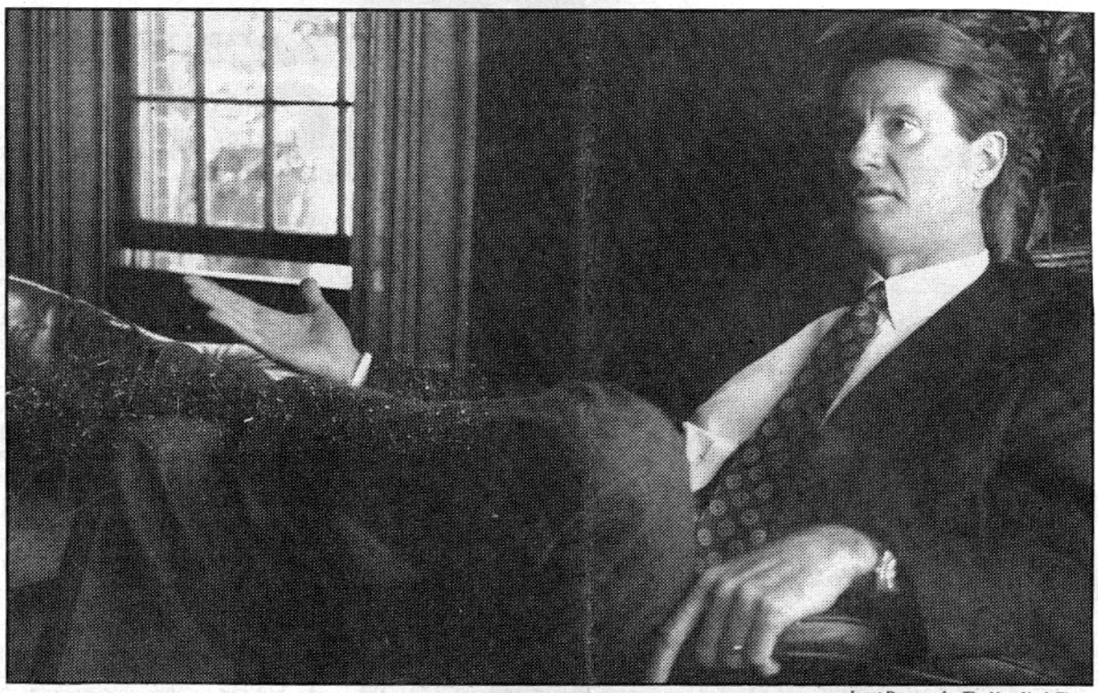
Connecticut Q&A: **Dr. Charles H. Rousell**

The Hidden Costs of Emotional Trauma

By JAMES LOMUSCIO



Janet Durrans for The New York Times

Dr. Charles H. Rousell, a Greenwich psychiatrist and lecturer at Yale.

ATTEMPTS at health-care cost containment will be for naught in many cases if health professionals do not take a closer look at the need for treating psychological and emotional trauma, said a Greenwich psychiatrist, Dr. Charles H. Rousell, who is deputy director of the department of psychiatry at Greenwich Hospital.

Unlike physical traumas, many of which are promptly remedied in emergency rooms around the nation, psychological wounds — whether deeply buried in childhood memories or resulting from devastating adult life experiences — often go untreated, Dr. Rousell said. Such neglect, he added, can exact a toll of psychological and physical suffering, not to mention mounting medical bills.

Even the psychiatric profession as a whole has given the notion of trauma recovery short shrift, focusing more on the inner workings of the individual rather than an otherwise healthy person's reaction to a negative experience, Dr. Rousell said.

A lecturer in psychiatry at the Yale University School of Medicine, Dr. Rousell recently opened the Northeast Center for Trauma Recovery in Greenwich. In a recent interview at his office, Dr. Rousell, 48, discussed the nature of traumatic experiences and their treatment. The following are excerpts from that interview:

Q. How do you define the term psychological trauma?

A. The traumatic memory is encoded differently in the brain and is processed differently. A good analogy would be a flashbulb going off. What is burned into the mind is the traumatic action perpetrated against the victim. That memory has a greater intensity than a normal memory, and a greater staying power.

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Q. What are the basic types?

A. I find it useful to look at trauma from basically two perspectives. One would be from the perspective of childhood trauma, something that happens to a little girl or a little boy during their critical periods of development. The other would be adult onset trauma. Someone who would have a good stable childhood, a good stable family, but finds themselves in the unfortunate circumstance as an adult in which they experience a sudden, rather devastating trauma.

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Q. What events would constitute an adult onset trauma?

A. One would be rape. Another would be a physical attack on a spouse or a child. The tragic loss of a loved one. These are the most common ones. And unfortunately, an increasingly common one is the increase in random acts of violence in our country, like the Long Island Rail Road shooting. I mention that because it affected thousands of people.

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Q. Thousands?

A. It was a traumatic assault on the people riding the train. It was totally unexpected. The trauma was devastating and life-threatening. Not only were the people who were injured traumatized, but 100 percent of the witnesses were severely traumatized. Those that witnessed this could have flashbacks or breakthroughs of the perpetrator's hand, the pistol, the blood splattering. And people watching this on television experienced a distant traumatic effect, but nonetheless a trauma.

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Q. Can adult onset traumas be just as devastating as childhood ones, or are adults better able to cope?

A. The adult has the coping mechanisms in place and also the freedom and autonomy to do whatever he or she needs to do to get help. A child is basically captive in that environment in which traumas go on. If we look at the adult consequences of childhood trauma, frequently it begins in early adulthood, sometimes midlife. There begin to be re-experiences of the original trauma. There may have been a lot of mental energy being used to hold it back. But in adulthood it gets to the point where the dam begins to break, the reservoirs of feelings and memories, and you start to have breakthrough phenomena.

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Q. What are some examples of breakthrough phenomena?

A. Sudden changes in mood that are unexplained. There can be intense feelings of despair that take hold out of the blue. Sometimes you have a picture memory. There can be intrusive, unwanted mini-flashbacks. There might just be a brief little picture coming into the mind, often occuring when someone is doing a fairly neutral task, like folding laundry or driving a car. Another is a sensory memory, such as a sudden pain in the abdominal area.

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Q. What are some specific examples of a childhood trauma that would resurface like this?

A. The typical examples are traumatic experiences that are recurrent and repetitive, beginning at an early age such as 4 or 5 and maybe continuing for several years. For example, physical abuse or even severe emotional abuse.

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Q. Since everyone is different, with different threshholds, could a trauma to one person not be a trauma to another?

A. In certain areas of milder traumatic experiences or a single traumatic event, there may be individual variations. But if a child experiences repetitive sexual abuse spanning a series of several years, it's unlikely that any child could escape from that unscathed. Maybe just a word as to why this can be so devastating. One is that the trauma is being induced by in most cases a trusted relative, caretaker, friend, parent. So, the person who may give you oatmeal in the morning or be running alongside your bicycle while you are learning to ride your bike, at night comes into your room and will exploit and hurt you. The results are a damaging effect on the child's ability to form relationships, to develop a sense of trust and a solid sense of identity and self-esteem.

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Q. What are some of the physiological effects?

A. There is a whole array of physical symptoms. Women in domestic abuse situations may frequently see their gynecologist. They might even come into the emergency room with a whole variety of physical complaints. Some of them are hypertension, headaches, irritable bowel syndrome, lots of cardiopulmonary symptoms. There could be chest pains. There could be hyperventilation with tingling in the arms and legs, and they think maybe they are having a stroke or whatever. These physical symptoms often defy medical explanation and usually lead nowhere but to the conclusion that they seem to be resulting from an emotional problem, and it may be important for you to talk to someone.

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Q. Any specific examples?

A. A woman had been in and out of her internist's office for a number of years with flare-ups of gastro-intestinal disorders. She also had periods where her energy was very low. She would be tearful when talking to her internist, saying there may be something physical going on like anemia. But nothing was really wrong, despite a lot of sophisticated tests over a number of years. There were mountains of medical tests and mountains of bills. The one thing she didn't tell her internist was probably the most critical thing, but one she was ashamed to tell, that her husband was abusing her in a repetitive manner — verbally and physically. As she began to deal with the traumatic origins of her symptoms, she felt a growing sense of control and understanding.

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Q. Describe your treatment process.

A. The role of trauma on mental function has been grossly underestimated by the mental health profession. So much of what our training has been in psychiatry is to look at the internal functioning of the individual and to approach it from that as opposed to seeing how much of it may be a reaction to something going on out there.

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Q. So you look at patients as well-functioning individuals reacting to negative events?

A. Exactly. It's reacting to an outside stimulus that has overwhelmed the organism's capacity to cope and function temporarily. And to approach it from this perspective means that we are able to cut short sometimes interminable therapeutic situations that go on for long periods of time.

We put together a team of professionals who evaluate and use specialized techniques such as hypnosis, group and family therapy and a brief number of psychotherapy sessions for adult onset trauma. Specialized techniques of a trauma-focused therapy can greatly shorten the duration of treatment.

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Q. Can't some traumas eventually be healed by the passage of time?

A. Unfortunately not. We all wish it could. But traumatic memories have no concept of time.

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Q. Do you see a lot more women than men?

A. Women tend to find it easier to talk about what they are suffering. So no matter what the origin of their suffering is, women tend to come to mental health professionals in greater numbers. Research shows that one out of three women has experienced some form of sexual abuse by the age of 18, whereas with men, it can be anywhere from 2 to 9 percent. Men are more reluctant to divulge this.

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Q. In looking to root out childhood traumas, isn't there a danger of people fabricating events because of the power of suggestion?

A. Around any issue that is as frightening as this one, society tends to get polarized so that one group tends to see that the issue of child sexual abuse is greatly overexaggerated, and it's played into the patient's mind by the therapist. We find with good solid research that if someone comes in with symptoms and a degree of suffering, and if that person is allowed to let the memories come in a neutral environment without any suggestion, what comes out tends to be valid. The details may be sketchy. ■