CHAPTER 1: A Forgotten History

THE STUDY OF PSYCHOLOGICAL TRAUMA has a curious history—one of episodic amnesia. Periods of active investigation have alternated with periods of oblivion. Repeatedly in the past century, similar lines of inquiry have been taken up and abruptly abandoned, only to be rediscovered much later. Classic documents of fifty or one hundred years ago often read like contemporary works. Though the field has in fact an abundant and rich tradition, it has been periodically forgotten and must be periodically reclaimed.

This intermittent amnesia is not the result of the ordinary changes in fashion that affect any intellectual pursuit. The study of psychological trauma does not languish for lack of interest. Rather, the subject provokes such intense controversy that it periodically becomes anathema. The study of psychological trauma has repeatedly led into realms of the unthinkable and foundered on fundamental questions of belief.

To study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature. To study psychological trauma means bearing witness to horrible events. When the events are natural disasters or "acts of God," those who bear witness sympathize readily with the victim. But when the traumatic events are of human design, those who bear witness are caught in the conflict between victim and perpetrator. It is morally impossible to remain neutral in this conflict. The bystander is forced to take sides.

It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement, and remembering. Leo Eitinger, a psychiatrist who has studied survivors of the Nazi concentration camps, describes the cruel conflict of interest between victim and bystander: "War and victims are something the community wants to forget; a veil of oblivion is drawn over everything painful and unpleasant. We find the two sides face to face; on one side the victims who perhaps wish to forget but cannot, and on the other all those with strong, often unconscious motives who very intensely both wish to forget and succeed in doing so. The contrast . . . is frequently very painful for both sides. The weakest one . . . remains the losing party in this silent and unequal dialogue."

In order to escape accountability for his crimes, the perpetrator does everything in his power to promote forgetting. Secrecy and silence are the perpetrator's first line of defense. If secrecy fails, the perpetrator attacks the credibility of his victim. If he cannot silence her absolutely, he tries to make sure that no one listens. To this end, he marshals an impressive array of arguments, from the most blatant denial to the most sophisticated and elegant rationalization. After every atrocity one can expect to hear the same predictable apologies: it never happened; the victim lies; the victim exaggerates; the victim brought it upon herself; and in any case it is time to forget the past and move on. The more powerful the perpetrator, the greater is his prerogative to name and define reality, and the more completely his arguments prevail.

The perpetrator's arguments prove irresistible when the bystander faces them in isolation. Without a supportive social environment, the bystander usually succumbs to

the temptation to look the other way. This is true even when the victim is an idealized and valued member of society. Soldiers in every war, even those who have been regarded as heroes, complain bitterly that no one wants to know the real truth about war. When the victim is already devalued (a woman, a child), she may find that the most traumatic events of her life take place outside the realm of socially validated reality. Her experience becomes unspeakable.

The study of psychological trauma must constantly contend with this tendency to discredit the victim or to render her invisible. Throughout the history of the field, dispute has raged over whether patients with posttraumatic conditions are entitled to care and respect or deserving of contempt, whether they are genuinely suffering or malingering, whether their histories are true or false and, if false, whether imagined or maliciously fabricated. In spite of a vast literature documenting the phenomena of psychological trauma, debate still centers on the basic question of whether these phenomena are credible and real.

It is not only the patients but also the investigators of post-traumatic conditions whose credibility is repeatedly challenged. Clinicians who listen too long and too carefully to traumatized patients often become suspect among their colleagues, as though contaminated by contact. Investigators who pursue the field too far beyond the bounds of conventional belief are often subjected to a kind of professional isolation.

To hold traumatic reality in consciousness requires a social context that affirms and protects the victim and that joins victim and witness in a common alliance. For the individual victim, this social context is created by relationships with friends, lovers, and family. For the larger society, the social context is created by political movements that give voice to the disempowered.

The systematic study of psychological trauma therefore depends on the support of a political movement. Indeed, whether such study can be pursued or discussed in public is itself a political question. The study of war trauma becomes legitimate only in a context that challenges the sacrifice of young men in war. The study of trauma in sexual and domestic life becomes legitimate only in a context that challenges the subordination of women and children. Advances in the field occur only when they are supported by a political movement powerful enough to legitimate an alliance between investigators and patients and to counteract the ordinary social processes of silencing and denial. In the absence of strong political movements for human rights, the active process of bearing witness inevitably gives way to the active process of forgetting. Repression, dissociation, and denial are phenomena of social as well as individual consciousness.

Three times over the past century, a particular form of psychological trauma has surfaced into public consciousness. Each time, the investigation of that trauma has flourished in affiliation with a political movement. The first to emerge was hysteria, the archetypal psychological disorder of women. Its study grew out of the republican, anticlerical political movement of the late nineteenth century in France. The second was shell shock or combat neurosis. Its study began in England and the United States after the First World War and reached a peak after the Vietnam War. Its political context was the collapse of a cult of war and the growth of an antiwar movement. The last and most recent trauma to come into public awareness is sexual and domestic violence. Its political context is the feminist movement in Western Europe and North America. Our

contemporary understanding of psychological trauma is built upon a synthesis of these three separate lines of investigation.

THE HEROIC AGE OF HYSTERIA

For two decades in the late nineteenth century, the disorder called hysteria became a major focus of serious inquiry. The term hysteria was so commonly understood at the time that no one had actually taken the trouble to define it systematically. In the words of one historian, “for twenty-five centuries, hysteria had been considered a strange disease with incoherent and incomprehensible symptoms. Most physicians believed it to be a disease proper to women and originating in the uterus.” Hence the name, hysteria. As another historian explained, hysteria was “a dramatic medical metaphor for everything that men found mysterious or unmanageable in the opposite sex.”`

The patriarch of the study of hysteria was the great French neurologist Jean-Martin Charcot. His kingdom was the Salpetriere, an ancient, expansive hospital complex which had long been an asylum for the most wretched of the Parisian proletariat: beggars, prostitutes, and the insane. Charcot transformed this neglected facility into a temple of modern science, and the most gifted and ambitious men in the new disciplines of neurology and psychiatry journeyed to Paris to study with the master. Among the many distinguished physicians who made the pilgrimage to the Salpetriere were Pierre Janet, William James, and Sigmund Freud.

The study of hysteria captured the public imagination as a great venture into the unknown. Charcot’s investigations were renowned not only in the world of medicine but also in the larger worlds of literature and politics. His Tuesday Lectures were theatrical events, attended by “a multi-colored audience, drawn from all of Paris: authors, doctors, leading actors and actresses, fashionable demimondaines, all full of morbid curiosity.” In these lectures, Charcot illustrated his findings on hysteria by live demonstrations. The patients he put on display were young women who had found refuge in the Salpetriere from lives of unremitting violence, exploitation, and rape. The asylum provided them greater safety and protection than they had ever known; for a selected group of women who became Charcot’s star performers, the asylum also offered something close to fame.

Charcot was credited for great courage in venturing to study hysteria at all; his prestige gave credibility to a field that had been considered beyond the pale of serious scientific investigation. Prior to Charcot’s time, hysterical women had been thought of as malingerers, and their treatment had been relegated to the domain of hypnotists and popular healers. On Charcot’s death, Freud eulogized him as a liberating patron of the afflicted: “No credence was given to a hysteric about anything. The first thing that Charcot’s work did was to restore its dignity to the topic. Little by little, people gave up the scornful smile with which the patient could at that time feel certain of being met. She was no longer necessarily a malingerer, for Charcot had thrown the whole weight of his authority on the side of the genuineness and objectivity of hysterical phenomena.”

Charcot’s approach to hysteria, which he called “the Great Neurosis,” was that of the taxonomist. He emphasized careful observation, description, and classification. He documented the characteristic symptoms of hysteria exhaustively, not only in writing but

also with drawings and photographs. Charcot focused on the symptoms of hysteria that resembled neurological damage: motor paralyses, sensory losses, convulsions, and amnesias. By 1880 he had demonstrated that these symptoms were psychological, since they could be artificially induced and relieved through the use of hypnosis.

Though Charcot paid minute attention to the symptoms of his hysterical patients, he had no interest whatsoever in their inner lives. He viewed their emotions as symptoms to be cataloged. He described their speech as “vocalization.” His stance regarding his patients is apparent in a verbatim account of one of his Tuesday Lectures. Where a young woman in hypnotic trance was being used to demonstrate a convulsive hysterical attack:

CHARCOT: Let us press again on the hysterogenic point. (A male intern touches the patient in the ovarian region.) Here we go again. Occasionally subjects even bite their tongues, but this would be rare. Look at the arched back, which is so well described in textbooks.

PATIENT: Mother, I am frightened.

CHARCOT: Note the emotional outburst. If we let things go unabated we will soon return to the epileptoid behavior. . . . (The patient cries again: “Oh! Mother.”)

CHARCOT: Again, note these screams. You could say it is a lot of noise over nothing.

The ambition of Charcot’s followers was to surpass his work by demonstrating the cause of hysteria. Rivalry was particularly intense between Janet and Freud. Each wanted to be the first to make the great discovery. In pursuit of their goal, these investigators found that it was not sufficient to observe and classify hysterics. It was necessary to talk with them. For a brief decade men of science listened to women with a devotion and a respect unparalleled before or since. Daily meetings with hysterical patients, often lasting for hours, were not uncommon. The case studies of this period read almost like collaborations between doctor and patient.

These investigations bore fruit. By the mid 1890s Janet in France and Freud, with his collaborator Joseph Breuer, in Vienna had arrived independently at strikingly similar formulations: hysteria was a condition caused by psychological trauma. Unbearable emotional reactions to traumatic events produced an altered state of consciousness, which in turn induced the hysterial symptoms. Janet called :his alteration in consciousness “dissociation.” Breuer and Freud called it “double consciousness.”

Both Janet and Freud recognized the essential similarity of altered states of consciousness induced by psychological trauma and those induced by hypnosis. Janet believed that the capacity for dissociation or hypnotic trance was a sign of psychological weakness and suggestibility. Breuer and Freud argued, on the contrary, that hysteria, with its associated alterations of consciousness, could be found among “people of the clearest intellect, strongest will, greatest character, and highest critical power.”

Both Janet and Freud recognized that the somatic symptoms of hysteria represented disguised representations of intensely distressing events which had been banished from memory. Janet described his hysterical patients as governed by

“subconscious fixed ideas,” the memories of traumatic events. Breuer and Freud, in an immortal summation, wrote that “hysterics suffer mainly from reminiscences.”

By the mid 1890s these investigators had also discovered that hysterical symptoms could be alleviated when the traumatic memories, as well as the intense feelings that accompanied them, were recovered and put into words. This method of treatment became the basis of modern psychotherapy. Janet called the technique “psychological analysis,” Breuer and Freud called it “abreaction” or “catharsis,” and Freud later called it “psycho-analysis.” But the simplest and perhaps best name was invented by one of Breuer’s patients, a gifted, intelligent, and severely disturbed young woman to whom he gave the pseudonym Anna O. She called her intimate dialogue with Breuer the “talking cure.”

The collaborations between doctor and patient took on the quality of a quest, in which the solution to the mystery of hysteria could be found in the painstaking reconstruction of the patient’s past. Janet, describing his work with one patient, noted that as treatment proceeded, the uncovering of recent traumas gave way to the exploration of earlier events. “By removing the superficial layer of the delusions, I favored the appearance of old and tenacious fixed ideas which dwelt still at the bottom of her mind. The latter disappeared in turn, thus bringing forth a great improvement. “ Breuer, describing his work with Anna O, spoke of “following back the thread of memory.”

It was Freud who followed the thread the furthest, and invariably this led him into an exploration of the sexual lives of women. In spite of an ancient clinical tradition that recognized the association of hysterical symptoms with female sexuality, Freud’s mentors, Charcot and Breuer, had been highly skeptical about the role of sexuality in the origins of hysteria. Freud himself was initially resistant to the idea: “When I began to analyze the second patient . . . the expectation of a sexual neurosis being the basis of hysteria was fairly remote from my mind. I had come fresh from the school of Charcot, and I regarded the linking of hysteria with the topic of sexuality as a sort of insult—just as the women patients themselves do.”

This empathic identification with his patients’ reactions is characteristic of Freud’s early writings on hysteria. His case histories reveal a man possessed of such passionate curiosity that he was willing to overcome his own defensiveness, and willing to listen. What he heard was appalling. Repeatedly his patients told him of sexual assault, abuse, and incest. Following back the thread of memory, Freud and his patients uncovered major traumatic events of childhood concealed beneath the more recent, often relatively trivial experiences that had actually triggered the onset of hysterical symptoms. By 1896 Freud believed he had found the source. In a report on eighteen case studies, entitled *The Aetiology of Hysteria*, he made a dramatic claim: “I therefore put forward the thesis that at the bottom of every case of hysteria there are *one or more occurrences of premature sexual experience,* occurrences which belong to the earliest years of child-hood, but which can be reproduced through the work of psycho-analysis in spite of the intervening decades. I believe that this is an important finding, the discovery of a *caput Nili* in neuropathology.”

A century later, this paper still rivals contemporary clinical descriptions of the effects of childhood sexual abuse. It is a brilliant, compassionate, eloquently argued,

closely reasoned document. Its triumphant title and exultant tone suggest that Freud viewed his contribution as the crowning achievement in the field.

Instead, the publication of *The Aetiology of Hysteria* marked the end of this line of inquiry. Within a year, Freud had privately repudiated the traumatic theory of the origins of hysteria. His correspondence makes clear that he was increasingly troubled by the radical social implications of his hypothesis. Hysteria was so common among women that if his patients' stories were true, and if his theory were correct, he would be forced to conclude that what he called "perverted acts against children" were endemic, not only among the proletariat of Paris, where he had first studied hysteria, but also among the respectable bourgeois families of Vienna, where he had established his practice. This idea was simply unacceptable. It was beyond credibility.

Faced with this dilemma, Freud stopped listening to his female patients. The turning point is documented in the famous case of Dora. This, the last of Freud's case studies on hysteria, reads more like a battle of wits than a cooperative venture. The interaction between Freud and Dora has been described as "emotional combat." In this case Freud still acknowledged the reality of his patient's experience: the adolescent Dora was being used as a pawn in her father's elaborate sex intrigues. Her father had essentially offered her to his friends as a sexual toy. Freud refused, however, to validate Dora's feelings of outrage and humiliation. Instead, he insisted upon exploring her feelings of erotic excitement, as if the exploitative situation were a fulfillment of her desire. In an act that Freud viewed as revenge, Dora broke off the treatment.

The breach of their alliance marked the bitter end of an era of collaboration between ambitious investigators and hysterical patients. For close to a century, these patients would again be scorned and silenced. Freud's followers held a particular grudge against the rebellious Dora, who was later described by a disciple as "one of the most repulsive hysterics he had ever met.

Out of the ruins of the traumatic theory of hysteria, Freud created psychoanalysis. The dominant psychological theory of the next century was founded in the denial of women's reality. Sexuality remained the central focus of inquiry. But the exploitative social context in which sexual relations actually occur became utterly invisible. Psychoanalysis became a study of the internal vicissitudes of fantasy and desire, dissociated from the reality of experience. By the first decade of the twentieth century, without ever offering any clinical documentation of false complaints, Freud had concluded that his hysterical patients' accounts of childhood sexual abuse were untrue: "I was at last obliged to recognize that these scenes of seduction had never taken place, and that they were only fantasies which my patients had made up."

Freud's recantation signified the end of the heroic age of hysteria. After the turn of the century the entire line of inquiry initiated by Charcot and continued by his followers fell into neglect. Hypnosis and altered states of consciousness were once more relegated to the realm of the occult. The study of psychological trauma came to a halt. After a time, the disease of hysteria itself was said to have virtually disappeared.

This dramatic reversal was not simply the work of one man. In order to understand how the study of hysteria could collapse so completely and how great

discoveries could be so quickly forgotten, it is necessary to understand something of the intellectual and political climate that gave rise to the investigation in the first place.

The central political conflict in nineteenth-century France was the struggle between the proponents of a monarchy with an established religion and the proponents of a republican, secular form of government. Seven times since the Revolution of 1789 this conflict had led to the overthrow of the government. With the establishment of the Third Republic in 1870, the founding fathers of a new and fragile democracy mobilized an aggressive campaign to consolidate their power base and to undermine the power of their main opposition, the Catholic Church.

The republican leaders of this era were self-made men of the rising bourgeoisie. They saw themselves as representatives of a tradition of enlightenment, engaged in mortal struggle with the forces of reaction: the aristocracy and the clergy. Their major political battles were fought for control of education. Their ideological battles were fought for the allegiance of men and the dominion of women. As Jules Ferry, a founding father of the Third Republic, put it: “Women must belong to science, or they will belong to the church.”

Charcot, the son of a tradesman who had risen to wealth and fame, was a prominent member of this new bourgeois elite. His salon was a meeting place for government ministers and other notables of the Third Republic. He shared with his colleagues in government a zeal for the dissemination of secular, scientific ideas. His modernization of the Salpetriere in the 1870s was carried out to demonstrate the superior virtues of secular teaching and hospital administration. And his investigations of hysteria were carried out to demonstrate the superiority of a secular over a religious conceptual framework. His Tuesday Lectures were political theater. His mission was to claim hysterical women for science.

Charcot’s formulations of hysteria offered a scientific explanation for phenomena such as demonic possession states, witchcraft, exorcism, and religious ecstasy. One of his most cherished projects was the retrospective diagnosis of hysteria as portrayed throughout the ages in works of art. With a disciple, Paul Richer, he published a collection of medieval artworks illustrating his thesis that religious experiences depicted in art could be explained as manifestations of hysteria. Charcot and his followers also entered into acrimonious debates on contemporary mystical phenomena, including cases of stigmatics, apparitions, and faith healing. Charcot was particularly concerned with the miraculous cures reportedly occurring in the newly established shrine at Lourdes. Janet was preoccupied with the American phenomenon of Christian Science. Charcot’s disciple Desire Bourneville used the newly established diagnostic criteria in an attempt to prove that a celebrated stigmatic of the time, a devout young woman named Louise Lateau, was actually a hysteric. All of these phenomena were claimed for the domain of medical pathology.

It was thus a larger, political cause that stimulated such passionate interest in hysteria and gave impetus to the investigations of Charcot and his followers in the late nineteenth century. The solution of the mystery of hysteria was intended to demonstrate the triumph of secular enlightenment over reactionary superstition, as well as the moral superiority of a secular world view. Men of science contrasted their benevolent patronage of hysterics with the worst excesses of the Inquisition. Charles Richet, a

disciple of Charcot, observed in 1880: “Among the patients locked away in the Salpetriere are many who would have been burned in former times, whose illness would have been taken for a crime.” William James echoed these sentiments a decade later: “Amongst all the many victims of medical ignorance clad in authority the poor hysteric has hitherto fared the worst; and her gradual rehabilitation and rescue will count among the philanthropic conquests of our generation.”

While these men of science saw themselves as benevolent rescuers, uplifting women from their degraded condition, they never for a moment envisioned a condition of social equality between women and men. Women were to be the objects of study and humane care, not subjects in their own right. The same men who advocated an enlightened view of hysteria often strongly opposed the admission of women into higher education or the professions and adamantly opposed female suffrage.

In the early years of the Third Republic the feminist movement was relatively weak. Until the late 1870s feminist organizations did not even have the right to hold public meetings or publish their literature. At the first International Congress for the Rights of Women, held in Paris in 1878, advocates of the right to vote were not permitted to speak, because they were considered too revolutionary. Advocates of women’s rights, recognizing that their fortunes depended upon survival of the fragile new democracy, tended to subordinate their interests in order to preserve consensus within the republican coalition.

But a generation later, the regime of the founding fathers had become securely established. Republican, secular government had survived and prospered in France. By the end of the nineteenth century, the anticlerical battle had essentially been won. In the meantime, it had become more problematic for enlightened men to pose as the champions of women, for women were now daring to speak for themselves. The militancy of feminist movements in the established democracies of England and the United States had begun to spread to the Continent, and French feminists had become much more assertive on behalf of women’s rights. Some were pointedly critical of the founding fathers and challenged the benevolent patronage of men of science. One feminist writer in 1888 derided Charcot for his “vivisection of women under the pretext of studying a disease,” as well as for his hostility toward women entering the medical profession.

By the turn of the century, the political impulse that had given birth to the heroic age of hysteria had dissipated; there was no longer any compelling reason to continue a line of investigation that had led men of science so far from where they originally intended to go. The study of hysteria had lured them into a netherworld of trance, emotionality, and sex. It had required them to listen to women far more than they had ever expected to listen, and to find out much more about women’s lives than they had ever wanted to know. Certainly they had never intended to investigate sexual trauma in the lives of women. As long as the study of hysteria was part of an ideological crusade, discoveries in the field were widely applauded and scientific investigators were esteemed for their humanity and courage. But once this political impetus had faded, these same investigators found themselves compromised by the nature of their discoveries and by their close involvement with their women patients.

The backlash began even before Charcot's death in 1893. Increasingly he found himself called upon to defend the credibility of the public demonstrations of hysteria that had enthralled Parisian society. It was widely rumored that the performances were staged by suggestible women who, knowingly or not, followed a script dictated under hypnosis by their patron. At the end of his life, he apparently regretted opening up this area of investigation.

As Charcot retreated from the world of hypnosis and hysteria, Breuer retreated from the world of women's emotional attachments. The first "talking cure" ended with Breuer's precipitate flight from Anna O. He may have broken off the relationship because his wife resented his intense involvement with the fascinating young woman. Abruptly, he discontinued a course of treatment which had involved prolonged, almost daily meetings with his patient over a period of two years. The sudden termination provoked a crisis not only for the patient, who had to be hospitalized, but apparently also for the doctor, who was appalled at the realization that his patient had become passionately attached to him. He left his final session with Anna O in a "cold sweat."

Though Breuer later collaborated with Freud in publishing this extraordinary case, he was a reluctant and doubting explorer. In particular, Breuer was troubled by the repeated findings of sexual experiences at the source of hysterical symptoms. As Freud complained to his confidant, Wilhelm Fliess: "Not long ago, Breuer made a big speech to the physician's society about me, putting himself forward as a convert to belief in sexual aetiology. When I thanked him privately for this, he spoiled my pleasure by saying, 'But all the same, I *don't* believe it.'"

Freud's investigations led the furthest of all into the unrecognized reality of women's lives. His discovery of childhood sexual exploitation at the roots of hysteria crossed the outer limits of social credibility and brought him to a position of total ostracism within his profession. The publication of *The Aetiology of Hysteria,* which he had expected to bring him glory, was met with a stony and universal silence among his elders and peers. As he wrote to Fliess shortly afterward, "I am as isolated as you could wish me to be: the word has been given out to abandon me, and a void is forming around me."

Freud's subsequent retreat from the study of psychological trauma has come to be viewed as a matter of scandal. His recantation has been vilified as an act of personal cowardice. Yet to engage in this kind of ad hominem attack seems like a curious relic of Freud's own era, in which advances in knowledge were understood as Promethean acts of solitary male genius. No matter how cogent his arguments or how valid his observations, Freud's discovery could not gain acceptance in the absence of a political and social context that would support the investigation of hysteria, wherever it might lead. Such a context had never existed in Vienna and was fast disappearing in France. Freud's rival Janet, who never abandoned his traumatic theory of hysteria and who never retreated from his hysterical patients, lived to see his works forgotten and his ideas neglected.

Over time, Freud's repudiation of the traumatic theory of hysteria did take on a peculiarly dogmatic quality. The man who had pursued the investigation the furthest and grasped its implications the most completely retreated in later life into the most rigid denial. In the process, he disavowed his female patients. Though he continued to focus

on his patients' sexual lives, he no longer acknowledged the exploitative nature of women's real experiences. With a stubborn persistence that drove him into ever greater convolutions of theory, he insisted that women imagined and longed for the abusive sexual encounters of which they complained.

Perhaps the sweeping character of Freud's recantation is understandable, given the extremity of the challenge he faced. To hold fast to his theory would have been to recognize the depths of sexual oppression of women and children. The only potential source of intellectual validation and support for this position was the nascent feminist movement, which threatened Freud's cherished patriarchal values. To ally himself with such a movement was unthinkable for a man of Freud's political beliefs and professional ambitions. Protesting too much, he dissociated himself at once from the study of psychological trauma and from women. He went on to develop a theory of human development in which the inferiority and mendacity of women are fundamental points of doctrine. In an antifeminist political climate, this theory prospered and thrived.

The only one of the early investigators who carried the exploration of hysteria to its logical conclusion was Breuer's patient Anna O. After Breuer abandoned her, she apparently remained ill for several years. And then she recovered. The mute hysteric who had invented the "talking cure" found her voice, and her sanity, in the women's liberation movement. Under a pseudonym, Paul Berthold, she translated into German the classic treatise by Mary Wollstonecraft, *A Vindication of the Rights of Women,* and authored a play, *Women's Rights.* Under her own name, Bertha Pappenheim became a prominent feminist social worker, intellectual, and organizer. In the course of a long and fruitful career she directed an orphanage for girls, founded a feminist organization for Jewish women, and traveled throughout Europe and the Middle East to campaign against the sexual exploitation of women and children. Her dedication, energy, and commitment were legendary. In the words of a colleague, "A volcano lived in this woman. . . . Her fight against the abuse of women and children was almost a physically felt pain for her." At her death, the philosopher Martin Buber commemorated her: "I not only admired her but loved her, and will love her until the day I die. There are people of spirit and there are people of passion, both less common than one might think. Rarer still are the people of spirit and passion. But rarest of all is a passionate spirit. Bertha Pappenheim was a woman with just such a spirit. Pass on her memory. Be witnesses that it still exists." In her will, she expressed the wish that those who visited her grave would leave a small stone, "as a quiet promise . . . to serve the mission of women's duties and women's joy . . . unflinchingly and courageously."

The reality of psychological trauma was forced upon public consciousness once again by the catastrophe of the First World War. In this prolonged war of attrition, over eight million men died in four years. When the slaughter was over, four European empires had been destroyed, and many of the cherished beliefs that had sustained Western civilization had been shattered.

One of the many casualties of the war's devastation was the illusion of manly honor and glory in battle. Under conditions of unremitting exposure to the horrors of trench warfare, men began to break down in shocking numbers. Confined and rendered helpless, subjected to constant threat of annihilation, and forced to witness the mutilation and death of their comrades without any hope of reprieve, many soldiers began to act like hysterical women. They screamed and wept uncontrollably. They froze and could not

move. They became mute and unresponsive. They lost their memory and their capacity to feel. The number of psychiatric casualties was so great that hospitals had to be hastily requisitioned to house them. According to one estimate, mental breakdowns represented 40 percent of British battle casualties. Military authorities attempted to suppress reports of psychiatric casualties because of their demoralizing effect on the public.

Initially, the symptoms of mental breakdown were attributed to a physical cause. The British psychologist Charles Myers, who examined some of the first cases, attributed their symptoms to the concussive effects of exploding shells and called the resulting nervous disorder "shell shock." The name stuck, even though it soon became clear that the syndrome could be found in soldiers who had not been exposed to any physical trauma. Gradually military psychiatrists were forced to acknowledge that the symptoms of shell shock were due to psychological trauma. The emotional stress of prolonged exposure to violent death was sufficient to produce a neurotic syndrome resembling hysteria in men.

When the existence of a combat neurosis could no longer be denied, medical controversy, as in the earlier debate on hysteria, centered upon the moral character of the patient. In the view of traditionalists, a normal soldier should glory in war and betray no sign of emotion. Certainly he should not succumb to terror. The soldier who developed a traumatic neurosis was at best a constitutionally inferior human being, at worst a malingerer and a coward. Medical writers of the period described these patients as "moral invalids." Some military authorities maintained that these men did not deserve to be patients at all, that they should be court-martialed or dishonorably discharged rather than given medical treatment.

The most prominent proponent of the traditionalist view was the British psychiatrist Lewis Yealland. In his 1918 treatise, *Hysterical Disorders of Warfare,* he advocated a treatment strategy based on shaming, threats, and punishment. Hysterical symptoms such as mutism, sensory loss, or motor paralysis were treated with electric shocks. Patients were excoriated for their laziness and cowardice. Those who exhibited the "hideous enemy of negativism" were threatened with court martial. In one case, Yealland reported treating a mute patient by strapping him into a chair and applying electric shocks to his throat. The treatment went on without respite for hours, until the patient finally spoke. As the shocks were applied, Yealland exhorted the patient to "remember, you must behave as the hero I expect you to be. . . . A man who has gone through so many battles should have better control of himself."

Progressive medical authorities argued, on the contrary, that combat neurosis was a bona fide psychiatric condition that could occur in soldiers of high moral character. They advocated humane treatment based upon psychoanalytic principles. The champion of this more liberal point of view was W. H. R. Rivers, a physician of wide-ranging intellect who was a professor of neurophysiology, psychology, and anthropology. His most famous patient was a young officer, Siegfried Sassoon, who had distinguished himself for conspicuous bravery in combat and for his war poetry. Sassoon gained notoriety when, while still in uniform, he publicly affiliated himself with the pacifist movement and denounced the war. The text of his *Soldier's Declaration,* written in 1917, reads like a contemporary antiwar manifesto:

I am making this statement as an act of willful defiance of military authority, because I believe that the war is being deliberately prolonged by those who have the power to end it.

I am a soldier, convinced that I am acting on behalf of soldiers. I believe that this war, upon which I entered as a war of defence and liberation, has now become a war of aggression and conquest. . . . I have seen and endured the sufferings of the troops, and I can no longer be a party to prolong these sufferings for ends which I believe to be evil and unjust.

Fearing that Sassoon would be court-martialed, one of his fellow officers, the poet Robert Graves, arranged for him to be hospitalized under Rivers's care. His antiwar statement could then be attributed to a psychological collapse. Though Sassoon had not had a complete emotional breakdown, he did have what Graves described as a "bad state of nerves."[4] He was restless, irritable, and tormented by nightmares. His impulsive risk-taking and reckless exposure to danger had earned him the nickname "Mad Jack." Today, these symptoms would undoubtedly have qualified him for a diagnosis of post-traumatic stress disorder.

Rivers's treatment of Sassoon was intended to demonstrate the superiority of humane, enlightened treatment over the more punitive traditionalist approach. The goal of treatment, as in all military medicine, was to return the patient to combat. Rivers did not question this goal. He did, however, argue for the efficacy of a form of talking cure. Rather than being shamed, Sassoon was treated with dignity and respect. Rather than being silenced, he was encouraged to write and talk freely about the terrors of war. Sassoon responded with gratitude: "He made me feel safe at once, and seemed to know all about me. . . . I would give a lot for a few gramophone records of my talks with Rivers. All that matters is my remembrance of the great and good man who gave me his friendship and guidance."

Rivers's psychotherapy of his famous patient was judged a success. Sassoon publicly disavowed his pacifist statement and returned to combat. He did so even though his political convictions were unchanged. What induced him to return was the loyalty he felt to his comrades who were still fighting, his guilt at being spared their suffering, and his despair at the ineffectiveness of his isolated protest. Rivers, by pursuing a course of humane treatment, had established two principles that would be embraced by American military psychiatrists in the next war. He had demonstrated, first, that men of unquestioned bravery could succumb to overwhelming fear and, second, that the most effective motivation to overcome that fear was something stronger than patriotism, abstract principles, or hatred of the enemy. It was the love of soldiers for one another.

Sassoon survived the war, but like many survivors with combat neurosis, he was condemned to relive it for the rest of his life. He devoted himself to writing and rewriting his war memoirs, to preserving the memory of the fallen, and to furthering the cause of pacifism. Though he recovered from his "bad case of nerves" sufficiently to have a productive life, he was haunted by the memory of those who had not been so fortunate:

Shell shock. How many a brief bombardment had its long-delayed aftereffect in the minds of these survivors, many of whom had looked at their companions and laughed while inferno did its best to destroy them. Not then was their evil hour; but now; now, in the sweating suffocation of nightmare, in paralysis of limbs, in the stammering of dislocated speech. Worst of all, in the disintegration of those qualities through which they had been so gallant and selfless and uncomplaining—this, in the finer types of men, was the unspeakable tragedy of shell-shock. . . . In the name of civilization these soldiers had been martyred, and it remained for civilization to prove that their martyrdom wasn't a dirty swindle.

Within a few years after the end of the war, medical interest in the subject of psychological trauma faded once again. Though numerous men with long-lasting psychiatric disabilities crowded the back wards of veterans' hospitals, their presence had become an embarrassment to civilian societies eager to forget.

In 1922 a young American psychiatrist, Abram Kardiner, returned to New York from a year-long pilgrimage to Vienna, where he had been analyzed by Freud. He was inspired by the dream of making a great discovery. "What could be more adventurous," he thought, "than to be a Columbus in the relatively new science of the mind." Kardiner set up a private practice of psychoanalysis, at a time when there were perhaps ten psychoanalysts in New York. He also went to work in the psychiatric clinic of the Veterans' Bureau, where he saw numerous men with combat neurosis. He was troubled by the severity of their distress and by his inability to cure them. In particular, he remembered one patient whom he treated for a year without notable success. Later, when the patient thanked him, Kardiner protested, "But I never did anything for you. I certainly didn't cure your symptoms." "But, Doc," the patient replied, "You did try. I've been around the Veterans Administration for a long time, and I know they don't even try, and they don't really care. But you did."

Kardiner subsequently acknowledged that the "ceaseless nightmare" of his own early childhood—poverty, hunger, neglect, domestic violence, and his mother's untimely death—had influenced the direction of his intellectual pursuits and allowed him to identify with the traumatized soldiers. Kardiner struggled for a long time to develop a theory of war trauma within the intellectual framework of psychoanalysis, but he eventually abandoned the task as impossible and went on to a distinguished career, first in psychoanalysis and then, like his predecessor Rivers, in anthropology. In 1939, in collaboration with the anthropologist Cora du Bois, he authored a basic anthropology text, *The Individual and His Society.*

It was only then, after writing this book, that he was able to return to the subject of war trauma, this time having in anthropology a conceptual framework that recognized the impact of social reality and enabled him to understand psychological trauma. In 1941 Kardiner published a comprehensive clinical and theoretical study, *The Traumatic Neuroses of War*, in which he complained of the episodic amnesia that had repeatedly disrupted the field:

The subject of neurotic disturbances consequent upon war has, in the past 25 years, been submitted to a good deal of capriciousness in public interest and psychiatric whims. The public does not sustain its interest, which was very great after World War I, and neither does psychiatry. Hence these conditions are not subject to continuous study

. . . but only to periodic efforts which cannot be characterized as very diligent. In part, this is due to the declining status of the veteran after a war. . . . Though not true in psychiatry generally, it is a deplorable fact that each investigator who undertakes to study these conditions considers it his sacred obligation to start from scratch and work at the problem as if no one had ever done anything with it before.

Kardiner went on to develop the clinical outlines of the traumatic syndrome as it is understood today. His theoretical formulation strongly resembled Janet's late nineteenth-century formulations of hysteria. Indeed, Kardiner recognized that war neuroses represented a form of hysteria, but he also realized that the term had once again become so pejorative that its very use discredited patients: "When the word 'hysterical' . . . is used, its social meaning is that the subject is a predatory individual, trying to get something for nothing. The victim of such a neurosis is, therefore, without sympathy in court, and . . . without sympathy from his physicians, who often take . . . 'hysterical' to mean that the individual is suffering from some persistent form of wickedness, perversity, or weakness of will."

With the advent of the Second World War came a revival of medical interest in combat neurosis. In the hopes of finding a rapid, efficacious treatment, military psychiatrists tried to remove the stigma from the stress reactions of combat. It was recognized for the first time that *any* man could break down under fire and that psychiatric casualties could be predicted in direct proportion to the severity of combat exposure. Indeed, considerable effort was devoted to determining the exact level of exposure guaranteed to produce a psychological collapse. A year after the war ended, two American psychiatrists, J. W. Appel and G. W. Beebe, concluded that 200-240 days in combat would suffice to break even the strongest soldier: "There is no such thing as 'getting used to combat.' . . . Each moment of combat imposes a strain so great that men will break down in direct relation to the intensity and duration of their exposure. Thus psychiatric casualties are as inevitable as gunshot and shrapnel wounds in warfare."

American psychiatrists focused their energy on identifying those factors that might protect against acute breakdown or lead to rapid recovery. They discovered once again what Rivers had demonstrated in his treatment of Sassoon: the power of emotional attachments among fighting men. In 1947 Kardiner revised his classic text in collaboration with Herbert Spiegel, a psychiatrist who had just returned from treating men at the front. Kardiner and Spiegel argued that the strongest protection against overwhelming terror was the degree of relatedness between the soldier, his immediate fighting unit, and their leader. Similar findings were reported by the psychiatrists Roy Grinker and John Spiegel, who noted that the situation of constant danger led soldiers to develop extreme emotional dependency upon their peer group and leaders. They observed that the strongest protection against psychological breakdown was the morale and leadership of the small fighting units.

The treatment strategies that evolved during the Second World War were designed to minimize the separation between the afflicted soldier and his comrades. Opinion favored a brief intervention as close as possible to the battle lines, with the goal of rapidly returning the soldier to his fighting unit. In their quest for a quick and effective method of treatment, military psychiatrists once again discovered the mediating role of altered states of consciousness in psychological trauma. They found that artificially induced altered states could be used to gain access to traumatic memories. Kardiner

and Spiegel used hypnosis to induce an altered state, while Grinker and Spiegel used sodium amytal, a technique they called “narcosynthesis.” As in the earlier work on hysteria, the focus of the “talking cure” for combat neurosis was on the recovery and cathartic reliving of traumatic memories, with all their attendant emotions of terror, rage, and grief.

The psychiatrists who pioneered these techniques understood that unburdening traumatic memories was not in itself sufficient to effect a lasting cure. Kardiner and Spiegel warned that although hypnosis could expedite the retrieval of traumatic memories, a simple cathartic experience by itself was useless. Hypnosis failed, they explained, where “there is not sufficient follow-through.” Grinker and Spiegel observed likewise that treatment would not succeed if the memories retrieved and discharged under the influence of sodium amytal were not integrated into consciousness. The effect of combat, they argued, “is not like the writing on a slate that can be erased, leaving the slate as it was before. Combat leaves a lasting impression on men’s minds, changing them as radically as any crucial experience through which they live.”

These wise warnings, however, were generally ignored. The new rapid treatment for psychiatric casualties was considered highly successful at the time. According to one report, 80 percent of the American fighting men who succumbed to acute stress in the Second World War were returned to some kind of duty, usually within a week. Thirty percent were returned to combat units. Little attention was paid to the fate of these men once they returned to active duty, let alone after they returned home from the war. As long as they could function on a minimal level, they were thought to have recovered. With the end of the war, the familiar process of amnesia set in once again. There was little medical or public interest in the psychological condition of returning soldiers. The lasting effects of war trauma were once again forgotten.

Systematic, large-scale investigation of the long-term psychological effects of combat was not undertaken until after the Vietnam War. This time, the motivation for study came not from the military or the medical establishment, but from the organized efforts of soldiers disaffected from war.

In 1970, while the Vietnam War was at its height, two psychiatrists, Robert Jay Lifton and Chaim Shatan, met with representatives of a new organization called Vietnam Veterans Against the War. For veterans to organize against their own war while it was still ongoing was virtually unprecedented. This small group of soldiers, many of whom had distinguished themselves for bravery, returned their medals and offered public testimony of their war crimes. Their presence contributed moral credibility to a growing antiwar movement. “They raised questions,” Lifton wrote, “about everyone’s version of the socialized warrior and the war system, and exposed their country’s counterfeit claim of a just war.”

The antiwar veterans organized what they called “rap groups.” In these intimate meetings of their peers, Vietnam veterans retold and relived the traumatic experiences of war. They invited sympathetic psychiatrists to offer them professional assistance. Shatan later explained why the men sought help outside of a traditional psychiatric setting: “A lot of them were ‘hurting,’ as they put it. But they didn’t want to go to the Veterans’ Administration for help. . . . They needed something that would take place on their own turf, where they were in charge.”

The purpose of the rap groups was twofold: to give solace to individual veterans who had suffered psychological trauma, and to raise awareness about the effects of war. The testimony that came out of these groups focused public attention on the lasting psychological injuries of combat. These veterans refused to be forgotten. Moreover, they refused to be stigmatized. They insisted upon the rightness, the dignity of their distress. In the words of a marine veteran, Michael Norman:

Family and friends wondered why we were so angry. What are you crying about? they would ask. Why are you so ill-tempered and disaffected. Our fathers and grandfathers had gone off to war, done their duty, come home and got on with it. What made our generation so different? As it turns out, nothing. No difference at all. When old soldiers from "good" wars are dragged from behind the curtain of myth and sentiment and brought into the light, they too seem to smolder with choler and alienation. . . . So we were angry. Our anger was old, atavistic. We were angry as all civilized men who have ever been sent to make murder in the name of virtue were angry.

By the mid-1970s, hundreds of informal rap groups had been organized. By the end of the decade, the political pressure from veterans' organizations resulted in a legal mandate for a psychological treatment program, called Operation Outreach, within the Veterans' Administration. Over a hundred outreach centers were organized, staffed by veterans and based upon a self-help, peer-counseling model of care. The insistent organizing of veterans also provided the impetus for systematic psychiatric research. In the years following the Vietnam War, the Veterans' Administration commissioned comprehensive studies tracing the impact of wartime experiences on the lives of returning veterans. A five-volume study on the legacies of Vietnam delineated the syndrome of post-traumatic stress disorder and demonstrated beyond any reasonable doubt its direct relationship to combat exposure.

The moral legitimacy of the antiwar movement and the national experience of defeat in a discredited war had made it possible to recognize psychological trauma as a lasting and inevitable legacy of war. In 1980, for the first time, the characteristic syndrome of psychological trauma became a "real" diagnosis. In that year the American Psychiatric Association included in its official manual of mental disorders a new category, called "post-traumatic stress disorder." The clinical features of this disorder were congruent with the traumatic neurosis that Kardiner had outlined forty years before. Thus the syndrome of psychological trauma, periodically forgotten and periodically rediscovered through the past century, finally attained formal recognition within the diagnostic canon.

The late nineteenth-century studies of hysteria foundered on the question of sexual trauma. At the time of these investigations there was no awareness that violence is a routine part of women's sexual and domestic lives. Freud glimpsed this truth and retreated in horror. For most of the twentieth century, it was the study of combat veterans that led to the development of a body of knowledge about traumatic disorders. Not until the women's liberation movement of the 1970s was it recognized that the most common post-traumatic disorders are those not of men in war but of women in civilian life.

The real conditions of women's lives were hidden in the sphere of the personal, in private life. The cherished value of privacy created a powerful barrier to consciousness and rendered women's reality practically invisible. To speak about

experiences in sexual or domestic life was to invite public humiliation, ridicule, and disbelief. Women were silenced by fear and shame, and the silence of women gave license to every form of sexual and domestic exploitation.

Women did not have a name for the tyranny of private life. It was difficult to recognize that a well-established democracy in the public sphere could coexist with conditions of primitive autocracy or advanced dictatorship in the home. Thus, it was no accident that in the first manifesto of the resurgent American feminist movement, Betty Friedan called the woman question the “problem without a name.” It was also no accident that the initial method of the movement was called “consciousness-raising.”

Consciousness-raising took place in groups that shared many characteristics of the veterans’ rap groups and of psychotherapy: they had the same intimacy, the same confidentiality, and the same imperative of truth-telling. The creation of a privileged space made it possible for

women to overcome the barriers of denial, secrecy, and shame that prevented them from naming their injuries. In the protected environment of the consulting room, women had dared to speak of rape, but the learned men of science had not believed them. In the protected environment of consciousness-raising groups, women spoke of rape and other women believed them. A poem of this era captures the exhilaration that women felt in speaking aloud and being heard:

THE COMBAT NEUROSIS OF THE SEX WAR

Today
in my small natural body
I sit and learn—
my woman’s body
like yours
target on any street
taken from me
at the age of twelve . . .
I watch a woman dare
I dare to watch a woman
we dare to raise our voices.

Though the methods of consciousness-raising were analogous to those of psychotherapy, their purpose was to effect social rather than individual change. A feminist understanding of sexual assault empowered victims to breach the barriers of privacy, to support one another, and to take collective action. Consciousness-raising was also an empirical method of inquiry. Kathie Sarachild, one of the originators of consciousness-raising, described it as a challenge to the prevailing intellectual orthodoxy: “The decision to emphasize our own feelings and experiences as women and to test all generalizations and reading we did by our own experience was actually the scientific method of research. We were in effect repeating the 17th century challenge of science to scholasticism: ‘study nature, not books,’ and put all theories to the test of living practice and action.”

The process that began with consciousness-raising led by stages to increased levels of public awareness. The first public speak out on rape was organized by the New York Radical Feminists in 1971. The first International Tribunal on Crimes Against Women was held in Brussels in 1976. Rape reform legislation was initiated in the United States by the National Organization for Women in the mid 1970s. Within a decade reforms had been enacted in all fifty states, in order to encourage the silenced victims of sexual crimes to come forward.

Beginning in the mid-1970s, the American women's movement also generated an explosion of research on the previously ignored subject of sexual assault. In 1975, in response to feminist pressure, a center for research on rape was created within the National Institute of Mental Health. For the first time the doors were opened to women as the agents rather than the objects of inquiry. In contrast to the usual research norms, most of the "principal investigators" funded by the center were women. Feminist investigators labored close to their subjects. They repudiated emotional detachment as a measure of the value of scientific investigation and frankly honored their emotional connection with their informants. As in the heroic age of hysteria, long and intimate personal interviews became once again a source of knowledge.

The results of these investigations confirmed the reality of women's experiences that Freud had dismissed as fantasies a century before. Sexual assaults against women and children were shown to be pervasive and endemic in our culture. The most sophisticated epidemiological survey was conducted in the early 1980s by Diana Russell, a sociologist and human rights activist. Over 900 women, chosen by random sampling techniques, were interviewed in depth about their experiences of domestic violence and sexual exploitation. The results were horrifying. One woman in four had been raped. One woman in three had been sexually abused in childhood.

In addition to documenting pervasive sexual violence, the feminist movement offered a new language for understanding the impact of sexual assault. Entering the public discussion of rape for the first time, women found it necessary to establish the obvious: that rape is an atrocity. Feminists redefined rape as a crime of violence rather than a sexual act. This simplistic formulation was advanced to counter the view that rape fulfilled women's deepest desires, a view then prevailing in every form of literature, from popular pornography to academic texts.

Feminists also redefined rape as a method of political control, enforcing the subordination of women through terror. The author Susan Brownmiller, whose landmark treatise on rape established the subject as a matter for public debate, called attention to rape as a means of maintaining male power: "Man's discovery that his genitalia could serve as a weapon to generate fear must rank as one of the most important discoveries of prehistoric times, along with the use of fire and the first crude stone axe. From prehistoric times to the present, I believe, rape has played a critical function. It is nothing more or less than a conscious process of intimidation by which all men keep all women in a state of fear."

The women's movement not only raised public awareness of rape but also initiated a new social response to victims. The first rape crisis center opened its doors in 1971. A decade later, hundreds of such centers had sprung up throughout the United States. Organized outside the framework of medicine or the mental health system, these

grass-roots agencies offered practical, legal, and emotional support to rape victims. Rape crisis center volunteers often accompanied victims to the hospital, to the police station, and to the courthouse, in order to advocate for the dignified and respectful care that was so conspicuously lacking. Though their efforts were often met with hostility and resistance, they were also at times a source of inspiration for professional women working within those institutions.

In 1972, Ann Burgess, a psychiatric nurse, and Lynda Holmstrom, a sociologist, embarked on a study of the psychological effects of rape. They arranged to be on call day or night in order to interview and counsel any rape victim who came to the emergency room of Boston City Hospital. In a year they saw 92 women and 37 children. They observed a pattern of psychological reactions which they called “rape trauma syndrome.” They noted that women experienced rape as a life-threatening event, having generally feared mutilation and death during the assault. They remarked that in the aftermath of rape, victims complained of insomnia, nausea, startle responses, and nightmares, as well as dissociative or numbing symptoms. And they commented that some of the victims’ symptoms resembled those previously described in combat veterans.

Rape was the feminist movement’s initial paradigm for violence against women in the sphere of personal life. As understanding deepened, the investigation of sexual exploitation progressed to encompass relationships of increasing complexity, in which violence and intimacy commingled. The initial focus on street rape, committed by strangers, led step by step to the exploration of acquaintance rape, date rape, and rape in marriage. The initial focus on rape as a form of violence against women led to the exploration of domestic battery and other forms of private coercion. And the initial focus on the rape of adults led inevitably to a rediscovery of the sexual abuse of children.

As in the case of rape, the initial work on domestic violence and the sexual abuse of children grew out of the feminist movement. Services for victims were organized outside of the traditional mental health system, often with the assistance of professional women inspired by the movement. The pioneering research on the psychological effects of victimization was carried out by women who saw themselves as active and committed participants in the movement. As in the case of rape, the psychological investigations of domestic violence and child sexual abuse led to a rediscovery of the syndrome of psychological trauma. The psychologist Lenore Walker, describing women who had fled to a shelter, initially defined what she called the “battered woman syndrome.” My own initial descriptions of the psychology of incest survivors essentially recapitulated the late nineteenth-century observations of hysteria.

Only after 1980, when the efforts of combat veterans had legitimated the concept of post-traumatic stress disorder, did it become clear that the psychological syndrome seen in survivors of rape, domestic battery, and incest was essentially the same as the syndrome seen in survivors of war. The implications of this insight are as horrifying in the present as they were a century ago: the subordinate condition of women is maintained and enforced by the hidden violence of men. There is war between the sexes. Rape victims, battered women, and sexually abused children are its casualties. Hysteria is the combat neurosis of the sex war.

Fifty years ago, Virginia Woolf wrote that “the public and private worlds are inseparably connected . . . the tyrannies and servilities of one are the tyrannies and servilities of the other.” It is now apparent also that the traumas of one are the traumas of the other. The hysteria of women and the combat neurosis of men are one. Recognizing the commonality of affliction may even make it possible at times to transcend the immense gulf that separates the public sphere of war and politics—the world of men—-and the private sphere of domestic life—the world of women.

Will these insights be lost once again? At the moment, the study of psychological trauma seems to be firmly established as a legitimate field of inquiry. With the creative energy that accompanies the return of repressed ideas, the field has expanded dramatically. Twenty years ago, the literature consisted of a few out-of-print volumes moldering in neglected corners of the library. Now each month brings forth the publication of new books, new research findings, new discussions in the public media.

But history teaches us that this knowledge could also disappear. Without the context of a political movement, it has never been possible to advance the study of psychological trauma. The fate of this field of knowledge depends upon the fate of the same political movement that has inspired and sustained it over the last century. In the late nineteenth century the goal of that movement was the establishment of secular democracy. In the early twentieth century its goal was the abolition of war. In the late twentieth century its goal was the liberation of women. All of these goals remain. All are, in the end, inseparably connected.

CHAPTER 4: Captivity

A SINGLE TRAUMATIC EVENT can occur almost anywhere. Prolonged, repeated trauma, by contrast, occurs only in circumstances of captivity. When the victim is free to escape, she will not be abused a second time; repeated trauma occurs only when the victim is a prisoner, unable to flee, and under the control of the perpetrator. Such conditions obviously exist in prisons, concentration camps, and slave labor camps. These conditions may also exist in religious cults, in brothels and other institutions of organized sexual exploitation, and in families.

Political captivity is generally recognized, whereas the domestic captivity of women and children is often unseen. A man's home is his castle; rarely is it understood that the same home may be a prison for women and children. In domestic captivity, physical barriers to escape are rare. In most homes, even the most oppressive, there are no bars on the windows, no barbed wire fences. Women and children are not ordinarily chained, though even this occurs more often than one might think. The barriers to escape are generally invisible. They are nonetheless extremely powerful. Children are rendered captive by their condition of dependency. Women are rendered captive by economic, social, psychological, and legal subordination, as well as by physical force.

Captivity, which brings the victim into prolonged contact with the perpetrator, creates a special type of relationship, one of coercive control. This is equally true whether the victim is taken captive entirely by force, as in the case of prisoners and hostages, or by a combination of force, intimidation, and enticement, as in the case of religious cult members, battered women, and abused children. The psychological impact of subordination to coercive control may have many common features, whether that subordination occurs within the public sphere of politics or within the private sphere of sexual and domestic relations.

In situations of captivity, the perpetrator becomes the most powerful person in the life of the victim, and the psychology of the victim is shaped by the actions and beliefs of the perpetrator. Little is known about the mind of the perpetrator. Since he is contemptuous of those who seek to understand him, he does not volunteer to be studied. Since he does not perceive that anything is wrong with him, he does not seek help—unless he is in trouble with the law. His most consistent feature, in both the testimony of victims and the observations of psychologists, is his apparent normality. Ordinary concepts of psychopathology fail to define or comprehend him.

This idea is deeply disturbing to most people. How much more comforting it would be if the perpetrator were easily recognizable, obviously deviant or disturbed. But he is not. The legal scholar Hannah Arendt created a scandal when she reported that Adolf Eichmann, a man who committed unfathomable crimes against humanity, had been certified by half a dozen psychiatrists as normal: "The trouble with Eichmann was precisely that so many were like him, and that the many were neither perverted nor sadistic, that they were, and still are, terribly and terrifyingly normal. From the viewpoint of our legal institutions and of our moral standards of judgment, this normality was much more terrifying than all the atrocities put together."

Authoritarian, secretive, sometimes grandiose, and even paranoid, the perpetrator is nevertheless exquisitely sensitive to the realities of power and to social

norms. Only rarely does he get into difficulties with the law; rather, he seeks out situations where his tyrannical behavior will be tolerated, condoned, or admired. His demeanor provides an excellent camouflage, for few people believe that extraordinary crimes can be committed by men of such conventional appearance.

The perpetrator's first goal appears to be the enslavement of his victim, and he accomplishes this goal by exercising despotic control over every aspect of the victim's life. But simple compliance rarely satisfies him; he appears to have a psychological need to justify his crimes, and for this he needs the victim's affirmation. Thus he relentlessly demands from his victim professions of respect, gratitude, or even love. His ultimate goal appears to be the creation of a willing victim. Hostages, political prisoners, battered women, and slaves have all remarked upon the captor's curious psychological dependence upon his victim. George Orwell gives voice to the totalitarian mind in the novel *1984*: "We are not content with negative obedience, nor even with the most abject submission. When finally you surrender to us, it must be of your own free will. We do not destroy the heretic because he resists us; so long as he resists us we never destroy him. We convert him, we capture his inner mind, we reshape him. We burn all evil and all illusion out of him; we bring him over to our side, not in appearance, but genuinely, heart and soul."

The desire for total control over another person is the common denominator of all forms of tyranny. Totalitarian governments demand confession and political conversion of their victims. Slaveholders demand gratitude of their slaves. Religious cults demand ritualized sacrifices as a sign of submission to the divine will of the leader. Perpetrators of domestic battery demand that their victims prove complete obedience and loyalty by sacrificing all other relationships. Sex offenders demand that their victims find sexual fulfillment in submission. Total control over another person is the power dynamic at the heart of pornography. The erotic appeal of this fantasy to millions of terrifyingly normal men fosters an immense industry in which women and children are abused, not in fantasy but in reality.

PSYCHOLOGICAL DOMINATION

The methods that enable one human being to enslave another are remarkably consistent. The accounts of hostages, political prisoners, and survivors of concentration camps from every corner of the globe have an uncanny sameness. Drawing upon the testimony of political prisoners from widely differing cultures, Amnesty International in 1973 published a "chart of coercion," describing these methods in detail. In tyrannical political systems, it is sometimes possible to trace the actual transmission of coercive methods from one clandestine police force or terrorist group to another.

These same techniques are used to subjugate women, in prostitution, in pornography, and in the home. In organized criminal activities, pimps and pornographers sometimes instruct one another in the use of coercive methods. The systematic use of coercive techniques to break women into prostitution is known as "seasoning." Even in domestic situations, where the batterer is not part of any larger organization and has had no formal instruction in these techniques, he seems time and again to reinvent them. The psychologist Lenore Walker, in her study of battered women, observed that the abusers' coercive techniques, "although unique for each individual, were still remarkably similar."

The methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma. They are the organized techniques of disempowerment and disconnection. Methods of psychological control are designed to instill terror and helplessness and to destroy the victim's sense of self in relation to others.

Although violence is a universal method of terror, the perpetrator may use violence infrequently, as a last resort. It is not necessary to use violence often to keep the victim in a constant state of fear. The threat of death or serious harm is much more frequent than the actual resort to violence. Threats against others are often as effective as direct threats against the victim. Battered women, for example, frequently report that their abuser has threatened to kill their children, their parents, or any friends who harbor them, should they attempt to escape.

Fear is also increased by inconsistent and unpredictable outbursts of violence and by capricious enforcement of petty rules. The ultimate effect of these techniques is to convince the victim that the perpetrator is omnipotent, that resistance is futile, and that her life depends upon winning his indulgence through absolute compliance. The goal of the perpetrator is to instill in his victim not only fear of death but also gratitude for being allowed to live. Survivors of domestic or political captivity often describe occasions in which they were convinced that they would be killed, only to be spared at the last moment. After several cycles of reprieve from certain death, the victim may come to view the perpetrator, paradoxically, as her savior.

In addition to inducing fear, the perpetrator seeks to destroy the victim's sense of autonomy. This is achieved by scrutiny and control of the victim's body and bodily functions. The perpetrator supervises what the victim eats, when she sleeps, when she goes to the toilet, what she wears. When the victim is deprived of food, sleep, or exercise, this control results in physical debilitation. But even when the victim's basic physical needs are adequately met, this assault on bodily autonomy shames and demoralizes her. Irina Ratushinskaya, a political prisoner, describes the methods of her captors:

All those norms of human behavior which are inculcated in one from the cradle are subjected to deliberate and systematic destruction. It's normal to want to be clean? . . . Contract scabies and skin fungus, live in filth, breathe the stench of the slop bucket—then you'll regret your misdemeanors! Women are prone to modesty? All the more reason to strip them naked during searches. . . . A normal person is repelled by coarseness and lies? You will encounter such an amount of both that you will have to strain all your inner resources to remember that there is . . . another reality. . . . Only by a maximum exertion of will is it possible to retain one's former, normal scale of values.

In religious cults, members may be subjected to strict regulation of their diet and dress and may be subjected to exhaustive questioning regarding their deviations from these rules. Similarly, sexual and domestic prisoners frequently describe long periods of sleep deprivation during sessions of jealous interrogation as well as meticulous supervision of their clothing, appearance, weight, and diet. And almost always with female prisoners, whether in political or in domestic life, control of the body includes sexual threats and violations. A battered woman describes her experience of marital rape: "It was a very brutal marriage. He was so patriarchal. He felt he owned me and the

children—that I was his property. In the first three weeks of our marriage, he told me to regard him as God and his word as gospel. If I didn't want sex and he did, my wishes didn't matter. One time . . . I didn't want it so we really fought. He was furiously angry that I would deny him. I was protesting and pleading and he was angry because he said I was his wife and had no right to refuse him. We were in bed and he was able to force himself physically on me. He's bigger than I am and he just held me down and raped me."

Once the perpetrator has succeeded in establishing day-to-day bodily control of the victim, he becomes a source not only of fear and humiliation but also of solace. The hope of a meal, a bath, a kind word, or some other ordinary creature comfort can become compelling to a person long enough deprived. The perpetrator may further debilitate the victim by offering addictive drugs or alcohol. The capricious granting of small indulgences undermines the psychological resistance of the victim far more effectively than unremitting deprivation and fear. Patricia Hearst, held hostage by a terrorist cell, describes how her compliance was rewarded by small improvements in the conditions of her imprisonment: "By agreeing with them, I was taken out of the closet more and more often. They allowed me to eat with them at times and occasionally I sat blindfolded with them late into the night as they held one of their discussion meetings or study groups. They allowed me to remove my blindfold when I was locked in the closet for the night and that was a blessing."

Political prisoners who are aware of the methods of coercive control devote particular attention to maintaining their sense of autonomy. One form of resistance is refusing to comply with petty demands or to accept rewards. The hunger strike is the ultimate expression of this resistance. Because the prisoner voluntarily subjects himself to greater deprivation than that willed by his captor, he affirms his sense of integrity and self-control. The psychologist Joel Dimsdale describes a woman prisoner in the Nazi concentration camps who fasted on Yom Kippur in order to prove that her captors had not defeated her. Political prisoner Natan Sharansky describes the psychological effect of active resistance: "As soon as I announced my hunger strike I got rid of the feeling of despair and helplessness, and the humiliation at being forced to tolerate the KGB's tyranny. . . . The bitterness and angry determination that had been building up during the past nine months now gave way to a kind of strange relief; at long last I was actively defending myself and my world from *them."*

The use of intermittent rewards to bind the victim to the perpetrator reaches its most elaborate form in domestic battery. Since no physical barrier prevents escape, the victim may attempt to flee after an outburst of violence. She is often persuaded to return, not by further threats but by apologies, expressions of love, promises of reform, and appeals to loyalty and compassion. For a moment, the balance of power in the relationship appears to be reversed, as the batterer does everything in his power to win over his victim. The intensity of his possessive attention is unchanged, but its quality is dramatically transformed. He insists that his domineering behavior simply proves his desperate need and love for her. He may himself believe this. Further, he pleads that his fate is in her hands, and that she has the power to end the violence by offering ever greater proofs of her love for him. Walker observes that the "reconciliation" phase is a crucial step in breaking down the psychological resistance of the battered woman." A woman who eventually escaped a battering relationship describes how these intermittent rewards bound her to her abuser: "It was really cyclical actually . . . and the odd thing

was that in the good periods I could hardly remember the bad times. It was almost as if I was leading two different lives."

Additional methods, however, are usually needed to achieve complete domination. As long as the victim maintains any other human connection, the perpetrator's power is limited. It is for this reason that perpetrators universally seek to isolate their victims from any other source of information, material aid, or emotional support. The stories of political prisoners are filled with accounts of their captors' attempts to prevent communication with the outside world and to convince them that their closest allies have forgotten or betrayed them. And the record of domestic violence is filled with accounts of jealous surveillance, such as stalking, eavesdropping, and intercepting letters or telephone calls, which results in solitary confinement of the battered woman within her home. Along with relentless accusations of infidelity, the batterer demands that his victim prove her loyalty to him by giving up her work and, with it, an independent source of income, her friendships, and even her ties to her family.

The destruction of attachments requires not only the isolation of the victim from others but also the destruction of her internal images of connection to others. For this reason, the perpetrator often goes to great lengths to deprive his victim of any objects of symbolic importance. A battered woman describes how her boyfriend demanded a ritual sacrifice of tokens of attachment: "He didn't hit me, but he got very angry. I thought it was because he was fond of me and he was jealous, but I didn't realize until afterwards that it was nothing to do with fondness. It was quite different. He asked me a lot of questions about who I had been out with before I knew him and he made me bring from the house a whole file of letters and photographs and he stood over me as I stood over an open drain in the road and I had to put them in one by one—tear them up and put them in."

At the beginning of the relationship, this woman was able to persuade herself that she was making only a small symbolic concession. The accounts of battered women are filled with such sacrifices, reluctantly made, which slowly and imperceptibly destroy their ties to others. Many women in hindsight describe themselves as walking into a trap. The coerced prostitute and pornographic film star Linda Lovelace describes how she was gradually ensnared by a pimp, who first persuaded her to break her ties to her parents: "I went along with him. As I say these words, I realize that I went along with too much in those days. . . . No one was twisting my arm, not yet. Everything was mild and gradual, one small step and then another. . . . It started in such small ways that I didn't see the pattern until much later."

Prisoners of conscience, who have a highly developed awareness of the strategies of control and resistance, generally understand that isolation is the danger to be avoided at all costs, and that there is no such thing as a small concession when the issue is preserving their connections with the outside world. As tenaciously as their captors seek to destroy their relationships, these prisoners tenaciously seek to maintain communication with a world outside the one in which they are confined. They deliberately practice evoking mental images of the people they love, in order to preserve their sense of connection. They also fight to preserve physical tokens of fidelity. They may risk their lives for the sake of a wedding ring, a letter, a photograph, or some other small memento of attachment. Such risks, which may appear heroic or foolish to outsiders, are undertaken for supremely pragmatic reasons. Under conditions of

prolonged isolation, prisoners need “transitional objects” to preserve their sense of connection to others. They understand that to lose these symbols of attachment is to lose themselves.

As the victim is isolated, she becomes increasingly dependent on the perpetrator, not only for survival and basic bodily needs but also for information and even for emotional sustenance. The more frightened she is, the more she is tempted to cling to the one relationship that is permitted: the relationship with the perpetrator. In the absence of any other human connection, she will try to find the humanity in her captor. Inevitably, in the absence of any other point of view, the victim will come to see the world through the eyes of the perpetrator. Hearst describes entering into a dialogue with her captors, thinking she could outwit them, but before long she was the one outwitted:

In time, although I was hardly aware of it, they turned me around completely, or almost completely. As a prisoner of war, kept blindfolded in that closet for two long months, I had been bombarded incessantly with the SLA’s interpretation of life, politics, economics, social conditions, and current events. Upon my release from the closet, I had thought I was humoring them by parroting their clichés and buzz words without personally believing in them. Then . . . a sort of numbed shock set in. To maintain my own sanity and equilibrium while functioning day by day in this new environment, I had learned to act by rote, like a good soldier, doing as I was told and suspending disbelief. . . . Reality for them was different from all that I had known before, and their reality by this time had become my reality.

Prisoners of conscience are well aware of the danger of ordinary human engagement with their captors. Of all prisoners, this group is the most prepared to withstand the corrosive psychological effects of captivity. They have chosen a course in life with full knowledge of its dangers, they have a clear definition of their own principles, and they have strong faith in their allies. Nevertheless, even this highly conscious and motivated group of people realize that they are at risk of developing emotional dependence upon their captors. They protect themselves only by uncompromising refusal to enter into even the most superficial social relationship with their adversaries. Sharansky describes how he felt drawn to his captors: “I was becoming aware of all the human areas that the KGB men and I had in common. While this was natural enough, it was also dangerous, for the growing sense of our common humanity could easily become the first step in my surrender. If my interrogators were my only link to the outside world, I would come to depend on them and to look for areas of agreement.”

Whereas prisoners of conscience need to summon all their resources to avoid developing emotional dependence upon their captors, people who lack this remarkable degree of preparation, political awareness, and moral support usually develop some degree of dependence. Attachment between hostage and captor is the rule rather than the exception. Prolonged confinement while in fear of death and in isolation from the outside world reliably produces a bond of identification between captor and victim. Hostages, after their release, have been known to defend their captors’ cause, to visit them in prison, and to raise money for their defense.

The emotional bond that develops between a battered woman and her abuser, though comparable to that of a hostage and captor, has some unique aspects based on the special attachment between victim and perpetrator in domestic abuse. A hostage is

taken prisoner by surprise. She initially knows nothing about the captor, or she regards him as an enemy. Under duress, the hostage gradually loses her previous belief system; she eventually comes to empathize with the captor and to see the world from the captor's point of view. In domestic battering, by contrast, the victim is taken prisoner gradually, by courtship. An analogous situation is found in the recruitment technique of "love-bombing," practiced by some religious cults.

The woman who becomes emotionally involved with a batterer initially interprets his possessive attention as a sign of passionate love. She may at first feel flattered and comforted by his intense interest in every aspect of her life. As he becomes more domineering, she may minimize or excuse his behavior, not only because she fears him but also because she cares for him. In order to resist developing the emotional dependence of a hostage, she will have to come to a new and independent view of her situation, in active contradiction to the belief system of her abuser. Not only will she have to avoid developing empathy for her abuser, but she will also have to suppress the affection she already feels. She will have to do this in spite of the barterer's persuasive arguments that just one more sacrifice, one more proof of her love, will end the violence and save the relationship. Since most women derive pride and self-esteem from their capacity to sustain relationships, the batterer is often able to entrap his victim by appealing to her most cherished values. It is not surprising, therefore, that battered women are often persuaded to return after trying to flee from their abusers.

TOTAL SURRENDER

Terror, intermittent reward, isolation, and enforced dependency may succeed in creating a submissive and compliant prisoner. But the final step in the psychological control of the victim is not completed until she has been forced to violate her own moral principles and to betray her basic human attachments. Psychologically, this is the most destructive of all coercive techniques, for the victim who has succumbed loathes herself. It is at this point, when the victim under duress participates in the sacrifice of others, that she is truly "broken."

In domestic battery, the violation of principles often involves sexual humiliation. Many battered women describe being coerced into sexual practices that they find immoral or disgusting; others describe being pressured to lie, to cover up for their mate's dishonesty, or even to participate in illegal activities. The violation of relationship often involves the sacrifice of children. Men who batter their wives are also likely to abuse their children. Although many women who do not dare to defend themselves will defend their children, others are so thoroughly cowed that they fail to intervene even when they see their children mistreated. Some not only suppress their own inner doubts and objections but cajole their children into compliance or punish them for protesting. Once again, this pattern of betrayal may begin with apparently small concessions but eventually progresses to the point where even the most outrageous physical or sexual abuse of the children is borne in silence. At this point, the demoralization of the battered woman is complete.

Survivors of political imprisonment and torture similarly describe being forced to stand by helplessly while witnessing atrocities committed against people they love. In his tale of survival in the Nazi extermination camps at Auschwitz-Birkenau, Elie Wiesel chronicles the devotion and loyalty that sustained him and his father through

unspeakable ordeals. He describes numerous times when both braved danger in order to stay together, and many moments of sharing and tenderness. Nevertheless, he is haunted by the imagery of the few moments when he was faithless to his father: “[The guard] began to beat him with an iron bar. At first my father crouched under the blows, then he broke in two, like a dry tree struck by lightning, and collapsed. I had watched the whole scene without moving. I kept quiet. In fact I was thinking of how to get farther away so that I would not be hit myself. What is more, any anger I felt at that moment was directed, not at the [guard], but against my father. I was angry with him, for not knowing how to avoid Idek’s outbreak. That is what concentration camp life had made of me.”

Realistically, one might argue that it would have been fruitless for the son to come to his father’s aid, that in fact an active show of support for his father might have increased the danger to both. But this argument offers little comfort to the victim who feels completely humiliated by his helplessness. Even the feeling of outrage no longer preserves his dignity, for it has been bent to the will of his enemies and turned against the person he loves. The sense of shame and defeat comes not merely from his failure to intercede but also from the realization that his captors have usurped his inner life.

Prisoners, even those who have successfully resisted, understand that under extreme duress anyone can be “broken.” They generally distinguish two stages in this process. The first is reached when the victim relinquishes her inner autonomy, world view, moral principles, or connection with others for the sake of survival. There is a shutting down of feelings, thoughts, initiative, and judgment. The psychiatrist Henry Krystal, who works with survivors of the Nazi Holocaust, describes this state as “robotization.” Prisoners who have lived through this psychological state often describe themselves as having been reduced to a nonhuman life form. Here is the testimony of Lovelace on reaching this state of degradation while being forced into prostitution and pornography: “At first I was certain that God would help me escape, but in time my faith was shaken. I became more and more frightened, scared of everything. The very thought of trying to escape was terrifying. I had been degraded every possible way, stripped of all dignity, reduced to an animal and then to a vegetable. Whatever strength I had began to disappear. Simple survival took everything: making it all the way to tomorrow was a victory.” And here is the description of a similarly debased experience by Jacobo Timerman, publisher and man of letters, who was imprisoned and tortured for political dissent: “Although I cannot transmit the magnitude of that pain, I can perhaps offer some advice to those who will suffer torture in the future. . . . In the year and a half I spent under house arrest I devoted much thought to my attitude during torture sessions and solitary confinement. I realized that, instinctively, I’d developed an attitude of absolute passivity. . . . I felt I was becoming a vegetable, casting aside all logical emotions and sensations—fear, hatred, vengeance—for any emotion or sensation meant wasting useless energy.”

This state of psychological degradation is reversible. During the course of their captivity, victims frequently describe alternating between periods of submission and more active resistance. The second, irreversible stage in the breaking of a person is reached when the victim loses the will to live. This is not the same thing as becoming suicidal: people in captivity live constantly with the fantasy of suicide, and occasional suicide attempts are not inconsistent with a general determination to survive. Timerman, in fact, describes the wish for suicide in these extreme circumstances as a sign of resistance and pride. Suicide, he states, “means introducing into your daily life

something that is on a par with the violence around you. . . . It's like living on an equal footing with one's jailers." The stance of suicide is active; it preserves an inner sense of control. As in the case of the hunger strike, the captive asserts his defiance by his willingness to end his life.

Losing the will to live, by contrast, represents the final stage of the process that Timerman describes as adopting an "attitude of absolute passivity." Survivors of the Nazi extermination camps describe this uniformly fatal condition, which was given the name of "musulman." Prisoners who had reached this point of degradation no longer attempted to find food or to warm themselves, and they made no effort to avoid being beaten. They were regarded as the living dead." The survivors of extreme situations often remember a turning point, at which they felt tempted to enter this terminal state but made an active choice to fight for life. Hearst describes this moment in her captivity:

I knew that I was growing weaker and weaker from my confinement. But this time the clear sensation came over me that I was dying. There was a threshold of no return that I could sense and I felt that I was on the brink. My body was exhausted, drained of strength: I could not stand up even if I were free to walk away. . . . I was so tired, so tired; all I wanted to do was sleep. And I knew that was dangerous, fatal, like the man lost in Arctic snow who, having laid his head down for that delicious nap, never woke again. My mind, suddenly, was alive and alert to all this. I could see what was happening to me, as if I were outside myself. . . . A silent battle was waged there in the closet, and my mind won. Deliberately and clearly, I decided that I would not die, not of my own accord. I would fight with everything in my power to survive."

THE SYNDROME OF CHRONIC TRAUMA

People subjected to prolonged, repeated trauma develop an insidious, progressive form of post-traumatic stress disorder that invades and erodes the personality. While the victim of a single acute trauma may feel after the event that she is "not herself," the victim of chronic trauma may feel herself to be changed irrevocably, or she may lose the sense that she has any self at all.

The worst fear of any traumatized person is that the moment of horror will recur, and this fear is realized in victims of chronic abuse. Not surprisingly, the repetition of trauma amplifies all the hyperarousal symptoms of post-traumatic stress disorder. Chronically traumatized people are continually hypervigilant, anxious, and agitated. The psychiatrist Elaine Hilberman describes the state of constant dread experienced by battered women: "Events even remotely connected with violence—sirens, thunder, a door slamming—elicited intense fear. There was chronic apprehension of imminent doom, of something terrible always about to happen. Any symbolic or actual sign of potential danger resulted in increased activity, agitation, pacing, screaming and crying. The women remained vigilant, unable to relax or to sleep. Nightmares were universal, with undisguised themes of violence and danger."

Chronically traumatized people no longer have any baseline state of physical calm or comfort. Over time, they perceive their bodies as having turned against them. They begin to complain, not only of insomnia and agitation, but also of numerous types of somatic symptoms. Tension headaches, gastrointestinal disturbances, and abdominal, back, or pelvic pain are extremely common. Survivors may complain of tremors, choking

sensations, or rapid heartbeat. In studies of survivors of the Nazi Holocaust, psychosomatic reactions were found to be practically universal. Similar observations are reported in refugees from the concentration camps of Southeast Asia. Some survivors may conceptualize the damage of their prolonged captivity primarily in somatic terms. Or they may become so accustomed to their condition that they no longer recognize the connection between their bodily distress symptoms and the climate of terror in which these symptoms were formed.

The intrusive symptoms of post-traumatic stress disorder also persist in survivors of prolonged, repeated trauma. But unlike the intrusive symptoms after a single acute trauma, which tend to abate in weeks or months, these symptoms may persist with little change for many years after liberation from prolonged captivity. For example, studies of soldiers who had been taken prisoner in the Second World War or the Korean War found that 35-40 years after their release the majority of these men still had nightmares, persistent flashbacks, and extreme reactions to reminders of their prisoner-of-war experiences. Their symptoms were more severe than those of combat veterans of the same era who had not been captured or imprisoned. After 40 years, survivors of the Nazi concentration camps similarly reported tenacious and severe intrusive symptoms.

But the features of post-traumatic stress disorder that become most exaggerated in chronically traumatized people are avoidance or constriction. When the victim has been reduced to a goal of simple survival, psychological constriction becomes an essential form of adaptation. This narrowing applies to every aspect of life—to relationships, activities, thoughts, memories, emotions, and even sensations. And while this constriction is adaptive in captivity, it also leads to a kind of atrophy in the psychological capacities that have been suppressed and to the overdevelopment of a solitary inner life.

People in captivity become adept practitioners of the arts of altered consciousness. Through the practice of dissociation, voluntary thought suppression, minimization, and sometimes outright denial, they learn to alter an unbearable reality. Ordinary psychological language does not have a name for this complex array of mental maneuvers, at once conscious and unconscious. Perhaps the best name for it *is doublethink,* in Orwell's definition:

"Doublethink means the power of holding two contradictory beliefs in one's mind simultaneously, and accepting both of them. The [person] knows in which direction his memories must be altered; he therefore knows that he is playing tricks with reality; but by the exercise of *doublethink* he also satisfies himself that reality is not violated. The process has to be conscious, or it would not be carried out with sufficient precision, but it also has to be unconscious, or it would bring with it a feeling of falsity. . . . Even in using the word *doublethink* it is necessary to exercise doublethink."

The ability to hold contradictory beliefs simultaneously is one characteristic of trance states. The ability to alter perception is another. Prisoners frequently instruct one another in the induction of these states through chanting, prayer, and simple hypnotic techniques.

These methods are consciously applied to withstand hunger, cold, and pain. Alicia Partnoy, a "disappeared" woman in Argentina, describes her unsuccessful first

attempt to enter a trance state: “It was probably hunger that triggered my curiosity for the extrasensory world. I started by relaxing my muscles. I thought that my mind, relieved of its weight, would travel in the direction I wanted. But the experiment failed. I was expecting that my psyche, lifted to the ceiling, would be able to observe my body lying on a mattress striped with red and filth. It didn’t happen quite that way. Perhaps my mind’s eyes were blindfolded too.”

Later, after learning meditation techniques from other prisoners, she was able to limit her physical perception of pain and emotional reactions of terror and humiliation by altering her sense of reality. Illustrating the degree to which she succeeded in dissociating her experience, she narrates it in the third person:

> “Take off your clothes.”
> She stood in her underwear, her head up. She waited.
> “All clothes off I told you.”

She took off the rest of her clothes. She felt as if the guards did not exist, as if they were just repulsive worms that she could erase from her mind by thinking of pleasant things.

During prolonged confinement and isolation, some prisoners are able to develop trance capabilities ordinarily seen only in extremely hypnotizable people, including the ability to form positive and negative hallucinations and to dissociate parts of the personality. Elaine Mohamed, a South African political prisoner, describes the psychological alterations of her captivity:

> I started hallucinating in prison, presumably to try to combat loneliness. I remember someone asking me during the period of my trial, “Elaine, what are you doing?” I kept whipping up my hand behind me, and I said to him, “I’m stroking my tail.” I had conceptualized myself as a squirrel. A lot of my hallucinations were about fear. The windows in my cell were too high to look through, but I would hallucinate something coming into my cell, like a wolf, for example. . . .
>
> And I started talking to myself. My second name is Rose, and I’ve always hated the name. Sometimes I was Rose speaking to Elaine, and sometimes I was Elaine speaking to Rose. I felt that the Elaine part of me was the stronger part, while Rose was the person I despised. She was the weak one who cried and got upset and couldn’t handle detention and was going to break down. Elaine could handle it.

In addition to the use of trance states, prisoners develop the capacity voluntarily to restrict and suppress their thoughts. This practice applies especially to any thoughts of the future. Thinking of the future stirs up such intense yearning and hope that prisoners find it unbearable; they quickly learn that these emotions make them vulnerable to disappointment and that disappointment will make them desperate. They therefore consciously narrow their attention, focusing on extremely limited goals. The future is reduced to a matter of hours or days.

Alterations in time sense begin with the obliteration of the future but eventually progress to the obliteration of the past. Prisoners who are actively resisting consciously cultivate memories of their past lives in order to combat their isolation. But as coercion

becomes more extreme and resistance crumbles, prisoners lose the sense of continuity with their past. The past, like the future, becomes too painful to bear, for memory, like hope, brings back the yearning for all that has been lost. Thus, prisoners are eventually reduced to living in an endless present. Primo Levi, a survivor of the Nazi death camps, describes this timeless state: “In the month of August, 1944, we who had entered the camp five months before now counted among the old ones. . . . Our wisdom lay in ‘not trying to understand,’ not imagining the future, not tormenting ourselves as to how and when it would all be over; not asking others or ourselves any questions. . . . For living men, the units of time always have a value. For us, history had stopped.”

The rupture in continuity between present and past frequently persists even after the prisoner is released. The prisoner may give the appearance of returning to ordinary time, while psychologically remaining bound in the timelessness of the prison. In an attempt to reenter ordinary life, former prisoners may consciously suppress or avoid the memories of their captivity, bringing to bear all the powers of thought control that they have acquired. As a result, the chronic trauma of captivity cannot be integrated into the person’s ongoing life story. Studies of prisoners of war, for example, report with astonishment that the men never discussed their experiences with anyone. Often those who married after liberation never told even their wives or children that they had been prisoners. Similarly, studies of concentration camp survivors consistently remark on their refusal to speak of the past. The more the period of captivity is disavowed, however, the more this disconnected fragment of the past remains fully alive, with the immediate and present characteristics of traumatic memory.

Thus, even years after liberation, the former prisoner continues to practice doublethink and to exist simultaneously in two realities, two points in time. The experience of the present is often hazy and dulled, while the intrusive memories of the past are intense and clear. A study of concentration camp survivors found this “double consciousness at work” in a woman who had been liberated more than twenty years earlier. Watching Israeli soldiers passing outside her window, the woman reported that she knew the soldiers were leaving to fight at the frontier. Simultaneously, however, she “knew” that they were being driven to their deaths by a Nazi commander. While she did not lose touch with the reality of the present, the compelling reality was that of the past.

Along with the alteration in time sense comes a constriction in initiative and planning. Prisoners who have not been entirely “broken” do not give up the capacity for active engagement with their environment. On the contrary, they often approach the small daily tasks of survival with extraordinary ingenuity and determination. But the field of initiative is increasingly narrowed within confines dictated by the perpetrator. The prisoner no longer thinks of how to escape, but rather of how to stay alive, or how to make captivity more bearable. A concentration camp inmate schemes to obtain a pair of shoes, a spoon, or a blanket; a group of political prisoners conspire to grow a few vegetables; a prostitute maneuvers to hide some money from her pimp; a battered woman teaches her children to hide when an attack is imminent.

This narrowing in the range of initiative becomes habitual with prolonged captivity, and it must be unlearned after the prisoner is liberated. A political dissident, Mauricio Rosencof, describes the difficulties of returning to a life of freedom after many years of imprisonment:

Once we got out, we were suddenly confronted with all these problems. . . . Ridiculous problems—doorknobs, for instance. I had no reflex any longer to reach for the knobs of doors. I hadn't had to—hadn't been allowed to—for over thirteen years. I'd come to a closed door and find myself momentarily stymied—I couldn't remember what to do next. Or how to make a dark room light. How to work, pay bills, shop, visit friends, answer questions. My daughter tells me to do this or that, and one problem I can handle, two I can handle, but when the third request comes I can hear her voice but my head is lost in the clouds.

This constriction in the capacities for active engagement with the world, which is common even after a single trauma, becomes most pronounced in chronically traumatized people, who are often described as passive or helpless. Some theorists have mistakenly applied the concept of "learned helplessness" to the situation of battered women and other chronically traumatized people. Such concepts tend to portray the victim as simply defeated or apathetic, whereas in fact a much livelier and more complex inner struggle is usually taking place. In most cases the victim has not given up. But she has learned that every action will be watched, that most actions will be thwarted, and that she will pay dearly for failure. To the extent that the perpetrator has succeeded in enforcing his demand for total submission, she will perceive any exercise of her own initiative as insubordination. Before undertaking any action, she will scan the environment, expecting retaliation.

Prolonged captivity undermines or destroys the ordinary sense of a relatively safe sphere of initiative, in which there is some tolerance for trial and error. To the chronically traumatized person, any action has potentially dire consequences. There is no room for mistakes. Rosencof describes his constant expectation of punishment: "I'm in a perpetual cringe. I'm constantly stopping to let whoever is behind me pass: my body keeps expecting a blow."

The sense that the perpetrator is still present, even after liberation, signifies a major alteration in the victim's relational world. The enforced relationship during captivity, which of necessity monopolizes the victim's attention, becomes part of the victim's inner life and continues to engross her attention after release. In political prisoners, this continued relationship may take the form of a brooding preoccupation with the criminal careers of their captors or with more abstract concerns about the unchecked forces of evil in the world. Released prisoners often continue to track their captors and to fear them. In sexual, domestic, and religious cult prisoners, this continued relationship may take a more ambivalent form: the victim may continue to fear her former captor and to expect that he will eventually hunt her down, but she may also feel empty, confused, and worthless without him.

In political prisoners who have not been entirely isolated, the malignant relationship with the perpetrator may be mitigated by attachments to people who share their fate. Those prisoners who have had the good fortune to bond with others know the generosity, courage, and devotion that people can muster in extremity. The capacity to form strong attachments is not destroyed even under the most diabolical conditions: prisoner friendships flourished even in the Nazi death camps. A study of prisoner relationships in these camps found that the overwhelming majority of survivors became part of a "stable pair," a loyal buddy relationship of mutual sharing and protection,

leading to the conclusion that the pair, rather than the individual, was the “basic unit of survival.

In isolated prisoners, however, where there is no opportunity to bond with peers, pair bonding may occur between victim and perpetrator, and this relationship may come to feel like the “basic unit of survival.” This is the “traumatic bonding” that occurs in hostages, who come to view their captors as their saviors and to fear and hate their rescuers. Martin Symonds, a psychoanalyst and police officer, describes this process as an enforced regression to “psychological infantilism” which “compels victims to cling to the very person who is endangering their life.” He observes this process regularly in policemen who have been kidnapped and held hostage in the line of duty.

The same traumatic bonding may occur between a battered woman and her abuser. The repeated experience of terror and reprieve, especially within the isolated context of a love relationship, may result in a feeling of intense, almost worshipful dependence upon an all-powerful, godlike authority. The victim may live in terror of his wrath, but she may also view him as the source of strength, guidance, and life itself. The relationship may take on an extraordinary quality of specialness. Some battered women speak of entering a kind of exclusive, almost delusional world, embracing the grandiose belief system of their mates and voluntarily suppressing their own doubts as a proof of loyalty and submission. Similar experiences are regularly reported by people who have been inducted into totalitarian religious cults.

Even after the victim has escaped, it is not possible simply to reconstitute relationships of the sort that existed prior to captivity. For all relationships are now viewed through the lens of extremity. Just as there is no range of moderate engagement or risk for initiative, there is no range of moderate engagement or risk for relationship. No ordinary relationship offers the same degree of intensity as the pathological bond with the abuser.

In every encounter, basic trust is in question. To the released prisoner, there is only one story: the story of atrocity. And there are only a limited number of roles: one can be a perpetrator, a passive witness, an ally, or a rescuer. Every new or old relationship is approached with the implicit question: Which side are you on? The victim’s greatest contempt is often reserved, not for the perpetrator, but for the passive bystander. Again we hear the voice of the coerced prostitute Lovelace, dismissing those who failed to intervene: “Most people don’t know how hard I judge them because I don’t say anything. All I do is cross them off the list. Forever. These men had their chance to help me and they didn’t respond.” The same bitterness and sense of abandonment is expressed by the political prisoner Timerman: “The Holocaust will be understood not so much for the number of victims as for the magnitude of the silence. And what obsesses me most is the repetition of silence.”

Prolonged captivity disrupts all human relationships and amplifies the dialectic of trauma. The survivor oscillates between intense attachment and terrified withdrawal. She approaches all relationships as though questions of life and death are at stake. She may cling desperately to a person whom she perceives as a rescuer, flee suddenly from a person she suspects to be a perpetrator or accomplice, show great loyalty and devotion to a person she perceives as an ally, and heap wrath and scorn on a person who appears to be a complacent bystander. The roles she assigns to others may change

suddenly, as the result of small lapses or disappointments, for no internal representation of another person is any longer secure. Once again, there is no room for mistakes. Over time, as most people fail the survivor's exacting tests of trustworthiness, she tends to withdraw from relationships. The isolation of the survivor thus persists even after she is free.

Prolonged captivity also produces profound alterations in the victim's identity. All the psychological structures of the self—the image of the body, the internalized images of others, and the values and ideals that lend a person a sense of coherence and purpose—have been invaded and systematically broken down. In many totalitarian systems this dehumanizing process is carried to the extent of taking away the victim's name. Timerman calls himself a "prisoner without a name." In concentration camps the captive's name is replaced with a nonhuman designation, a number. In political or religious cults and in organized sexual exploitation, the victim is often given a new name to signify the total obliteration of her previous identity and her submission to the new order. Thus Patricia Hearst was rebaptized Tania, the revolutionary; Linda Boreman was renamed Linda Lovelace, the whore.

Even after release from captivity, the victim cannot assume her former identity. Whatever new identity she develops in freedom must include the memory of her enslaved self. Her image of her body must include a body that can be controlled and violated. Her image of herself in relation to others must include a person who can lose and be lost to others. And her moral ideals must coexist with knowledge of the capacity for evil, both within others and within herself. If, under duress, she has betrayed her own principles or has sacrificed other people, she now has to live with the image of herself as an accomplice of the perpetrator, a "broken" person. The result, for most victims, is a contaminated identity. Victims may be preoccupied with shame, self-loathing, and a sense of failure.

In the most severe cases, the victim retains the dehumanized identity of a captive who has been reduced to the level of elemental survival: the robot, animal, or vegetable. The psychiatrist William Niederland, in studies of survivors of the Nazi Holocaust, observed that alterations of personal identity were a constant feature of the "survivor syndrome." While the majority of his patients complained, "I am now a different person," the most severely harmed stated simply, "I am not a person."

These profound alterations in the self and in relationships inevitably result in the questioning of basic tenets of faith. There are people with strong and secure belief systems who can endure the ordeals of imprisonment and emerge with their faith intact or strengthened. But these are the extraordinary few. The majority of people experience the bitterness of being forsaken by God. The Holocaust survivor Wiesel gives voice to this bitterness: "Never shall I forget those flames which consumed my faith forever. Never shall I forget that nocturnal silence which deprived me, for all eternity, of the desire to live. Never shall I forget those moments which murdered my God and my soul and turned my dreams to dust. Never shall I forget those things, even if I am condemned to live as long as God Himself. Never."

These staggering psychological losses can result in a tenacious state of depression. Protracted depression is the most common finding in virtually all clinical studies of chronically traumatized people. Every aspect of the experience of prolonged

trauma works to aggravate depressive symptoms. The chronic hyperarousal and intrusive symptoms of posttraumatic stress disorder fuse with the vegetative symptoms of depression, producing what Niederland calls the “survivor triad” of insomnia, nightmares, and psychosomatic complaints. The dissociative symptoms of the disorder merge with the concentration difficulties of depression. The paralysis of initiative of chronic trauma combines with the apathy and helplessness of depression. The disruption in attachment of chronic trauma reinforces the isolation of depression. The debased self-image of chronic trauma fuels the guilty ruminations of depression. And the loss of faith suffered in chronic trauma merges with the hopelessness of depression.

The intense anger of the imprisoned person also adds to the depressive burden. During captivity, the victim cannot express her humiliated rage at the perpetrator, for to do so would jeopardize her survival. Even after release, the former prisoner may continue to fear retribution and may be slow to express rage against her captor. Moreover, she is left with a burden of unexpressed rage against all those who remained indifferent to her fate and who failed to help her. Occasional outbursts of rage may further alienate the survivor from others and prevent the restoration of relationships. In an effort to control her rage, the survivor may withdraw even further from other people, thus perpetuating her isolation.

Finally, the survivor may direct her rage and hatred against herself. Suicidality, which sometimes served as a form of resistance during imprisonment, may persist long after release, when it no longer serves any adaptive purpose. Studies of returned prisoners of war consistently document increased mortality as the result of homicide, suicide, and suspicious accidents. Studies of battered women similarly report a tenacious suicidality. In one group of a hundred battered women, 42 percent had attempted suicide.

Thus, former prisoners carry their captors’ hatred with them even after release, and sometimes they continue to carry out their captors’ destructive purposes with their own hands. Long after their liberation, people who have been subjected to coercive control bear the psychological scars of captivity. They suffer not only from a classic posttraumatic syndrome but also from profound alterations in their relations with God, with other people, and with themselves. In the words of the Holocaust survivor Levi: “We have learnt that our personality is fragile, that it is in much more danger than our life; and the old wise ones, instead of warning us, ‘remember that you must die,’ would have done much better to remind us of this greater danger that threatens us. If from inside the Lager, a message could have seeped out to free men, it would have been this: take care not to suffer in your own homes what is inflicted on us here.”