Understanding Psychological Trauma Through Literature

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The following passage is from the J D Salinger Short story *For Esme' – with Love and Squalor*. Two *soldiers* are talking, one of them, X, is just out of the hospital following being wounded in the aftermath of the D Day invasion. Clay appears to know the state of accepted science on the psychological effects of war then, and too often even now.[i]

Clay suddenly looked at X with new higher interest than before. "Hey" he said, Did you know the goddam side of your face is jumping all over the place?"

X said he knew all about it, and covered his tic with his hand.

Clay stared at him for a moment, the said rather vividly, as if he were the bearer of exceptionally good news, " I wrote Loretta you had a nervous breakdown."

"Oh?"

"Yeah. She is interested in all that stuff. She's majoring in psychology." Clay stretchered himself out on the bed, shoes included. " You know what she said? She says nobody gets a nervous breakdown just from the war and all. She says you probably were unstable like, your whole goddam life."

X bridged his hands over his eyes – the light over the bed seemed to be blinding him – and said that Loretta's insight into things was always a joy.

Clay glanced over at him, "Listen ya bastard. " he said, "She knows a goddam sight more psychology than you do."

"Do you think you can bring yourself to take your stinking feet off my bed?" X asked. (p 109).

Table of Contents

I. Introduction and Acknowledgements

As a psychology graduate student, in the 1970's, I came across an edited volume, *The Abnormal Personality Through Literature*, by Alan A. and Sue Smart Stone (1966), which presented long passages of great works of fiction to describe psychiatric syndromes and psychotherapeutics. I thought it a great idea then, and still do. The work you are reading attempts to apply their method more specifically, to just the destructive psychological effects of trauma and efforts to overcome them. The other variations from Stone and Stone include the use of shorter passages, and comments on changes in the way trauma has been recognized over the years, since it has been officially acknowledged in the Diagnostic and Statistical Manual (DSM) as the official United States standard.

While this book focuses on passages that illustrate one or another specific point about the destructive effects of trauma and recovery from them, I recognize that many whole works do something that a passage cannot. They show the person in depth and breadth, and how the events affect and do not affect the person and his or her life. When clinicians work to understand and help clients ameliorate the destructive events of trauma we, reasonably, tend to focus on the negative. A novel, for example, in which a character is fully drawn directs us to a perspective about the person we can otherwise miss. This understanding through the larger work, which is exemplified by most of the works surrounding the passages presented here provide this. Obviously, it is not just the works presented here; a moment's thought will lead one to the conclusion that great many of the works of literature contain reaction the great challenges of life and reaction to them. (For a while, I thought that perhaps we might exclude great works by an author like Jane Austin. That was until I read a comment on her work which pointed out that women in Jane Austin's world, the very basics of survival often had to do with whether or not they made a marital match, and if so what kind. I stood corrected.) [ii]

Also different from Stones' work is the inclusion of comments reflecting my professional experience in the field. Traumatology changed in revolutionary ways during the time span of my career, and I was able to

observe them, was affected by them, and even participated, as a bit player, in fostering them.

Like the Stones I have chosen fiction for my examples from literature. It is well known that there are also many great works of memoir which describe how traumatic events are experienced, and there are a few I couldn't resist, however fiction has the one great advantage of not having to consider whether on not an event is factual. As Albert Camus said, "Fiction is the lie through which we tell the truth". It should also be mentioned that the examples employed here, though overwhelmingly not memoir, were almost all written by authors whose personal experience with trauma allow them to write with authority.

Readers may notice a few patterns other than the reliance on fiction. There are a couple authors represented more than once. I would have liked to sampled more widely, and I know there are many many great works not represented, since it does seem that the overwhelming majority of fiction includes at lease one example of a serious traumatic event. Understandably telling about and trying to make sense of the extremes of life, of our greatest fears and tragedies, is what interests both readers and writers. However, some of the examples from authors already cited fit too well to pass-up. And then there are my limitations as a scholar; I have only been able to read so much. Another pattern is that war related examples are heavily relied upon. This seems warranted because of how much war trauma exists, how much good writing there is about the effects of combat, and the fact that for most of my 40 years in the field of psychology I have worked with combat veterans.

Long before this manuscript was ready to be offered to the public a version of the idea was presented through a regular feature in *Traumatic StressPoints*, the newsletter of the International Society for Traumatic Stress Studies (ISTSS). The feature, Trauma and World Literature (TWL) is edited in what, for me, has been a most edifying and enjoyable partnership with Dr. Harold Kudler. Harold and I developed the feature after I saw his similar interest in a workshop on the subject he chaired at an ISTSS meeting. The support of newsletter editor Anne DePrince led us to begin in 2006. As of this writing it continues under the guidance of her successor, editor Patricia Kerig.

This manuscript varies from the newsletter feature in several ways.

1) While T&WL includes passages contributed from Harold, myself, and others, this work, except for one credited example, includes passages I have found in my own reading.

2) It includes my comments on the modern history of mental health trauma work. At the risk of appearing overly self centered, by modern I mean what I have seen, which coincidentally starts from about the time the diagnosis of PTSD was first added to a Diagnositc and statistical Manual of the American Psychiatric Association (DSM).

3) It begins by being roughly structured around a version of the diagnostic nomenclature of January 2014 - This will involve some elaboration-

II PTSD

The structure: DSM- I through 5, ICD and the transcendence from diagnosis.

The major point of this book is to show the insight that can be gained from literature about the destructive psychological effects of trauma. The purpose of the DSM was to reasonably catalogue those effects. It makes sense for the book to be organized around that structure. This is not such a simple task, as there have been continual changes in what has been judged to be the best way to understand and describe those destructive effects. As the current version of the categorization is described in this book I will also provide a commentary on how changes have occurred, on how I, as a clinical practitioner have seen the field unfold. What is said is intended to be generally informative on the subject matter, but not meant to be comprehensive or a primary source of education to students of the field, only a useful, and I hope interesting companion to more thoroughly academic works.

To begin this commentary: In the original version of this manuscript the literary passages were keyed to the DSM IV symptoms of PTSD followed by consideration of other aspects of problem trauma responses and attempts to overcome these. After I was well into the project, a forthcoming DSM 5 was announced, necessitating the reworking of the manuscript around the new categorization. At the time I was awakened to the announcement I did not predict how complex things would become. The development of DSM5 was moving ahead at the same time that changes in the World Health Organization's International Classification of Disease (ICD) diagnostic criteria were also changing to what will be the ICD 11. The commission of the DSM developers was to be conservative in making changes from DSM-IV-Tr to DSM 5. The ICD instructions were to begin from scratch, and be focused on symptoms that did not overlap other kinds of problems, such as depression. The ICD team put together a classification system and took on several controversies with bold decisions. There had been long standing controversy about the declaring what was and wasn't a traumatic event. The ICD team decided to cut through the controversy by eliminating the description of the stressor, and just rely on the symptoms to

define the disorder. (Friedman, 2013)

A couple of other factors added to the controversy. One was related to the fact that DSM 5 moved to Arabic from Roman numerals in order to make it easy to label a DSM a 5.1 and 5.2 as research developed. This meant that the structure could change any time the DSM committee found there to be enough evidence to make a change. Thus, the structure of this manuscript could be made obsolete at any time.

The other factor butting in was the reception of DSM5 by authorities such as Thomas Insel, the head of NIMH, who is reported to have described it as having a "lack of scientific validity" (Belluck & Carey, 2013) which meant there might be resistance to considering it the accepted diagnostic criteria. DSM5 was being called into question as to being the kind of structure one would want to build a manuscript on (not to be too cynical, at least not unless one was the APA who could succeed at getting it to be a serious money making project).

A decision had to be made. DSM5 has a more inclusive list of psychological problems than ICD, and I want to be inclusive, so I am going to ride APA's horse, though not without making some critical comments as we move along. Also contributing to the decision is the fact that DSM-5 criteria can change so easily, which may be helpful in motivating rapid completion of this work so it is not obsolete between the times it is written and when it is made available. While the structure will be based on DSM5, when the DSM5 and ICD symptoms overlap, the proposed ICD take on the symptom will be mentioned. All ICD symptoms will be included since they are all included in DSM5.

While large amounts of money and expert time have gone into exactly specifying what PTSD is and is not, the developers of DSM 5, like the developers of DSM IV have left provision for the orderly consideration of treatment of individuals who do not meet the full criteria for the disorder. In DSM IV there was the category Anxiety Disorder Not Otherwise Specified, and in DSM 5 there are Other Specified Trauma – and Other Stressor-Related Disorder as well as Unspecified Trauma- and Stressor-Related

Disorder. The specific category a survivor of trauma falls into may have some important non-treatment (e.g. disability pension related) and research consequences. However, psychological and even psychiatric treatment may not be much affected, as able practitioners of the mental health arts will have a diagnosis enableing them to continue to treat as they always have, which I hope means emphasizing client goals and specific desired changes rather than diagnosis.

Lest I seem too critical of aspects of the diagnostic effort in this matter let me first concede that without institutionalized medicine taking on the psychological problems which often follow traumatic events there would be very little help offered to many of the most deserving people in the world. Survivors of crimes (including sexual abuse) war, disasters and other traumatic events who have found themselves with subsequent debilitating psychological distress would have few ways to get effective help. Their problems would be seen as weaknesses for them to overcome with whatever resources they could find.

So, despite my enthusiasm for the wisdom artists provide and critiques of systems of diagnosis, both the limits of the wisdom of and the value of the efforts based on diagnosis must also be made explicit. One example of limitation comes from one of the greatest writers on the effects of psychological trauma

For a New Yorker article (Fraser, 2008) about her, Pat Barker, who provides some of the insightful examples used later, was asked '…whether she thought everyone could be redeemed, whether damage to the family could be arrested. "I think it can," she is reported to have said, "and I don't think it necessarily requires professional. It requires someone to so something very, very creative with the materials of everyday life. A lot of ordinary people are capable of that."

True, a professional is not necessarily required, but Barker's statement puts too much of the burden on "creative" family responses. I don't think any amount of creativity by family members will help some survivors accomplish transforming war experience from unpredictably intrusive reliving memory to manageable or growth promoting recollection, as can

often be done with the assistance of experienced professionals, using some current methods of psychotherapy. I fear Ms. Barker's words, in this case, instead of illuminating, as does her fiction, could add to the burden of needless feelings of guilt when relatives can't succeed. Her comment could also provide justification for avoiding necessary psychotherapeutic work for survivors who falsely believe they are just not making sufficient effort. Ms. Barker appears to fall in the trap of many immensely talented people, thinking the others are just not trying hard enough. (as opposed to the trap of people who have not succeeded, which is to believe it is all due to luck, including the luck to have talent.) Without the sophisticated contributions of the medical/scientific perspective trauma survivors may be in the position of soldier "X" described in the Salinger passage above, SOL.

To summarize, this work will proceed to first be organized around what are being called the symptoms of PTSD in DSM-5. It will then consider other kinds of reactions, and then on to efforts to try to ameliorate the destructive effects. It should be noted that the adult list of symptoms so overlaps with the list for children and for Acute Stress disorder that full separate sections are not offered.

Before progressing to the list of symptoms, it may be interesting to note the symptom of a stress reaction ("traumatic neurosis") that Stone and Stone chose to illustrate was a conversion reaction. They told of the acquisition of a facial tic, drawn from a section of a W. Somerset Maugham (1940) story, *Flotsam and Jetsam*. The character Mrs. Grange is introduced with a brief physical description i

"But the strangest thing about her was a tick she had that made her jerk her head as though she were beckoning you to an inner room. It seemed to come at regular intervals, perhaps three times a minute, and her left had was in almost constant movement; it was not quite a tremble it was a rapid twirl as though she wanted to draw your attention to something behind her back. Skelton was startled by her appearance embarrassed by her tick…(p186- 187)

As the story unfolds, the murder of Mrs. Grange's lover, while in her arms, is described, then Maugham writes

That night she had a miscarriage and was so ill that for a few days it looked as if she would die. When she recovered she had the nervous tic she'd had ever since. (p190)

Also shedding some light on their time, in describing traumatic neurosis, the Stone and Stone introduction to Maughm's work noted that some psychiatrists only used the term "traumatic neurosis" when there was accompanying head trauma.

As we start to share literary representations of the effects of trauma it is worth mentioning that the Stones' one example of a psychological effect of trauma from those pre PTSD days, turned out, like the first example cited here, that of soldier X, to be absent from DSMIII. It did appear in DSM IV (it stayed in 5) where would probably be considered part of criterion B (intrusive symptoms) or 5 (physiological reactivity to cues), that is assuming X's and Mrs. Grange's afflictions are not continuously displayed.

The next section will describe the DSM 5 categories, partly quoted, partly summarized, followed by comments and literary passages. Because of copyright concerns direct quotes will be limited and the lists of diagnostic criteria will be summarized.

Category A: Stressor

From DSM 5*: For people older than 6 years "Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways*:" which can be summarized as

Direct experiencing, witnessing , learning of (in reference to family or close friend) , repeated exposure to aversive details. Notable for its suggestion of arbitrariness, exposure through electronic media only counts if the trauma is work related.

Outside of psychiatry medical problems or diagnoses are generally defined by physical changes to the organism, knowledge of which then guides treatment. Physical findings such as x-rays or blood test results, lead to definitive diagnosis. In psychiatric illness there are generally not physical findings to determine the diagnosis; for psychiatry behavioral symptoms

determine the diagnosis. Thomas Szasz (1961), who used to be more famous than he is now for the phrase and book title "The Myth of Mental Illness" argued that once there are physical findings to diagnose a disease it moves from the purview of psychiatry to that of the specialty covering its major biological system dysfunction.

If the goal is to get to a biological understanding of the changes that take place when the effects of psychological trauma are medically destructive, then the biological sciences are progressing mightily, but are not yet able to provide clinically acceptable biological markers. While there are measurable psycho- physiological changes that are more likely to be noticed in people diagnosed with PTSD (e.g. resting heart rate, changes in kinds of brain activation), no one is offering these changes as being part of the diagnostic criteria for PTSD. This is not to say that when there is a clear biological pathophysiology psychological or psychiatric treatment could not be helpful to a person so troubled, only that the primary perspective would be from another specialty, for example, people with heart disease may be referred by a cardiologist to psychotherapy to help reduce social stress and decrease risks of heart attacks.

When the definition of the stressor is part of the diagnosis of PTSD, psychiatry is a step further removed (a step beyond symptoms) from physical findings to determine the disease entity, or the structural change. Now in DSM it is necessary to know the delivery system of the presumed change. To say that only certain stressors can produce PTSD is like saying that botulism introduced through a tuna sandwich is a different disease than botulism introduced from salmon steak, or than an arm fracture from a car accident would require a different diagnosis than an arm fracture from a fall from a ladder.

The complexity of specification of traumatic event has led to continuing change in DSM stressor criteria, I would say evolution, but its not that comprehensible of a process. The proposed ICD (11) yields to what its authors see as the impossibility of the problem in its abandonment of the stressor criteria.

If I have to pick a side in the argument between specifying the nature

of events or not, I think I have to go with don't specify. This is partly because of the somewhat arbitrary nature of the definition of trauma, partly because of research that shows how many of the symptoms associated with the PTSD diagnosis occur with what are usually officially considered "lesser" traumas (e.g. divorce). It is also because of the psychological effects (so eloquently described by Ernest Becker) of the fact that from a very early age we are all profoundly affected by knowledge off our mortality, and that knowledge seems pretty traumatic to me. This is not to mention the mortality of everyone else. However, as a practical matter for treatment, it does not much matter, one still must orient treatment to the problems the client identifies, regardless of whether they came from a qualifying event.

The struggle about which individual events are capable of creating PTSD was predated by the effort to reestablish that events actually could cause psychopathology. On reflection, this seems odd in that the predominate psychotherapist theories on the creation of psychopathology have been some version of psychodynamic theory or learning theory, which both formulate life problems to be based on life experience. Once the possibility of experience causing psychopathology is acknowledged, as almost all schools of psychotherapy do, it would seem that there would be some experiences whose pathology causing potential could not be debated.

The destructive psychological effects of trauma such as war have been documented for thousands of years. Jonathan Shay (1995) has shown in great detail how Homer recorded these, as do some examples from early literature in this manuscript. Despite the obvious power of war to destroy there has been resistance to making even war related problems part of an official psychiatric nomenclature. This can most generously be ascribed to a possible genuine belief that underlying character is the crucial issue, not the traumatic experience. The potentially self serving nature of this stance is evident in the question, that if trauma causes a diagnosable problem would those who had some responsibility for the trauma then have some responsibility for preventing the trauma, or for fixing the results of it, or at the very least feel bad for not having done either? The strong initial resistance to the acknowledgement of trauma creating psychopathology and the creation of the PTSD diagnosis is documented by Scott, Wilber, J.

(1993) The Politics of Readjustment. New York: Walter de Gruyter.),

But the time was right for things to change, American society changed. Circumstances, as lots of social science research has supported (see Ross & Nisbett, 1991), were beginning to be recognized in their rightful place of importance of determining events. Nurture began to give nature a run for its money (as if you could actually split them). The civil rights, anti-war and women's movements allowed for the more open acknowledgement of pain and loss, and encouraged a more thorough understanding of the forces that led to that pain. While all three movements played important roles in the acceptance of the effects of trauma, I think it was probably the role of veterans, with the difficult to assail moral force of having served the nation, and their demographic similarity to decision makers that had the most important role. Men with the power to enforce the status quo might be able to get away with blaming the victim when the victims were a different race, or gender, but not many wanted to be seen slapping combat veterans anymore. The case for the influence of "nurturance" has become overwhelming with the recent discoveries of the role of experience in gene expression (Burris et al., 2013)

With that said, it is ironically appropriate that the first example of literature illustrating a PTSD diagnostic category comes from a moment in which the character suffering the symptoms, did not experience, see or even hear of the event, but only imagined what may have occurred.

The following passage is from the novel *Pnin (1953)*, by V. Nabokov, who was a refugee/exile of both Russia (because his father was a prominent aristocrat and liberal) and western Europe of the 1930's (Nabokov, 1967). Thus, he knows what he is talking about when, in *Pnin*, he tells the story of a Russian immigrant academic in the US in the 1950s. The similarities end in that Pnin stumbles through the English language while Nabokov was and is one of its most admired practitioners. Toward the end of the novel Professor Pnin has contact with some fellow immigrants, and is prompted to think about a lost love, who did not escape the war. In this passage it appears Nabokov's character is having recurrent and intrusive images of an event which he has not witnessed, and may not have occurred.

"One had to forget- because one could not live with the thought that this graceful, fragile, tender young woman with those eyes, that smile, those gardens and snows in the background had been brought in a cattle car to an extermination camp and killed by an injection of phenol into the heart, into the gentle heart one had heard beating under one's lips in the dusk of the past. And since the exact form of her death had not been recorded, Mira kept dying a great number of deaths in one's mind, and undergoing resurrections, only to die again and again, led away by a trained nurse, inoculated with filth, tetanus bacilli, broken glass, gassed in a sham shower bath with prussic acid, burned alive in a pit of a gasoline-soaked pile of beechwood. (p. 134)"

It may also be considered that in this passage Nabokov helps make clear part of what might be sought when the problematical term "closure" is invoked.

B. Intrusion Experiences

1. Involuntary memories
2. Recurrent distressing dreams
3. Dissociative experiences (flashbacks)
4. Distress at external or internal cues
5. Physiological reactions to cues

The presence of one of the DSM5 designated five types of intrusion experiences is necessary for the full PTSD diagnosis. These include involuntary memories, distressing dreams, dissociative or flashback experiences, and distress or physiological reactions to cues. They frequently overlap. For example, distress is part of these involuntary memories and flashbacks have many of the qualities of recurrent dreams. The dream and daytime intrusive memories comprise what appears to be the forthcoming first category of PTSD symptoms in ICD 11.

Joseph Heller, the author of *Catch 22* was a crew member on a bomber flying combat missions in Europe during WWII. Intermittently in the book, paralleling how these occur in life, his protagonist Yousarrian has intrusive memories of the death of Snowden, a new crew member on his bomber. One of Heller's literary devices is that each time the memory is

recalled it is reported more and more thoroughly. We can see that this intrusive memory begins with the introceptive cue that Yossarian feels cold, which reminds him of Snowden's cold.

…It was dark in the hospital and perfectly quiet. He had no watch to tell him the time… He was wide-awake, and knew he was a prisoner of one of those sleepless, bedridden nights that would take an eternity to dissolve into dawn. A throbbing chill oozed up his legs. He was cold, and he thought of Snowden, who had never been his pal but was a vaguely familiar kid who was badly wounded and freezing to death in the puddle of harsh yellow sunlight splashing into his face through the side gunport when Youssarian crawled to the rear section of the plane over the bomb bay after Dobbs had beseeched him on the intercom to help the gunner, please help the gunner…

(Here we can see Heller start to move Youssarian from recallling the event to mentally reliving the event.)

"I'm cold," Snowden said softly." I'm cold"

" You're going to be alright, kid." Youssarian reassured him with

a grin." "You're going to be alright."

"I'm cold." Snowden said again in a frail childlike voice. " I'm cold."

"There, there," Youssarian said, because he did not know what else to say. "There, there."

"I'm cold," Snowden whimpered. "I'm cold."

"There, there. There, there." (pp. 438-9)

It might also be mentioned that Heller also reminds us that despite our need to say something, sometimes the best we can do is words that don't mean much, but let the other person know we are present. We can't know if Snowden was comforted or not, but it was a good try.

The next example comes from a poem, *Haunted*, by Sigfreid Sassoon. Sassoon's service in WWI as a British infantry officer in Europe, and his psychological, political, psychotherapeutic and literary reactions to it have been profoundly influencial. The story of his service, eventual public protest

of the war after an opportunity for armistice was rejected, the successful work by the author and fellow veteran Robert Graves to have him medically "boarded" for mental illness (it appeared he would have easily met any criteria for PTSD) to prevent his prosecution for his protest, his psychiatric treatment and association with other poets have been described artfully in many literary forms including, biography (Egremont, 2005), memoir (Graves, 1929) , autobiographical novel Sassoon, 1937), and historical novel (Barker, 1991). In Haunted, a war veteran goes for a walk in the woods. It is notable that the veteran in this story seeks the open, when so often being in the open is a sign for increased vulnerablility in combat. It well illustrates how particular to the individual triggers of a trauma response can be.

Uneasy was the man who wandered, brooding
His face a little whiter than dusk.
A drone of sultry wings flicker'd in his head,
The end of sunset burning thro' the boughs
Died in a smear of red; exhausted hours
Cumber'd, and ugly sorrows hemmed him in.

He though: "Somewhere there's thunder, as he strove
To shake off dread; he dared not look behind him,
But, stood, the sweat of horror on his face.
He blunder'd down a path, trampling on thistles,
In a sudden race to leave the ghostly trees,
And: 'Soon I'll be in open fields,' the thought,
And half remembered starlight on the meadows,
Scent to mown grass and voices of tired men,
Fading along the field-paths; home and sleep
And cool-swept upland spaces, whispering leaves,
And far off the long churring night-jar's note.

But something in the wood, trying to daunt him,
Led him confused in circles through the thicket.
He was forgetting his old wretched folly,
And freedom was his need; his throat was choking,
Barbed brambles gripped and clawed him round his legs,
And he floundered over snags and hidden stumps.
Mumbling: 'I will get out! I must get out!'

Butting and thrusting up the baffling gloom,
Pausing to listen in a space 'twixt thorns,
He peers around with peering, frantic eyes.
An evil creature in the twilight looping.
Flapped blindly in his face.
Beating it off,
He screeched in terror, and straightaway something clambered
Heavily from an oak, and dropped, bent double,
To shamble at him zigzag, squat and bestial.
Headlong he charges down the wood, and falls
With roaring brain – agony – the snap't spark –
And blots of green and purple in his eyes,
Then the slow fingers groping on his neck,
And at his heart the strangling clasp of death.

In the next example to be considered, we see that the person suffering this problem does not always have to be a victim, or even a survivor of trauma. As Rachel MacNair (2002) has described from her own work and that of others, those initiating trauma whether for noble or other causes can show intrusive symptoms. In this famous scene, Lady Macbeth, one of Shakespeare's great villains, seems to be displaying problems, such fear of the dark and hand washing, which cut across diagnostic lines, a point well substantiated in work by Kessler (et al. 1995) However, here we focus on the intrusive "spot", and the smell.

Enter Lady Macbeth with a taper.

Gent: Lo you here she comes! Tis her very guise, and upon my life, fast asleep. Observe her, stand close.

Dr: How came she by that light?

Gent.: Why it stood by her. She has light by her continually, 'tis her command.

Dr. You see her eyes are open.

Gent: Ay but their sense are shut.

Dr: What is that she does now? Look how she rubs her hands.

Gent: It is an accostom'ed action with her, to seem thus washing her hands. I have known her continue in this a quarter of an hour.

Lady M: Yet here is a spot.

Doct: Hark, she speaks. I will set down what comes fro her, to satisfy my remembrance the more strongly.

Lady M: Out, damn'd spot! Out I say! One-two-why the 'tis time to do't. Hell is murky. Fie, my lord, fie, a soldier, and afeard? What need we fear who knows it, when none can call our pow'r to accompt? Yet, who would have thought the old man to have so much blood in him?

And later, Illustrating that some of the most powerful imagery is olfactory:

Lady M: Here's the smell of the blood still. All the perfumes of Arabia will not sweeten this little hand. O,O,O.

While Lady MacBeth has the most famous lines, Shakespeare did not spare her lord, who is bereft of sleep and hallucinates the presence of one of his victims at a celebratory banquet.

Finally, this is the place to hark back to the facial tics described in opening passage from Salinger and the Stone and Stone example.

C. Avoidance of Associated Stimuli or Memories

Prior to DSM5, back when PTSD is an Anxiety Disorder this type of avoidance was combined with emotional numbing. Reasons to object to this combination seem obvious, and change was effected. A category very much like the DSM 5 Avoidance category appears to be one of the three ICD11 diagnostic categories.

In "Year of Wonder" her first novel, Geraldine Brooks (2001), a former reporter who covered the tragedies of Bosnia, Somalia and the Middle East, imagines life in an English village in 1665 during the time of the bubonic plague. In the following passage the novel's protagonist is returning from ministering to the afflicted.

At days end when I leave the rectory for home, I prefer to walk through the orchard on the hill rather than go by the road and risk meeting people. After all we've been through together, it just not possible to pass with a polite, "Good night t'ye." And yet I haven't the strength for more. Sometimes, not often, the orchard can bring back better times to me. These memories of happiness are fleeting things, reflections in a stream, glimpses all broken for a second and then swept away in the current of grief that is our life now. I can't say that I ever feel what it felt like then, when I was happy. But sometimes something will touch the place where that feeling was, a touch as slight and swift as the brush of a moth's wing in the dark". (p. 6)

The effected change solved the problem in that it separated the two types of avoidance as they did seem to be of two different types. However, the change may lead to the exclusion of people who have been particularly troubled by an event(s) and meet all the other criteria of the PTSD diagnosis, but immerse themselves in, rather than avoid associated stimuli. For example, some combat veterans watch war movies and wear military clothing. Psychodynamic theory recognizes the ways in which opposite behaviors can reflect the same underlying dynamic with terms such as 'counter-phobic" behavior, or "repetition compulsion".

Since the immersion behavior does not appear to fit into other diagnostic categories, and does occur in individuals who meet the other criteria for PTSD it is particularly fortunate that the category Other Specified Trauma- and Stressor-Related Disorders (309.89) was created for people who did not meet all of the PTSD criteria.

It does seem that people who meet other criteria and immerse themselves in stimuli related to the trauma would better be considered to have a subtype of PTSD rather than an "other" diagnosis.

In the classic 18th century comic novel Tristram Shandy, by Laurence Sterne, Tristram describes the situation of his Uncle Toby who had been severely wounded in a Siege of Namur.

He was one morning lying upon his back in his bed, the anguish and nature of the wound upon his groin suffering him to lye in no other position when the thought came into his head, that if he could purchase such a thing, and have it pasted down upon a board, as a large map of the fortifications of

the town and citadel of Namur, with its enviorns, it might be means to give him ease. (pp. 58-9)

As the story continues, an actual model of the battleground is constructed in the countryside, providing Uncle Toby with some of the relief he has sought.

A more serious version of this preoccupation occurs in the "The Rime of the Ancient Mariner" by Samuel Taylor Coleridge, which was called to my attention by Dr. Andrew Stone. In this poem the narrator tries to rid himself of the horror and the guilt he feels from the now famous deaths of his shipmates.

O shrieve me, shrieve me, holy man! The Hermit crossed his brow. `Say quick,' quoth he `I bid thee say - What manner of man art thou?'
Forthwith this frame of mine was wrenched With a woeful agony, Which forced me to begin my tale; And then it left me free.
Since then, at an uncertain hour, That agony returns; And till my ghastly tale is told, This heart within me burns.
I pass, like night, from land to land; I have strange power of speech; That moment that his face I see, I know the man that must hear me: To him my tale I tell

Criterion D Negative Changes in thoughts mood Associated with Traumatic Events

1. Failure to remember important aspects of the events
2. Persistent and exaggerated negative thoughts about oneself others or the world.
3. Unwarranted blame of self or others
4. Persistent aversive emotional states such as fear, terror, rage, guilt or shame
5. Decreased caring about important activities
6. Feeling detached from others
7. Inability to experience positive emotions.

The seven specific symptoms listed in this criterion, are in some ways as disparate as the old forcing together of numbing and behavioral avoidance. They range from appearing to be more closely related to dissociation, or to intrusions of emotion, and even closer perhaps to changed meaning, which could be considered outside the realm of psychopathology.

Rather than harp further on possible inconsistencies, since all seven can be destructive effects on trauma, better to just move on and show how literature illustrates them

1. Failure to remember important aspects of the events

My previous objection to one of Pat Barker's opinions is more than counterbalanced by examples of the authority of her fiction, such as in her *Regeneration* trilogy of novels about the psychological effects of combat in WWI. These effects are told of from multiple perspectives, including those of soldiers, family and therapists. They are as good an example of the value of art illuminating trauma effects as one could hope to find. In her work, Barker includes compelling fictional portraits of Sigfried Sassoon, Robert Graves, Wilfred Owen, the psychiatrist W. H. Rivers, and even Lewis Carroll.

In the following passage the fictional version of the psychiatrist, Rivers, is treating the fictional combat veteran, Prior. The passage, in one short paragraph illustrates the blocking of memory, and one kind the therapeutic response, as well as the complexity of the internal response of the therapist. This last point I can verify from personal experience.

Rivers let him continue. This had been Prior's attitude through out the three weeks they'd spent trying to recover his memories of France. He seemed to be saying, 'All right. You can make me dredge up the horrors, you can make me remember the deaths, but you will never make me feel.' Rivers tried to break down the detachment, to get to the emotion, but he knew that, confronted with the same task, he would have tackled it in the exactly same way as Prior. (p.79)

Items 2,3 and 4 Negative thoughts about self and others, unwarranted blame, and persistent negative emotional states considerably overlap.

Let's start with the exaggerated negative thought of unwarranted blame, where the overlap is most complete. Blame is a negative thought explicitly

given its own category, and when blame is called "guilt", it can be considered as both a thought and a feeling. The explicit inclusion of "blame" marks the return of recognizing guilt attribution and feelings, which had been exclude in DSM IIIR and IV. This prior exclusion was surprising to many practitioners who so often saw "survivor's guilt" especially as a particularly painful and irrational response to trauma, and guilt feelings in general as often unnecessarily destructive and difficult to overcome. The difficulty in overcoming of guilt may be because while the "victim" may find release of pain, the person blaming himself cannot give himself the permission to do so, which the "victim" may not require.

Survivor guilt mostly referred to the guilt one would feel despite having no role in causing the traumatic event, it was guilt for simply surviving. Guilt's return as "self blame" is explicitly
due to " distorted cognition about cause" (p145). A key difference from DSMIII is that in III, the self-blame could have been about simply surviving, but also "about behavior required for survival" (III p238).

The return of guilt to DSM may be related to recent discussions of the concept of "moral injury"(see Litz et al. 2009) in influential professional journals and scientific/professional societies. Though it should be noted that it had not ever been deleted by practitioners. An easily documented example is the inclusion of awareness of client belief in "responsibility" for a traumatic event that has been a primary area of assessment and treatment in EMDR a widely acknowledged "evidence based" method of PTSD treatment established in the early 1990s.

This acknowledgement that destructive psychological effects of trauma can be related to emotions other than just terror is certainly welcome, however applying the medical metaphor of "injury" to moral questions brings up the essential problem inherent to basing the field of amelioration of psychological or philosophical problems on medical metaphors. A moral "problem" is truly in the eye of the beholder, not identifiable by medical tests. Then again, it is difficult to deny the power of the African-American hymm:

There is balm in Gilead,
To make the wounded whole ;
There's power enough in heaven,

To cure a sin-sick soul.

If we set aside my own philosophizing for a moment we can see how survivor guilt is at the core of the following passage from *Enemies, A Love Story* by Isaac Bashevis Singer. The character Sarah Puah has survived the concentration camps of Nazi Germany and immigrated to the United States. In this passage her self-blame is made palpable.

Shifrah Puah picked up a slice of bread as if she were touching some sacred object. She bit into it carefully as if she were touching a sacred object. She bit into it carefully. Guilt stared out of her dark eyes. Could she permit herself to enjoy God's bounty when so many Jews had died of starvation? Shifrah Puah often maintained that she had been permitted to survive only because of her sins." (P 49)

While Singer's passage compellingly described survivor guilt and unwarranted blame, if we return to Lady MacBeth we can see a description of a guilt symptom which is hardly unwarranted. This raises the question, that if Lady MacBeth's symptoms are also displayed in real life do we not need to attend to a nomenclature, such as described above in reference to Rachel McNair and perpetration induced PTSD, which can describe symptoms even in those who might be seen as deserving them?

By way of introduction of another literary passage on the subject we may consider the writings of Bonnie Janoff-Bulman who considers the specific nature of the "negative thoughts about one's self, others and the world." She describes the trauma response as leading to the violation and changing of the deeply held beliefs, "assumptions", the violation of which has profound emotional impact. She posits three fundamental assumptions: "The world is benevolent. The world is meaningful. The self is worthy." So, when the narrator of Tim O'Brian's novel *The Things They Carried* says,

A true war story is never moral. It does not instruct, nor encourage virtue, nor suggest models of proper human behavior, nor restrain men from doing thinks men have always done. If a story seems moral, do not believe it. If at the end of the war sorry you feel uplifted, or if you feel that some small bit of rectitude has been salvaged from the larger waste, then you have been made victim of a very old and

terrible lie. There is no rectitude whatsoever. There is no virtue. As a first rule of thumb, therefore, you can tell a true war story by its absolute and uncompromising allegiance to obscenity and evil." (p76).

In Janoff-Bulman's terms he is saying, the soldier's world is not benevolent, not meaningful and the self is not worthy. The question then occurs, are we to consider the narrator to demonstrating a symptom, or accurately reflecting a reasonable philosophical position? In this case perhaps O'Brien, a combat veteran, (who should not be confused with the narrator, as tempting as that may be) helps us by dedicating his war story thus: "This book is lovingly dedicated to the men of Alpha Company, and in particular Jimmy Cross, Norman Bowker, Rat Kiley, Mitchell Sanders, Henry Dobbins, and Kiowa." This seems to say that his love of his comrades in war endures despite the passage in the book about absence of meaning. Perhaps, not **all** is lost.

Numbers 5,6 and 7, decreased caring, about activities, detachment and inability to experience positive emotion all seem too closely related to separate very well.

These are sometimes described as in the old term emotional "numbing." It is worth mentioning here that a combat veteran client of mine suggested that "callousness" was a better descriptor. Despite my aversion to medical type metaphors I can't help but use this one. A callous, based on personal observation, is skin which has become, often usefully, rough and insensitive from stress, and protects highly sensitive tissue below it. The callousness can only stand so much pressure before it breaks and creates an even more painful situation. The following passage from Hemingway's (1925) story *Soldier's Home* seems to demonstrate 5, 6 and 7. The story describes the life of a young veteran of WWI. He has returned to his family in small town Oklahoma in 1919. He has been hanging around, not doing much, avoiding his formerly pleasurable activities, passive; his parents are concerned.

His mother says: We want you to enjoy yourself. But you are going to have

to settle down to work, Harold. Your father doesn't care what you start in at. All work is honorable as he says. But, you've got to make a start at something. He asked me to speak to you this morning and then you can stop in and see him at his office."
"Is that all?" Krebs said

"Yes, don't you love your mother, dear boy?"

"No," Krebs said.

His mother looked at him across the table. Her eyes were shiny. She started to crying.

"I don't love anybody," Krebs said.

It wasn't any good. He couldn't tell her, he couldn't make her see it. It was silly to have said it. He had only hurt her. He went over and took hold of her arm. She was crying with her head in her hands.

"I didn't mean it ." he said. " I was just angry at something I didn't mean I didn't love you." (pp. 151 – 152)

In All Quiet on the Western Front, Erich Marie Remarque, a multiply wounded combat veteran, has his protagonist say, at the end of the novel describing his time on the front line:

"…The armistice is coming soon, I believe it now too. Then we will go home.

Here my thoughts stop and will not go any farther. All that meets me, all that floods over me are but feelings – greed of life, love of home, yearning for the blood, intoxication of deliverance. But, no aims.

Had we gone returned home in 1916, out of the suffering and the strength of our experience we might have unleashed a storm. Now if we go back we will be weary, broken, burnt out, rootless, and without hope. We will not be about to find our way anymore.

And men will not understand us…a few will adapt themselves, and most will be bewildered;-the years will pass by and in the end we shall fall into ruin." (pp. 293 – 294)

Let's move away from war to the example of a teenage girl who has become paraplegic in a school bus accident gives a very different sense of the experience of estrangement as a consequence of traumatic experience. Some might even call it "enlightened non-attachment". This passage, from the Russell Banks' (1991) novel *The Sweet Hereafter,* was made into the rare film as good as a good book it was based on,

All of us- ...the children who survived the accident, and the children who did not- it was as if we were the citizens of a wholly different town now, as if we were a town of solitaries living in a sweet hereafter, and no matter how the people of [our town] treated us, whether they memorialized us or despised us, whether they cheered for our destruction or applauded our victory over adversity, they did it to meet their needs, not ours. Which, since it could be no other way, was exactly as it should be." (p254)

Criterion E: Changes in arousal and reactivity

1. Irritability and angry behavior
2. Recklessness of self destructive behavior
3. Hypervigilence
4. Increased startle

5 concentration problems

6. sleep problems

The five symptoms listed under this criterion appear to have less overlap than in Criterion D. However, while all six symptoms in Criterion E appear to be distinct within the criterion, a kind of overlap does occur with symptoms outside of E. Symptom five is "concentration problems". Here we appear to have a chicken and egg situation. When someone is not focusing on the task at hand, and is instead absorbed by memory of trauma (intrusion) or blocking memory of trauma (avoidance) is this a failure of the mechanism which provides concentration, or is it a Criterion B or D symptom? Likewise for symptom six, difficulty falling or staying asleep, what is the underlying process? Is it intrusions (Criterion B, see Yosarrian's problem with sleep above), or some more basic arousal mechanism disorder? That increased resting heart rate is often associated with PTSD (McFall, et al. 1989) makes it difficult to deny that there is not some arousal mechanism

problem independent of intrusive thoughts.

And then there is the problem with anger, symptom one. If we agree with the psychiatrist Harry Stack Sullivan (1954), or Virgil (below), or Yoda that anger is a defense against some other more painful emotion, is anger then an independent arousal issue, or is it more basically a grief or fear issue? (see Lipke, 2013, I couldn't resisit) Perhaps it will be helpful to be aware of these questions as the symtoms are illustrated below.

In Virgil's *Aneid* Troy was destroyed, and Aneis is about to focus on taking revenge when his mother the goddess Venus intervenes.

What joy, to glut my heart with the fires of vengence, bring some peace to the ashes of my people. Whirling words- I was swept away by fury now when all of a sudden there my loving mother stood before my eyes, but I had never seen her more clearly, her pure radiance shining down upon me through the night, the goddess in all her glory, just as the gods behold her build, her awsome beauty. Grasping my hand she held me back, adding this from her rose-red lips: ' My son what grief could insite such blazing anger? Why such fury? And the love you bore for me once where has it gone? Why don't you look first to where you left your father, Anchiese, spent with age? Do your wife an Creusa, and son Ascanius still survive? (p. 95)

1. Irritability and angry behavior

Primo Levi survived the concentration camps of Nazi Germany and wrote about it with overwhelming power. This poem uses the cadences and some of the commands of the most sacred Jewish prayer, the Shema, a word which means "hear" or "listen", and in the original goes on to praise God.

You who live secure
In your warm houses
Who return at evening to find
Hot food and friendly faces:
Consider whether this is a man,
Who labours in the mud
Who knows of peace
Who fights for a crust of bread
Who dies at a yes or no.
Consider whether this is a woman,
Without hair or name

With no more strength for member
Eyes empty and womb cold
As a frog in winter,
Consider that his has been:
I commend these words to you.
Engrave them on your hearts
When you are in your house,
When you walk on your way,
When you go to bed, when you rise.
Repeat them to your children. Or may your house crumble,
Disease render you powerless,
Yuor offspring avert their faces from you.

And there is Ralph Ellison's (1952) *Invisible Man*, for whom the specific multiple traumatic events of his own life seem inseparable from the American legacy of slavery and racism. The unnamed narrator, the "Invisible Man" describes the expression of his rage:

One night I accidentally bumped into a man, and perhaps because of the neat darkness he saw me and called me an insulting
name. I sprang at him, seized his coat lapels and demanded that he apologize. He was a tall blond man, and as my face came close to his he looked insolently out of his blue eyes and cursed me., his breath hot in my face as I he struggled. I pulled his chin down sharp upon the crown of my head, butting him as I had seen the West Indians do, and I felt his flesh tear and the blood gush out, and I yelled, "Apologize! Apologize!!" But he continued to curse and struggle, and I butted again until he went down heavily, on his knees, profusely bleeding, I kicked him repeatedly, in a frenzy because he still uttered insults though his lips were frothy with blood. Oh yes, I kicked him! And in my outrage I got out my knife and prepared to slit his throat, right there beneath the lamplight in the deserted street, holding him in the collar with one hand, and opening the knife with my teeth (when it occurred to me that the man had not seen me actually; that he, as far as he knew , was in the midst of a walking nightmare! And I stopped the blade, slicing the air as I pushed him away, letting him fall back on the street. I stared at him hard as the lights of a car stabbed through the darkness. He lay there, moaning on the asphalt; a man almost killed by a phantom, I was both disgusted and ashamed, I was like a drunken man myself wavering about on weakened legs. Then I

was amused: Something in this man's thick head had sprung out and beaten him within an inch of his life. I began to laugh at this crazy discovery." (p 3)

2. Recklessness or self destructive behavior

In the film *Fearless* (1993) Jeff Bridges plays a character who survives a plane crash and then acts heroically to rescue some of his fellow passengers. He quickly develops many stress disorder (post and acute) symptoms. These are written and played compellingly. While I cannot adequately describe this aspect of the film in print, it is included to refer readers to the film.

Noteworthy among the demonstrated symptoms is Bridges portrayal of episodic reckless and self-destructive behavior. First, after becoming overwhelmed by anxiety in an outdoor press interview he runs in panic, first, still panicked, across a busy highway, and then, surviving, he calms, and starts to walk, almost challenging cars to hit him. He looks up the sky, clearly addressing God and proclaims: "You can't do it. You want to kill me but you can't." His face then reflects peace and seeming joy. (24:54)

In another scene he is asked by the widow of a friend who died in the crash to misrepresent what he saw during the crash in order to improve her legal claim. He first says that he can't lie, and then agrees. Then, again in panic, he runs out of the office and onto the roof of the tall building. First he cowers behind a low wall, he sees a flashback from the crash, then calms and says "Let it go, I can let it go" (1:05). He climbs the wall standing on the ledge, again shaking with fear, says "I can't live as a coward, oh fuck". He looks down and yells, again becomes peaceful and starts to move and chuckle, and eventually dance

Finally, in a startling scene. Bridge's character has been trying to comfort Rosie Perez's character, whose babe in arms died in the crash. She is overwhelmed by guilt over having failed to hold the child as the plane crashed to a halt. Without explaining why Bridges convinces her to hold a bowling ball in her lap, seat belt on in the back seat and he crashes the car into a wall. The Perez character does, in fact, appear to get the point that it would have been impossible to maintain her hold on the child.

The Jeff Bridges character acting out of the threat situation brings to mind the Freudian concept or repetition compulsion and the attempt to master the terrifying situation.

I have used this film in class to teach, often stopping for discussion of what is being portrayed, pro and con. Con, as the portrayal of a therapist's approach and therapy in the film is an excellent guide to therapists in training of what not to do, when a therapist hired by the airline is shown making initial contact by pretending to have, just by chance, been in a seat next to the Bridges character.

From another source comes a more equivocal example of reckless behavior and an illustration of how subjectively some symptoms are evaluated. The short story "Tips for a Smooth Transition", by Siobhan Fallon an author and "army spouse' (p229) is a work full of insight and art embedded in a short story collection, *Fire and Forget,* of other short stories also full of insight and art. In this story "tips" from a fictive guide to military spouses meant to prepare them for the transition from deployment are interspersed with example of how things play out for a veteran and his spouse, as told from her point of view. In the story the wife arranges for a celebratory homecoming trip to Hawaii.

The fictional manual reads:

Be aware that many soldiers return home with a feeling of post-combat invincibility. One consequence of combat exposure may be an increased propensity for risk-taking and unsafe behavior. Specific combat experiences, including greater exposure to violent combat and contact with high levels of human trauma, are predictive of greater risk-taking after homecoming, as well as more frequent alcohol use and increased verbal and physical aggression toward others. (p. 31)

This is exemplified in the story when after Evie, the wife, refuses to go in a cage surrounded by sharks which is part of a tourist attraction, Colin the husband, and veteran, responds.

"It'd be safe if we weren't even in the cage. Galapogos sharks are harmless" …Then Colin's eyes lock on her, and calm suffuses his face, "I'll prove it," he says softly.

His eyes still on Evie's, never hesitating, he climbs up on the boat railing, and before anyone can even think to stop him, he steps off, right into open water, sinking into the center of the feeding animals. (pp 33-34)

When Colin explains to Evie that diving in among Gallapagos sharks is not really very risky (An assertion which several web sites I examined agree). So, the lesson here may partly be that sometimes the "risk taking" is in the eye of the beholder. It may also be noted that the calm that comes to Colin the veteran of repeated terrifying experiences occurs just before he enters the water, where as the calm that comes to the character in "Fearless", a not a veteran, and the survivor of one traumatic experience comes after he engages in the risky behavior.

The following example of self destructive behavior is from the novel *Push*, by Sapphire, which has been made into the film *Precious*. Precious, a young teenager, describes her reaction immediately following one of the times she was raped by her father.

Afterward I go bafroom. I smear shit on my face. Feel good. Don't know why it do. I never tell anybody about that before. But I would do that. I go to insect (incest) support group what I will hear from other girls. I bite my fingernails till they look like disease, pull strips of my skin away. Get Daddy's razor out cabinet. Cut cut cut arm wrist, not trying to die trying to plud myself back in. I am a TV set wif no picture. I am broke wif no mind. No past no present time… (p 111 - 112)

3. Hypervigilance

This and the following symptom "exaggerated startle" are the two ICD 11 symptoms in this category (E) which appears with the name "Hyperarousal" in ICD 11.

The following passage illustrates this item, and also provides an argument for explicitly helping children understand a traumatic event. Don DeLillo's novel *Falling Man* concerns Manhattan families who have been profoundly affected by the destruction of the World Trade Center in New York on 9.11.01. The passages below illustrate an effect on the behavior of three children, two siblings and a friend. The children have been sneaking away to look out of their highrise window with binoculars for a purpose which their mothers do not yet understand. In the following passages the mothers are trying to figure it out:

"You mean what they are looking at, behind closed doors?"
"Can't be much, can it? Maybe hawks. You know about the red-tails?"
"No, It's definitely something to do with Bill Lawton. I am sure of this,

absolutely, because the binoculars are part of the whole hush-hush syndrome these kids are engulfed in."
"Bill Lawton." "The man. The name I mentioned." "I don't think so." Lianne said.
"This is their secret. I know the name but that is all. And I thought maybe Justin. Because my kids totally blank out when I bring up the subject." (pp. 36-37)

Later, on p. 72, the secret is revealed. Lianne is talking to her husband about the children and their strange behavior:

"The name originates with Robert. This much I know. The rest I mostly surmise. Robert thought, from television or school or somewhere, that he was hearing a certain name. Maybe he heard the name once, or misheard it, then imposing this version on future occasions. In other words he never adjusted his original sense of what he was hearing."
"What was he hearing?"
"He was hearing Bill Lawton. They were saying bin Laden."

4**. Increased startle**

Shakespeare's Henry IV Part 1, contains almost its own DSM in the following speech from Lady Percy, the wife of Hotspur one of the bravest of knights. It is included here in the section on exaggerated startle, though as it easy enough to see it is almost a summary of the whole criteria for diagnosing PTSD. It is instructive that American psychiatry, populated mostly by highly educated men, many of whom undoubtedly studied this play, this passage, managed to find it so easy to resist the inclusion of a diagnostic category in early DSMs reflecting problems so commonly experienced by their patients. Were my mental health colleagues demonstrating dissociation? repression? denial?

Hotspur: How now Kate, I must leave you within these two hours.
Lady: O my good lord, why are yo thus alone?
For what offence have I this fortnight been
A banish'd woman from my Harry's bed?
Tell me, sweet lord, what is't that takes from thee
Thy stomach, pleasure and they golden sleep?
Why does't thou bend they eyes upon the earth
And start so often when though sit'st alone?

Why has't thou lost the fresh blood in thy cheeks,
And given my treasures and my rights of thee
To thick-ey'd musing and curst melancholy?
In thy faint slumbers. I by thee have watch'd,
And heard thee murmur tales of iron wars,
Speak terms of manage to thy bounding steed,
Cry, "Courage! To the field!" And thou hast talk'd
Of sallies and retires, of trenches, tents.
Of palisades, frontiers, parapets,
Of basilisks, of canton, culverin,
Of prisoners' ransom, and of soldiers slain,
And all the currents of a heady fight;
Thy spirit within thee hath been so at war,
And thus hath so bestirr'd thee in sleep,
That bed of sweat have stood upon thy brow,
Like bubbles I a late-disturbed stream,
And in thy face strange motions have appear'd,
Such as we see when men restrain their breath
Of some great sudden hest. O, what portents are these?
Some heavy business hath my lord in hand,
And I must know.
(IIiii)

5. Concentration problems

This symptom is, again, one that is difficult to consider out of context. What will look like a change in " arousal and reactivity" may actually be more a reflection of intrusive experiences, which lead to distraction from tasks, and/or in thoughts… such as in preoccupation with blame, or decreased caring.

In Judith Guest's novel *Ordinary People,* Jarrett, who survived a boating accident, which his older brother did not, is lying in bed remembering why his high school teacher had paid extra attention to him. Then he remembers a time, after the accident, during which he demonstrated difficulty concentrating. The novel, and the film based on it, well portrays a whole family's response to this traumatic loss.

In bed he waits for sleep… What about the test? Did he pass it? He thinks so but something else- what had he said to Suzanne? It doesn't matter

and suddenly it clicks into place: why Simmons had kept such an eye on him all through the hour. Oh god, that was the class. Last year. A quiz was returned. Across the paper in red pencil 'Incomplete. See Me.' He had stared at it all through the hour while the rest of the class discussed and made corrections. No use listening, none of it meant anything to him. He sat there, his eyes slowly filling with tears, trying to blink them back but they would not stop, and Simmons bending over his desk, asking Jarrett, are you sick? Nodding, stumbling up the aisle, facing the blackboard as Simmons wrote out a hall pass." (P75)

6. Sleep Problems

As above, the overlap is profound.

Remember Youssarian, having intrusive thoughts a few pages ago. Just before those thoughts crept in:

…It was dark in the hospital and perfectly quiet. He had no watch to tell him the time. He was wide-awake, and knew he was a prisoner of one of those sleepless, bedridden nights that would take an eternity to dissolve into dawn. (Heller, p. 439)

Other Specified Features

Dissociative symptoms

It appears that the authors of DSM5 are distinguishing types of dissociative symptoms. Some are clearly listed in category B, and some, depersonalization and derealization are relegated to this "other" category. In the earlier version of this work, when it was organized according to the previous DSM system the PTSD was listed as an anxiety disorder. At that time I noted how that listing was controversial and suggested, as had others (see Brett, 1996), that it could have just as easily been considered a dissociative disorder, or, as it is now in the category of Trauma Related or Stress Disorders.

The following passage is the poem Back, by Wilfred Gibson (1915/1991)

They ask me where I've been,
Andwhat I've done and seen.
But what can I reply
Who knows it wasn't I,
But someone just like me,
Who went across the sea
Andwith myhead and hands
Killed men in foreign lands…
Though I must bear the blame,
Because he bore my name.

Delayed Expression

Also to be specified in DSM5 is whether onset is delayed
Some people, with a time proximity limited understanding of causality find the idea of delayed onset of symptoms particularly difficult to accept as legitimate. So, taking an example from a professedly autobiographical work, though still technically classified as fiction, might be helpful.

The following is from Ari Folman and David Polonsky's animated film and graphic novel based on Folman's combat and post-war experiences. It shows the delayed onset of nightmares. The dialogue is from the opening scene of the film and spread across pages 1-12 of the novel with the accompanying drawings, regrettably not included here:

The Narrator (Folman): "The night Boaz called was the worst night that winter. It was January 2006. Nothing in our thirty years of friendship had prepared me for the story he was about to tell.

Boaz: The dogs have been coming for two years he said. Twenty-six dogs. I see their mean faces from the window. They've come to kill me. They tell Bertold, the guy who owns the office downstairs either to give us Boaz Rein's head or we'll eat your clients. You've got one minute.

Narrator: How do you know it's twenty-six and not thirty?

Boaz: Believe me, I know. These dreams don't come from nowhere. There are things I haven't told you.

Narrator: Like what?

Boaz: You know...from Lebanon. At the beginning of the war, in the summer of '82 we'd go into the villages searching for Palestinians on our wanted list. When you come to a village the dogs smell you first and start barking. The whole village wakes up and the man you're looking for gets away. Somehow we had to finish the dogs off. They knew I was incapable of shooting people, so they said, Okay Boaz... You go in with your silencer and take care of the dogs. I remember every one of them. Every face, every scar, the look in their eyes as they died.

Narrator: How long was it before they stared showing up in your dreams?
Boaz: Twenty years.

Narrator: Have you seen anyone?

Boaz: Like who?

Narrator: A therapist, a shrink, Shiatsu, someone?

Boaz: No, no one. I called you instead.

Narrator: What do I know I'm a screenwriter?

Boaz: That's kind of psychotherapy, too, isn't it?" Don't you ever have flashbacks from Lebanon? From Beirut, Sabra and Shatila?

Narrator: What about Sabra and Shatila?

Boaz: You were, what a hundred yards away from the massacre?

Narrator: Two hundred, three hundred. No, to tell you the truth, it's not in my system. No, there is nothing. You'll be okay, right?

Boaz: Think so?

They embrace, and the narrator walks away into the night.

Narrator: That night, for the first time in twenty years I had a terrible flashback from the Lebanon War, and not just from Lebanon, but from West

Beirut, and not just from West Beirut…

That is it for the current official DSM5 PTSD symptoms. Next to be addressed are other psychological effects of trauma, again stunningly illustrated in literature, even if not fully recognized by science.

III Other Psychological Effects and Phenomena

In the newly added section of DSM5 Trauma- and Stressor-Related Disorders there are several "disorders accompanying PTSD, Reactive Attachment Disorder, adjustment disorders and more. These will not be specifically addressed under their DSM categories.

In the earlier discussion of the development of the PTSD diagnosis, and in the early examples from literature, mention was made of how trauma survivor problems would have been considered signs of neurosis, psychosis, personality disorder or substance abuse prior to the addition of PTSD to DSM. In this section we get to step away from the details of diagnostic categories and examine some psychological problems which are frequently seen following traumatic experiences, and may or may not be part of somebody's definition of Post-traumatic Stress Disorder. The areas address will be class consistent. For example Depression is a category, as is Suicide, one is a diagnostic category, one an act.

Depression

If a traumatized person has negative psychological effects, after PTSD, depression would be the problem that would most likely describe the effects. (see Kessler et al. 1995).

In her autobiographical novel *Bastard Out of Carolina,* Dorothy Allison shows the experience of physical, emotional and sexual abuse in a working class family, and as she has said (Allison, 2006), provides a memorial to her family. In the following passage Bone, the survivor of abuse by her step-father, has finally been rescued after a final brutal beating and rape. She returns from the hospital to the protection of her aunt. She has many symptom of PTSD, however his passage certainly sounds like depression:

I stayed on the porch and would not talk to anyone, not to Raylene and not to Earle when he brought me his battered record played and tried to make

me laugh. He played some of the same records I had listened to with Aunt Ruth, but I sat unmoved, dry – eyed and distant. Eventually he left me alone. Raylene didn't try to talk to me. She brought me beans to pick over, which I did with no interest. She also asked me to rip out the hem of some old curtains, but that I refused to do. Not that I argued with her. I just left them lying untouched on the dusty boards by the rocker. I could have slept in the rocker, but Raylene threatened to drag me out of it kicking an screaming. (p 303 – 304)

Given the difficulty in gaining consensus about the nature of PTSD and other diagnoses, one might expect that there will be new ways of understanding what we call "mental illness" in the not too distant future. In a recent paper called Beyond Depression: Toward a Process-Based Approach to Research, Diagnosis and Treatment, (Foregard et al. 2011) some of our most eminent scientists in the field discuss possible future paths, categorizing based on the process underlying the visible symptom, rather than the symptoms themselves, they refer to this as "process-based taxonomy".

Suicide

A program called Theater of War has used presentations of plays by Sophocles in a Department of Defense sponsored program to engage veterans and their families around the psychological effects of war, and to help get those who need it to psychotherapy. The title of the article is "You Are Not Alone Across Time: Using Sophocles to Treat PTSD" by Wyatt Mason (2014). If we accept the idea that witnessing a representation of someone else's distress, even when what is witness does not show a specific path to comfort, provides therapeutic benefit, then the question arises, "How could this happen?" One answer might be that the witnessing of the other provides a kind of companionship which may provide relief from a possible belief that one is uniquely inferior for being so troubled by events. Another, could be some of the same kind of benefit sometimes derived from talking (or writing) about an event and one's feelings and thoughts about it. As one hears one's self, or goes through the process of writing the information is contemplated in a way different from the repetitive ruminations that went before. The repetitive destructive thoughts, feelings and even images can be

considered from another perspective, would be one way to put that. Another would be to describe the occurrences as being re- or further processed, or perhaps reconsolidated. Perhaps moving from non-declarative to declarative memory systems. This kind of processing is discussed in many places. There is a representation of it in Lipke (2013) which I hope I can be excused for suggesting is particularly usefully presented for both clinicians and the general public.

To return to the literature itself, in the following passage Aias speaks of the motivation for his eventual suicide. Sophocles, a veteran himself, shows both the intellectual and emotional aspects of the motivation. The motivation is clear, but its also clear that Aias did not <u>have</u> to see this as a necessary path.

…I must find some act that will prove
my nature and show my father
that his son was not born gutless.
To stretch your life out when you see
That nothing can break its misery
Is shameful- day after day
Moving forward or back from end line
Of death. There is not joy in that
Any mortal who warms his heart
Over empty hopes is worthless
In my eyes. Honor in life
Or in death: if a man is born noble,
He must have one or the other.
You've heard all there is to say
(p44)

As the play goes on the reaction of those who loved him is also poignantly shown. As the article makes clear that at least some of the audience did not agree with Aias that his speech was all there was to say.

Fear Based Behavior

Attempting to prevent recurrence

The avoidance and hyper-vigilance symptoms described in the DSM5 section capture some of the aspects of the heightened need to take precautions for protection. Clinically, I have seen this most clearly in some combat veterans who stayed armed in civilian life, even if they intellectually knew that being armed could be more dangerous for them, and their families, than if they weren't armed. Hoarding behavior, another kind of protection, as seen below, is not rare.

In Martell's allegorical tale *Life of Pi*, Pi Patel, a young boy has survived many horrors as the victim of a shipwreck, including starvation. In the following scene, having been rescued he is in the hospital being questioned by investigators from an insurance company. The dialogue in italics is meant to portray that the investigators are speaking to each other in Japanese, to prevent Pi from understanding what they are saying to each other. In this moment from the novel an investigator asks and Pi responds:

"Would you like a cookie?"
"Oh, yes!"
"Here you go."
"Thank-you!"
"You're welcome. It's only a cookie. Now Mr. Patel, we were wondering if you could tell us what happened to you, with as much detail as possible."
"Yes, I'd be happy to... (p 291)

Pi tells the story

Mr. Okamoto: Very interesting.

Mr. Chiba: What a story. He thinks we're fools. Mr. Patel, we'll take a little break and then we'll come back, yes
"That's fine. I'd like another cookie."
"Yes, of course."
Mr. Chiba: " He's already had plenty and most he hasn't even eaten. They're right there beneath his bedsheet."
" Just give him another one. We have to humour him. We'll be back in a few minutes." (p292)

In this context a cigar is not just a cigar; a kid trying to get extra cookies is not just a kid trying to get an extra cookie.

Counter-phobic behavior

While not at the center of articles in mental health journals many psychoanalytic concepts and much of the language, like the title of this subsection, still have resonance in therapist thinking and discussion. In addition to the idea of counter-phobic behavior, the idea of repetition compulsion seems a compelling way to think of s some "intrusive" symptoms.

As a war correspondent in Iraq Dexter Filkin was clearly aware of the risks of leaving the safety of his base to go running for exercise. In the following passage he demonstrates the attraction of the feared situation. There are similarities to the description above of Uncle Toby's building a replica of the fort where he was grievously injured. While running for exercise does have its addictive aspects, which may partially explain the attraction to it, there were other exercise options.

I pulled on my running shoes and headed outside. I went through the heavy bulletproof door of the compound and down the long cement chute, a gauntlet of blast walls with a checkpoint at the far end. I ran south about fifty yards, and swung around the coils of razor wire, jumped from the cement wall into the dirt…

Running at night: it was madness. I was courting death, or at least a kidnapping…They kidnapped children now, they killed them and dumped them in the street. One of the kidnapping gangs could have driven up in a

car and beat me and gagged me and I could have screamed like a crazy person, but I doubt anyone would have done anything. Not even the guards. They weren't bad people, the guards, but who in Bagdad was going to step in the middle of a kidnapping? The kidnappers had more power than anyone.

I had been in Iraq too long. Going on four years… The one thing I wasn't numb to was the running itself. Running out there on the Tigris, with the dogs, in the dark in the dying city, was one of the few things I could still feel. In Baghdad, the most hopeless of cities, for a few blissful minutes, my heart would race. (pp 292 – 295)

Paradoxical Pride

And then there is something most often discussed in the context of military comradery, but is not exclusive to that. There is the pride of being singled out, of being made special by the traumatic event. It is, perhaps, a "covering up" feeling, like when anger is a defense against grief and fear, but that it is normal is something worth acknowledging.

James Agee's autobiographical novel, "A Death in the Family," was left uncompleted at the time of his own death in 1955. At least two versions of it have been published; one of these was highly edited while the other, quoted below is supposed to be closer to Agee's original manuscript. In this passage, young Rufus, has just found out about the death of his father. He is in his front yard and is approached by older boys who have regularly teased him by pretending that they don't remember who he is.

…the nearer they came but were yet at a distance, the more gray, sober air was charged with the great energy and with a sense of glory and of the danger, and deeper and more exciting the silence became, and the more tall, proud, shy and exposed he felt; so that as they came still nearer he once again felt his face break into a wide smile, with which he had nothing to do, and feeling that there was something deeply wrong in such a smile, tried his best to quieten his face and told them, shyly and proudly, "My daddy's dead." (p 221)

Then, in Dicken's *David Copperfield* after David has been told by the headmaster of his school that his mother has died…

I am sensible of having felt a dignity attached to me among the rest of the boys, and that I was important in my affliction.

If ever a child was stricken with sincere grief, I was. But I remember that this importance was a kind of satisfaction to me, when I walked in the playground that afternoon while the boys were in school. When I saw them glancing at me out of the windows, as they went up to their classes, I felt distinguished, and looked more melancholy, and walked slower. When school was over, and they came out and spoke to me, I felt it rather good in myself not to be proud to any of them, and to take exactly the same notice of them all, s before." (p 134)

This Dickens passage as well as anything I have seen also demonstrates that competing emotions and seemingly antithetical thoughts can, and do, coexist in us with equal sincerity, even if it might be difficult to admit.

IV Mental Health Intervention

Asking about trauma, the acute situation

The decision to ask survivors details about traumatic events is influenced by many factors. It is important for the therapist to not shy away from getting into the specifics of a client's experience, however there are times not to ask. Among the many things Toni Morrison (1987) illustrates in the following passage is the need to take care of physical survival concerns first.

In the passage below from the novel *Beloved* Morrison describes the situation of Paul D, himself a former slave, as he observes the entrance of Beloved, the character whose name is the title of this classic work about life near the time of the American Civil War. The "talking sheets", mentioned in the passage, appears to refer to the Ku Klux Klan.

The war had been over four or five years then, but nobody, white or black seemed to know it. Odd clusters and strays of Negroes wandered the back road and cowpaths from Schenectady to Jackson. Dazed but insistent, they searched each other out for word of a cousin, an aunt an friend who once said, "Call on me. Anytime you get near Chicago, just call on me." Some of them were running from family that could not support them, some to family; some were running from dead crops, dead kin, life threats, and took-over land. Boys younger than Buglar and Howard; configurations and blends of families of women and children, while elsewhere, solitary, hunted and hunting for, were men, men, men. Forbidden public transportation, chased by debt and filthy "talking sheets", they followed secondary routes, scanned the horizon for signs and counted heavily on each other. Silent , except for social courtesies, when they met one another they neither described nor asked about the sorrow that drove them from one place to another. The whites didn't bear speaking on. Everybody knew.

So he didn't press the young woman with the broken hat about where from or how come. If she wanted them to know and was strong enough to get through the telling, she would. What occupied them at the moment was what it might be that she needed. (p. 63)

Asking about trauma and self disclose in the therapeutic relationship

One heavily promoted "evidence based" approach to psychotherapy[1] has recommended that if the client asks if you (the therapist) have ever been in combat, one appropriate answer would be "What is the point of asking that question?" In my first efforts to do group psychotherapy with combat veterans, a friend and more experienced therapist, Jim Moore, made it clear to me that if the veteran did not see me as humanly responsive (e.g. willing to answer reasonable questions directly) then I would never get far as a therapist with my clients. What could be more reasonable than asking another person if he or she had a similar experience before disclosing painful information?

Garry Trudeau has been writing and drawing insightfully about many aspects of society in his cartoon strip, *Doonesbury*, for 40 years. He is one of the national commentators convincingly able to condemn a war while supporting the warriors. In response to the current wars in Iraq and Afghanistan, Trudeau created a new character, Elias, a Vet Center counselor, a combat veteran and an amputee. He also re-created the character B.D., a fighting conservative, a football star, and then coach, who he had always drawn wearing a football helmet. B.D., a reservist, was deployed to fight in Iraq. He returned missing a leg and suffering from PTSD. Through B.D., Trudeau has sensitively described the psychological effects of war, and a path toward recovery. This recovery process is shown in a series of strips, beginning in 2006. B.D. starts out extremely avoidant, and then ambivalently approaches therapy with Elias at his local Vet Center. The strip referenced below describes an early moment in their therapeutic relationship. The strip, with its art, can be found at http://www.amureprints.com by selecting *Doonesbury* and the entering the date of publication, 01/26/06.

First Panel
B.D. So how's this supposed to work?
Elias: There's no set drill, B.D. …
2nd Panel

*Elias: But sometimes I start by telling vets a little bit of my story. Not that it's likely **anything** like your story…*
3rd Panel
Elias: But it may help you to know you're talking to someone who was once chest deep in it same as you.
4th Panel
B.D. What if your story's better?
Elias: I buy lunch. But it doesn't happen often.

Elias's timing and level of self disclosure is the other end of the spectrum from what is recommended by some.[iii]

Elias, as noted is a combat veteran. I, not being a veteran at all, have taken the approach of indicating very early in the therapeutic relationship that I am not. I have learned to give background about what makes me think I can be of help. I generally don't wait to be asked. The client wants to know. I also think it is important the client know my credentials, just as he or she should of any employee. I think even a student without much experience will be better off sharing what she or he does have instead of ignoring the issue. The client will usually have guessed the therapists level of experience and will usually appreciate the honesty, not to mention that it is good modeling of openness, and can set a solid basis for developing the therapeutic relationship.

B.D.'s opening comment, "How is this supposed to work?" is also worth considering. Most combat vets will be as comfortable and knowledgeable about therapy as most therapists would be performing in a rodeo. Respectful, not effusive, explanation and reassurance with therapy naïve clients will do much more to help the therapy, than giving up a distant neutral stance will harm it.

The next strip in the series illustrates another point, particularly relevant in working with veterans.

In the first three panels Elias, the therapist, reveals his own combat experience:
Elias: Okay B.D. Let me give you a short version of my war. Anything grabs your attention I can elaborate. First tour I was a fire support spotter stationed outside DaNang. Saw lots of stuff blow up, but not much of it near me...Second tour though, I got screwed and sent to the field. South of the

DMZ. On a typical day, my platoon'd get hit five times."

B.D.: "Where'd you lose the leg?

Fourth panel:

Elias: Reno. Oil skid on my Harley.

B.D.: Whoa. Bike Okay?

My admiration for Trudeau's understanding of the complex experience of veterans, and his wise irreverence grew greater still after I ran into a combat vet I had known for quite a while, but hadn't seen in months. I asked where he had been. He said that he was laid up, recovering from a motorcycle accident. Before I could show concern, or ask any questions, he, showing the same priorities as B.D., assured me that the bike was OK. Some of the earlier work in Trudeau's series, showing events prior to the strip referenced above, is available in a collection, *The Long Road Home*, published in 2005 by Andrews McMeel. The proceeds benefit Fisher House, a home away from home for families of veterans receiving medical care at more than 30 federal health care centers. As this is written follow up works by Trudeau continue to be made available.

Therapeutic intervention

There have been many kinds of efforts to ameliorate the effects of psychological trauma by mental health professionals, with varying effects. Claims for effectiveness by scientists have increased in recent years, and there has been scientific evidence to support some of these. I can assure readers that my preference for EMDR as an individual method of psychotherapy, over other supported methods, including prolonged exposure, in no way influenced my inclusion of the following satirical example of the implementation of the homework aspect of an exposure based intervention.

Using characters created by Matt Groening, Carol Omine scripted the following scene from an episode of the television show, *The Simpsons*, titled The *Strong Arm of the Ma* (first aired 2/2/03), which provides interesting

illustration of one kind of response to therapeutic homework. In the dominant story line of this episode, Marge, the usually resilient loving mother, is a victim of a street robbery. This leaves her housebound and facing a dreaded future of social isolation. To help her overcome her fear her therapist prescribes an in vivo exposure approach, which is "facilitated" by her children Bart and Lisa, and her husband Homer, as illustrated in the following instructions and lines from a copy of the script:

Marge sits in a rolling desk chair in front of the open door. Homer stands behind her rubbing her shoulders. She wears knee, shin, elbow and wrists pads and oven mitts on her hands. Lisa places a football helmet on Marge's head as she says:

Lisa: Don't worry, Mom. The first time we'll only take a few steps outside.
Marge: (DEEP BREATH) All right, just to the mailbox and back.

Bart and Lisa walk out first brandishing a tennis racket and a baseball bat. Homer rolls Marge forward.

Homer: Now Dr. Hibbart said to use a number from one to ten to describe how anxious you are.

Marge: Two, three, two…

Homer continues to roll her along.
Homer: Don't worry. Everything is fine.
(NOTICING SOMETHING) What the hell is that.?

Marge: Eight…

Lisa: Dad its just a bug.

Marge: Two…

Homer: It's not just a bug, it's the queen of something!

Marge: Ten, ten, ten…

Homer: Don't worry. I'll set fire to the hive.
HOMER LIGHTS THE HIVE ON FIRE.

Marge: Twelve…fifteen…seven hundred and three…

We hear an ominous buzzing. Bart and Lisa wheel Marge toward the house.
Homer: Run!

As the episode continues, to our relief, Marge eventually solves her problem.

It may not escape notice that the two examples of therapeutic intervention have relied on cartoons. In these the therapeutic intervention is batting .500. From what I have seen portrayed in literature and the arts in general, we are looking a lot better in cartoons than in the other media.

Social Support

Social support is difficult to define, but has been identified as something which can decrease the destructive psychological effects of trauma. Social support is expected to increase "resilience", which has become a popular term. Alice Sebold became famous for a novel, *The Lovely Bones*, which starts with a rape and murder. She has said that before she could take on a fictionalized version of rape she had to first write about her own experience, which she did in the memoir *Lucky*. The title of *Lucky*, came from what she was told by a police officer, who explained that the previous person raped in the park where she had been assaulted was also murdered. This, in fact, was the fate of the victim in Sebold's novel.

Before getting to Sebold's memoir, I'll mention that in a pilot survey of the general population I asked subjects to briefly describe what someone did or said which was helpful, and what someone did or said which was harmful, after a traumatic experience. The response "They told me they knew how I felt" was cited in both the helpful and harmful categories. In the following passage from Sebold's memoir this form of social support is addressed.

The scene is in her parents home where she is visited by family friends.

Myra came last.

I wish I remembered her visit. Or, I should say, I wish I could remember in the detail of what we wore or how we sat or what she said. But what I remember is suddenly being in the presence of someone who 'got it'. Not just knew the facts, but – as near as he could- understand what I felt.

She sat in the winged chair. Her presence was a comfort and succor to me. Ed (her husband) had not fully recovered from the beating. He never would. He had taken too many blows to the head. He was addled now, confused a lot. Myra was like me: People expected her to be strong. Her outward traits and reputation led them to believe that if it had happened to any of the old ladies at church, it had happened to the most resilient one. She told me about the three men. She laughed as she repeated how they hadn't known how feisty a woman her age could be. She was going to testify. They had arrested Joey based on her description. Still, her eyes clouded over when she talked about Ed.

My mother watched Myra to find evidence that I would recover. I watched Myra for proof that she understood. At one point, she said, " What happened to me was nothing like what happened to you. You're young and beautiful. No one's interested in me that way."

"I was raped. I said"

The room was still, my mother suddenly uncomfortable. The living room, where the antiques had been carefully arranged and polished, where my mother's needlepoint pillows decorated most of he chairs, where gloomy portraits of Spanish noblemen stared down from the walls, was changed now. I felt I had to say it. But I felt also that that saying it was an act of vandalism. As if I had thrown a bucket of blood out across the living room at the blue couch, Myra, the winged chair, my mother.

The three of us sat there and watched it drip.

"I know," Myra said.

"I needed to say that word. "I said.

"It's a hard one."

"It's not 'the thing that happened to me' or 'the assault.' or 'the beating' or 'that.' I think it is important to call it what it is."

"It's rape," she said, "and it didn't happen to me."

We returned to forgettable conversation. A while later, she left. But I had made contact with a planet different from the one my parents or sister lived on. It was a planet where an act of violence changed your life.

In the last sentence, one may be reminded of the reference to "living in a wholly different town" in the passage from *The Sweet Hereafter*.

Despite this and other support Sebold, undoubtedly for many reasons, describes a very tough go of life for many years after the rape.

Reconnection

In *Trauma and Recovery* Judith Herman uses this term to describe the third stage of recovery from the effects of trauma. She, like many others who have discussed such stages, recognizes that it is not necessarily an orderly progression. Herman names the stages Safety (see the passage from *Beloved* above), Remembrance and Mourning, and Reconnection. Reconnection has been expressed in literature, and from this expression many have found comfort through both the great horrors and common painful difficulties of life. In addition to reconnection with the world there is also the consideration of connection to those who have died.

The following two poems describe different paths of reconnection, one religious and one connected to social support though both relating to the death of a child, which some may see as worlds apart, and others as very similar. The first was brought to my attention in the dedication of a book, *Affective Neuroscience*, by Jaak Paanksepp, which appears to be a masterpiece, but, in fact, sits above my ability to judge it Panksaap (2004) He also has a more recent (2012) , somewhat less technical summary of the field. Here is his dedication and the poem by his friend Anesa :

I dedicate this book to my lost child, Tiina, and my friend Anesa, who supported me when I was in need.

A Road Beyond Loss

When the world came down upon me
And the sky closed like a door,
sounds filled my ears from far away.
I lay down on the floor.
And no one near could find me,
And nothing near was mine.
I sank into the floorboards
From the voices, soft and kind.
Until one thought got through to me,
One image filled my mind:
A pencil and paper lying
Close at hand, nearby.

Somehow I took them up and trace
One word then the next,
Until they liked together in a chain
that first perplexed the darkness
In my eyes, then, rowing on my paper barque,
I soon was far away
And saw the water trail I'd left
Rise up into the chain---
A ladder reaching high above
To light and sound of friends.
And that is how I climbed out
Of the grief that has no end.
-Anesa Miller

The second example consists of the first stanzas of a Victor Hugo poem of reflection at the grave of his daughter, who died at age 19 just six months after her marriage.

The Graveyard at Villequier
(September 4. 1847)

Now with the streets of Paris and the stones,
The haze and roofs, all out of sight,
Now under the branching trees,
Under the dreaming brilliance of the sky.

Now, out of the darkness, after the years spent mourning
Ghastly her in my triumph,
Now that I come to feel the peace of the universal nature,
Breaking into my heart.

Now that I can sit beside the wave in awe
Of oceanic splendor calm to the horizon;
Now that I look inside myself at distant truths,
And see the little flowers

Now my Lord, that I can feel your silent power, able,
As day fades, with unafflicted eyes
At last to see the stone where in the shade
I know she sleeps forever;

Now left tender, Lord by this vast show of yours,
The plains, the woods and the crags, the valley
With its river lit white gold, seeing my smallness;
I regain my reason here in view of your immensity.
(p. 39)

The third passage is from former infantryman Mark Helprin's novel, *A Soldier of the Great War* (1991). A character in the novel gives advice how to honor those who have perished in war.

It's simple. You can do something just, and that is to remember them. Remember them. To think of them in their flesh, not as abstractions. To make no generalizations of war or peace that override their souls. To draw no lessons of history on their behalf. Their history is over.Remember them, just remember them -- in their millions -- for they were not history, they were only men, women and children. Recall them, if you can, with affection, and recall them, if you can, with love. That is all you need to do in regard to them, and all they ask. (p. 852)

Where Mourning May Lead Us

Perhaps, outside of comfort by spiritual beliefs, in the end, the best one can do is to come to Tennyson's (1849) well known realization, after the death of his friend,

Tis better to have loved and lost
Than never to have loved at all"

V Conclusion

Looking back on what has been written I see a lot of apparent contradictions. Response to trauma is full of such, there is the avoidance and obsession with reminders, there are intrusive memories and the amnesia. Pride and grief are mixed up with each other, guilt (anger at the self) and anger at others chase each other in circles. I criticized the field of mental health, and the producers of DSM for so often missing things, and getting things wrong. I reserve a satiric entry for my life's work, the practice of psychotherapy. Yet, without the effort where most of my criticism lies, we, I, might still be barking up the same tree as Salinger's Clay and Loretta. I even criticize my artists when they dare to step outside their territory. But then, as the verbally challenged Christian said to Cyrano, after being complimented on the effectiveness of his repartee, "Anyone can pick a quarrel." (Rostand, 1897)

To further put my critical comments in perspective- understanding, preventing and ameliorating the effects of traumatic experience is not rocket science… it is much more difficult. Since the times from which the earliest passages above are drawn, transportation science has moved from horse drawn carts to, well, rockets; making progress of the problems addressed by social science has been so difficult that Virgil and Shakespeare are still in some ways at the forward edge of our knowledge.

I could leave it at that, but I think it will be best to close with a passage from literature. In the effort to try to understand the effects of trauma, and the best we humans can do under the circumstances I offer a quote from the novel *Life After Life* by Kate Atkinson (2013). The hero, Ursula Todd, is followed through many incarnations, which have been determined both by even her small decisions and by chance. When she dies (as she does multiple times) in the course of events, Ursula Todd returns to her life at an earlier point. Then a single moment changes her trajectory. The majority of Ursula's adulthoods takes place in Britain during the repeated bombings of London during World War II. As an air raid marshal,

she encounters many traumatic events (but this is not to say that other types of life trauma are neglected in the telling of her story). As an overall work I think this does the most admirable job of showing how events can change life trajectory and even personality.

In this passage Miss Woolf, the consistently stoic supervisor of an air marshal team has finally taken all she can take after witnessing the death ofa boy who had been assisting her. Ursula, one of her team members, both shows her strength and emotion:

"Your mother will be awfully glad to see you come home tonight .'Miss. Woolf said, joining the charade. She stifled a sob with her hand. Tony made no sign of having heard them and they watched as he slowly turned a deathly pale, the color of thin milk.
He had gone.

"Oh, God," Miss Woolf cried. "I can't bear it."

"But bear it we must." Ursula said, wiping away the snot and the tears and filth from her cheeks with the back of her hand. (p 438)

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[i] The following passage is from the second edition of a book by Kardiner with Spiegel collaborating, originally published as *The Traumatic Neurosis of War* by Kardiner alone. If this was not a manuscript featuring literature but rather scientific and clinical examples, this passage would have been a good starting paragraph.

"The subject of neurotic disturbance consequent upon war, has in the past twenty-five years (from 1941), been submitted to a good deal of capriciousness in public interest and psychiatric whims. The public does not sustain its interest, which was very great after World War I, and neither does psychiatry. Hence these conditions are not subject to continuous study, as are many psychiatric conditions of peacetime, but only periodic efforts which cannot be characterized as very diligent. In part this state of affairs is due to the declining status of the veteran after a war; in part it is due to continuously changing personnel. Though not true of psychiatry in general, it is a deplorable fact that each investigator who undertakes to study these conditions considers it his sacred obligation to start from scratch and work at the problem as if no one had ever done anything with it before. The result of these uncoordinated efforts has been to create a confusion that would be difficult to equal in any endeavor in any other scientific discipline. Many investigators, failing to uncover new data, give new terminology to old data. This does not add to our knowledge; it merely prevents any experience from becoming cumulative and organized, and any constructive effort from being directed toward the essentials.

The simple fact is that the stresses of war create only one syndrome, which though unique to war conditions, is extremely frequent." (Kardiner & Spiegel, 1947, p.1)

[ii] In my own work I have developed a traumatic events questionnaire (HowardLipke.com, the GL)order increase the chances that the clients trauma history is understood. The second page of this questionnaire focuses on positive aspects of the clients life to ensure that I do not miss the greater context

[iii] The manual for Cognitive Processing Therapy (Resick, et. al 2007) used in the VA states: "Often therapists become flustered when patients ask direct

questions of make direct statements toward the therapist that may even appear to be 'challenging the therapist' or an attempt to violate therapist-patient boundaries. For example, '*Have you ever been to war?*' or '*Have you ever been raped?*' At these points in therapy it can be very helpful to *question the question*. By putting the focus back on the patient and his intentions, the dialogue is often de-escalated and this can allow the patient to more thoroughly examine his motives for asking in the first place." (p 10)