18Forty Profiles: Giving Voice to Survivors, with Judith Herman

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By: Yehuda Fogel

This reader considers the work of Dr. Judith Herman, psychiatrist, researcher, author, and activist. Dr. Herman's approach to trauma has had a significant impact, and have forged a path forward for clinicians, researchers, and survivors. Click the link to receive the full PDF of this profile.

Dr. Judith Herman

In the wake of a great trauma, how does the survivor tell their story? The challenges in finding one's voice after experiencing a trauma are manifold. Our mind and bodies collaborate in protecting us by engaging the flight, fight, or freeze instincts, and recent research indicates that our coding of trauma events in our memory operates differently than our normative coding of everyday experience. This complicates one's understanding of what they experienced, and the mind's attempts at protecting itself from the harshness of its memories contributes to the difficulty of learning to speak to the pain of the event.

While these challenges are real, for a long time they were exacerbated by a medical establishment that saw trauma as an isolated experience, one largely local to the battlefield and combat victims. The contemporary understanding of an interrelationship between abuse, trauma, and the totality of one's mental health is a relatively recent phenomenon, and for a long time people with mental illness were not asked about a history of trauma. Like in the mind, trauma was silenced in large part because it makes us uncomfortable to consider. It is far easier to write off a few bad people as abusers than it is to contend with the unfortunate ubiquity of trauma in this still-imperfect world.

Enter Dr. Judith Herman. Herman is a psychiatrist, researcher, and author, whose work on trauma and familial abuse has been foundational to the field. Herman's writings have been hugely important among clinicians, researchers, and survivors of trauma. Herman is a founder of the Women's Mental Health Collective, a professor of psychiatry at Harvard University Medical School, and the Director of Training at the Victims of Violence Program at Cambridge Health Alliance.

As we consider the topic of abuse in the Jewish community, we turn to consider and appreciate those who brought the impact and import of trauma out of the shadows. In this reader, we honor the work of Dr. Judith Herman, with our introduction to Dr. Herman's work, along with an interview with her about her life and work, followed by an article by Dr. Herman on "Recovery from psychological trauma". A note of warning: Some of this content might be triggering to our readers, so take care to read only if you feel up for it. Above all, these words are no replacement for working with a mental-health professional, so if you feel that you might have experienced anything like this, we urge you to reach out to a therapist. When the Jews were in Egypt, the Zohar tells us that the "word was in exile," which speaks powerfully to the challenge of expressing ourselves that so many have in the most challenging of circumstances. We can all work to give voice who those voices are in exile, and to redeem the silence of this world. All of the articles will be included in the PDF, so remember to click the link to get the full reader.

An Introduction to Judith Herman

Judith Herman grew up in a secular Jewish home, although her father had grown up in an Orthodox home. Herman's father was a professor of classics at CUNY, and her mother was a psychologist and psychoanalyst who taught and practiced. Herman came to trauma work in the field, after finding that a large number of patients that she had been working with had survived childhood sexual abuse, a fact that was largely ignored by their presiding doctors and mental-health professionals. This prompted Herman to start a group that brought together clinicians, researchers, and survivors of abuse to collaborate in talking and thinking about trauma. Herman began researching trauma, working with Bessel van der Kolk, author of *The Body Keeps the Score*, a psychiatrist who had been treating combat veterans. Herman's writings on incest and abuse were passed around in manuscript form for years, at a time in which the long-term impact of trauma were little-appreciated by the medical establishment. Later, her book *Trauma and Recovery: The Aftermath of Violence – from Domestic Abuse to Political Terror*, in which Herman outlines her theory of recovery from trauma, became an instant classic, beloved by clinicians and survivors alike.

There are several strands to Herman's work that are important to appreciate. Most broadly, Herman has been hugely important for the opening of the conversation around trauma in the medical world, and the increasing focus on the psychological and medical effects of trauma on the survivor of trauma. Herman brought the experience out of the shadows, giving voice to a huge group of people who had their voice taken from them. In *Trauma and Recovery,* Herman outlines three stages of recovery: Establishing trust, speaking the trauma narrative, and reconnecting with life. These stages are non-linear and non-exhaustive, and each survivor learns how to live in their own distinct and unique way, and are rather attempts at capturing a road towards healing.

It is no coincidence that Herman considers political terror side-by-side with familial abuse; although the experiences are different, there are shared themes, such as the challenge of one that underwent a profound trauma expressing the pain of what they experienced. One thinks

of the years of silence that Elie Wiesel had before deciding to write about the Holocaust, and the place that the impossible relationships between silence, speech, testimony, and trauma had in post-Holocaust writers such as Nelly Sachs, Paul Celan, Edmond Jabes, and so many others. A growing body of research on Holocaust survivors, as well as the second and third generation survivors of the Holocaust, pioneered by scholars like Rachel Yehuda, has been indelibly influenced by Herman's work. Herman has also been a staunch advocate for the classification of complex post-traumatic stress disorder as a disorder independent from post-traumatic stress disorder.

Above all, Herman helped the world remember that profound pain is not incidental or happenstance, but is often the result of systematic inequalities, and it is only when we listen to the voices of survivors themselves that we can understand what is happening in our world. This deep insight, gleaned from the deepest and darkest recesses of the mental health field, is vital for all of us, as we strive to build a safer and stronger world. If we are to address and prevent abuse in all of its forms, we must understand the experience of those who have been vulnerable to abuse.

Background

globetrotter.berkeley.edu/people/Herman/herman-con1.html

Judith Herman Interview: Conversations with History; Institute of International Studies, UC Berkeley

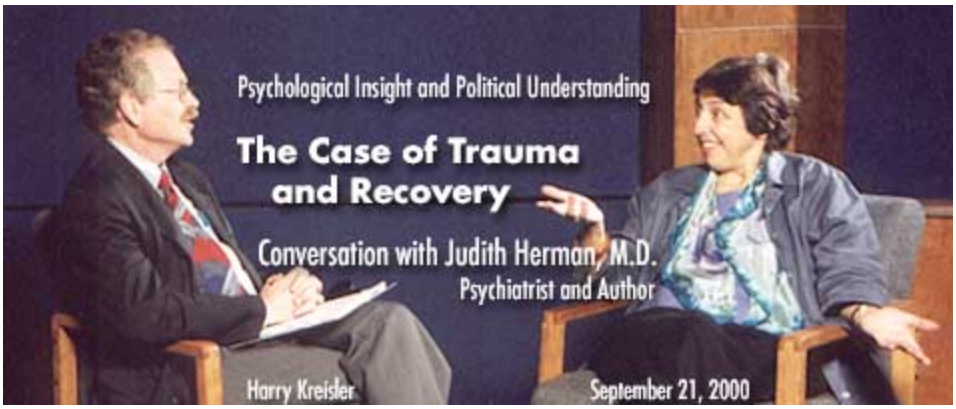


Photo by Jane Scherr

Dr. Herman, welcome to Berkeley.

Thank you.

How did your parents shape your character?

My parents are first-generation Americans. They're the children of Jewish immigrants from Central Europe. Both grew up in New York City. My father was a child of working-class parents, and his father worked in the garment industry. My mother was the daughter of a doctor, a family practitioner on the Lower East Side of New York. I think both of them were raised in a secular, socialist tradition. Or, I should say, my mother was. My father found his way to it from his father's observant Orthodoxy. And when they both became academics -- my father became a professor of classics, my mother became a psychologist -- I think they instilled what I would call Enlightenment values or progressive values in their children.

Your mother especially had a strong influence on you. You write in one of your books, "Her psychological insight, her intellectual daring and integrity, her compassion for the afflicted and oppressed, her righteous indignation, and her political vision are my inheritance." Quite a powerful effect.

My mother, was raised, I think, by her father, who was a family doctor very much in a tradition of service to others. If she'd been in my generation, I imagine she'd have gone to medical school. That was really not unheard of, or not totally, but very unusual for women of her generation. She went to Barnard and then did graduate studies at Columbia in psychology, and started on an academic track to become a research psychologist. Then she was blacklisted because of a short period of membership in the Communist Party. So the early years of my growing up, when I was around ten, for example, we were introduced to the idea of political persecution and what people do under those circumstances in a very personal way. My father had never been a member of the Party, so when called to testify before McCarthy, he could, in honesty, say to the question, "Are you now or have you ever been ...?" "No."

My mother took the Fifth Amendment. It was clear that she was never going to get an academic job, so she then went a different route and got clinical training. But in her later work, she tried to bridge the divide between academic research and clinical experience. I think she also tried to bridge the divide between academia and activism in a way that did become a model for me. I should also say that a lot of her righteous indignation and her sense of an expectation of integrity and standing up for your beliefs came out of actual experience. There were a lot of dinner table conversations about who was going to testify, who was going to inform, who was going to back up people who refused to inform, and so forth. She had a really keen sense of irony and indignation about all the weaseling, all the fancy excuses that people made to compromise with something -- that it was morally reprehensible. So that was a pretty formative growing up experience for me.

Any other experiences from your childhood? Mentors, books read, that had a profound influence before the women's movement? We'll talk about that in a second. But anything else stand out in your mind?

I had a college mentor that I really should recognize, I think, and honor. This was a professor of French Civilization at Harvard named Laurence Wylie. An anthropologist, really. He had done a village study in France in which he applied the methods of anthropology ordinarily applied in so-called primitive societies to a French village. He was a participant observer. He had gone there with his family. He had written about it in a deceptively simple manner that, I think, actually was extremely sophisticated, but didn't involve any high sort of ...

Theoretical concepts?

Well, they were embedded in the observations and the presentations.

There was a lucidity.

There was a lucidity and the warmth of storytelling in this book, and it became a very popular book, and he ended up becoming the Douglas Dillon Professor of French Civilization at Harvard, which was a funny fit for him, because he was so very modest and unpretentious. I

don't know if he ever lived up to the grandeur of this endowed chair. But he was a wonderful teacher.

Both of these influences strike me as pushing you, leading you, guiding you in the direction of thinking outside the box, which is one of the characteristics of your work.

Yes, and also of keeping your concepts very close to direct observation and direct experience. In the case of Larry Wylie, he had a seminar on village culture where we read all the classics, but then the idea was to immerse ourselves in primary data and eventually to go to the village. The assignment was basically to keep a journal and to record your observations directly and see what you could then infer from your observations. The other thing he taught was cooperative learning, there wasn't a name for it then, but he got these very high-powered students to be in his seminar and they would all raise their hands and kind of spout forth with their ideas, and he would say things like, "That's such an interesting idea. And it sounds so much like what so-and-so said. Why don't the two of you work together and see if you can develop this idea together." And they'd look at each other in horror because that was sort of cheating. But he, through his actions and through his example, modeled a different kind of learning and a different kind of intellectual enterprise for me.

And it's something that you've carried out in your work, namely the whole notion of listening and reporting what you're observing, but also learning in the process from others. In this regard, the women's movement of the sixties seems to have had an impact on you. I'm curious, after learning of these other influences, what the women's movement added to the education of Judith Herman?

For me this was a logical extension of the activism that I was already involved with. I had been involved in the Civil Rights Movement, I had been involved in the Anti-War Movement, prior to the explosion of "second wave" feminism in the late sixties. Kathie Sarachild of New York Red Stockings, who was a classmate of mine at Harvard, Radcliffe, and who had been in Mississippi also with me in 1964, she's the originator of the term "consciousness-raising," -- like many of the early feminists who came out of the Civil Rights Movement, her organizing technique came out of the work she had done in civil rights and involved people speaking directly of their experience as a way to study our condition. She called consciousness-raising an empirical method of investigation. And her view was that for people whose experience was not articulated, not recognized, not visible in the theory class, so to speak, the only way to begin to make our experience known to ourselves was to start with the testimony about the concrete conditions of our lives. So, it was a connect for me and many women of my generation, I think, to start to apply those methods not only to the social issues of racism and more, but to the conditions of our own rather privileged lives. And to recognize that oppression takes many forms.

So it was a spark for your creativity and it helped you to look at yourself and your condition and the broader context in which that condition was created, namely the oppression of women.

Right. And also, the lesson for me was that one becomes most effective when one is speaking out of one's personal experience and one's action grows out of the understanding of one's immediate personal experience.

You went to Radcliffe, then to Harvard Medical School. You're a medical doctor. What were you doing in Mississippi? Just part of the Civil Rights Movement?

I was recruited by a friend and colleague and now more recently a partner, Allen Graubard, who had gone to Mississippi the summer before Freedom Summer with Marian Wright, now Marian Wright Edelman. And they had developed the idea that it would be good to have an academic exchange between Harvard and Tougaloo College, which was based outside of Jackson, Mississippi, and was a black college. And so they implemented this program that involved an exchange of students and faculty during that summer, and then when SNCC [Student Nonviolent Coordinating Committee] and the other organizations developed Freedom Summer, we became an affiliated part of that project.

Lessons Learned

In looking at your career, you combine political activism with accomplishment in a professional field. Some concluded in the sixties that it was not possible to bring radical insight to expertise in given areas. I'm curious as to what your advice would be to students who might read this interview and say, "That's the kind of thing I would want to do with my life." How do you prepare to be both an activist and a professional in a field like medicine or law?

I think it was a lot easier in my generation. We didn't have to find the movement. It just found us. I have a 21-year-old daughter who's just graduated from college. She's trying to figure this out now. But the truth is that you could start almost anywhere. There are so many things in the world that need to be set right. You can start with whatever fires you up, whatever excites you, whatever fires your indignation, and put your energy there. And it's as good a place to start as any. I think that if it speaks to your heart, if it engages your imagination, if it makes you want to get out of bed in the morning and do something, that's probably the best place to start. And that to me is the inside of the political movements that I was part of. Organizations come and go. Intellectual theories come and go. The power to change the way people think and what people do comes out of small groups of people who care enough about something to try something new. And that can be done any time.

It's also about ideas, right? Embedding yourself in history, in a way, to go with those new ideas and then formulate them yourself.

There is an intellectual tradition of political activism that isn't as strong in this country as in many others, and often needs to be re-invented and rediscovered in each generation. But, yes, it helps if you know that other people have thought about these things before you try organizing. You don't have to invent everything from scratch. But, on the other hand, one's immediate historical circumstances are always new. I'd rather see people take the plunge and try innovating and then have to study up because, "Oh my God! I'd better inform myself, because I need to arm myself with knowledge" than try to deduce from the history of the past what should be done now.

But for you, the study of history and politics is absolutely fundamental to the study of psychiatry and psychology? Or is that an overstatement?

To me it is. It's absolutely fundamental. Let's just stop with that.

You express a concern in your book that new researchers will lack the passionate intellectual and social commitment of your generation. You say, "They will not see the essential interconnection between biological, psychological, social, and political dimensions of trauma."

Well, I think that's happening already. It's the price of respectability, unfortunately. The trauma field is now ... you know, we're ...

Legitimate.

We're legit. Yep. People write dissertations and people apply for research money and, you know, drug companies get approval for their drugs for treatment of Post-Traumatic Stress Disorder. And so it's ... I can see it happening already in the traumatic stress field. If you want to keep it clean, it's nice to have some nice, clean auto accident victim study. And hopefully not where there's any sort of corporate liability in the accident, corporate negligence, but where it was truly an accident. And then you don't have to get into any of this murky, messy, social issue stuff. And you can just do a nice psycho-biological study and you can randomly assign people to eight sessions of cognitive behavioral therapy or eight sessions of a serotonin re-uptake inhibitor, or a combination of the two, or a placebo, and see what works best. That's probably a legitimate study. I'm not against it. I just think that's not really where the interesting questions lie.

So finally, the interesting questions lie in values. Is that the answer?

They lie in those areas that we don't understand yet that are so murky and so confusing and so emotionally laden and so riddled with controversy that if you want to get research funding, you probably should stay away from there. But if you want to really figure out how the mind works or how society works, that's the place to go.

Dr. Herman, thank you very much for being here today, sharing your story with us and your example with future generations.

Thank you for having me.

Thank you. And thank you very much for joining us in this Conversation with History.

Post-Traumatic Stress Disorder

So you focused on trauma, especially in women and children. Help us understand what Post-Traumatic Stress Disorder is.

Okay. Well, I can tell you about what it says in the DSM-IV.

Which is the official Bible of the Psychiatric Association.

Right. The Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition. I was on the committee that helped write this definition, so I have to take some responsibility. And the committee, I have to say, brought together people who'd worked with traumatized people on many different social settings -- combat veterans, accident victims, less from the sphere of sexual and domestic violence, but we were represented to some degree, and political violence. And what the consensus came out to be was that traumatic events were those that instilled a feeling of terror and helplessness. We used to say, by the way, that these had to be events outside the realm of ordinary human experience. We had to get rid of that, because if you're living in a war zone or you're living in a country emerging from dictator or that's experienced dictatorship, these are not out-of-the-ordinary experiences, unfortunately, but experiences that instill helplessness and terror. And terror turns out to be different from fear.

Fear is something that we're all biologically wired to experience when we're in danger. We share this with other animals. When we perceive danger, we alert, we startle, we look around and figure out, do a quick appraisal of the situation, and we either fight or flee. That's being revised now by some researchers looking more at women who say that "fight or flight" is a little bit more the male response. "Tend and befriend" -- there's a tendency to kind of huddle with one's kind that you observe more in females. But, okay, fight or flight: there's a whole biology of fear that's involved.

Fight or flight doesn't work in conditions of terror and helplessness. Under those conditions, it appears that some kind of biological rewiring seems to happen in people and in animals as well. So that even after the danger is over, the person continues to respond to reminders, to both specific reminders and to generally threatening situations as though this terrifying event were still occurring in the present. So you have the activation of the fear system, hyper-arousal. You have a kind of re-experiencing of the trauma that takes the form of flashbacks, nightmares, and so forth. And then you have this other more poorly understood part of the traumatic syndrome that has to do with a shutting down of responsiveness. Numbing, a sense

that things aren't real. There may be amnesia for some, more, or all of the event. A sense in the aftermath that one is just not really oneself. One is going through the motions. There's a loss of connection of things that are or previously of interest. And these are called the numbing or withdrawal or symptoms of PTSD. So hyper-arousal, re-experiencing, numbing is the triad. It's a descriptive formulation. We understand a little bit about the psycho-biology, not a whole lot. And I think we're coming to understand more and more that that's the simple form. That is what happens to some people after a single impact trauma. If you repeat it, over and over, and especially if it begins early on and one's development is formed in this environment, it gets a lot more complicated.

This is often the case of women and children who are in domestic situations where the cycle goes on and on.

I think it's true of people in any situation of coercive control, whether you're talking about a hostage situation that goes on for a long time, whether you're talking about domestic violence or sexual child abuse ... some religious cults have this same captivity kind of situation. And then, of course, the political situations of concentration camps or political prisoners.

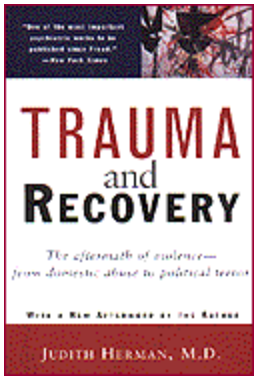
In summarizing or introducing your discussion, you say, "The dialectic of trauma gives rise to complicated, sometimes uncanny alterations of consciousness." And then you go on to compare the political doublethink in an Orwell novel with what the psychologists and the psychiatrists call disassociation. So, you're suggesting that this kind of repression, inability to confront both the individual reality and the larger reality, is something that happens to the individual and in some ways to the society.

Yes. It's fascinating. If you talk to survivors of, especially the prolonged and repeated trauma, where the perpetrator, the captor, the torturer isn't content to just have external compliance, but wants the captive to adopt and endorse his worldview, even after liberation you'll get people saying, "I'm living in a double reality. I have the present and the past co-existing in my mind. It's not clear which is more real to me. I have what's left of my old value system, and my old way of seeing the world, and the perpetrator's way of seeing the world co-existing in my mind. I can go back and forth between the two, and I'm not sure which I belong to or which belongs to me any longer." So people have the experience of living in a double reality. And they describe ... even the amnesia, people will describe simultaneously knowing and not knowing what happened. Remembering and not remembering what happened. When people get their memories back, they will often describe it as simultaneously re-living the experience and being outside of it as though it happened to somebody else. So, people learn to divide their consciousness under captivity, under conditions of coercive control. And since we don't even understand unitary consciousness very well, when people have double consciousness, double reality, I'm in awe. I think it's a fascinating window into how the mind works.

This experience that you're describing in your book; you quote extensively from the memoirs of everyone from a forced participant in pornographic films to a political prisoner. And there are common elements that run through their sense of this experience which you have just summarized.

That's not surprising, given that the methods of the torturer and the methods of the pimp or the pornographer are often similar. I think when we understand more about criminal gangs as an intermediary form of organization between, say, state-sponsored terrorism and one-family cells of domestic violence, we'll understand more about the transmission of methods of torture, methods of coercive control. But if you use the same methods on people, whether you're doing it in the name of the state, in the name of a criminal gang that's marketing your body, or whether you're doing it in the name of the authority of a father, or the name of some religious cult, the methods are the same and so the mental processes that they produce are likely to be the same.

In your work, you enter this realm of such apparent hopelessness and despair, but the other side of your work is identifying the features of hope and recovery and the road back. I want you to discuss with us the elements of survival. That is, survival and recovery, which is the other part of the title of your book [*Trauma and Recovery*]. So what are the common elements that we see in people who experience this but make it back?



First of all, I guess I should say, that that's the other reason I stick with this work: I'm constantly in awe of the resilience of the people we work with. They really do get better; they really do make new lives for themselves. They find incredibly creative ways to put the pieces of their lives back together, and a lot of times, since a lot of the work I do now is supervising students, teaching them how to be therapists, I get to observe the way the patients re-instill hope, constantly, not only in my students, but in those who are privileged to watch and observe this process. The students will come in and say, "I just met with the woman from Rwanda. She lost her whole family. She managed finally to get out to Uganda with two of her brother's kids, staying with a minister in Uganda. And she came here. They only could get papers to bring her. She's working under the table, cleaning houses or cleaning offices at night. She has no money. She's living in an apartment with ten people. She has the worst PTSD I ever saw, and she's here for a political asylum evaluation. What do I possibly have to offer this person?" In the first interview, the woman speaks in monosyllables. Her eyes are down, her head is bowed, her shoulders are like this, she's hunched over. If you drop something on the floor or a car backfires outside, she jumps out of her seat. Otherwise, she's immobile like this. You think, "This is the worst depression, this is the worst PTSD I've ever seen ... "

PTSD means Post-Traumatic ...

Post-Traumatic Stress Disorder. "What am I going to do?" So you work on documenting her case for her political asylum here. And you also work with her on trying to understand if she's safe now. What's her environment like now? What does she need now to begin to rebuild her life? And within a few months, this same person comes back into our office and she's lively. She's smiling, she's talking. She's gotten her asylum, so she's safe now. She's starting to work on bringing those kids over. She's joined a church, or she's started an English class (a lot of work we do is through interpreters). She's found, on her own, some kind of community, with our encouragement. And she will come back and say, "You listened to me. You seemed to care. You helped me out. You gave me what I needed to get what I needed. That restored my faith in people." And we feel like all we did was ... we did so little! But it was enough. There's a way in which survivors, many survivors, make do with the least little bit of human caring, human concern, to put back the pieces of their lives. And so, from my point of view, if we can provide that, it's a gift that comes back to us many times over.

So, as you just said, there are three elements. It's providing them a zone of safety. Then they remember and tell their story. And then, very importantly, they have to reconnect. I'm curious as to how you would characterize what you do beyond what you just said. Obviously, you do some interviewing. And is an important element of that interviewing to be a witness and to provide the essential elements of this safety, this support for telling the story?

I think bearing witness is important. I don't want to minimize the skill or the sophistication of the treatment that we do, because a lot of people who come to us do have complicated medical and psychiatric conditions. And they don't just necessarily have Post-Traumatic Stress Disorder. They need all of their needs attended to and they're often quite complex. I'm thinking of a woman, for example, who, it turned out ... here's an example of how complicated it becomes. This is someone who had been repeatedly raped -- it's another political asylum case -- and was having persistent vaginal bleeding, and had never had a medical exam. But because of the vaginal bleeding, was considered unclean, she couldn't have intercourse. Also couldn't enter a mosque. This was an Arab woman, a Muslim woman from Algeria. So getting her proper GYN attention, on the one hand, the medical part of it, needed to be attended to, and on the other hand, we needed to find sort of a friendly mosque. We needed to find someone in the clergy who could actually begin to reconnect her with a spiritual community. And we needed to do some family work in order to start helping her repair her relationship with her husband. And this is someone for whom the meaning of the trauma, in terms of a sense of stigma, contamination, ostracism, and so on, was not metaphorical. It was carried on in the physical symptom of bleeding. And until the bleeding was addressed, there really wasn't any hope of making new meaning out of what happened to her. So we pay a lot of attention to the meaning of specific symptoms in individual cases, and we take an approach that ranges from the biological to the social.

In your work, this emphasis on community, and broader issues such as power, recur again and again. In a specific case of your careful examination of the problem of incest, you end up, if I can summarize, and I hope I'm not being unfair, by looking at the broader society and asking the question, "Will this kind of problem ever go away in a patriarchal society?" And your answer is "No." But that leads you to propose the need for political action. What you have to then look at is the family in which the partners are equal, the male is not the dominant one. And it's only in such an environment that one can find a kind of equality where men, for example, are involved in the rearing of children. More than involved -- are equal partners. And that's how you get at the root of the problem. So, in a way, this analysis goes back to what you learned at the dinner table.

That's right.

That psychological insight cannot be separated from political insight. And action.

Absolutely.

So would you add anything to that? I hope it wasn't an unfair summary. But the individual can't deal with this alone, is what I'm trying to get at.

No, and I think that's the take-home message that I try to give whenever I teach, and whenever I do my therapeutic work. I don't think patients, survivors, victimized people can recover in isolation. They need other people and they need to take action in affiliation with others. I don't think therapists can do therapeutic work alone. When we're isolated with this, we do give in to despair. We do burn out. Or we lose our perspective. Ultimately if you're talking about horrible abuses of power, you're talking about the atrocious things that one person does to another person. And just when you think you've heard everything, and there's simply nothing else that you could imagine that one person would intentionally do to another, somebody comes along with a story that just blows you away all over again. So, you're dealing with very profound questions of human evil, human cruelty, human sadism. The abuse of power and authority. And the antidote to that is the solidarity of resistance. Nobody can do that alone.

You say at one point, "But we do know that the women who recover most successfully are those who discover some meaning in their experience that transcends the limits of personal tragedy. Most commonly women find this meaning by joining with others in social action." And this means concrete things. It means hearing other

people's stories, it means mentoring in the context of a tragedy, but also joining organizations that change the laws about what the criminal justice system says is a violation of human rights.

Right. It means going down and testifying before the legislature. Or taking part in some kind of public education campaign, or going to court, or accompanying someone else to court, or demonstrating in favor of the assertion of victim's rights, human rights.

Next page: Lessons Learned

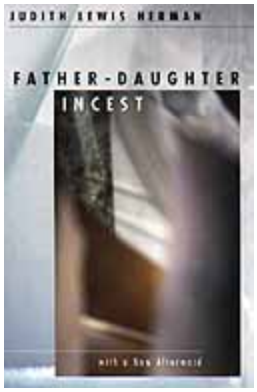
Seeing Face to Face

globetrotter.berkeley.edu/people/Herman/herman-con2.html

Judith Herman Interview: Conversations with History; Institute of International Studies, UC Berkeley

You developed an interest early on in trauma, but specifically in the problem of incest. In one of your books, you describe a paper, your first paper with Lisa Hirschman, and it really was almost an underground paper. Tell us a little about that. The ideas that you were proposing, both that there should be focus on the subject, and on its broader context was quite revolutionary, quite radical. It went to the roots of the problems.

Well, that's what we thought at the time. The reason we thought that was that we were seeing cases. Lisa had just finished her training as a psychologist. I had just finished my psychiatry residency. We were doing some peer supervision, really, and we'd seen all these incest cases. And we kept wondering, "What's going on here? Why are we seeing all these cases? Is there something about us that's attracting it? Or is this something that everybody starting out as a therapist sees? And, if so, why isn't anybody else saying anything about it?" We kept waiting for someone else to say something about it. We waited and waited and nobody did. So then we finally said, "Well, maybe we ought to." I think what gave us the courage to do that, besides our relationship with each other, was having come out of consciousness raising, feeling that we're part of a movement where it was okay to trust your own observations even if nobody else seemed to think that what you saw made any sense.



Before we talk about trauma, which became a major focus of your work, I want you to talk about something you say at the beginning of your book on trauma and recovery, and that is, you relate the history of psychological insight to the ferment of the times. In a short history you show how Freud's work and that of others on hysteria came at a political moment in French history. That the work on war veterans and trauma in war veterans came as part of an anti-war struggle during and after World War I. And then, finally, that insights on women and the traumas that they suffer came in the political climate or the aftermath of the political climate of the sixties. Tell us a little about that, because that's very important in your thinking about these issues, especially the issue of trauma.

Well, you know, psychology is a very soft science. That's putting it at its most charitable light. What one observes about human behavior, human consciousness, human relationships is so embedded ... what we observe and how we conceptualize what we observe is so embedded in the context of what we're looking for. And how we name it. This isn't physics. So that even the paying of attention, the selection of what it is that we're going to consider interesting and significant in human behavior is formed by the social and political context that we're embedded in. And I think that's particularly true about the emotions related to power and control, the emotions related to one's place in society, one's place in the family, the emotions of shame, of resentment, of pride, of a sense of legitimacy or illegitimacy. So, even to pay attention to what women say about sex, motherhood, relationships, depends so much on what one thinks a woman ought to be saying, ought to be feeling, on what is legitimate to express. Unless you have a political movement that says, "Forget what everybody else thinks you ought to be feeling, what you ought to be saying. Get down to it. Tell the truth. What did you actually think and feel and notice in your body." You need a safe space to be able to do that. You need a political context to be able to do that.

One of the intriguing points that emerges from your book is that in focusing on a new agenda -- trauma endured by children and mothers -- you realize that what you find is an insight that actually extends beyond them to victims of political torture, to war veterans, and so on. So in a way, in looking at the particular, you end up with the universal.

To me that seems so clear. I don't know why it's so hard to figure out, you know? Oppression is oppression. Being the underdog is being the underdog. Being treated with contempt is being treated with contempt. Being treated violently is being treated violently. People respond the same way to it. When you get right down to it, pain is pain.

But showing that obvious point is radical, and was radical at the time you did it, because of the boxes that are created to avoid make those connections.

Well, radical ideas are always very simple, it seems to me, for precisely that reason. They're only radical because of those obstacles. You know what I mean? Not because of their complexity.

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Recovery from psychological trauma

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Abstract

Trauma destroys the social systems of care, protection, and meaning that support human life. The recovery process requires the reconstruction of these systems. The essential features of psychological trauma are disempowerment and disconnection from others. The recovery process therefore is based upon empowerment of the survivor and restoration of relationships. The recovery process may be conceptualized in three stages: establishing safety, retelling the story of the traumatic event, and reconnecting with others. Treatment of posttraumatic disorders must be appropriate to the survivor's stage of recovery. Caregivers require a strong professional support system to manage the psychological consequences of working with survivors.

The core experiences of psychological trauma are disempowerment and disconnection from others.[1] Recovery therefore is based upon empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation. In renewed connections with other people, the survivor recreates the psychological faculties that were damaged or deformed by the traumatic experience. These include the basic capacities for trust, autonomy, initiative, competence, identity, and intimacy.[2] Just as these capabilities are originally formed, they must be re-formed in relationships with other people.

Trauma robs the victim of a sense of power and control over her own life; therefore, the guiding principle of recovery is to restore power and control to the survivor.[3] She must be the author and arbiter of her own recovery. Others may offer advice, support, assistance, affection, and care, but not cure. Many benevolent and well-intentioned attempts to assist the survivor founder because this fundamental principle of empowerment is not observed. No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest. Caregivers schooled in a medical model of treatment often have difficulty grasping this fundamental principle and putting it into practice.

With trauma survivors, the therapeutic alliance cannot be taken for granted but must be painstakingly built.[4] Psychotherapy requires a collaborative working relationship in which both partners act on the basis of their implicit confidence in the value and efficacy of persuasion rather than coercion, ideas rather force, mutual cooperation rather than authoritarian control. These are precisely the beliefs that have been shattered by the traumatic experience.[5] Trauma damages the patient's ability to enter into a trusting

relationship; it also has an indirect but very powerful impact on the therapist. As a result, both patient and therapist will have predictable difficulties coming to a working alliance. These difficulties must be understood and anticipated from the outset.

Trauma is contagious. In the role of witness to disaster or atrocity, the therapist at times is emotionally overwhelmed. She experiences, to a lesser degree, the same terror, rage, and despair as the patient. This phenomenon is known as `vicarious traumatization'.[6] The therapist may begin to experience intrusive, numbing, or hyperarousal symptoms. Hearing the patient's trauma story is also likely revive strong feelings connected with any personal traumatic experiences that the therapist may have suffered in the past.

The therapist, like the patient, may defend against overwhelming feelings by withdrawal or by impulsive, intrusive action. The most common forms of action are rescue attempts, boundary violations, or attempts to control the patient. The most common constrictive responses are doubting or denial of the patient's reality, dissociation or numbing, minimization or avoidance of the traumatic material, professional distancing, or frank abandonment of the patient.[7] The therapist should expect to lose balance from time to time. She is not infallible. The guarantee of her integrity is not her omnipotence but her capacity to trust others. Therapists who work with traumatized people require an ongoing support system. Just as no survivor can recover alone, no therapist can work with trauma alone.

Ideally, the therapist's support system should include a safe, structured, and regular forum for reviewing her clinical work. This might be a supervisory relationship or a peer support group, preferably both. The setting must offer permission to express emotional reactions as well as technical or intellectual concerns related to the treatment of patients with histories of trauma. In addition to professional support, the therapist must attend to the balance in her own professional and personal life, paying respectful attention to her own needs. Confronted with the daily reality of patients in need of care, the therapist is in constant danger of professional overcommitment. The role of professional support is not simply to focus on the tasks of treatment but also to remind the therapist of her own realistic limits and to insist that she take as good care of herself as she does of others.

The therapist who commits herself to working with survivors commits herself to an ongoing contention with herself, in which she must rely on the help of others and call upon her most mature coping abilities. Sublimation, altruism, and humor are the therapist's saving graces. In the words of one disaster relief worker, `To tell the truth, the only way me and my friends found to keep sane was to joke around and keep laughing. The grosser the joke the better'.[8] The reward of engagement is the sense of an enriched life. Therapists who work with survivors report appreciating life more fully, taking life more seriously, having a greater scope of understanding of others and themselves, forming new friendships and deeper intimate relationships, and feeling inspired by the daily examples of their patients' courage, determination, and hope.[9]

The traumatic syndromes are complex disorders, requiring complex treatment. Because trauma affects every aspect of human functioning, treatment must be comprehensive. At each stage of recovery, treatment must address the characteristic biological, psychological, and social components of the disorder. Well-designed biological treatments, for example, may be unsuccessful if the social dimensions of the patient's traumatic experience are not addressed. Conversely, even excellent social support may be ineffective if the patient's psychophysiologic disturbance remains untreated. There is no single, efficacious `magic bullet' for the traumatic syndromes.

The therapist's first task is to conduct a thorough and informed diagnostic evaluation, with full awareness of the many disguises in which a traumatic disorder may appear. With patients who have suffered a recent acute trauma, the diagnosis is usually fairly straightforward. In these situations clear, detailed information regarding posttraumatic reactions is often invaluable to the patient and her family or friends. If the patient is prepared for the symptoms, she will be far less frightened when they occur. If she and those closest to her are prepared for the disruptions in relationship that follow upon traumatic experience, they will be far more able to take them in their stride. Furthermore, if the patient is offered advice on adaptive coping strategies and warned against common mistakes, her sense of competence and efficacy will be immediately enhanced. Working with survivors of a recent acute trauma offers therapists an excellent opportunity for preventive education.

With patients who have suffered prolonged, repeated trauma, the matter of diagnosis is not nearly so straightforward. Disguised presentations are common in complex posttraumatic stress disorder (PTSD).[10] Initially the patient may complain only of physical symptoms, or of chronic insomnia or anxiety, or of intractable depression, or of problematic relationships. Explicit questioning is often required to determine whether the patient is presently living in fear of someone's violence or has lived in fear in the past. Traditionally these questions have rarely been asked. They should be a routine part of every diagnostic evaluation.

If the therapist believes the patient is suffering from a traumatic syndrome, she should share this information fully with the patient. Knowledge is power. The traumatized person is often relieved simply to learn the true name of her condition. By ascertaining her diagnosis, she begins the process of mastery. No longer imprisoned in the wordlessness of the trauma, she discovers that there is a language for her experience. She discovers that she is not alone; others have suffered in similar ways. She discovers further that she is not crazy; the traumatic syndromes are normal human responses to extreme circumstances. And she discovers, finally, that she is not doomed to suffer this condition indefinitely; she can expect to recover, as others have recovered.

Recovery unfolds in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central task of the the third stage is reconnection with ordinary life. Treatment must be appropriate to the patient's stage of recovery. A form of therapy that may be useful at one stage may be of little use or even harmful to the same patient at another stage.

The first task of recovery is to establish the survivor's safety. This task takes precedence over all others, for no other therapeutic work can possibly succeed if safety has not been adequately secured. No other therapeutic work should even be attempted until a reasonable degree of safety has been achieved. This initial stage may last days to weeks with acutely traumatized people or months to years with survivors of chronic abuse. The work of the first stage of recovery becomes increasingly complicated in proportion to the severity, duration, and early onset of abuse.

Establishing safety begins by focusing on control of the body and gradually moves outward toward control of the environment. Survivors often feel unsafe in their bodies. Their emotions and their thinking feel out of control. Issues of bodily integrity include attention to basic health needs, regulation of bodily functions such as sleep, eating, and exercise, management of posttraumatic symptoms, and abstinence from substance abuse.

Environmental issues include the establishment of a safe living situation, financial security, mobility, and a plan for self-protection that encompasses the full range of the patient's daily life. Securing a safe environment requires strategic attention to the patient's economic and social ecosystem. The patient must become aware of her own resources for practical and emotional support as well as the realistic dangers and vulnerabilities in her social situation. Many patients are unable to move forward in their recovery because of their present involvement in unsafe or oppressive relationships. In order to gain their autonomy and their peace of mind, survivors may have to make difficult and painful life choices. Battered women may lose their homes, their friends, and their livelihood. Survivors of childhood abuse may lose their families. Political refugees may lose their homes and their homeland. The social obstacles to recovery are not generally recognized, but they must be identified and adequately addressed in order for recovery to proceed.

With survivors of prolonged, repeated trauma, the initial stage of recovery may be protracted and difficult because of the degree to which the traumatized person has become a danger to herself. The sources of danger may include active self-harm, passive failures of self-protection, and pathological dependency on the abuser. Self-care is almost always severely disrupted. Self-harming behavior may take numerous forms, including chronic suicidality, self-mutilation, eating disorders, substance abuse, impulsive risk-taking, and repetitive involvement in exploitative or dangerous relationships. Many self-destructive behaviors can be understood as symbolic or literal re-enactments of the initial abuse. They serve the function of regulating intolerable feeling states, in the absence of more adaptive self-soothing strategies. The patient's capacities for self-care and self-soothing must be painstakingly reconstructed in the course of long-term individual and/or group treatment. Biologic, behavioral, cognitive, interpersonal, and social therapeutic modalities have all shown promise with some patients; each patient should be encouraged to develop a personal repertoire of coping strategies.

When safety and a secure therapeutic alliance are established, the second stage of recovery has been reached. The survivor is now ready to tell the story of the trauma, in depth and in detail. This work of reconstruction actually transforms the traumatic memory, so that it can be integrated into the survivor's life story.[11] The basic principle of empowerment continues to apply during the second stage of recovery. The choice to confront the horrors of the past rests with the survivor. The therapist plays the role of a witness and ally, in whose presence the survivor can speak of the unspeakable. Out of the fragmented components of frozen imagery and sensation, patient and therapist slowly reassemble an organized, detailed, verbal account, oriented in time and in its historical context. The narrative includes not only the event itself but also the survivor's emotional response to it and the responses of the important people in her life.

As the survivor summons her memories, the need to preserve safety must be balanced constantly against the need to face the past. The patient and therapist together must learn to negotiate a safe passage between the twin dangers of constriction and intrusion. Avoiding the traumatic memories leads to stagnation in the recovery process, while approaching them too precipitously leads to a fruitless and damaging reliving of the trauma. Decisions regarding pacing and timing need meticulous attention and frequent review by patient and therapist in concert. The patient's intrusive symptoms should be monitored carefully so that the uncovering work remains bearable.

Because the truth is so difficult to face, survivors often vacillate in reconstructing their stories. Denial of reality makes them feel crazy, but acceptance of the full reality seems beyond what any human being can bear. Both patient and therapist must develop tolerance for some degree of uncertainty, even regarding the basic facts of the story. In the course of reconstruction, the story may change as missing pieces are recovered. This is particularly true in situations where the patient has had significant gaps in memory. Thus both patient and therapist must accept the fact that they do not have complete knowledge, and they must learn to live with ambiguity while exploring at a tolerable pace.

In order to develop a full understanding of the trauma story, the survivor must examine the moral questions of guilt and responsibility and reconstruct a system of belief that makes sense of her undeserved suffering. The moral stance of the therapist is therefore of enormous importance. It is not enough for the therapist to be `neutral' or `non-judgmental'. The patient challenges the therapist to share her own struggles with these immense philosophical questions. The therapist's role is not to provide ready-made answers, which would be impossible in any case, but rather to affirm a position of moral solidarity with the survivor.[12]

The telling of the trauma story inevitably plunges the survivor into profound grief. The descent into mourning is a necessary but dreaded part of the recovery process. Patients often fear that the task is insurmountable, that once they allow themselves to start grieving, they will never stop. Survivors of prolonged childhood trauma face the task of grieving not only for what was lost but also for what was never theirs to lose. The childhood that was stolen from

them is irreplaceable. They must mourn the loss of the foundation of basic trust, the belief in a good parent. As they come to recognize that they were not responsible for their fate, they confront the existential despair that they could not face in childhood.[13]

Grieving has an additional meaning for survivors who have themselves harmed or abandoned others. The combat veteran who has committed atrocities may feel he no longer belongs in a civilized community. The political prisoner who has betrayed others under duress or the battered woman who has failed to protect her children may feel she has committed a worse crime than the perpetrator. Although the survivor may come to understand that these violations of relationship were committed under extreme circumstances, this understanding by itself does not fully resolve her profound feelings of guilt and shame. The survivor needs to mourn for the loss of her moral integrity and to find her own way to atone for what cannot be undone. This restitution in no way exonerates the perpetrator of his crimes; rather, it reaffirms the survivor's claim to moral choice in the present.[14]

The confrontation with despair brings with it, at least transiently, an increased risk of suicide. In contrast to the impulsive self-destructiveness of the first stage of recovery, the patient's suicidality during this second stage may evolve from a calm, flat, apparently rational decision to reject a world where such horrors are possible. Patients may engage in sterile philosophical discussions about their right to choose suicide. It is imperative to get beyond this intellectual defense and engage the feelings and fantasies that fuel the patient's despair. Commonly, the patient has the fantasy that she is already among the dead, because her capacity for love has been destroyed. What sustains the patient through this descent into despair is the smallest evidence of an ability to form loving connections.

The second stage of recovery has a timeless quality that is very frightening. The reconstruction of the trauma requires immersion in a past experience of frozen time; the descent into mourning feels like a surrender to endless tears. Patients often ask how long this painful process will last. There is no fixed answer to the question, only the assurance that the process cannot be bypassed or hurried. It will almost surely take longer than the patient wishes, but that it will not go on forever. After many repetitions, the moment comes when the telling of the trauma story no longer arouses quite such intense feeling. It has become a part of the survivor's experience, but only one part of it. It is a memory like other memories, and it begins to fade as other memories do. Her grief, too, begins to lose its vividness. It occurs to the survivor that perhaps the trauma is only one part, and perhaps not even the most important part, of her life story.

The reconstruction of the trauma is never entirely completed; new conflicts and challenges at each new stage of the lifecycle will inevitably reawaken the trauma and bring some new aspect of the experience to light. The major work of the second stage is accomplished, however, when the patient reclaims her own history and feels renewed hope and energy for engagement with life. Time starts to move again. When the second stage has come to its conclusion, the traumatic experience belongs to the past.

At this point, the survivor faces the tasks of rebuilding her life in the present and pursuing her aspirations for the future. She has mourned the old self which the trauma destroyed; now she must develop a new self. Her relationships have been tested and forever changed by the trauma; now she must develop new relationships. The old beliefs that gave meaning to her life have been challenged; now she must find anew a sustaining faith. These are the tasks of the third stage of recovery.

The issues of the first stage of recovery are often revisited at this time. Once again the survivor devotes attention to the care of her body, her immediate environment, her material needs, and her relationships with others. But while in the first stage the goal was simply to secure a defensive position of basic safety, by the third stage the survivor is ready to engage more actively in the world. She can establish an agenda. She can recover some of her aspirations from the time before the trauma, or perhaps for the first time she can discover her own ambitions.

By the third stage of recovery, the survivor has regained some capacity for appropriate trust. She can once again feel trust in others when that trust is warranted, she can withhold her trust when it is not warranted, and she knows how to distinguish between the two situations. She has also regained the ability to feel autonomous while remaining connected to others; she can maintain her own point of view and her own boundaries while respecting those of others. She has begun to take more initiative in her life and is in the process of creating a new identity. With others, she is now ready to risk deepening her relationships. With peers, she can now seek mutual friendships that are not based on performance, image, or maintenance of a false self.[15] With lovers and family, she is now ready for greater intimacy.

At this point, the survivor may be ready to devote her energy more fully to a relationship with a partner. If she has not been involved in an intimate relationship, she may begin to consider the possibility without feeling either dread or desperate need. If she has been involved with a partner during the recovery process, she often becomes much more aware of the ways in which her partner suffered from her preoccupation with the trauma. At this point she can express her gratitude more freely and make amends when necessary. The survivor may also become more open to new forms of engagement with children. If the survivor is a parent, she may come to recognize the ways in which the trauma experience has indirectly affected her children, and she may take steps to rectify the situation. If she does not have children, she may begin to take a new and broader interest in young people.

Most survivors seek the resolution of their traumatic experience within the confines of their personal lives. But a significant minority, as a result of the trauma, feel called upon to engage in a wider world. These survivors recognize a political or religious dimension in their misfortune, and discover that they can transform the meaning of their personal tragedy by making it the basis for social action. While there is no way to compensate for an atrocity, there is a way to transcend it, by making it a gift to others. The trauma is redeemed only when it becomes the source of a survivor mission.[16]

Social action offers the survivor a source of power that draws upon her own initiative, energy, and resourcefulness, but which magnifies these qualities far beyond her own capacities. It offers her an alliance with others based on cooperation and shared purpose. Participation in organized, demanding social efforts calls upon the survivor's most mature and adaptive coping strategies of patience, anticipation, altruism, and humor. It brings out the best in her; in return, the survivor gains the sense of connection with the best in other people. In this sense of reciprocal connection, the survivor can transcend the boundaries of her particular time and place.[17]

Social action can take many forms, from concrete engagement with particular individuals, to the abstract intellectual pursuits. Survivors may focus their energies on helping others who have been similarly victimized, on educational, legal, or political efforts to prevent others from being victimized in the future. Common to all these efforts is a dedication to raising public awareness. Survivors understand that the natural human response to horrible events is to put them out of mind. They also understand that those who forget the past are often condemned to repeat it. It is for this reason that public truth-telling is the common denominator of all social action.[18]

The survivor mission may also take the form of pursuing justice. In the third stage of recovery, the survivor recognizes that the trauma cannot be undone, and that personal wishes for compensation or revenge cannot be fulfillled. She also recognizes, however, that holding the perpetrator accountable for his crimes is important not only for her personal well-being but also for the health of the larger society.

The survivor who undertakes public action also needs to come to terms with the fact that not every battle will be won. Her particular battle becomes part of a larger, ongoing struggle to uphold the rule of law and the principles of non-violence against the rule of force. She must be secure in the knowledge that simply in her willingness to tell the truth in public, she has taken the action that perpetrators fear the most. Her recovery is not based on the illusion that evil has been overcome, but rather on the knowledge that it has not prevailed, and on the hope that restorative love may still be found in the world.