

TRAUMA  
AND  
RECOVERY

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## CHAPTER 2

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# Terror

**P**SYCHOLOGICAL TRAUMA is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning.

It was once believed that such events were uncommon. In 1980, when post-traumatic stress disorder was first included in the diagnostic manual, the American Psychiatric Association described traumatic events as "outside the range of usual human experience."<sup>1</sup> Sadly, this definition has proved to be inaccurate. Rape, battery, and other forms of sexual and domestic violence are so common a part of women's lives that they can hardly be described as outside the range of ordinary experience. And in view of the number of people killed in war over the past century, military trauma, too, must be considered a common part of human experience; only the fortunate find it unusual.

Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events generally involve threats to life or bodily integrity, or a close personal encounter with violence and death. They confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe. According to the *Comprehensive Textbook of Psychiatry*, the common denominator of psychological trauma is a feeling of "intense fear, helplessness, loss of control, and threat of annihilation."<sup>2</sup>

The severity of traumatic events cannot be measured on any single

dimension; simplistic efforts to quantify trauma ultimately lead to meaningless comparisons of horror. Nevertheless, certain identifiable experiences increase the likelihood of harm. These include being taken by surprise, trapped, or exposed to the point of exhaustion.<sup>3</sup> The likelihood of harm is also increased when the traumatic events include physical violation or injury, exposure to extreme violence, or witnessing grotesque death.<sup>4</sup> In each instance, the salient characteristic of the traumatic event is its power to inspire helplessness and terror.

The ordinary human response to danger is a complex, integrated system of reactions, encompassing both body and mind. Threat initially arouses the sympathetic nervous system, causing the person in danger to feel an adrenalin rush and go into a state of alert. Threat also concentrates a person's attention on the immediate situation. In addition, threat may alter ordinary perceptions: people in danger are often able to disregard hunger, fatigue, or pain. Finally, threat evokes intense feelings of fear and anger. These changes in arousal, attention, perception, and emotion are normal, adaptive reactions. They mobilize the threatened person for strenuous action, either in battle or in flight.

Traumatic reactions occur when action is of no avail. When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized. Each component of the ordinary response to danger, having lost its utility, tends to persist in an altered and exaggerated state long after the actual danger is over. Traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory. Moreover, traumatic events may sever these normally integrated functions from one another. The traumatized person may experience intense emotion but without clear memory of the event, or may remember everything in detail but without emotion. She may find herself in a constant state of vigilance and irritability without knowing why. Traumatic symptoms have a tendency to become disconnected from their source and to take on a life of their own.

This kind of fragmentation, whereby trauma tears apart a complex system of self-protection that normally functions in an integrated fashion, is central to the historic observations on post-traumatic stress disorder. A century ago, Janet pinpointed the essential pathology in hysteria as "dissociation": people with hysteria had lost the capacity to integrate the memory of overwhelming life events. With careful investigative techniques, including hypnosis, Janet demonstrated that the traumatic memories were preserved in an abnormal state, set apart from ordinary consciousness. He believed that the severing of the normal connections of

memory, knowledge, and emotion resulted from intense emotional reactions to traumatic events. He wrote of the "dissolving" effects of intense emotion, which incapacitated the "synthesizing" function of the mind.<sup>5</sup>

Fifty years later Abram Kardiner described the essential pathology of the combat neurosis in similar terms. When a person is overwhelmed by terror and helplessness, *"the whole apparatus for concerted, coordinated and purposeful activity is smashed. The perceptions become inaccurate and pervaded with terror, the coordinative functions of judgment and discrimination fail . . . the sense organs may even cease to function. . . . The aggressive impulses become disorganized and unrelated to the situation in hand. . . . The functions of the autonomic nervous system may also become disassociated with the rest of the organism."*<sup>6</sup>

Traumatized people feel and act as though their nervous systems have been disconnected from the present. The poet Robert Graves recounts how in civilian life he continued to react as though he were back in the trenches of the First World War: "I was still mentally and nervously organized for War. Shells used to come bursting on my bed at midnight, even though Nancy shared it with me; strangers in the daytime would assume the faces of friends who had been killed. When strong enough to climb the hill behind Harlech and visit my favorite country, I could not help seeing it as a prospective battlefield."<sup>7</sup>

The many symptoms of post-traumatic stress disorder fall into three main categories. These are called "hyperarousal," "intrusion," and "constriction." Hyperarousal reflects the persistent expectation of danger; intrusion reflects the indelible imprint of the traumatic moment; constriction reflects the numbing response of surrender.

## HYPERAROUSAL

After a traumatic experience, the human system of self-preservation seems to go onto permanent alert, as if the danger might return at any moment. Physiological arousal continues unabated. In this state of hyperarousal, which is the first cardinal symptom of post-traumatic stress disorder, the traumatized person startles easily, reacts irritably to small provocations, and sleeps poorly. Kardiner proposed that "the nucleus of the [traumatic] neurosis is a *physioneurosis*."<sup>8</sup> He believed that many of the symptoms observed in combat veterans of the First World War—startle reactions, hyperalertness, vigilance for the return of danger, nightmares, and psychosomatic complaints—could be understood as resulting from

chronic arousal of the autonomic nervous system. He also interpreted the irritability and explosively aggressive behavior of traumatized men as disorganized fragments of a shattered "fight or flight" response to overwhelming danger.

Similarly, Roy Grinker and John Spiegel observed that traumatized soldiers of the Second World War "seem to suffer from chronic stimulation of the sympathetic nervous system. . . . The emergency psychological reactions of anxiety and physiological preparedness . . . have overlapped and become not episodic, but almost continuous. . . . Eventually the soldier is removed from the environment of stress and after a time his subjective anxiety recedes. But the physiological phenomena persist and are now maladaptive to a life of safety and security."

After the Vietnam War, researchers were able to confirm these hypotheses, documenting alterations in the physiology of the sympathetic nervous system in traumatized men. The psychiatrist Lawrence Kolb, for example, played tapes of combat sounds to Vietnam veterans. The men with post-traumatic stress disorder showed increased heart rate and blood pressure when the tapes were played. Many became so distraught that they asked to discontinue the experiment. Veterans without the disorder and those who had not experienced combat were able to listen to the combat tapes without emotional distress and without significant physiological responses.<sup>10</sup>

A wide array of similar studies has now shown that the psychophysiological changes of post-traumatic stress disorder are both extensive and enduring. Patients suffer from a combination of generalized anxiety symptoms and specific fears.<sup>11</sup> They do not have a normal "baseline" level of alert but relaxed attention. Instead, they have an elevated baseline of arousal: their bodies are always on the alert for danger. They also have an extreme startle response to unexpected stimuli, as well as an intense reaction to specific stimuli associated with the traumatic event.<sup>12</sup> It also appears that traumatized people cannot "tune out" repetitive stimuli that other people would find merely annoying; rather, they respond to each repetition as though it were a new, and dangerous, surprise.<sup>13</sup> The increase in arousal persists during sleep as well as in the waking state, resulting in numerous types of sleep disturbance. People with post-traumatic stress disorder take longer to fall asleep, are more sensitive to noise, and awaken more frequently during the night than ordinary people. Thus traumatic events appear to recondition the human nervous system.<sup>14</sup>

## INTRUSION

Long after the danger is past, traumatized people relive the event as though it were continually recurring in the present. They cannot resume the normal course of their lives, for the trauma repeatedly interrupts. It is as if time stops at the moment of trauma. The traumatic moment becomes encoded in an abnormal form of memory, which breaks spontaneously into consciousness, both as flashbacks during waking states and as traumatic nightmares during sleep. Small, seemingly insignificant reminders can also evoke these memories, which often return with all the vividness and emotional force of the original event. Thus, even normally safe environments may come to feel dangerous, for the survivor can never be assured that she will not encounter some reminder of the trauma.

Trauma arrests the course of normal development by its repetitive intrusion into the survivor's life. Janet described his hysterical patients as dominated by an "idée fixe." Freud, struggling to come to grips with the massive evidence of combat neuroses after the First World War, remarked, "The patient is, one might say, fixated to the trauma. . . . This astonishes us far too little."<sup>15</sup> Kardiner described "fixation on the trauma" as one of the essential features of the combat neurosis. Noting that traumatic nightmares can recur unmodified for years on end, he described the perseverative dream as "one of the most characteristic and at the same time one of the most enigmatic phenomena we encounter in the disease."<sup>16</sup>

Traumatic memories have a number of unusual qualities. They are not encoded like the ordinary memories of adults in a verbal, linear narrative that is assimilated into an ongoing life story. Janet explained the difference:

[Normal memory,] like all psychological phenomena, is an action; essentially it is the action of telling a story. . . . A situation has not been satisfactorily liquidated . . . until we have achieved, not merely an outward reaction through our movements, but also an inward reaction through the words we address to ourselves, through the organization of the recital of the event to others and to ourselves, and through the putting of this recital in its place as one of the chapters in our personal history. . . . Strictly speaking, then, one who retains a fixed idea of a happening cannot be said to have a "memory" . . . it is only for convenience that we speak of it as a "traumatic memory."<sup>17</sup>

The frozen and wordless quality of traumatic memories is captured in Doris Lessing's portrait of her father, a First World War combat veteran

who considered himself fortunate to have lost only a leg, while the rest of his company lost their lives, in the trenches at Passchendaele: "His childhood and young man's memories, kept fluid, were added to, grew, as living memories do. But his war memories were congealed in stories that he told again and again, with the same words and gestures, in stereotyped phrases. . . . This dark region in him, fate-ruled, where nothing was true but horror, was expressed inarticulately, in brief, bitter exclamations of rage, incredulity, betrayal."<sup>18</sup>

Traumatic memories lack verbal narrative and context; rather, they are encoded in the form of vivid sensations and images.<sup>19</sup> Robert Jay Lifton, who studied survivors of Hiroshima, civilian disasters, and combat, describes the traumatic memory as an "indelible image" or "death imprint."<sup>20</sup> Often one particular set of images crystallizes the experience, in what Lifton calls the "ultimate horror." The intense focus on fragmentary sensation, on image without context, gives the traumatic memory a heightened reality. Tim O'Brien, a combat veteran of the Vietnam War, describes such a traumatic memory: "I remember the white bone of an arm. I remember the pieces of skin and something wet and yellow that must've been the intestines. The gore was horrible, and stays with me. But what wakes me up twenty years later is Dave Jensen singing 'Lemon Tree' as we threw down the parts."<sup>21</sup>

In their predominance of imagery and bodily sensation, and in their absence of verbal narrative, traumatic memories resemble the memories of young children.<sup>22</sup> Studies of children, in fact, offer some of the clearest examples of traumatic memory. Among 20 children with documented histories of early trauma, the psychiatrist Lenore Terr found that none of the children could give a verbal description of the events that had occurred before they were two and one-half years old. Nonetheless, these experiences were indelibly encoded in memory. Eighteen of the 20 children showed evidence of traumatic memory in their behavior and their play. They had specific fears related to the traumatic events, and they were able to reenact these events in their play with extraordinary accuracy. For example, a child who had been sexually molested by a babysitter in the first two years of life could not, at age five, remember or name the babysitter. Furthermore, he denied any knowledge or memory of being abused. But in his play he enacted scenes that exactly replicated a pornographic movie made by the babysitter.<sup>23</sup> This highly visual and enactive form of memory, appropriate to young children, seems to be mobilized in adults as well in circumstances of overwhelming terror.

These unusual features of traumatic memory may be based on alterations in the central nervous system. A wide array of animal experiments

show that when high levels of adrenaline and other stress hormones are circulating, memory traces are deeply imprinted.<sup>24</sup> The same traumatic engraving of memory may occur in human beings. The psychiatrist Bessel van der Kolk speculates that in states of high sympathetic nervous system arousal, the linguistic encoding of memory is inactivated, and the central nervous system reverts to the sensory and iconic forms of memory that predominate in early life.<sup>25</sup>

Just as traumatic memories are unlike ordinary memories, traumatic dreams are unlike ordinary dreams. In form, these dreams share many of the unusual features of the traumatic memories that occur in waking states. They often include fragments of the traumatic event in exact form, with little or no imaginative elaboration. Identical dreams often occur repeatedly. They are often experienced with terrifying immediacy, as if occurring in the present. Small, seemingly insignificant environmental stimuli occurring during these dreams can be perceived as signals of a hostile attack, arousing violent reactions. And traumatic nightmares can occur in stages of sleep in which people do not ordinarily dream.<sup>26</sup> Thus, in sleep as well as in waking life, traumatic memories appear to be based in an altered neurophysiological organization.

Traumatized people relive the moment of trauma not only in their thoughts and dreams but also in their actions. The reenactment of traumatic scenes is most apparent in the repetitive play of children. Terr differentiates between normal play and the "forbidden games" of children who have been traumatized: "The everyday play of childhood . . . is free and easy. It is bubbly and light-spirited, whereas the play that follows from trauma is grim and monotonous. . . . Play does not stop easily when it is traumatically inspired. And it may not change much over time. As opposed to ordinary child's play, post-traumatic play is obsessively repeated. . . . Post-traumatic play is so literal that if you spot it, you may be able to guess the trauma with few other clues."<sup>27</sup>

Adults as well as children often feel impelled to re-create the moment of terror, either in literal or in disguised form. Sometimes people reenact the traumatic moment with a fantasy of changing the outcome of the dangerous encounter. In their attempts to undo the traumatic moment, survivors may even put themselves at risk of further harm. Some reenactments are consciously chosen. The rape survivor Sohaila Abdulali describes her determination to return to the scene of the trauma:

I've always hated feeling like something's got the better of me. When this thing happened, I was at such a vulnerable age—I was seventeen—I had to prove they weren't going to get me down. The guys who raped me told

me, "If we ever find you out here alone again we're going to get you." And I believed them. So it's always a bit of a terror walking up that lane, because I'm always afraid I'll see them. In fact, no one I know would walk up that lane at night alone, because it's just not safe. People have been mugged, and there's no question that it's dangerous. Yet part of me feels that if I don't walk there, then they'll have gotten me. And so, even more than other people, I *will walk up that lane*.<sup>28</sup>

More commonly, traumatized people find themselves reenacting some aspect of the trauma scene in disguised form, without realizing what they are doing. The incest survivor Sharon Simone recounts how she became aware of a link between her dangerous risk-taking behavior and her childhood history of abuse:

For a couple of months, I had been playing chicken on the highway with men, and finally I was involved in an auto accident. A male truck driver was trying to cut me off, and I said to myself in the crudest of language, there's no f—ing way you're going to push your penis into my lane. Like right out of the blue! Boom! Like that! That was really strange.

I had not really been dealing with any of the incest issues. I knew vaguely there was something there and I knew I had to deal with it and I didn't want to. I just had a lot of anger at men. So I let this man smash into me and it was a humongous scene. I was really out of control when I got out of the car, just raging at this man. I didn't tell my therapist about it for about six weeks—I just filed it away. When I told I got confronted—it's very dangerous—so I made a contract that I would deal with my issues with men.<sup>29</sup>

Not all reenactments are dangerous. Some, in fact, are adaptive. Survivors may find a way to integrate reliving experiences into their lives in a contained, even socially useful manner. The combat veteran Ken Smith describes how he managed to re-create some aspects of his war experience in civilian life:

I was in Vietnam 8 months, 11 days, 12 hours, and 45 minutes. These things you remember. I remember it exactly. I returned home a much different person from when I left. I went to work as a paramedic, and I found a considerable amount of self-satisfaction out of doing that work. It was almost like a continuance of what I had been doing in Vietnam, but on a much, much lower capacity. There was no gunshot trauma, there was no burn trauma, I wasn't seeing sucking chest wounds or amputations or shrapnel. I was seeing a lot of medical emergencies, a lot of diabetic emergencies, a lot of elderly people. Once in awhile there would be an auto accident, which would be the juice. I would turn on the sirens and know

going to something, and the adrenalin rush that would run through my veins would fuel me for the next 100 calls.<sup>30</sup>

There is something uncanny about reenactments. Even when they are consciously chosen, they have a feeling of involuntariness. Even when they are not dangerous, they have a driven, tenacious quality. Freud called this recurrent intrusion of traumatic experience the "repetition compulsion." He first conceptualized it as an attempt to master the traumatic event. But this explanation did not satisfy him. It somehow failed to capture what he called the "daemonic" quality of reenactment. Because the repetition compulsion seemed to defy any conscious intent to resist change so adamantly, Freud despaired of finding any adaptive, life-affirming explanation for it; rather, he was driven to invoke the concept of a "death instinct."<sup>31</sup>

Most theorists have rejected this Manichaean explanation, concurring with Freud's initial formulation. They speculate that the repetitive reliving of the traumatic experience must represent a spontaneous, unsuccessful attempt at healing. Janet spoke of the person's need to "assimilate" and "update" traumatic experience, which, when accomplished, produces a feeling of "triumph." In his use of language, Janet implicitly recognized that helplessness constitutes the essential insult of trauma, and that restitution requires the restoration of a sense of efficacy and power. The traumatized person, he believed, "remains confronted by a difficult situation, one in which he has not been able to play a satisfactory part, one in which his adaptation has been imperfect, so that he continues to make efforts at adaptation."<sup>32</sup>

More recent theorists also conceptualize intrusion phenomena, including reenactments, as spontaneous attempts to integrate the traumatic event. The psychiatrist Mardi Horowitz postulates a "completion principle" which "summarizes the human mind's intrinsic ability to process new information in order to bring up to date the inner schemata of the self and the world." Trauma, by definition, shatters these "inner schemata." Horowitz suggests that unassimilated traumatic experiences are stored in a special kind of "active memory," which has an "intrinsic tendency to repeat the representation of contents." The trauma is resolved only when the survivor develops a new mental "schema" for understanding what has happened.<sup>33</sup>

The psychoanalyst Paul Russell conceptualizes the emotional rather than the cognitive experience of the trauma as the driving force of the repetition compulsion. What is reproduced is "what the person needs to

feel in order to repair the injury." He sees the repetition compulsion as an attempt to relive and master the overwhelming feelings of the traumatic moment.<sup>34</sup> The predominant unresolved feeling might be terror, helpless rage, or simply the undifferentiated "adrenaline rush" of mortal danger.

Reliving a trauma may offer an opportunity for mastery, but most survivors do not consciously seek or welcome the opportunity. Rather, they dread and fear it. Reliving a traumatic experience, whether in the form of intrusive memories, dreams, or actions, carries with it the emotional intensity of the original event. The survivor is continually buffeted by terror and rage. These emotions are qualitatively different from ordinary fear and anger. They are outside the range of ordinary emotional experience, and they overwhelm the ordinary capacity to bear feelings.

Because reliving a traumatic experience provokes such intense emotional distress, traumatized people go to great lengths to avoid it. The effort to ward off intrusive symptoms, though self-protective in intent, further aggravates the post-traumatic syndrome, for the attempt to avoid reliving the trauma too often results in a narrowing of consciousness, a withdrawal from engagement with others, and an impoverished life.

### CONSTRICTION

When a person is completely powerless, and any form of resistance is futile, she may go into a state of surrender. The system of self-defense shuts down entirely. The helpless person escapes from her situation not by action in the real world but rather by altering her state of consciousness. Analogous states are observed in animals, who sometimes "freeze" when they are attacked. These are the responses of captured prey to predator or of a defeated contestant in battle. A rape survivor describes her experience of this state of surrender: "Did you ever see a rabbit stuck in the glare of your headlights when you were going down a road at night. Transfixed—like it knew it was going to get it,—that's what happened."<sup>35</sup> In the words of another rape survivor, "I couldn't scream. I couldn't move. I was paralyzed . . . like a rag doll."<sup>36</sup>

These alterations of consciousness are at the heart of constriction or numbing, the third cardinal symptom of post-traumatic stress disorder. Sometimes situations of inescapable danger may evoke not only terror and rage but also, paradoxically, a state of detached calm, in which terror, rage, and pain dissolve. Events continue to register in awareness, but it

as though these events have been disconnected from their ordinary meanings. Perceptions may be numbed or distorted, with partial anesthesia or the loss of particular sensations. Time sense may be altered, often with a sense of slow motion, and the experience may lose its quality of ordinary reality. The person may feel as though the event is not happening to her, as though she is observing from outside her body, or as though the whole experience is a bad dream from which she will shortly awaken. These perceptual changes combine with a feeling of indifference, emotional detachment, and profound passivity in which the person relinquishes all initiative and struggle. This altered state of consciousness might be regarded as one of nature's small mercies, a protection against unbearable pain. A rape survivor describes this detached state: "I left my body at that point. I was over next to the bed, watching this happen. . . . I dissociated from the helplessness. I was standing next to me and there was just this shell on the bed. . . . There was just a feeling of flatness. I was just there. When I repicture the room, I don't picture it from the bed. I picture it from the side of the bed. That's where I was watching from."<sup>37</sup> A combat veteran of the Second World War reports a similar experience: "Like most of the 4th, I was numb, in a state of virtual disassociation. There is a condition . . . which we called the two-thousand-year-stare. This was the anesthetized look, the wide, hollow eyes of a man who no longer cares. I wasn't to that state yet, but the numbness was total. I felt almost as if I hadn't actually been in a battle."<sup>38</sup>

These detached states of consciousness are similar to hypnotic trance states. They share the same features of surrender of voluntary action, suspension of initiative and critical judgment, subjective detachment or calm, enhanced perception of imagery, altered sensation, including numbness and analgesia, and distortion of reality, including depersonalization, derealization, and change in the sense of time.<sup>39</sup> While the heightened perceptions occurring during traumatic events resemble the phenomena of hypnotic absorption, the numbing symptoms resemble the complementary phenomena of hypnotic dissociation.<sup>40</sup>

Janet thought that his hysterical patients' capacity for trance states was evidence of psychopathology. More recent studies have demonstrated that although people vary in their ability to enter hypnotic states, trance is a normal property of human consciousness.<sup>41</sup> Traumatic events serve as powerful activators of the capacity for trance.<sup>42</sup> As the psychiatrist David Spiegel points out, "it would be surprising indeed if people did *not* spontaneously use this capacity to reduce their perception of pain during acute trauma."<sup>43</sup> But while people usually enter hypnotic states under

controlled circumstances and by choice, traumatic trance states occur in an uncontrolled manner, usually without conscious choice.

The biological factors underlying these altered states, both hypnotic trance and traumatic dissociation, remain an enigma. The psychologist Ernest Hilgard speculates that hypnosis "may be acting in a manner parallel to morphine."<sup>44</sup> The use of hypnosis as a substitute for opiates to produce analgesia has long been known. Both hypnosis and morphine produce a dissociative state in which the perception of pain and the normal emotional responses to pain are severed. Both hypnosis and opiates diminish the distress of intractable pain without abolishing the sensation itself. The psychiatrists Roger Pitman and van der Kolk, who have demonstrated persistent alterations in pain perception in combat veterans with post-traumatic stress disorder, suggest that trauma may produce long-lasting alterations in the regulation of endogenous opioids, which are natural substances having the same effects as opiates within the central nervous system.<sup>45</sup>

Traumatized people who cannot spontaneously dissociate may attempt to produce similar numbing effects by using alcohol or narcotics. Observing the behavior of soldiers in wartime, Grinker and Spiegel found that uncontrolled drinking increased proportionately to the combat group's losses; the soldiers' use of alcohol appeared to be an attempt to obliterate their growing sense of helplessness and terror.<sup>46</sup> It seems clear that traumatized people run a high risk of compounding their difficulties by developing dependence on alcohol or other drugs. The psychologist Josefina Card, in a study of Vietnam-era veterans and their civilian peers, demonstrated that men who developed post-traumatic stress disorder were far more likely to have engaged in heavy consumption of narcotics and street drugs, and to have received treatment for problems with alcohol or drug abuse after their return from the war.<sup>47</sup> In another study of 100 combat veterans with severe post-traumatic stress disorder, Herbert Hendin and Ann Haas noted that 85 percent developed serious drug and alcohol problems after their return to civilian life. Only 7 percent had used alcohol heavily before they went to war. The men used alcohol and narcotics to try to control their hyperarousal and intrusive symptoms—insomnia, nightmares, irritability, and rage outbursts. Their drug abuse, however, ultimately compounded their difficulties and further alienated them from others.<sup>48</sup> The largest and most comprehensive investigation of all, the National Vietnam Veterans Readjustment Study, reported almost identical findings: 75 percent of men with the disorder developed problems with alcohol abuse or dependence.<sup>49</sup>

Although dissociative alterations in consciousness, or even intoxication, may be adaptive at the moment of total helplessness, they become maladaptive once the danger is past. Because these altered states keep the traumatic experience walled off from ordinary consciousness, they prevent the integration necessary for healing. Unfortunately, the constrictive or dissociative states, like other symptoms of the post-traumatic syndrome, prove to be remarkably tenacious. Lifton likened "psychic numbing," which he found to be universal in survivors of disaster and war, to a "paralysis of the mind."<sup>50</sup>

Constrictive symptoms, like intrusive symptoms, were first described in the domain of memory. Janet noted that post-traumatic amnesia was due to a "constriction of the field of consciousness" which kept painful memories split off from ordinary awareness. When his hysterical patients were in a hypnotic trance state, they were able to replicate the dissociated events in exquisite detail. His patient Irene, for example, reported a dense amnesia for a two-month time period surrounding her mother's death. In trance, she was able to reproduce all the harrowing events of those two months, including the death scene, as though they were occurring in the present.<sup>51</sup>

Kardiner also recognized that a constrictive process kept traumatic memories out of normal consciousness, allowing only a fragment of the memory to emerge as an intrusive symptom. He cited the case of a navy veteran who complained of a persistent sensation of numbness, pain, and cold from the waist down. This patient denied any traumatic experiences during the war. On persistent questioning, without formal use of hypnosis, he recalled the sinking of his ship and the many hours he had spent awaiting rescue in the icy water, but he denied having any emotional reaction to the event. However, as Kardiner pressed on, the patient became agitated, angry, and frightened:

The similarities between the symptoms of which he complained . . . and his being submerged in cold water from his waist down, were pointed out to him. He admitted that when he closed his eyes and *allowed himself to think* of his present sensations, he still imagined himself clinging to the raft, half submerged in the sea. He then said that while he was clinging to the raft, his sensations were extremely painful and that he thought of nothing else during the time. He also recalled the fact that several of the men had lost consciousness and had drowned. To a large extent, the patient obviously owed his life to his concentration of the painful sensations occasioned by the cold water. Hence the symptom represented a . . . reproduction of the original sensations of being submerged in the water.<sup>52</sup>

In this case, the constrictive process resulted not in complete amnesia but in the formation of a truncated memory, devoid of emotion and meaning. The patient did not "allow himself to think" about the meaning of his symptom, for to do so would have brought back all the pain, terror, and rage of narrowly escaping death and witnessing the deaths of his comrades. This voluntary suppression of thoughts related to the traumatic event is characteristic of traumatized people, as are the less conscious forms of dissociation.

The constrictive symptoms of the traumatic neurosis apply not only to thought, memory, and states of consciousness but also to the entire field of purposeful action and initiative. In an attempt to create some sense of safety and to control their pervasive fear, traumatized people restrict their lives. Two rape survivors describe how their lives narrowed after the trauma:

I was terrified to go anywhere on my own. . . . I felt too defenseless and too afraid, and so I just stopped doing anything. . . . I would just stay home and I was just frightened.<sup>53</sup>

I cut off all my hair. I did not want to be attractive to men. . . . I just wanted to look neutered for awhile because that felt safer.<sup>54</sup>

The combat veteran Ken Smith describes how he rationalized the constriction in his life that occurred after combat, so that for a long time he did not recognize how much he was ruled by fear: "I worked exclusively midnight to eight or eleven to seven. Never understood why. I was so concerned about being awake at night, because I had this thing about being *afraid of the night*. Now I know that; then I didn't. I rationalized it because there wasn't as much supervision, I got more freedom, I didn't have to listen to the political infighting bullshit, nobody really bothered me, I was left alone."<sup>55</sup>

Constrictive symptoms also interfere with anticipation and planning for the future. Grinker and Spiegel observed that soldiers in wartime responded to the losses and injuries within their group with diminished confidence in their own ability to make plans and take initiative, with increased superstitious and magical thinking, and with greater reliance on lucky charms and omens.<sup>56</sup> Terr, in a study of kidnapped schoolchildren, described how afterward the children came to believe that there had been omens warning them of the traumatic event. Years after the kidnapping, these children continued to look for omens to protect them and guide

their behavior. Moreover, years after the event, the children retained a foreshortened sense of the future; when asked what they wanted to be when they grew up, many replied that they never fantasized or made plans for the future because they expected to die young.<sup>57</sup>

In avoiding any situations reminiscent of the past trauma, or any initiative that might involve future planning and risk, traumatized people deprive themselves of those new opportunities for successful coping that might mitigate the effect of the traumatic experience. Thus, constrictive symptoms, though they may represent an attempt to defend against overwhelming emotional states, exact a high price for whatever protection they afford. They narrow and deplete the quality of life and ultimately perpetuate the effects of the traumatic event.

### THE DIALECTIC OF TRAUMA

In the aftermath of an experience of overwhelming danger, the two contradictory responses of intrusion and constriction establish an oscillating rhythm. This dialectic of opposing psychological states is perhaps the most characteristic feature of the post-traumatic syndromes.<sup>58</sup> Since neither the intrusive nor the numbing symptoms allow for integration of the traumatic event, the alternation between these two extreme states might be understood as an attempt to find a satisfactory balance between the two. But balance is precisely what the traumatized person lacks. She finds herself caught between the extremes of amnesia or of reliving the trauma, between floods of intense, overwhelming feeling and arid states of no feeling at all, between irritable, impulsive action and complete inhibition of action. The instability produced by these periodic alternations further exacerbates the traumatized person's sense of unpredictability and helplessness.<sup>59</sup> The dialectic of trauma is therefore potentially self-perpetuating.

In the course of time, this dialectic undergoes a gradual evolution. Initially, intrusive reliving of the traumatic event predominates, and the victim remains in a highly agitated state, on the alert for new threats. Intrusive symptoms emerge most prominently in the first few days or weeks following the traumatic event, abate to some degree within three to six months, and then attenuate slowly over time. For example, in a large-scale community study of crime victims, rape survivors generally reported that their most severe intrusive symptoms diminished after three to six months, but they were still fearful and anxious one year following

the rape.<sup>60</sup> Another study of rape survivors also found the majority (80 percent) still complaining of intrusive fears at the one-year mark.<sup>61</sup> When a different group of rape survivors were recontacted two to three years after they had first been seen in a hospital emergency room, the majority were still suffering from symptoms attributable to rape. Trauma-specific fears, sexual problems, and restriction of daily life activities were the symptoms these survivors reported most commonly.<sup>62</sup>

The traumatic injury persists over even a longer period. For example, four to six years after their study of rape victims at a hospital emergency room, Ann Burgess and Lynda Holmstrom recontacted the women. By that time, three-fourths of the women considered themselves to have recovered. In retrospect, about one-third (37 percent) thought it had taken them less than a year to recover, and one-third (37 percent) felt it had taken more than a year. But one woman in four (26 percent) felt that she still had not recovered.<sup>63</sup>

A Dutch study of people who were taken hostage also documents the long-lasting effects of a single traumatic event. All of the hostages were symptomatic in the first month after being set free, and 75 percent were still symptomatic after six months to one year. The longer they had been in captivity, the more symptomatic they were, and the slower they were to recover. On long-term follow-up six to nine years after the event, almost half the survivors (46 percent) still reported constrictive symptoms, and one-third (32 percent) still had intrusive symptoms. While general anxiety symptoms tended to diminish over time, psychosomatic symptoms actually got worse.<sup>64</sup>

While specific, trauma-related symptoms seem to fade over time, they can be revived, even years after the event, by reminders of the original trauma. Kardiner, for example, described a combat veteran who suffered an "attack" of intrusive symptoms on the anniversary of a plane crash which he had survived eight years previously.<sup>65</sup> In a more recent case, nightmares and other intrusive symptoms suddenly recurred in a Second World War combat veteran after a delay of thirty years.<sup>66</sup>

As intrusive symptoms diminish, numbing or constrictive symptoms come to predominate. The traumatized person may no longer seem frightened and may resume the outward forms of her previous life.<sup>67</sup> But the severing of events from their ordinary meanings and the distortion in the sense of reality persist. She may complain that she is just going through the motions of living, as if she were observing the events of daily life from a great distance. Only the repeated reliving of the moment of horror temporarily breaks through the sense of numbing and disconnec-

tion. The alienation and inner deadness of the traumatized person is captured in Virginia Woolf's classic portrait of a shell-shocked veteran:

"Beautiful," [his wife] would murmur, nudging Septimus that he might see. But beauty was behind a pane of glass. Even taste (Rezia liked ices, chocolates, sweet things) had no relish to him. He put down his cup on the little marble table. He looked at people outside; happy they seemed, collecting in the middle of the street, shouting, laughing, squabbling over nothing. But he could not taste, he could not feel. In the tea-shop among the tables and the chattering waiters the appalling fear came over him—he could not feel."

The constraints upon the traumatized person's inner life and outer range of activity are negative symptoms. They lack drama; their significance lies in what is missing. For this reason, constrictive symptoms are not readily recognized, and their origins in a traumatic event are often lost. With the passage of time, as these negative symptoms become the most prominent feature of the post-traumatic disorder, the diagnosis becomes increasingly easy to overlook. Because post-traumatic symptoms are so persistent and so wide-ranging, they may be mistaken for enduring characteristics of the victim's personality. This is a costly error, for the person with unrecognized post-traumatic stress disorder is condemned to a diminished life, tormented by memory and bounded by helplessness and fear. Here, again, is Lessing's portrait of her father:

The young bank clerk who worked such long hours for so little money, but who danced, sang, played, flirted—this naturally vigorous, sensuous being was killed in 1914, 1915, 1916. I think the best of my father died in that war, that his spirit was crippled by it. The people I've met, particularly the women, who knew him young speak of his high spirits, his energy, his enjoyment of life. Also of his kindness, his compassion and—a word that keeps recurring—his wisdom. . . . I do not think these people would have easily recognized the ill, irritable, abstracted, hypochondriac man I knew."

Long after the event, many traumatized people feel that a part of themselves has died. The most profoundly afflicted wish that they were dead. Perhaps the most disturbing information on the long-term effects of traumatic events comes from a community study of crime victims, including 100 women who had been raped. The average time elapsed since the rape was nine years. The study recorded only major mental health problems, without paying attention to more subtle levels of post-traumatic symptomatology. Even by these crude measures, the lasting,

destructive effects of the trauma were apparent. Rape survivors reported more "nervous breakdowns," more suicidal thoughts, and more suicide attempts than any other group. While prior to the rape they had been no more likely than anyone else to attempt suicide, almost one in five (19.2 percent) made a suicide attempt following the rape.<sup>70</sup>

The estimate of actual suicide following severe trauma is riddled with controversy. Popular media have reported, for example, that there were more deaths of Vietnam veterans by suicide after the war than deaths in combat. These accounts appear to be highly exaggerated, but mortality studies nevertheless suggest that combat trauma may indeed increase the risk of suicide.<sup>71</sup> Hendin and Haas found in their study of combat veterans with post-traumatic stress disorder that a significant minority had made suicide attempts (19 percent) or were constantly preoccupied with suicide (15 percent). Most of the men who were persistently suicidal had had heavy combat exposure. They suffered from unresolved guilt about their wartime experiences and from severe, unremitting anxiety, depression, and post-traumatic symptoms. Three of the men died by suicide during the course of the study.<sup>72</sup>

Thus, the very "threat of annihilation" that defined the traumatic moment may pursue the survivor long after the danger has passed. No wonder that Freud found, in the traumatic neurosis, signs of a "daemonic force at work."<sup>73</sup> The terror, rage, and hatred of the traumatic moment live on in the dialectic of trauma.

