving off from violence is not a change, but a return to the good person that they always were.

Make a Classroom

Describing his work with French street children, Boris Cyrulnik (2005) wrote: "It's surprising to see an adult organizing a philosophy club with street children . . . [but] we're inviting them to transcendence, suggesting that they can conquer a world other than the one they have to deal with" (p. 33). In revealing another world, the therapist invites the patient to transcend their past traumas and their world of ongoing trauma. To do this, therapists can reveal and share their own areas of interest and curiosity, and use them as the way to structure a relationship that involves elements of pedagogy. Structuring the therapeutic space or a portion of the treatment endeavor as a classroom can often be very effective. Areas of social disorganization are also areas of educational neglect and truancy. Parents are often too stressed to focus on the needs of their children. The combined effects of the caregivers' losing the struggle to provide focused, interactive attention to their children, and subsequent educational deprivation, are as significant and devastating to a child's future as exposure to violence (Bigelow, 2006; Kelly, Barr, & Weatherby, 2005). In these areas, schooling often essentially stops at the age of 14 or 15, or sometimes earlier. As Cyrulnik (2005) wrote, under conditions of loss and trauma, "all learning becomes a source of anxiety. Insecure . . . he does not take pleasure in discovery" (p. 19). Leaving off from the cycle of violence entails a willingness to discover the new. Treatment that opens doors to the world, while also opening doors within the patient's narrative, is an example of how interventions informed by multiple perspectives are required for success with these patients.

Conclusion

How difficult-to-treat patients are conceptualized can make all the difference in treatment.

The particular success of Marsha Linehan's dialectical behavior therapy has been its ability to change not merely patients' attitudes toward their problems, but also therapists' attitudes toward their problematic patients (Becker & Zayfert, 2001; Hazelton, Rossiter, & Milner, 2006). A diagnostic conceptualization of the "antisocial" or "psychopathic" patient as a legitimate endpoint for a life of ongoing, continuing trauma and violence moves the therapist's focus from reforming conduct to treating trauma. These patients can be scary, and they are ripe for countertransference fantasies that paint them as "monsters" both morally depraved and beyond help. But there can often be no development of vulnerability in these well-armed patients without it being modeled in the treatment. The therapist's willingness to expose his or her own internal process in front of those from cultures of violence, in which information about another's inside world is a way to gain advantage, to find chinks in the armor, requires a thoughtful courage and intelligence.

This is not a call for self-sacrifice or unreasonable optimism. Work with these patients is hard, and an informed view acknowledges that the odds are frequently against the patient's recovery and, sometimes, even his survival. Thought delays action, and encouraging thought in a world in which action equates with survival is itself a paradox. Finding and developing an emotional narrative that encompasses complexity and ambiguity in the patient who leaves the office to go out into a dangerous world requires that the therapist work with reason, science, art, and even faith.

For the therapist, these patients seldom fail to evoke a reaction. Their acts and their personalities may be repellent. Working with these patients requires the therapist to examine his or her own reaction to the patient's past as both a victim and a perpetrator, and to the patient's current environment of danger to both himself and others. America may not have had South Africa's formal apartheid, but for the therapist in the United States this work involves an understanding of political and economic oppression similar to that found in CTS. The therapist needs to understand his or her own and society's fears in regard to these patients. In her article on the moral development of child soldiers, Jo Boyden (2003) wrote: "It [research] also needs to acknowledge the possibility that images of

young former combatants as moral outlaws on the margins of society may be based more in the moral panics of adults than the lived realities" (pp. 359–360). As it is with Africa's child soldiers, so it is with our own Western urban combatants; if they are seen as fully human, complex, and worthy of care, a new world can unfold for them and for the therapist privileged to work with them.

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