

Psychic Trauma
11 March, 2007
The Philoctetes Center

Levy: I am now pleased to introduce Spencer Eth, Professor and Vice-Chairman in the Department of Psychiatry and Behavioral Sciences at New York Medical College. He serves as the Medical Director of Behavioral Health Services at Saint Vincent Catholic Medical Centers, whose Manhattan campus was the closest trauma hospital to Ground Zero. For the last 20 years, Dr. Eth has studied and treated children, Vietnam War veterans, and others struggling with issues of trauma and grief. Dr. Eth previously appeared at the Philoctetes Center to discuss Roger Copeland's film about 9/11, *The Unrecovered*. Dr. Eth will moderate this afternoon's discussion and introduce the other panelists. Thank you Dr. Eth.

Eth: Thank you. It's a pleasure for me to be here today and to moderate this roundtable, which will consist of a discussion amongst our panelists and then a discussion with the audience. It may be appropriate to begin this roundtable on psychic trauma with a brief introduction to the concept of psychic trauma. I'm a little constrained because I know the audience is a mixed group of professionals and people who do not have training in mental health, so I'll try—as I'm sure all the panelists will—to be sophisticated but not obscure as we talk about these issues.

Here we are in the building housing the New York Psychoanalytic Institute, so one has to start any introduction, I guess, by speaking about Sigmund Freud. In their 1893 text, *Studies on Hysteria*, Freud and Breuer traced the symptoms of patients with hysteria to distressing early life experiences. Freud then came to believe that these early life experiences involved a childhood seduction with actual sexual stimulation. In 1906, Freud presented this theory—that the origins of neuroses could be found in childhood sexual trauma—to the Viennese Society for Psychology and Neurology. The reaction was complete scorn, disbelief, professional rejection. The presiding chair of the lecture chided Freud that “it sounds like a scientific fairytale.” By 1906, Freud had retracted his theory and instead suggested that these traumatic memories of childhood were fantasies of seduction, not actual seduction—fantasies in the context of normative or normal infantile or childhood sexuality. This reformulation of the theory of neurosis became Freud's creative masterpiece of the Oedipal fantasy, the Oedipal conflict, and has been pivotal to psychoanalysis ever since. However, the rejection of the reality of childhood sexual abuse was undoubtedly an injustice to the many victims of incest and molestation, and was a factor in the long delay in acknowledging that these crimes in fact do occur.

The modern era of psychic trauma may be considered to have begun with the care of WWI soldiers who became symptomatic after their exposure to the unprecedented scale of death and destruction in that first total war. The term “shell shock” was offered to describe these casualties, who were initially thought to be suffering from neurological injury. Freud observed shell shock victims during WWI and he proposed an alternative. He thought that an unbearable situation, even in the absence of brain damage, could be pathologic. Now this is significant because it was a formulation that contrasted with his usual emphasis on regression to forbidden childhood fantasies, because here he was accepting that the actual war situation could itself be psychologically traumatic.

In his 1917 introductory lectures, Freud defined trauma as “an experience that presents the mind with a stimulus too powerful to be assimilated,” the result of an event that overwhelmed the stimulus barrier and was the cause of the mental disturbance. This concept was elaborated in 1926 in his work, *Inhibitions, Symptoms, and Anxiety*, where Freud wrote that trauma may arise as a reaction of helplessness to a threat of external danger or internal anxiety. In his final work, published after his death, *Moses and Monotheism*, Freud conceptualized psychic trauma as being composed of two types of symptoms: positive effects or symptoms, which are the fixations to the trauma and repetition compulsions; and negative effects or symptoms, which are the defensive reactions of avoidance, inhibition, and phobia. These constructs of the positive and negative effects are remarkably analogous to the DSM-IV diagnostic criteria of re-experiencing and numbing and avoidance.

Of course, large-scale traumas did not cease with the Armistice of 1919. World War II, the European Holocaust, the atomic bombing of Japan, all highlighted the psychiatric effects of what’s been called “massive psychic trauma.” Indeed, adult prisoners of war and survivors of concentration camps were often found to be suffering from severe post-traumatic syndromes that persisted or worsened over the course of years, despite intensive treatment and intensive psychoanalytic treatment. The widespread public attention to the psychological damage wrought on Vietnam veterans and on women rape victims led in the 1970s to the formal establishment of a condition that is called PTSD, or Post-Traumatic Stress Disorder, a condition that is an all-encompassing category for adult victims of trauma.

The impact of the horrors of WWII and the Holocaust on children was also seen to produce harmful and long-lasting effects. Child victims of maternal deprivation, separation, grief, physical abuse, and trauma of all types, began to be identified and treated. Ironically, the child psychiatrist, Lenore Terr, suffered a professional attack eighty years after Freud’s lecture before the Viennese Society when she presented her work with a group of children who had been kidnapped in their school bus in Chowchilla, California. The reaction of that audience was at first mocking and then openly hostile to the notion that these children were suffering post-traumatic symptoms. This was in the early ‘70s. She was accused of over-psychologizing and over-diagnosing. However, Lenore Terr was a prophetic pioneer in demonstrating that what we now call PTSD could be applied perfectly well to children and adolescents.

The initial DSM-III diagnosis of PTSD in 1980 has been accepted and revised slightly in the current DSM-IV, which includes child-specific examples. New treatments, including both medications and psychotherapies, have been developed, tested, and delivered to the more recent victims of trauma, the victims of 9/11, the victims of torture, soldiers returning from conflict in the Middle East, and that brings us to today and our panel of experts, who will address the current status of psychic trauma.

I will now introduce our distinguished panel and ask them to consider the question of whether there can be a synthesis of our notions of trauma and our treatments of trauma that range from biological to psychological to behavioral, as a first topic for discussion today. In alphabetical order, let me begin with Dr. Claude Chemtob, who is a clinical psychologist and researcher specializing in trauma in children and in adults. He is currently Clinical Professor of Psychiatry and Pediatrics at Mount Sinai School of Medicine and directs the Child and Family Resilience

Program. He's conducted and published research studies focusing on children, their reactions to natural disaster and other types of traumas, and is hard at work—even as we speak—in these studies. On my right is Dr. Marylene Cloitre, who is Director for the Institute of Trauma and Resilience and also holds the Cathy and Stephen Graham Professorship in child and adolescent psychiatry in the new Department of Child Psychiatry at NYU Medical School and the NYU Child Studies Center. Sitting across from me is Dr. Len Shengold, who is Clinical Professor of Psychiatry and former Director of the Psychoanalytic Institute at NYU Medical School. He's the author the very well known classic book, *Soul Murder: the Effects of Childhood Abuse and Deprivation*, as well as seven other books, the latest of which is *Haunted by Parents*. And finally, Dr. Rachel Yehuda, who is Professor of Psychiatry at Mount Sinai and Director of the Traumatic Stress Studies Division at Mount Sinai and also at the Bronx VA Medical Center. She has been an active researcher for many years in both the neurosciences and in the clinical care of persons suffering from PTSD, and is very widely published in the field.

I think our panelists probably represent collectively the best minds in the area of PTSD, certainly in the city, and possibly in the country as well. So, I'd like to ask Dr. Shengold to speak a little about the psychoanalytic view of psychic trauma.

Shengold: I'll begin with being critical of something that you said—

Eth: Uh-oh.

Shengold: Because I disagree. What you said about Freud, of course, was true—originally he thought that neurosis could be defined as “seduction by the father,” and when he had to change that, he felt all of his patients were repeating what he had said by suggestion—but although he went back to his very important discovery of the power of fantasy and fantasies, he never really dismissed the actuality of seduction. And in one of his case histories—the early case histories in *The Studies on Hysteria*—there is someone seduced in childhood. But it was certainly minimized from that first definition of neurosis as seduction in childhood, although it's been revived by the work of Jeffrey Masson, for example, who says the same thing. For a while there was the danger of Institutes for Child Abuse working by hypnosis—you know, making the suggestion, repeating what Freud did—because if you work with hypnosis, you're not going to get at what happened, you're going to get at what you're suggesting, in many cases. But then there's been a reaction from that. Certainly when I was training, the first three patients that I had were all men and they all had a history—so they told me—of being seduced. When I applied to the American Psychoanalytic I was turned down, even though I got very enthusiastic backing from my institute about my abilities and their confidence in me, because they said, “He's projecting—this couldn't possibly be so.” They told me to get a female patient and I had a female patient who hadn't been seduced, so I got in the next year.

It's almost two decades ago that I published *Soul Murder* and I had talked about it before. *Soul Murder* is a poetic term—it's not a diagnosis. I'm sorry, but I hate diagnoses and I hate DSM-3, 4, 10, or whatever it is, because I think they're reductionistic. There are very few people who can be reduced to a diagnosis. There are few diagnoses like Paranoid Personality or Severe Obsessive Compulsive, but there's almost a reduction to caricature of a human being. But even there, there are differences. Something like schizophrenia, for example—schizophrenia is

probably ten, fifty, a hundred diseases, so much is a mystery there. The difference between one schizophrenic and another—some are capable of love, some seem incapable of love—is so great that it seems to me that, although it isn't that there's no use with diagnosis, sometimes the disease is so outstanding that it takes over the whole personality.

But as a psychoanalyst, we don't see that many patients. We do intense treatment, and one sees how different every patient is. Every patient is a kind of new adventure and there are always new discoveries, even though there are general things that one sees. And there are general things that one sees in relation to child abuse and deprivation—don't forget deprivation because that's perhaps even more pathogenic than abuse. And there are very, very complicated difficulties that one has in diagnosis and history-taking.

I had a prepared program, but I think I'm going to abandon that. I'd just like to speak for a few minutes about what a psychoanalyst's approach is here, because to my mind, trauma is inherent to the human experience. That is, it begins at birth. Birth trauma used to be very, very fashionable as a syndrome, but that's not what I mean. I mean that birth is a trauma in the sense that there is a sudden change in the environment and in whatever the internal workings of the forming mind of the fetus is. Where the fetus is first the subject of pressure pushed through this narrow passage and suddenly appears in a world full of sensations absolutely different from anything before—a sudden change. Much was made of this, first by Therodore Reich, and it's something that poets have written about. I mention poets because Lionel Trilling once said—I think very tellingly—that Freud showed us that our mind was a poetic organ. So I'm going to quote some poetry, if I can get to it quickly. I'd like to quote W. H. Auden, who wrote a magnificent poem on the death of Freud. And he says, "He taught us to remember like the old and to be honest like children." Well, I think that's true, but, of course, the old don't always remember very well, and children aren't always honest. But we try to be honest and we try to remember and that's the best that we can do.

There's a wonderful paper that's somewhat neglected now by Alvin Frank from St. Louis called "The Unrememberable and The Unforgettable." The unrememberable has to do with what goes on before the mind is fully formed, because at the birth of a human being, the body is there, but the mind is forming. How it forms, when it forms, when the psychological birth comes, we can't exactly say from child observations, but there are things that are never going to be remembered from the first three months, the first year. That seems to vary somewhat from child to child. So that's one aspect of the unrememberable. The other, which is very important, is that sometimes in especially overwhelming early experiences when the mind is not fully formed—certainly the adult mind is not formed—there are these overwhelming things that happen from the outside which evoke internal over-stimulation—what I call "too-muchness." Which is the essence of trauma, I think. It can come from the outside, like what happened on September 11th. But what it evokes on the inside is what we have to deal with.

When and how things are registered early is full of mystery, it seems to me. But we can get to the way it's registered in psychoanalysis because of the reproduction from the past that occurs with emotional resonances, especially in what we call, in our jargon, the transference of the past feelings onto the analyst. And with the aid of that, so much can be revived and so much can be

addressed. It doesn't tell us exactly what happened, but it does tell us what's registered as having happened, and that we can deal with and hopefully do something about.

Eth: Marylene, that's an analytic view of trauma process and a beginning notion of trauma treatment. Your work has used another paradigm.

Cloitre: Well, first of all, I'll describe myself as having been trained psychoanalytically first at Adelphi University and, over time, because I was interested in empirical research, moving over at the Psychiatric Institute pretty much into a cognitive behavior frame. I think there are lots of ways in which psychodynamic and cognitive behavioral thinking are parallel to each other, but probably the way that I think they are most different—and the reason why I found it more comfortable to be in a cognitive behavioral frame—is the absence of systemic discussion about the interpersonal world in psychoanalysis. I know it's a bit of an old-fashioned idea, but basically the unit of analysis in that tradition is the individual and all of the internal pressures that come to bear against each other. As an analytic student, I was actually very interested in the work of Sandor Ferenczi, and working up through ultimately Anna Freud's work and, very powerfully, ultimately Bowlby's work, which basically says we are essentially social creatures. In my view, in order to understand trauma, you really need to understand the relationship of the individual to their social context, and certainly for a child, the relationship of him or her to the primary caretaker.

In my own work, I basically embrace both types of traditions. I remember one quote that I often use just to give my students recognition of the roots of understanding trauma. It's a quote by Freud, where he says, "When a patient comes to us, what they do is essentially reproduce their past. Our goal, the therapeutic action of our work, is to place that reenactment into the past where it belongs." So the idea is—shifting radically over to a cognitive behavioral intervention—when a person is traumatized, we ask them to tell about it and to tell about it in a coherent way with a beginning, middle, and end. And there are lots of reasons from that tradition why we do that, you know, from a cognitive perspective—to sort of create a whole from a shattered set of pieces about what has happened and what it's meant. But I think what the two traditions share in that regard is the idea that the traumatized person lives as if the event is in the present. And our task, from whatever tradition we come from, is to try and place some distance of the event into the past versus the present, so the person can identify their experience now as different from in the past.

I also think that when you talk about childhood abuse—and that's where most of my work is, with adults and adolescents who have been abused as kids—there's not only the sort of disintegration of the self and the organization of memory that's impaired in adults, but also, from a developmental perspective, trauma itself, and particularly the secrecy and the stigma around it, really disengages the individual from their society or community. So the adult parent who is abusing their child has a relationship with them and holds them secret to whatever's going on in the outside world. One set of rules apply in the household and a bunch of others apply in the outside world. The physical or sexual abuse itself disorganizes the child and has impact on cognitive and behavioral functioning, so that abused kids really fall off the developmental trajectory of social and emotional competencies. And there's tons of work by Dante Cicchetti and various other developmentalists showing that kids who are maltreated, including neglect and

various other kinds of deprivations, do not have emotion regulation skills, do not have the ability to connect effectively and empathically with their peers. They do not have a template of skills for reaching out and socially connecting with individuals when they're in high-stress or in conflict situations, essentially because they already have a template for functioning that basically says, you know, "you don't get help when you're in distress."

So the work that I do and I think is important for everyone to consider when they work with traumatized people is essentially the rehabilitation of the person in regards to their emotional and social competencies. So I take very much a developmental perspective into the work as well as a sense of organizing the traumatic experience and assessing its meaning in terms of who the person feels they are and who they are in relation to the world at large.

I'll say another thing, which probably every one in this room who lived in New York around 9/11 has had some time to contemplate if they were here. I worked for three months after 9/11 in a company that lost many, many people and our work was essentially to help the families manage those first three months, where basically the task was to help the companies communicate to their staff about what had happened to their loved ones. And it was a process of people accepting the death of their loved ones and what the next step should be. You know, we really had very little we could do there, except contain and support people as they tried to figure out what was going on. But what I was most impressed by was that the people who seemed to do the best were the people who had other people around them. I saw people literally fall into each other's arms, and really viscerally understood for the first time the power of the other to contain and support. It's really led me since that time, probably most powerfully in my own work, to appreciate the value of the support of other and the value of soothing and the importance of it in helping people regain capacity for functioning. And to really see how the interpersonal relationship between mother and child so early in life, which is really about developing a working model about self-soothing and good relatedness to other, is really reenacted on a community level, on a social level—the individual as they relate to their community. We're all here basically in a complimentary fashion to help soothe and regulate each other in our social and emotional capacities.

Eth: I'd like to do is ask Rachel Yehuda—who has done a number of things, but significant within her expertise is the neuroscience—how these early childhood experiences are transduced into the brain, the seat of the mind, and then how that gets accessed later on in some way that changes behavior and produces symptoms and that is perturbable by therapeutic interventions.

Yehuda: Gosh, I wanted you to give me a hard question. That one's so easy.

Eth: Put it all together for us.

Yehuda: Well, first let's make sure we're all on the same page because when I think about trauma, the very last thing I would think about is birth trauma. Because I don't even know what that is and even if I did, we're all born, so it kind of equalizes the playing field. We don't know what it's like to not have birth trauma, so we all start out from the same baseline and I don't see how it's possible to even consider, to even talk about that, because how do you talk about that in relation to something else. I work with Holocaust survivors and if I would suggest to them that

part of the problem might have to do with the birth trauma, they might get up and slap me across my face and I would deserve it. When I think about trauma, I'm talking about the kinds of things that we don't have to sort of second-guess about, that we don't have to draw a map for, because they're very obvious. They are experiences that are outside the realm of what we have come to expect, our normal civilized experiences. They involve abuse and interpersonal violence, things that really no one has the right to do to anyone else, that are meant to harm. Sometimes they are natural disasters that maybe aren't meant to harm, but still they still produce the same kind of visceral fear response. It's those kinds of experiences that usually someone is old enough to at least process, enough to know that this is a violation, even if they can't articulate it as such, that become problematic and can affect the developing brain. Now, I cannot tell you because I don't know exactly what happens in very, very early stages of life. The only thing that I can tell you is that I know that early attachment behavior from mother to child seems to be very important in transmitting things generationally that have to do with vulnerability or even resilience. But I can't tell you more about that, except that it exists.

Really from very early on, the experience of something that induces profoundly great fear changes the person. It recruits a reorganization of the brain to mobilize stress hormones that put the body on alert. This isn't necessarily a bad thing. It's probably a good thing, all things being equal, when you're afraid and you can't mobilize stress hormones, you would be worse off than if you're afraid and can mobilize them. Depending on the age you are when the trauma occurs, you mobilize different kinds of defenses and resources to cope with them. Dissociation is one kind of a defense that is recruited by younger children who are abused. But there are also other kinds that occur when children grow up and when people are abused as adolescents or adults. Now, a very important thing that I do want to say is that there isn't a specific roadmap that I can describe for you called "the effects of trauma," because people are very different. And that's why I'll disagree with another point: we kind of do need diagnoses and they're helpful because one person can respond to trauma one way, and another person can respond in another way. And I'm not talking about the fact that some people seem to respond by not showing any adverse symptoms, or about highly resilient people. If you're in practice, you've seen somebody with a profound eating disorder that you could trace back to early childhood sexual abuse, but someone else might have an anxiety disorder, and somebody else may have a psychotic depression. In all three cases, you may find or may not find a traumatic antecedent. If you're an analyst or a cognitive behaviorist or whatever—the doctor, let's put it that way—you've got to deal with the syndrome that's in front of you, right?

Shengold: You've got to deal with the human being.

Yehuda: The human being's symptoms, right? So if somebody has an eating disorder, we have a certain different treatment plan that I would suggest than if somebody is having anxiety, or if somebody is having a psychotic depression. Even if we could stipulate that the same traumatic experience may be the cause of some early dysregulation that leads to some alteration in behavior. So at some point, the trauma may become less important—except that it happened—depending on what the symptom presentation is. Now, Post-Traumatic Stress Disorder—that is a disorder that's particularly amenable to working with the trauma because sometimes in talking about the event, one can reduce some of the horrible symptoms of it. But talking about the

trauma may or may not help an eating disorder patient. It may or may not help a person who has developed schizophrenia.

So I think the issue isn't so much what are the effects of trauma, because the answer to that is trauma can have multiple effects, but how do we combine present, the symptom presentations, with the past. How do we pick out the salient traumas, the things that matter, from the kind of traumas that don't affect this particular individual but they have affected another individual in quite a profound way?

Eth: Claude, you're now working with very young children. And with children you're not only seeing the effects years and years later, but seeing the early reactions. What is your perspective?

Chemtob: First of all, I just want to say that it's a real privilege to be here today. I think of this as a unique New York moment. It's good to be with several people who are friends and to meet you, Dr. Shengold. So let me speak to several aspects of that, coming back to the young children in a moment. Dr. Yehuda has really helped give reality to the concept that being victimized is something of the moment and that it's important, because we tend to think of psychic trauma—because it's not necessarily visible—as not being solid and real. She's led us in understanding that it has an ongoing and definable and persistent effect on how the brain works. For many people, when you make something physical, that gives it a great reality. My good colleague Dr. Cloitre, has really reintroduced into contemporary cognitive behavioral things the importance of relationships and she's someone who has shown that with abused people, you cannot treat them as if they had been in combat or raped without appreciating that at the core their pathology has to do with sustaining an injury to their capacity to be connected. I wanted to highlight these points.

I want to start by speaking to the mythic aspect of trauma. Philoctetes, I learned today, was someone who was sent away to an island because his injury made everybody too uncomfortable, until there came a moment in which the very injury was a value to the community. And this, at the core, is a challenge when we think about trauma, which is, do we cast away those who are injured, those who are experiencing things that are painful, or do we in some way embrace them more assertively in order to take that wound and to turn it into a gift? So when I work with people exposed to disaster, I emphasize constantly that you are not recovered from an injury, from a disaster, from an act of terrorism, until you can find the gift in the horror.

So, what's a gift in the horror? A gift in the horror is that you're exposed to something that is potentially damaging—in fact, realistically damaging—but somehow you are able to create something new of value that would not have existed had you not experienced that. So, the mythic aspect and the heroic aspect of trauma are really about a wound that is transformed into something of value. Having put it in that context, we then ask, what's a practical way on a daily basis for those who are clinicians—how do we make sense of that? And I entirely agree that the first problem is for people to see those who are injured among us.

My good colleague, Rohini Luthra, who is here, and I, with others, are working on a study in which we studied the ability of child clinicians, who are presented with children coming to their clinics, to identify those children who are injured, who have been sexually abused, who have been traumatized. And when we send clinicians who are the trauma police, if you will, out to talk

to the same kids that the normal clinicians talked to. In about 157 kids that we talked to, the normal clinicians identify three kids with PTSD. We identify forty-nine. Now you say to me, as my good colleague Dr. Yehuda said, that's because it's not really that important—they're not coming in and talking about their problem. So she came over and we tested this hypothesis together. She says, "It's acne. These people are coming in because they have serious problems. Why do you want them to mention this stuff about sexual abuse? It makes no difference." Then, we were all shocked as we spent a few hours and we looked at what the presenting symptoms were of these people. One of the presenting symptoms said, "Child and mother come in, report child was sexually abused at five, two years ago. Since then, child has been regressed, can't do well in school, has problems with mother." So you say, of course, in this case, anybody would identify that—at least they would write it down somewhere, because we ask them to. We make it easy for them, we don't even ask them to write it, we give them a checkbox. By the way, the Joint Commissioner on Accreditation of Hospitals says, "I'm going to judge you on your ability to pick this out." You would think they would say sexual abuse, right? And you would think they would actually say PTSD. They don't even say sexual abuse. Now, were they in the same room?

Yehuda: They said "adjustment disorder."

Chemtob: Wait, I'm not finished. You get to say that in a minute. See, these are discussions we've all been having for a long time. So, they said "adjustment disorder," but it's not a secret anymore. After twenty years, we now know that if you want to harm somebody's development, expose them to early victimization. Early victimization increases rates of heart attacks, increases substance abuse, increases incarceration, increases domestic violence, increases smoking—I mean, if you just want to mess people up, if you want to increase the rate of suicidal ideation or suicide attempts in young women in high school, sexually abuse them. It's not a secret anymore. You want to mess people up—there are lots of different ways. All of these traumatic things lead to very bad outcomes. If somebody told you that if you inject a child with this liquid and you're going to have these bad outcomes, you'd bust down the door. Yet we're faced with a situation where people don't see it, and that's really, really problematic. And that really has an impact I'll venture to say, on our ability to be civilized—that we allow children up the road, all around us, to be victimized without investing proportionally. It's really a problem. So this notion of seeing is to me equivalent to banishing Philoctetes to the island because it makes us uncomfortable. So that's the mythic component. Now what do I think happens and how do you deal with it? Part of the reason I think of Marylene Cloitre as a professional sort of sister is because we really appreciate the attachment component. My approach to what trauma is started with the notion that—we human being don't recognize it—like every animal, when we're faced with a life threat, we go into a distinctive set of information processing ways. I call it "survival mode." So when we go into survival mode, we think differently. We look for the presence of threat, we vigilantly look for it. We have a bias to the negative. We have what I call a "confirmation bias"—if I see a little bit of threat, I believe everything else confirms it. Now that's a very useful way to think about the world if you are in fact faced with danger. You don't want to think that the tiger's not out there. You don't want to not see it because if you don't identify the tiger, you don't live another day to make a mistake. So survival mode is a very adaptive way of processing survival-related information. However, if you're not in a survival-related situation, to see danger everywhere will make you treat non-dangerous moments, people who are looking at you in a slightly funny way, as, "You're really out to get me. Don't smile—you're just fooling me, now."

And so you transform the way you see. By virtue of looking for danger, you are imagining, if you will, the danger.

There's enormous power to being in survival mode when you're in a safe situation because it creates new problems. The problem of being in survival mode is that you lose self-monitoring—you don't know you're in survival mode. When we work with people early after a disaster, one of the things we do is teach them about how people respond in a situation that provokes survival mode. From the work with disaster victims, from that early work, my group has become very interested in not only treating people after they've been injured, but how to take these lessons from early effects on people to try to prevent the injury. We approach this in the following way: we basically think about what attitudes, skills, knowledge, and connection will prevent the adversities from becoming injurious. For example, with children who have juvenile diabetes, Type I Diabetes, they're faced with an adversity. You know, it's not in the biology of the mind to deal with juvenile diabetes—most of these kids die very quickly. So how do you teach the mother and the child to stay connected, the family to stay connected in the face of such an adversity? We recognize that what you do is identify the skills that are needed, teach the positive skills to transform that negative bias that I talked about into an optimistic one, and sustain the connection and the collaboration between child and mother.

Having said all that, I'm back to what you really wanted me to talk about, and that is, what's the impact on the relationship? We studied children after 9/11 and brought in the mothers and children—these were preschool children—and we were fascinated by what happens between them. We discovered not only that children were exposed directly to bodies falling and buildings falling, but they were also exposed to the impact on their mothers. And we found that, indeed, these children, if they saw what we call extremely adverse events such as bodies falling, dead people, injured people, by themselves that was enough to impact them. But the far greater impact was the impact on their mothers. So if a mother was depressed and had PTSD, we found that those children, even three and four years later, were having substantial behavioral problems. And, at the level of the relationship, you could see that their relationships had been sucked dry of pleasure and play and flexibility. The mothers were treating these children as if they were still in a survival context. So, the challenge for us was to restore flexibility—the mother's ability to create a sense of safety, play, and perspective. To come back to this notion of imagination, a fantastic reality, the same thing we saw in *A Beautiful*—that movie about that child in the Holocaust—what was that?

Cloitre: *It's A Beautiful Life*.

Chemtob: *A Beautiful Life*—the father who created this fantastic reality to insulate his son as long as he could from the greatest horrors. When the mother's ability to create a safe world for the child was impacted, when she could not imagine that with the child, the child began to be injured and to see the impact of that. So that's really what I wanted to say, that there is a mythic context and there's a transformational context and, as therapists, our job is to join in creating a fantastic reality for our patients from which they can begin to re-imagine their lives.

Eth: Okay, since we've all had a chance to speak, perhaps it would be a good time to open up the microphone to the audience to engage us in questions, brief comments, if you would like.

Otherwise, we'll be happy to continue talking amongst ourselves, but I do want to give people a chance to engage with us.

Audience: I think I'll probably make less sense at the microphone. When you said that if you talk to someone who went through something like the Shoah, and you mentioned to them birth trauma and such, I thought that was the most important part. Anyway, I'm actually very anxious now.

Eth: Take a deep breath.

Audience: That's actually the other thing I wanted to address—I think it's probably a little more complicated. I'm obviously interested in the topic and I've been treating survivors of the Shoah and I think it's very hard to come up with something like “you just have to find the positive aspects of this.” I guess that's what I'm trying to say—I think it's helpful in someone who's very stable and very adult and verbal, and even that's questionable. This whole Resilience Movement that has come up over the last five, seven years or so—I'm not sure I can make the argument because I'm too anxious right now, but I think it's mostly a political way of dealing with horror. On the clinical level, I don't think it really works that well. The other thing I wanted to say is that I'm a little bit of a biologist as well, or a neuroscientist, and trauma is a big bag of many different things. We don't really know what it is because it's many things. Two things that have panned out in research is that trauma is, of course, the trauma of threat and it's the trauma of loss, which is both psychologically and biologically different. And, of course, since we're here, people like Panksepp have shown that, and perhaps people like Kalen [ph] have shown that even better, not that long ago. What I'm trying to say is that the biology of threat is totally different from loss and I think that's something that we can as psychoanalysts, or as psychoanalytically-interested people, take into account in how we treat people, because it's actually very different. If you think about your patients, you will find that it just makes intuitive sense, but there's also biology behind it.

Yehuda: Can I address that first?

Eth: Sure.

Yehuda: I think you've made some really important points and I think that this tension between resilience and pathology in response to trauma has really been something, especially when you take extreme trauma like the Holocaust, when on the one hand there's survivors, so, by definition, they are resilient, and on other hand, they can also be a mess. The fact that they can also maybe find some good out of it doesn't necessarily make them less of a mess.

Audience: The argument about resilience is mostly that they've gone and recreated families. Some of them are real estate developers.

Yehuda: Right. That doesn't compensate. Having a lot of money and doing well in work and having children—

Audience: No one looks at the—

Yehuda: No, I understand what you're saying, and I think it's important that we not think about resilience and pathology as extreme ends of a dichotomy. They're two things that coexist. Studies of the brain would support that completely, so I think that what I heard Dr. Chemtob say is that you try to look for that place of resilience, that you can begin to take something positive, which doesn't negate the fact that there's also a negative consequence. I also like very much the distinction between loss and threat, and I think it has clinical implications that are really very important because in mostly cognitive behavioral approaches, but also embedded in others, is that you try to get somebody who is thinking a certain way about the trauma—"I'm unsafe still, even though something happened in the past"—that it's a cognitive distortion, in a sense, that needs to be reframed, and maybe you can be safe now, even if at one time you were attacked. But it's much harder to convince somebody that's experienced a loss—there's some cognitive reframing that you can do around that. For example, "my life is meaningless without what I've lost." You can work with that, but you've lost something that you've really lost. So, in a sense, it is different. Not insurmountable, but I think people that lump trauma and loss together miss an opportunity to do a more nuanced work with someone. And brain studies and biologic studies support the distinction between a neurobiology of fear and threat, which is not the same as a neurobiology of loss, and so I think that that can translate into clinical work.

Shengold: I want to respond to Dr. Yehuda in relation to the birth trauma. You know, I didn't get into my written paper. I'm not trying to say that the birth trauma is a useful concept. It's useful as a kind of metaphor, that's all.

Yehuda: But it's equalizing, you see. It's not useful.

Shengold: I said it's not a useful concept.

Yehuda: It's not a useful metaphor.

Shengold: It's a useful metaphor for what we know and what we don't know. This is the unrememberable. The poets can say what it's like to be born, but we'll never know what it's like to be born. What I sketched out as a metaphor has to do with the suddenness of something, the change to something overwhelming. We don't know what the child sees—that's why it's not useful. You can say that we're all born, but we'll never know what being born means to any individual child. What I would want to stress, because it makes me sound very simple-minded to say, "let's think of the birth trauma as a causal thing," is how complex things are. That's what my objection is to diagnosis: not that we shouldn't use it, but as you say, there's the mensch part and there's the non-mensch part. What we have to bring in, I think, in relation to talking about what's traumatic to any and every individual being different, is that there's one category in which something is so overwhelming, like the Holocaust, or overwhelming as being seduced as a child, and especially seduced by a parent, where the parental centrality makes it all so traumatic. Those are different conditions. In thinking in terms of our all being neurotic, at the very least—as Freud says, sections of ego can even be psychotic—every individual is different and there is a period of developmental trauma in relation to what we are born with in the beginning. Think about what it means to be a child as best we can and that unrememberable first year: the child is the center of the universe, the child was part of the mother, and has to develop the feeling of the

centrality of its own ego. During that time, the nursery is the universe. The first mothering person is a parental God. One goes from the Garden of Eden of the womb, where as far as we know—and this may be an exaggeration—everything is taken care of automatically in a state in which the parents become all-important, God-like persons. Whether one is religious or not, the psychological basis of God is the beginning parent, the parent who can keep us away from death, who can save us, who has the promise of our living forever. And all of that narcissism, all of that grandiosity, in order to be able to conform to a reality that isn't very good, politely, has to shrink. We're not called shrinks for nothing. Our centrality in the universe shrinks and shrinks and shrinks. The best of parents, the most loving parents—and being loving is not a twenty-four hour, full-time possibility—if one is honest with oneself, and even if one thinks of oneself as capable of love and a loving person, how much of our day is taken up with narcissism, with our own interests, with keeping people away with our defenses?

Yehuda: But you see, I don't like that you're attacking the idea of a diagnosis. I can concede that—

Shengold: I'm not attacking the idea of a diagnosis.

Yehuda: Not everyone gets a diagnosis right; there are committees, you know. But we need a diagnosis.

Shengold: What we have to deal with is the individual. What the psychoanalyst works with, and I think what all people who are would-be psychic healers work with or should work with, is getting to know their patient as a human being.

Yehuda: Would you feel that way about your oncologist? Or would you not want him to make a diagnosis?

Levy: I want to make a statement.

Shengold: I'm not saying that you shouldn't make a diagnosis. I'm saying you shouldn't reduce a human being.

Eth: But that's a straw man because nobody wants to reduce a person to a diagnosis, at least nobody here.

Shengold: Well, I don't find that in the people that I see and that I teach.

Levy: I want to say that in terms of the Philoctetes Center, at least for me, and I can't speak for Ed entirely, there were two volumes that were very important to us in the genesis of the idea of the Center. One was Edmund Wilson's *The Wound and the Bow*, in which he talks about Kipling and Dickens, who had horrendous childhoods. The genesis of the creative personality out of this, where in one direction they go on to sociopathy and then turn to becoming artists. And then when I read *Soul Murder* for the first time, in the section on Chekov, with the description of the childhood. If you take a sample population of people who have been through horrendous experiences—and I realize again that we've fallen into this question of generalities because what

is a “horrendous experience”—are these externalizations? It seems to form a whole grid of possibilities that go from the extremely-horrendous-external to the extremely-horrendous-internal and combinations thereof. But if you take a grid of people, some people go in one direction, where their personality is totally destroyed and they move towards criminal behavior and all kinds of behaviors that you alluded to—drug addiction, the developmental kind of regression, and so forth—and the other is this notion of the personality in the kind of loving universe that’s in *Life is Beautiful*, a movie that I don’t totally cotton to. But still, that was a brilliant point about the creation of this universe out of which—and not to expel the suffering individual, but that is very much what you were talking about in your book, these two roads that come out of suffering. You could take people with similarly difficult pasts that are the result of an existential condition they’ve suffered—or inter-psychic condition that they’ve suffered. And what is the reason for this? Obviously, you get reductionism in that, but that was one of the things the Center was founded on.

Shengold: But we don’t know the reason. That’s a mystery. Pathogenesis is full of mystery. Obviously, if there’s something so absolutely traumatic as to kill a person, that’s a simple thing. But how one murders a soul—again, to use my metaphor—is a very difficult thing to predict in the way of what’s going to come out? How’s this individual going to react? It can be all in pathology, or mostly pathology. It can be a mixture of health and pathology. I think what we ignore when we focus on trauma is we ignore something again that is a mystery: what are we born with? To get back to birth—how do we know what strengths we have? This is what is extremely impressive to me in relation to the research that’s been done with identical twins. Two twins separated at birth turn out to have the same car, the same kind of wife, wearing the same kind of clothes—there’s a mystery in this, what our gifts are and what our gifts aren’t. There are people who are born with deprivations that make for over-stimulation with even very, very slight stress. There are other people who are strong enough to be able to bear even the loss of both parents. Children who are able to survive—

Audience: I loved hearing about how helpful it is to have support, a lot of support, so that the individual, through the support—and it can be a serious trauma—can develop into a new person, so to speak. Even having all the characteristics that one had, even from that, it changes so that one becomes a different person if that support is there. And suddenly there will be a new support and a higher growth. Of course, each person is different and the genetics of the people are different, personalities of the people are different, and the positivity that was talked about is so important. One wonders sometimes why some people can’t use that positivity, but it’s there, so we need patience for ourselves and for those others who we love because everybody goes through hell.

Chemtob: That’s right. That’s really the poetic way I would transform this notion of birth trauma. You know, in America, we sort of think that if we are really, really lucky, people will have immaculately clean lives their whole lives. Well-fed by Gerber and everything will be good, and even losing your virginity will come without anxiety. You know, there is no such thing as an untouched life—at least not one I’d want to live. So people are really going to be faced with suffering, and what we have to figure out by studying the people who handle suffering well is what it is that makes people recover well. Currently, I’m working with couples who have lost children—one couple in Jerusalem who lost an eighteen-year-old to a terrorist

attack. It's a powerful thing to work with this couple because the woman, when anything triggers it, becomes sucked into a vortex of pain and she literally loses the ability to speak. I have never seen it quite so powerful. You say, "Say something," and she cannot. But if you say, "Get up and walk over," and have her husband get up and touch her, she can come back. So, I really support what you were saying, Dr. Cloitre, that at the end, the connection you were speaking to is really critical. But this husband, who wants to please her so much, feels so helpless when she's in this hole that he stops reaching out, unless we sustain and teach him to stay connected and give him skills to remain connected. So how do you create this resilience? You create resilience by teaching people to deal with situations that otherwise overwhelm them. And hopefully you do it very early in the process, in my opinion.

Cloitre: I have two remarks to sort of segue off what Claude said. What you said reminded me of a recent study that some of you might have read about. A young investigator named James Cohen down at the University of Virginia did a study looking at very well functioning couples, where the wife was put into an fMRI scanner and subjected to the threat of getting a shock. And under these quote "threat conditions," she had the opportunity to hold the hand of her spouse, hold the hand of a guy in a white coat, or not hold anyone's hand at all. And when the handholding was by the intimate partner, the activation of the amygdala, which we know is present at the oncoming of an identified threat, was much reduced. So this is sort of an in-the-brain demonstration of what happens with the soothing presence of another—just sort of reinforcing the importance of the support. And I truly believe that recovery from trauma really requires the presence of others.

Yehuda: They were happily married?

Cloitre: Oh, we're not getting into that. You know, not to make it too simplistic, but the contrast between the affect of fear, which is the defining affect around Post-Traumatic Stress Disorder, and that of loss, is that with every threat, primarily every trauma, the threat recedes and the fear affect may reduce some, but loss is always present in every single trauma. Trauma is defined by an experience of loss, so that the person who experiences disaster loses a home, loses family members, and the kid who's sexually abused loses innocence. So I think there are ways in which we should think about trauma and loss as inextricably weaved when we work with our clients.

Audience: I'm feeling a bit traumatized and confused. I'm a therapist and have become more and more interested in the biological and neurobiology as a way to help me understand my patients. The core of my practice consists of Holocaust survivors, both individually and in group with their children, possibly soon the third generation. A couple of women from Argentina who were kidnapped and tortured, one of whom had her fetus ripped out of her while she was alive, and a Chilean woman who experienced abrupt, violent, sudden loss of her kidnapped family under the regime that was so horrific. This leads up to high-functioning neurotics who suffered birth trauma, which I think is something we're biologically geared to experience and survive because we have to be born. So the idea of trauma changing one into another person and not having to find a positive outcome—that's what I think is so upsetting.

Cloitre: I think that we have to be very careful when we work with trauma survivors in saying that you can recover from your trauma by finding some good in it versus just falling into the

quagmire of despair that can otherwise happen. I think it's a challenge that we all face as trauma therapists to be very careful in that regard. I don't know if it's necessarily a positive outcome we're striving to work with or that the goal is to find something positive about the trauma, but I think there is something critical in the capacity to go on, and that it is a transformative process. It's not so much finding something within, as things were before, but essentially just a will to survive and a will to transform what has happened into the capacity to go forward.

Audience: Can I clarify the question?

Shengold: I think what one finds in relation to people who have been traumatized by their parents is surprising resistance to change for the better—the need to hold on to the centrality that was given them by the sexual abuse or even by the beating. As against the feeling that I'm going to lose my parent entirely, the suppressed anger which threatens them, which they have to bear, which is of really murderous intensity—to be able to bring that out is very, very difficult and sometimes, paradoxically, to be kind, to be loving, to force love upon them, terrifies them.

Audience: Can I clarify the question?

Eth: Right, right. But since the hour runs late.

Nersessian: Don't worry about the time.

Eth: "Don't worry about the time." Then I won't worry about the time.

Audience: I just want to clarify the question.

Eth: But we have a number of people who would like to speak.

Chemtob: Dr. Yehuda wants to say something.

Eth: Okay, briefly.

Yehuda: You started out, when you came to the microphone, about neurobiology, and you didn't finish your question. You got distracted by the intensity of your patients' traumas. So finish the question because it might be very interesting.

Audience: Something I've noticed is that among the holocaust survivors, those who have been adopted, versus those who were in the traumatized mother's womb, have been much more anxious. I'm wondering if generally would it be functional imaging, would it be blood testing, that could help us as witnesses and healers put into effect the kinds of connections or words or language that can impact that particular chemistry?

Yehuda: I'd like to answer that because I get asked this question in many different ways, but the reason I asked you to ask it again is because the neuroscientist part of me would give you a very straight answer, which is yes, I could probably find in such people in proximity to the time of trauma of the mother and the in utero trimester, changes in an enzyme called 11 Beta Steroid

Dehydrogenase Type II, which is an enzyme that converts active cortisol into inactive cortisone. It's a placental enzyme that begins to develop about that time. And yes, you would probably now look at this enzyme in urine samples. But that's not really the issue, because you still have to deal with your patients and they still have the experiences they have and you don't need an enzyme test or a biomarker or an fMRI to validate that what has happened here is real. I think that what we struggle with is the distraction, which I think birth trauma is, from how awful—you can't even get to the mike and stop yourself from just talking about someone else's trauma, that's how horrible it is. Having a blood test to confirm it isn't going to—I mean, if it helps you, then I will tell you, yes, all of these horrendously stressful events can be confirmed and people whose mothers were exposed while they were in utero are going to start out with that much more vulnerability that they'll have to overcome. It's true.

Audience: Two brief comments. One is that I'm opposed to closing any doors of investigation, but I want to close this birth trauma door by saying the following: leaving aside the original ideas about birth trauma and psychoanalysis, the fact remains that what happens during pregnancy at the moment of delivery and after may have some impact on propensity to anxiety, propensity to all sorts of things, so anoxia at the time of the birth may have some kind of long-term impact. So leaving that aside, my next comment is to try to see if I can get something out of Spencer Eth based on his experience. And that is to do with the fact that yes, I understand that everybody knows it's good to have a nurturing environment, whether you are traumatized or not, and if you are traumatized you may need it even more. And it's good to have your wife hold your hand when you are in pain and your husband soothes you. I understand that. But do you work with people who are very severely traumatized, and when those environmental supports are not available, what happens to them, and what do you see long term from those people? And what's the effect of the treatment?

Eth: The patients we see are the patients who are not resilient. These are the people who have suffered, who have been injured and harmed by trauma. These are the people who we see and work with, and throughout all of our careers, we're impressed that the more severe the real trauma is, the more devastating the consequence. The people I've seen, aside from those suffering from biological-based illnesses like schizophrenia and manic-depressive illness, who are in the worst shape are the people who have endured the worst life circumstances, the most severe traumas. Those are the people who are the walking wounded. We know that. We also know that even using the best technology—medication, psychotherapies of a variety of sorts—we're not able to put Humpty Dumpty back together again. We do the best we can. I think what we've been talking about today are some of the notions we have of what seems to work. For me, what seems to work is—one, I think it's an important distinction between trauma and grief. Even though many traumatic events result in the loss of a person, it is still useful to keep those two concepts separate because the psychological processes associated with them are different. They may be intertwined, but they're different and we work with them differently with our patients. So I'm in the camp of trying to maintain that distinction. I also believe that the earlier the trauma and the more frequent the trauma occurs, the less the results of that trauma fit neatly into diagnostic categories. Remember, the DSM describes the disorders, it doesn't describe people, and it's sort of a platonic ideal of what the disorder is about. People don't fit neatly into pigeon holes, and the more complex and multiple and earlier the trauma is, the less able we are to diagnose them, because they just don't seem to correspond to these ideal diagnostic categories,

and these are the most difficult people to treat. Having said that, I've also been very impressed recently with people who have never recovered from 9/11. I've been doing some work with the FDNY with firefighters, and these are extraordinarily resilient people who run into fires—nobody I know, and certainly nobody in this room, would run into a burning building; we'd run the other way. These are guys who run into burning buildings, and I've seen so many of them who have never recovered from 9/11. They have failed multiple treatments by good people. It's reminiscent to me of Vietnam vets, who I attempted to treat and for whom I did research to try to develop new treatments, but who also failed. And there are lots of people who start out strong, whose life trajectory is robust, who are never able to overcome severe trauma, and our efforts are pathetically inadequate. How's that for an optimistic comment?

Audience: I work with Claude downtown and did a lot of group interventions and I'm also a trained psychoanalyst at another organization. I've written three papers on my work downtown and one of the first things I picked up here today, since my dissertation is in linguistics, is that "trauma" is a distancing term. It's a medical term, it's not a psychoanalytic term, and it's used constantly in this room. One of the first things I did for the teachers I work with was to deconstruct the term "trauma" so they would understand it. It has to do with pain and, as Claude mentioned before, we take distance from the thing that makes us uncomfortable, which is to say the actual pain that the people are suffering. Aside from my group work, I also work with fire people; I worked with an EMS man who was on the site for three days without sleeping. The people in the audience keep referring to trauma, not to the patient's pain at what happened. For example, if you talk about traumatic abuse by a parent, if you rephrase that to a patient in terms of violation of trust and expectancy, or violation of security, the patient responds very differently than if you use the term "trauma." And we use it constantly in here. So, I'd like you all to be aware that pain is a much more difficult thing to talk about in a patient and with a patient. If you're doing it here, I see it as a distance-taking mechanism.

The other thing is I saw a number of people who ran to the World Trade Center. I did interviews with all the staff at one of the evacuated high schools and I was struck with the number of people who ran away almost immediately, from someone who ran all the way to Brooklyn, who left the high school within minutes of the attack. Other people ran to look, and other people ran to work. This is a population that hasn't really been examined. There are a number of security people who were on the site who experienced "no anxiety, no threat, and no pain," and went and did their jobs for days afterwards, and when I spoke to them of pain and anxiety, they didn't know what I was talking about. So there is another subset of the population that I think your firemen belong to of people, who when anxious, as Claude said, run to kill the tiger. They don't run away from the tiger. And that is a subset that doesn't come into therapy and we don't know a lot about them. I think they're drawn to it. The head of security at the high school was a woman and when I said, "Well, don't you get anxious?" She said, "No, and neither did my father." The firefighters that I spoke to—the guy who came out of the subway at Christopher Street, commandeered a post office truck, and drove down to organize the ambulances at the World Trade Center. When I talked to him about whether he was frightened, he said, "That's my job. That's what I do all day. You don't understand me. You don't understand how I'm wired."

Eth: Yes.

Audience: My clinical experience with PTSD and the idea of trauma comes actually from three different clinical areas and I was wondering how much the panelists are in disagreement or have a different slant because they're dealing with different populations and maybe different definitions. As a child psychiatrist, oftentimes the presentation involves stating that there was a traumatic event up front, and often a one-time traumatic event, like 9/11 or something like that, which is publicly acknowledged, as opposed to something that's a secret. I'm not saying that's a hundred percent true, but it's more often in that population. A second clinical area is a forensic capacity, where it's a family evaluation and the issue of whether a child is abused or neglected or witnessed a family violence is much harder to disclose and verify, so there's the issue of what's kept a secret—a public secret is very different when you get a history. And the third area really has to do with analytic patients as adults, who may or may not present the traumatic history at all, and you're working with really the personality deformation that's occurred a long time before. Some of the differences in those populations have to do with the amount of support and also the chronicity of some of these experiences. In Dr. Shengold's population, it is more likely to have had something to do with neglect as opposed to the kind of traumatic experience that we often talk about. So my question is, how much does this have to do with the difference in the way the panelists are talking and, secondly, do they think there's a difference in PTSD presentation or effects when we're talking about sexual abuse or family violence or something that is not easily or openly acknowledged and where there's a great deal of shame, and other personal reactions that aren't as evident as a national disaster.

Eth: So, who's going to deal with secrets? The analyst, of course.

Shengold: I'd like to say something, just to give a little clinical vignette, because I was once going to write a paper called "Soul Murder Amongst the Rich." I could write it, but since I see people mostly in the field now I don't think I'm ever going to be able to publish it. But I would like to bring up just a very short clinical example of soul murder that doesn't specifically involve sexual abuse or being beaten, but simply a psychologically traumatic event, that is, an overwhelming event. This was a man whose two parents had a big horse farm—that was their hobby. They took great care of the horses, but not of their children. There was a kind of sexual abuse factor here because the only person who really cared about him—and not being cared about is, of course, a primal kind of pain—was a servant. There was some sexual play. But the overwhelming thing was illustrated by this anecdote: every Christmas the tree would be magnificently covered with ornaments, there would be presents all over the place, and every Christmas, after all the presents were opened, they were then packed up to be given to poor children. Every year this poor kid felt, "No, they won't do it to me this year," but they did it again and again and again. This man had no capacity for joy whatsoever, which is one definition of soul murder. Now this is a different category of what happens between parent and child. But between the parent and the child, so much goes on, and so much is so central, and I think that's true in relation to all our presentations here.

Yehuda: That isn't trauma, though.

Eth: What your describing is an empathic failure, but I don't think most of the rest of us would call that a trauma.

Yehuda: Right.

Eth: Anybody want to deal with the secret trauma versus the public trauma and the implications of that?

Yehuda: I will be very short. I think that we don't read minds. If we don't ask, they don't tell. If you don't know, you should ask.

Shengold: But how do you know you're going to get the truth?

Yehuda: If they say no, it doesn't mean that it didn't happen. If they say yes, it doesn't mean that it did happen. But you're starting from some place and you're starting from the ability to have a dialogue.

Chemtob: Absolutely. Even when they tell you, most clinicians, as we've just demonstrated, don't hear.

Yehuda: Even when they tell you, some people will ignore it.

Audience: It's not the whole population. You see what I'm saying? If you're there for a history and the patient says yes or no, you're eliminating the people who say no.

Yehuda: No, you're just noting it down. You might come back to it. They may say something that contradicts that later. But you ask them why they are there. I mean, don't we start by asking somebody, "What is the problem? How can I help you?"

Chemtob: In practical terms, because you're really saying, "how do you get practical about this," right? In practical terms we now know that if you've been in combat, you probably should ask about what's happened to you in combat. Most clinicians should ask about the traumas that somebody has experienced, if only because it may not be a truly traumatic event. But challenging adversities will always teach us about the adaptive style and capacity and functioning of the person. But most people neither ask nor hear, and that's really the first problem.

Shengold: But do you make that assumption about me? I'm afraid you do.

Chemtob: Just one second.

Audience: But there are some situations where children will just not disclose.

Chemtob: And that's okay because you can ask later. You don't have to ask only once. You know, I've had patients where I later found out that they'd been raped, and I'm supposed to be a trauma guy. And when I found out, it all fell into place why she couldn't set up relationships that work. There's something about being exposed to people's pain directly that's so discomfoting. I just need to say something to people who challenge this notion of resilience as a sort of simple-minded positive view of the world. When you talk to somebody who's been through the Holocaust or lost a child, let's say lost a child to terrorism, what idiot thinks that you're going to

tell them that life has not changed? Who in the world thinks you're going to feed them sugar? But if it's destroyed their ability to remain connected and if it's part of the nature of being traumatized that your ability to be connected is harmed, and worse, that the ability of others to connect to you because you're in pain is injured, then the positive view of this is: If I learn something about it, I can teach you, so that you're not injured forever. But you will be a twisted tree. You will not be a shooting-up tree; you will be twisted.

Cloitre: To put together everything that's been said—

Chemtob: Sorry I jumped in front of you. I apologize.

Cloitre: No, it's perfect. In relation to your question—by introducing the question, “Have you ever been raped? Have you ever been sexually abused? Have you ever committed a crime?” it introduces that as a possibility in the dialogue and it allows possible recognition of it in that world. I think what Len was saying when he told that story about the Christmas tree is that it is a terrible injury to not be recognized and that's what the story of the presents are. “This is not for you. This is not about you. I don't see you for who you are.” So a person may not be ready to acknowledge who they are, but you've said, “I'm here to listen if you care to tell,” at some point.

Shengold: But you have to take into account the resistance of some patients.

Audience: But my question really had to do with if a child has grown up without it being disclosed and it's a source of shame and whatever, at age thirty you see the—at some point it's disclosed. Is there a difference in the outcome for people who are traumatized for whom it was kept a secret for many, many years versus somebody where there was an open acknowledgement?

Cloitre: Well, I would say yes.

Audience: Well, common sense would say so.

Eth: There's no empirical data on that.

Cloitre: Yes, there is.

Eth: There is? On secrets?

Cloitre: Yes. We know that shame is one of the strongest predictors of poor outcome in psychotherapy treatment among trauma survivors.

Eth: Shame over secrets?

Cloitre: No, shame related to their trauma. And that's Chris Bruen's work.

Eth: Right. And secrets could be a source of shame.

Cloitre: Yes.

Chemtob: But part of the dimension that is completely confounded is that it's usually something that happens when the person is much younger and much more vulnerable. So that the developmental impact on the capacity to connect is part of the challenge that has to be addressed in terms of the treatment. It's one of those things that Marylene has really understood, that the very shame will make you shrink from the ability to join with a therapist, and that failure to form an effective treatment alliance, for one, will make you leave the therapist. You don't have to invent rocket science—the person won't come back, right? And so part of what she's been teaching us is how to modify technique to address the therapeutic alliance in the context of disclosing secrets that happen to you as injuries as a young person.

Audience: One of the themes earlier in the discussion was baselines—what we're all bringing to the table, what we're all born with, what's universal. When you speak about baselines, you also speak about evolution and what evolution has prepared us for. Evolution prepares us for predictable events in our environment and certainly psychic trauma, like losing loved ones or real conflicts. We have fight or flight mechanisms, defense mechanisms. I thought one of the interesting things in the description of the roundtable was right in the first sentence, where it mentions natural and technological trauma. For example, 9/11 to me would seem an example of a technological trauma, or the Holocaust—the genocidal events that were not happening on the proverbial savannah. Perhaps even sexual abuse, too; I'm naïve as to the anthropological history of sexual abuse and how far that goes back in human culture, whether that's a natural or technological trauma or if it's a more modern construction. I suppose my question is to what degree are we prepared at a very general level for trauma in our lives? Have we evolved adaptive mechanisms for certain types of events like losing loved ones and things like that, that were happening long ago in human culture, as opposed to less natural events such as 9/11, whether natural and technological? Are they both part and parcel of trauma or are those two things totally different concepts?

Eth: So what I hear you asking is whether or not fight or flight is a natural response, an evolutionarily based response to danger in the world. Fear is there. Can PTSD be understood or can abnormal reactions be understood as evolution gone awry, and are we adapting properly to the new threats in our environment? That's a Rachel question.

Yehuda: I think trauma has been around for a really long time. There are biblical accounts of sexual abuse, if you consider that a long time. I think that when we talk about being prepared, the fact that we mobilize stress hormones and we recruit many different physiological functions—to be able to do fight or flight is one type of preparation, but it doesn't necessarily prevent psychic pain. The good news is you're alive and the bad news is you have psychic pain. So that's what we do. I think we have to explain that survival isn't a dichotomy—“At least you're not dead. Okay, that'll be a hundred and fifty dollars.” There's more to it than that.

Audience: The talk about trauma in childbirth reminded me that lots of societies have officially sanctioned trauma. The most common one in this country is male circumcision. This is common amongst many, many cultures. I'm wondering how these kinds of body mutilation traumas to

children and sometimes adolescents relate to the types of traumas you're talking about? Do they also have psychic harm?

Yehuda: Well, I've never had a patient come in and complain about the trauma of their circumcision, so I don't know.

Eth: Right, in other cultures it's done older. Yes, initiation rites can be traumatic and are they adaptive in certain cultures. The question of the role of that would be an excellent roundtable, which would have to involve cultural anthropologists and people with other areas of expertise. How's that for dodging the question?

Yehuda: I think that question minimizes real trauma. The kind of trauma that you came up to the microphone and choked out is not the same.

Eth: As having a circumcision at age fourteen? I don't know about that.

Yehuda: At fourteen? If you complain about it and if you're traumatized by it, okay, but still. If you chose it and it was a ritual rite, even then. If it's something that you chose to take upon yourself, it's about how your brain perceives what is happening to you.

Shengold: Different brains are going to perceive it differently.

Yehuda: If you believe it to be barbaric and you're traumatized by it because someone's doing it against your will, it's assault. But if you're taking it upon yourself as a religious right, then it means something different, even though it's the same act. But I think that when we talk about potential trauma like this, I think we minimize the kind of traumas that are too hard for us to even know how to deal with.

Audience: But isn't there a spectrum of trauma that we've been dealing with, beginning with extreme, overt trauma?

Yehuda: All traumas are not alike.

Audience: No, they're not.

Chemtob: And not all pain is traumatic.

Audience: I think there are people in cultures where it is accepted to circumcise women at the age of fourteen. It is traumatic for them and they might be participating in it, but not willfully, and they don't know that it's potentially damaging because they're in a cultural reference that says that it's okay.

Yehuda: But let's talk about the traumas that we can agree that someone had absolutely no right to do to you and not go into culturally sensitive areas.

Shengold: Why not?

Chemtob: Because it's a way of avoiding the high frequency of at-home traumas.

Yehuda: Right. Thank you. That's why only three therapists wrote PTSD in Claude's study. That's why.

Eth: Anyway. Not to minimize it but I think that would be more suitable for a different kind of roundtable.

Audience: I am not a psychologist of any kind. Most of my experience with people like you is on the couch rather than on the chair. You all have different disciplines within psychology, and for me it was interesting to hear the comment about linguistics, because I actually find that a lot of the conversation is part of the traumatic experience. When I am listening to someone tell a story about having a fetus ripped from a woman's body and seeing her react to it, I feel the trauma of it, and clearly she does, too. So when you talked at the beginning about re-contextualizing something that happened, that was traumatic in someone's past, or when you speak of finding the gift in it, it's difficult to understand how effective that can really be when, even amongst the professionals, we have a hard time putting it in the past. She was recounting a story that didn't even happen to her; it happened to someone else in the past, and yet it was evidently traumatic enough then to her that it's even being relived now. So it's difficult for me as a layperson to parse out how to go about being effective at this, when even amongst the professionals, the trauma is not actually the thing that occurred; it's the reaction to the thing that occurred.

My idea of a traumatic experience until I was nineteen was getting into a shoving match at Hebrew school with my friend John, who invited me here. I'll say this because this is why I bring it up—I had a traumatic experience on the streets of London, where a bunch of guys basically mugged me and my friends. The next day at lunch, I'm totally traumatized, and one of my friends, who has the same background and who also got into the same shoving matches at Hebrew school about yarmulkes and stuff like that, is fine. He thought it was hilarious that we happened to get mugged in the street and that we happened to come out of it okay, whereas I ran every permutation of what could have gone wrong. I don't know if anyone has ever read anything about memes, like Richard Dawkins's meme, the idea of ideas being just like genes and how they spread virulently from one person to another, but there's a part of the conversation that I find is just the spreading of ideas from one person to the next and these ideas are fertile in one person's mind and not fertile in another person's mind.

Eth: What you're addressing is very important and very familiar to all the therapists in the room. Part of what you're talking about is the phenomenon of vicarious traumatization, where we respond to other people's traumas, and it was exceedingly well documented on 9/11, when people would watch television hours later and develop traumatic symptoms. The other piece of that is what we call counter-transference, which is that sometimes doing therapeutic work resonates with our own personal histories, perhaps even our unconscious conflicts, and we respond to that, peculiar to ourselves. Both of these phenomena have been looked at, written about, and would be a very important part if this were a series, rather than a single session today.

Yehuda: But the short answer is supervision, and that's why therapists come together like this in their spare time. That's why even therapists see therapists, for exactly this reason, because it is an ongoing thing. You don't want to say, "Oh, you'll get used to it." That would maybe be true, but you're happy to have the empathy on the one hand, and it does bring up conflicts on the other hand. There are ways to deal with it on the third hand, if you have a third hand. There is a systems-wide approach to this and being able understand that your patients events impact you is really the first step.

Eth: Okay, we need to have two last questions with the two last people who are standing up and then we're going to conclude.

Cloitre: Can I just mention, though, that I think it's a wonderful thing that a professional can disclose difficult case material and we respond accordingly, because I think the gift of empathy is wonderful; it's what really makes the therapy work that we do effective, managed within our own capacity for emotional regulation and problem-solving and meta-cognition.

Audience: I've been in a tremendous traumatic experience. I had a high-speed roll-over accident and rolled over six times and survived it. I thought someone else would get up who had a first-hand experience. I was treated by a trauma specialist and I had all the classic things—flashbacks, tremendous guilt. My girlfriend was with me; she was not as hurt as I was. I followed the rules, the rules of what the doctors told me. They told me what to do and how to act and how to face it and that really was it. One of the things I used to say is, "Don't worry about it, you're with me," and I found that I could no longer ever say that about anything ever in my life. I think the hardest thing that there was for me to get over personally was that I felt guilty for putting her in the situation. I was driving, and even though I was forced off the road, she was with me and she counted on me. She doesn't drive, which is one of the things, but I guess the only recurring thing that has to go on in my life—and we're still together—is that I have to prepare myself for any travel with her. Renting a car, we have to walk around it, we have to sit in it for a while, we have to make sure that we're ready to do it, and we do it. And it takes a little bit of work to overcome it.

Audience: How long ago was the accident?

Audience: Four years ago. And the other recurring thing with me is I have some anger because I was a marathon runner and I hurt my back and I cannot run anymore because of this accident. But the thing that remains to me, on a mental level, is that I have a sensitivity to sound. The sound that occurred while this thing was going over and over and over was just tremendous, and when I'm walking down the street sometimes, like when I'm going to get a sandwich or something, and I hear this sound in the street that kind of all of a sudden resonates in my ear, it is frightening to me. You know, it doesn't happen all the time, but it is frightening.

Eth: Thank you. Last question.

Audience: Very quickly—I'm not even sure it's a question. I do want to make one comment about the shame and the guilt that leads to the need to create secrets. In my experience as a therapist, there is something that hasn't been talked about, which is the patient's need to have not

only questions and an understanding and a lack of fear, so that neither of you have to go to the island, but also an assessment of whether or not you're deserving to actually witness their pain. I think it's very important for them to be cautious, that's all.

Eth: Thank you and that's a suitable last comment and I want to thank our panelists and our audience.