12. THE UNBEARABLE HEAVINESS OF REMEMBERING

You are being provided with a book chapter by chapter. I will request you to read the book for me after each chapter. After reading the chapter, 1. shorten the chapter to no less than 300 words and no more than 400 words. 2. Do not change the name, address, or any important nouns in the chapter. 3. Do not translate the original language. 4. Keep the same style as the original chapter, keep it consistent throughout the chapter. Your reply must comply with all four requirements, or it's invalid.
I will provide the chapter now.

S
CHAPTER 12
THE UNBEARABLE HEAVINESS OF
REMEMBERING
Our bodies are the texts that carry the memories and therefore
remembering is no less than reincarnation.
—Katie Cannon
cientific interest in trauma has fluctuated wildly during the past 150 years. Charcot's death in 1893 and Freud's shift in emphasis to inner conflicts, defenses, and instincts at the root of mental suffering were just part of mainstream medicine's overall loss of interest in the subject. Psychoanalysis rapidly gained in popularity. In 1911 the Boston psychiatrist Morton Prince, who had studied with William James and Pierre Janet, complained that those interested in the effects of trauma were like "clams swamped by the rising tide in Boston Harbor."
This neglect lasted for only a few years, though, because the outbreak of World War in 1914 once again confronted medicine and psychology with hundreds of thousands of men with bizarre psychological symptoms, unexplained medical conditions, and memory loss. The new technology of motion pictures made it possible to film these soldiers, and today on YouTube we can observe their bizarre physical postures, strange verbal utterances, terrified facial expressions, and tics—the physical, embodied expression of trauma: "a memory that is inscribed simultaneously in the mind, as interior images and words, and on the body."1
Early in the war the British created the diagnosis of "shell shock," which entitled combat veterans to treatment and a disability pension. The alternative, similar, diagnosis was "neurasthenia," for which they received neither treatment nor a pension. It was up to the orientation of the treating physician which diagnosis a soldier received.2
More than a million British soldiers served on the Western Front at any one time. In the first few hours of July 1, 1916 alone, in the Battle of the Somme, the British army suffered 57,470 casualties, including 19,240 dead, the bloodiest day in its history. The historian John Keegan says of their commander, Field Marshal Douglas Haig, whose statue today dominates Whitehall in London, once the center of the British Empire: "In his public manner and private diaries no concern for human suffering was or is discernible." At the Somme "he had sent the flower of British youth to death or mutilation."3
As the war wore on, shell shock increasingly compromised the

efficiency of the fighting forces. Caught between taking the suffering of their soldiers seriously and pursuing victory over the Germans, the British General Staff issued General Routine Order Number 2384 in June of 1917, which stated, “In no circumstances whatever will the expression ‘shell shock’ be used verbally or be recorded in any regimental or other casualty report, or any hospital or other medical document.” All soldiers with psychiatric problems were to be given a single diagnosis of “NYDN” (Not Yet Diagnosed, Nervous).4 In November 1917 the General Staff denied Charles Samuel Myers, who ran four field hospitals for wounded soldiers, permission to submit a paper on shell shock to the British Medical Journal. The Germans were even more punitive and treated shell shock as a character defect, which they managed with a variety of painful treatments, including electroshock.

In 1922 the British government issued the Southborough Report, whose goal was to prevent the diagnosis of shell shock in any future wars and to undermine any more claims for compensation. It suggested the elimination of shell shock from all official nomenclature and insisted that these cases should no more be classified “as a battle casualty than sickness or disease is so regarded.”5 The official view was that well-trained troops, properly led, would not suffer from shell shock and that the servicemen who had succumbed to the disorder were undisciplined and unwilling soldiers. While the political storm about the legitimacy of shell shock continued to rage for several more years, reports on how to best treat these cases disappeared from the scientific literature.6

In the United States the fate of veterans was also fraught with problems. In 1918, when they returned home from the battlefields of France and Flanders, they had been welcomed as national heroes, just as the soldiers returning from Iraq and Afghanistan are today. In 1924 Congress voted to award them a bonus of $1.25 for each day they had served overseas, but disbursement was postponed until 1945.

By 1932 the nation was in the middle of the Great Depression, and in May of that year about fifteen thousand unemployed and penniless veterans camped on the Mall in Washington DC to petition for immediate payment of their bonuses. The Senate defeated the bill to move up disbursement by a vote of sixty-two to eighteen. A month later President Hoover ordered the army to clear out the veterans’ encampment. Army chief of staff General Douglas MacArthur commanded the troops, supported by six tanks. Major Dwight D. Eisenhower was the liaison with the Washington police, and Major George Patton was in charge of the cavalry. Soldiers with fixed bayonets charged, hurling tear gas into the crowd of veterans. The next morning the Mall was deserted and the camp was in flames.7 The veterans never received their pensions.

While politics and medicine turned their backs on the returning soldiers, the horrors of the war were memorialized in literature and art. In All Quiet on the Western Front,8 a novel about the war experiences of frontline soldiers by the German writer Erich Maria Remarque, the book’s protagonist, Paul Bäumer, spoke for an entire generation: “I am aware that I, without realizing it, have lost my feelings—I don’t belong here anymore, I live in an alien world. I prefer to be left alone, not disturbed by anybody. They talk too much—I can’t relate to them—they are only busy with superficial things.”9 Published in 1929, the novel instantly became an international best seller, with translations in twenty-five languages. The 1930 Hollywood film version won the Academy Award for Best Picture.

But when Hitler came to power a few years later, All Quiet on the Western Front was one of the first "degenerate" books the Nazis burned in the public square in front of Humboldt University in Berlin.10 Apparently awareness of the devastating effects of war on soldiers' minds would have constituted a threat to the Nazis' plunge into another round of insanity. Denial of the consequences of trauma can wreak havoc with the social fabric of society. The refusal to face the damage caused by the war and the intolerance of "weakness" played an important role in the rise of fascism and militarism around the world in the 1930s. The extortionate war reparations of the Treaty of Versailles further humiliated an already disgraced Germany. German society, in turn, dealt ruthlessly with its own traumatized war veterans, who were treated as inferior creatures. This cascade of humiliations of the powerless set the stage for the ultimate debasement of human rights under the Nazi regime: the moral justification for the strong to vanquish the inferior—the rationale for the ensuing war.

THE NEW FACE OF TRAUMA

The outbreak of World War II prompted Charles Samuel Myers and the American psychiatrist Abram Kardiner to publish the accounts of their work with World War I soldiers and veterans. Shell Shock in France 1914–1918 (1940)11 and The Traumatic Neuroses of War (1941)12 served as the principal guides for psychiatrists who were treating soldiers in the new conflict who had "war neuroses." The U.S. war effort was prodigious, and the advances in frontline psychiatry reflected that commitment. Again, YouTube offers a direct window on the past: Hollywood director John Huston's documentary Let There Be Light (1946) shows the predominant treatment for war neuroses at that time: hypnosis.13

In Huston's film, made while he was serving in the Army Signal Corps, the doctors are still patriarchal and the patients are still terrified young men. But they manifest their trauma differently: While the World War I soldiers flail, have facial tics, and collapse with paralyzed bodies, the following generation talks and cringes. Their bodies still keep the score: Their stomachs are upset, their hearts race, and they are overwhelmed by panic. But the trauma did not just affect their bodies. The trance state induced by hypnosis allowed them to find words for the things they had been too afraid to remember: their terror, their survivor's guilt, and their conflicting loyalties. It also struck me that these soldiers seemed to keep a much tighter lid on their anger and hostility than the younger veterans I'd worked with. Culture shapes the expression of traumatic stress.

The feminist theorist Germaine Greer wrote about the treatment of her father's PTSD after World War II: "When [the medical officers] examined men exhibiting severe disturbances they almost invariably found the root cause in pre-war experience: the sick men were not first-grade fighting material. . . . The military proposition is [that it is] not war which makes men sick, but that sick men can not fight wars."14 It seems unlikely the doctors did her father any good, but Greer's efforts to come to grips with his suffering undoubtedly helped fuel her exploration of sexual domination in all its ugly manifestations of rape, incest, and domestic violence.

When I worked at the VA, I was puzzled that the vast majority of the patients we saw on the psychiatry service were young, recently discharged Vietnam veterans, while the corridors and elevators that led to the medical departments were filled by old men. Curious about this disparity, I conducted a survey of the World War II veterans in the medical clinics in 1983. The vast majority of them scored positive for PTSD on the rating

scales that I administered, but their treatment focused on medical rather than psychiatric complaints. These vets communicated their distress via stomach cramps and chest pains rather than with nightmares and rage, from which, my research showed, they also suffered. Doctors shape how their patients communicate their distress: When a patient complains about terrifying nightmares and his doctor orders a chest X-ray, the patient realizes that he'll get better care if he focuses on his physical problems. Like my relatives who fought in or were captured during World War II, most of these men were extremely reluctant to share their experiences. My sense was that neither the doctors nor their patients wanted to revisit the war.

However, military and civilian leaders came away from World War II with important lessons that the previous generation had failed to grasp. After the defeat of Nazi Germany and imperial Japan, the United States helped rebuild Europe by means of the Marshall Plan, which formed the economic foundation of the next fifty years of relative peace. At home, the GI Bill provided millions of veterans with educations and home mortgages, which promoted general economic well-being and created a broad-based, well-educated middle class. The armed forces led the nation in racial integration and opportunity. The Veterans Administration built facilities nationwide to help combat veterans with their health care. Still, with all this thoughtful attention to the returning veterans, the psychological scars of war went unrecognized, and traumatic neuroses disappeared entirely from official psychiatric nomenclature. The last scientific writing on combat trauma after World War II appeared in 1947.15

TRAUMA REDISCOVERED

As I noted earlier, when I started to work with Vietnam veterans, there was not a single book on war trauma in the library of the VA, but the Vietnam War inspired numerous studies, the formation of scholarly organizations, and the inclusion of a trauma diagnosis, PTSD, in the professional literature. At the same time, interest in trauma was exploding in the general public.

In 1974 Freedman and Kaplan's Comprehensive Textbook of Psychiatry stated that "incest is extremely rare, and does not occur in more than 1 out of 1.1 million people."16 As we have seen in chapter 2 this authoritative textbook then went on to extol the possible benefits of incest: "Such incestuous activity diminishes the subject's chance of psychosis and allows for a better adjustment to the external world. . . . The vast majority of them were none the worse for the experience."

How misguided those statements were became obvious when the ascendant feminist movement, combined with awareness of trauma in returning combat veterans, emboldened tens of thousands of survivors of childhood sexual abuse, domestic abuse, and rape to come forward. Consciousness-raising groups and survivor groups were formed, and numerous popular books, including The Courage to Heal (1988), a best-selling self-help book for survivors of incest, and Judith Herman's book Trauma and Recovery (1992), discussed the stages of treatment and recovery in great detail.

Cautioned by history, I began to wonder if we were headed toward another backlash like those of 1895, 1917, and 1947 against acknowledging the reality of trauma. That proved to be the case, for by the early 1990s articles had started to appear in many leading newspapers and magazines in United States and in Europe about a so-called False Memory Syndrome in

which psychiatric patients supposedly manufactured elaborate false memories of sexual abuse, which they then claimed had lain dormant for many years before being recovered.

What was striking about these articles was the certainty with which they stated that there was no evidence that people remember trauma any differently than they do ordinary events. I vividly recall a phone call from a well-known newsweekly in London, telling me that they planned to publish an article about traumatic memory in their next issue and asking me whether I had any comments on the subject. I was quite enthusiastic about their question and told them that memory loss for traumatic events had first been studied in England well over a century earlier. I mentioned John Eric Erichsen and Frederic Myers's work on railway accidents in the 1860s and 1870s and Charles Samuel Myers's and W. H. R. Rivers's extensive studies of memory problems in combat soldiers of World War I. I also suggested they look at an article published in The Lancet in 1944, which described the aftermath of the rescue of the entire British army from the beaches of Dunkirk in 1940. More than 10 percent of the soldiers who were studied had suffered from major memory loss after the evacuation.17 The following week, the magazine told its readers that there was no evidence whatsoever that people sometimes lose some or all memory for traumatic events.

The issue of delayed recall of trauma was not particularly controversial when Myers and Kardiner first described this phenomenon in their books on combat neuroses in World War I; when major memory loss was observed after the evacuation from Dunkirk; or when I wrote about Vietnam veterans and the survivor of the Cocoanut Grove nightclub fire. However, during the 1980s and early 1990s, as similar memory problems began to be documented in women and children in the context of domestic abuse, the efforts of abuse victims to seek justice against their alleged perpetrators moved the issue from science into politics and law. This, in turn, became the context for the pedophile scandals in the Catholic Church, in which memory experts were pitted against one another in courtrooms across the United States and later in Europe and Australia.

Experts testifying on behalf of the Church claimed that memories of childhood sexual abuse were unreliable at best and that the claims being made by alleged victims more likely resulted from false memories implanted in their minds by therapists who were oversympathetic, credulous, or driven by their own agendas. During this period I examined more than fifty adults who, like Julian, remembered having been abused by priests. Their claims were denied in about half the cases.

THE SCIENCE OF REPRESSED MEMORY

There have in fact been hundreds of scientific publications spanning well over a century documenting how the memory of trauma can be repressed, only to resurface years or decades later.18 Memory loss has been reported in people who have experienced natural disasters, accidents, war trauma, kidnapping, torture, concentration camps, and physical and sexual abuse. Total memory loss is most common in childhood sexual abuse, with incidence ranging from 19 percent to 38 percent.19 This issue is not particularly controversial: As early as 1980 the DSM-III recognized the existence of memory loss for traumatic events in the diagnostic criteria for dissociative amnesia: "an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by normal forgetfulness." Memory loss has been part of the criteria for PTSD since that diagnosis was first introduced.

One of the most interesting studies of repressed memory was conducted by Dr. Linda Meyer Williams, which began when she was a graduate student in sociology at the University of Pennsylvania in the early 1970s. Williams interviewed 206 girls between the ages of ten and twelve who had been admitted to a hospital emergency room following sexual abuse. Their laboratory tests, as well as the interviews with the children and their parents, were kept in the hospital's medical records. Seventeen years later Williams was able to track down 136 of the children, now adults, with whom she conducted extensive follow-up interviews.20 More than a third of the women (38 percent) did not recall the abuse that was documented in their medical records, while only fifteen women (12 percent) said that they had never been abused as children. More than two-thirds (68 percent) reported other incidents of childhood sexual abuse. Women who were younger at the time of the incident and those who were molested by someone they knew were more likely to have forgotten their abuse.

This study also examined the reliability of recovered memories. One in ten women (16 percent of those who recalled the abuse) reported that they had forgotten it at some time in the past but later remembered that it had happened. In comparison with the women who had always remembered their molestation, those with a prior period of forgetting were younger at the time of their abuse and were less likely to have received support from their mothers. Williams also determined that the recovered memories were approximately as accurate as those that had never been lost: All the women's memories were accurate for the central facts of the incident, but none of their stories precisely matched every detail documented in their charts.21

Williams's findings are supported by recent neuroscience research that shows that memories that are retrieved tend to return to the memory bank with modifications.22 As long as a memory is inaccessible, the mind is unable to change it. But as soon as a story starts being told, particularly if it is told repeatedly, it changes—the act of telling itself changes the tale. The mind cannot help but make meaning out of what it knows, and the meaning we make of our lives changes how and what we remember.

Given the wealth of evidence that trauma can be forgotten and resurface years later, why did nearly one hundred reputable memory scientists from several different countries throw the weight of their reputations behind the appeal to overturn Father Shanley's conviction, claiming that "repressed memories" were based on "junk science"? Because memory loss and delayed recall of traumatic experiences had never been documented in the laboratory, some cognitive scientists adamantly denied that these phenomena existed23 or that retrieved traumatic memories could be accurate.24 However, what doctors encounter in emergency rooms, on psychiatric wards, and on the battlefield is necessarily quite different from what scientists observe in their safe and well-organized laboratories.

Consider what is known as the "lost in the mall" experiment, for example. Academic researchers have shown that it is relatively easy to implant memories of events that never took place, such as having been lost in a shopping mall as a child.25 About 25 percent of subjects in these studies later "recall" that they were frightened and even fill in missing details. But such recollections involve none of the visceral terror that a lost child would actually experience.

Another line of research documented the unreliability of eyewitness testimony. Subjects might be shown a video of a car driving down a street

and asked afterward if they saw a stop sign or a traffic light; children might be asked to recall what a male visitor to their classroom had been wearing. Other eyewitness experiments demonstrated that the questions witnesses were asked could alter what they claimed to remember. These studies were valuable in bringing many police and courtroom practices into question, but they have little relevance to traumatic memory.

The fundamental problem is this: Events that take place in the laboratory cannot be considered equivalent to the conditions under which traumatic memories are created. The terror and helplessness associated with PTSD simply can't be induced de novo in such a setting. We can study the effects of existing traumas in the lab, as in our script-driven imaging studies of flashbacks, but the original imprint of trauma cannot be laid down there. Dr. Roger Pitman conducted a study at Harvard in which he showed college students a film called Faces of Death, which contained newsreel footage of violent deaths and executions. This movie, now widely banned, is as extreme as any institutional review board would allow, but it did not cause Pitman's normal volunteers to develop symptoms of PTSD. If you want to study traumatic memory, you have to study the memories of people who have actually been traumatized.

Interestingly, once the excitement and profitability of courtroom testimony diminished, the "scientific" controversy disappeared as well, and clinicians were left to deal with the wreckage of traumatic memory.

NORMAL VERSUS TRAUMATIC MEMORY

In 1994 I and my colleagues at Massachusetts General Hospital decided to undertake a systematic study comparing how people recall benign experiences and horrific ones. We placed advertisements in local newspapers, in laundromats, and on student union bulletin boards that said: "Has something terrible happened to you that you cannot get out of your mind? Call 727-5500; we will pay you $10.00 for participating in this study." In response to our first ad seventy-six volunteers showed up.[26]

After we introduced ourselves, we started off by asking each participant: "Can you tell us about an event in your life that you think you will always remember but that is not traumatic?" One participant lit up and said, "The day that my daughter was born"; others mentioned their wedding day, playing on a winning sports team, or being valedictorian at their high school graduation. Then we asked them to focus on specific sensory details of those events, such as: "Are you ever somewhere and suddenly have a vivid image of what your husband looked like on your wedding day?" The answers were always negative. "How about what your husband's body felt like on your wedding night?" (We got some odd looks on that one.) We continued: "Do you ever have a vivid, precise recollection of the speech you gave as a valedictorian?" "Do you ever have intense sensations recalling the birth of your first child?" The replies were all in the negative. Then we asked them about the traumas that had brought them into the study—many of them rapes. "Do you ever suddenly remember how your rapist smelled?" we asked, and, "Do you ever experience the same physical sensations you had when you were raped?" Such questions precipitated powerful emotional responses: "That is why I cannot go to parties anymore, because the smell of alcohol on somebody's breath makes me feel like I am being raped all over again" or "I can no longer make love to my husband, because when he touches me in a particular way I feel like I am being raped again."

There were two major differences between how people talked about

memories of positive versus traumatic experiences: (1) how the memories were organized, and (2) their physical reactions to them. Weddings, births, and graduations were recalled as events from the past, stories with a beginning, a middle, and an end. Nobody said that there were periods when they'd completely forgotten any of these events.

In contrast, the traumatic memories were disorganized. Our subjects remembered some details all too clearly (the smell of the rapist, the gash in the forehead of a dead child) but could not recall the sequence of events or other vital details (the first person who arrived to help, whether an ambulance or a police car took them to the hospital).

We also asked the participants how they recalled their trauma at three points in time: right after it happened; when they were most troubled by their symptoms; and during the week before the study. All of our traumatized participants said that they had not been able to tell anybody precisely what had happened immediately following the event. (This will not surprise anyone who has worked in an emergency room or ambulance service: People brought in after a car accident in which a child or a friend has been killed sit in stunned silence, dumbfounded by terror.) Almost all had repeated flashbacks: They felt overwhelmed by images, sounds, sensations, and emotions. As time went on, even more sensory details and feelings were activated, but most participants also started to be able to make some sense out of them. They began to "know" what had happened and to be able to tell the story to other people, a story that we call "the memory of the trauma."

Gradually the images and flashbacks decreased in frequency, but the greatest improvement was in the participants' ability to piece together the details and sequence of the event. By the time of our study, 85 percent of them were able to tell a coherent story, with a beginning, a middle, and an end. Only a few were missing significant details. We noted that the five who said they had been abused as children had the most fragmented narratives—their memories still arrived as images, physical sensations, and intense emotions.

In essence, our study confirmed the dual memory system that Janet and his colleagues at the Salpêtrière had described more than a hundred years earlier: Traumatic memories are fundamentally different from the stories we tell about the past. They are dissociated: The different sensations that entered the brain at the time of the trauma are not properly assembled into a story, a piece of autobiography.

Perhaps the most important finding in our study was that remembering the trauma with all its associated affects, does not, as Breuer and Freud claimed back in 1893, necessarily resolve it. Our research did not support the idea that language can substitute for action. Most of our study participants could tell a coherent story and also experience the pain associated with those stories, but they kept being haunted by unbearable images and physical sensations. Research in contemporary exposure treatment, a staple of cognitive behavioral therapy, has similarly disappointing results: The majority of patients treated with that method continue to have serious PTSD symptoms three months after the end of treatment.27 As we will see, finding words to describe what has happened to you can be transformative, but it does not always abolish flashbacks or improve concentration, stimulate vital involvement in your life or reduce hypersensitivity to disappointments and perceived injuries.

LISTENING TO SURVIVORS

Nobody wants to remember trauma. In that regard society is no different from the victims themselves. We all want to live in a world that is safe, manageable, and predictable, and victims remind us that this is not always the case. In order to understand trauma, we have to overcome our natural reluctance to confront that reality and cultivate the courage to listen to the testimonies of survivors.

In his book Holocaust Testimonies: The Ruins of Memory (1991), Lawrence Langer writes about his work in the Fortunoff Video Archive at Yale University: "Listening to accounts of Holocaust experience, we unearth a mosaic of evidence that constantly vanishes into bottomless layers of incompletion.28 We wrestle with the beginnings of a permanently unfinished tale, full of incomplete intervals, faced by the spectacle of a faltering witness often reduced to a distressed silence by the overwhelming solicitations of deep memory." As one of his witnesses says: "If you were not there, it's difficult to describe and say how it was. How men function under such stress is one thing, and then how you communicate and express that to somebody who never knew that such a degree of brutality exists seems like a fantasy."

Another survivor, Charlotte Delbo, describes her dual existence after Auschwitz: "[T]he 'self' who was in the camp isn't me, isn't the person who is here, opposite you. No, it's too unbelievable. And everything that happened to this other 'self,' the one from Auschwitz, doesn't touch me now, me, doesn't concern me, so distinct are deep memory and common memory. . . . Without this split, I wouldn't have been able to come back to life."29 She comments that even words have a dual meaning: "Otherwise, someone [in the camps] who has been tormented by thirst for weeks would never again be able to say: 'I'm thirsty. Let's make a cup of tea.' Thirst [after the war] has once more become a currently used term. On the other hand, if I dream of the thirst I felt in Birkenau [the extermination facilities in Auschwitz], I see myself as I was then, haggard, bereft of reason, tottering."30

Langer hauntingly concludes, "Who can find a proper grave for such damaged mosaics of the mind, where they may rest in pieces? Life goes on, but in two temporal directions at once, the future unable to escape the grip of a memory laden with grief."31

The essence of trauma is that it is overwhelming, unbelievable, and unbearable. Each patient demands that we suspend our sense of what is normal and accept that we are dealing with a dual reality: the reality of a relatively secure and predictable present that lives side by side with a ruinous, ever-present past.

NANCY'S STORY

Few patients have put that duality into words as vividly as Nancy, the director of nursing in a Midwestern hospital who came to Boston several times to consult with me. Shortly after the birth of her third child, Nancy underwent what is usually routine outpatient surgery, a laparoscopic tubal ligation in which the fallopian tubes are cauterized to prevent future pregnancies. However, because she was given insufficient anesthesia, she awakened after the operation began and remained aware nearly to the end, at times falling into what she called "a light sleep" or "dream," at times experiencing the full horror of her situation. She was unable to alert the OR team by moving or crying out because she had been given a standard muscle relaxant to prevent muscle contractions during surgery.

Some degree of "anesthesia awareness" is now estimated to occur in

approximately thirty thousand surgical patients in the United States every year,32 and I had previously testified on behalf of several people who were traumatized by the experience. Nancy, however, did not want to sue her surgeon or anesthetist. Her entire focus was on bringing the reality of her trauma to consciousness so that she could free herself from its intrusions into her everyday life. I'd like to end this chapter by sharing several passages from a remarkable series of e-mails in which she described her grueling journey to recovery.

Initially Nancy did not know what had happened to her. "When we went home I was still in a daze, doing the typical things of running a household, yet not really feeling that I was alive or that I was real. I had trouble sleeping that night. For days, I remained in my own little disconnected world. I could not use a hair dryer, toaster, stove or anything that warmed up. I could not concentrate on what people were doing or telling me. I just didn't care. I was increasingly anxious. I slept less and less. I knew I was behaving strangely and kept trying to understand what was frightening me so.

"On the fourth night after the surgery, around 3 AM, I started to realize that the dream I had been living all this time related to conversations I had heard in the operating room. I was suddenly transported back into the OR and could feel my paralyzed body being burned. I was engulfed in a world of terror and horror." From then on, Nancy says, memories and flashbacks erupted into her life.

"It was as if the door was pushed open slightly, allowing the intrusion. There was a mixture of curiosity and avoidance. I continued to have irrational fears. I was deathly afraid of sleep; I experienced a sense of terror when seeing the color blue. My husband, unfortunately, was bearing the brunt of my illness. I would lash out at him when I truly did not intend to. I was sleeping at most 2 to 3 hours, and my daytime was filled with hours of flashbacks. I remained chronically hyperalert, feeling threatened by my own thoughts and wanting to escape them. I lost 23 pounds in 3 weeks. People kept commenting on how great I looked.

"I began to think about dying. I developed a very distorted view of my life in which all my successes diminished and old failures were amplified. I was hurting my husband and found that I could not protect my children from my rage.

"Three weeks after the surgery I went back to work at the hospital. The first time I saw somebody in a surgical scrubsuit was in the elevator. I wanted to get out immediately, but of course I could not. I then had this irrational urge to clobber him, which I contained with considerable effort. This episode triggered increasing flashbacks, terror and dissociation. I cried all the way home from work. After that, I became adept at avoidance. I never set foot in an elevator, I never went to the cafeteria, I avoided the surgical floors."

Gradually Nancy was able to piece together her flashbacks and create an understandable, if horrifying, memory of her surgery. She recalled the reassurances of the OR nurses and a brief period of sleep after the anesthesia was started. Then she remembered how she began to awaken.

"The entire team was laughing about an affair one of the nurses was having. This coincided with the first surgical incision. I felt the stab of the scalpel, then the cutting, then the warm blood flowing over my skin. I tried desperately to move, to speak, but my body didn't work. I couldn't understand this. I felt a deeper pain as the layers of muscle pulled apart

under their own tension. I knew I wasn't supposed to feel this."
Nancy next recalls someone "rummaging around" in her belly and identified this as the laparoscopic instruments being placed. She felt her left tube being clamped. "Then suddenly there was an intense searing, burning pain. I tried to escape, but the cautery tip pursued me, relentlessly burning through. There simply are no words to describe the terror of this experience. This pain was not in the same realm as other pain I had known and conquered, like a broken bone or natural childbirth. It begins as extreme pain, then continues relentlessly as it slowly burns through the tube. The pain of being cut with the scalpel pales beside this giant."
"Then, abruptly, the right tube felt the initial impact of the burning tip. When I heard them laugh, I briefly lost track of where I was. I believed I was in a torture chamber, and I could not understand why they were torturing me without even asking for information. . . . My world narrowed to a small sphere around the operating table. There was no sense of time, no past, and no future. There was only pain, terror, and horror. I felt isolated from all humanity, profoundly alone in spite of the people surrounding me. The sphere was closing in on me.
"In my agony, I must have made some movement. I heard the nurse anesthetist tell the anesthesiologist that I was 'light.' He ordered more meds and then quietly said, 'There is no need to put any of this in the chart.' That is the last memory I recalled."
In her later e-mails to me, Nancy struggled to capture the existential reality of trauma.
"I want to tell you what a flashback is like. It is as if time is folded or warped, so that the past and present merge, as if I were physically transported into the past. Symbols related to the original trauma, however benign in reality, are thoroughly contaminated and so become objects to be hated, feared, destroyed if possible, avoided if not. For example, an iron in any form—a toy, a clothes iron, a curling iron, came to be seen as an instrument of torture. Each encounter with a scrub suit left me disassociated, confused, physically ill and at times consciously angry.
"My marriage is slowly falling apart—my husband came to represent the heartless laughing people [the surgical team] who hurt me. I exist in a dual state. A pervasive numbness covers me with a blanket; and yet the touch of a small child pulls me back to the world. For a moment, I am present and a part of life, not just an observer.
"Interestingly, I function very well at work, and I am constantly given positive feedback. Life proceeds with its own sense of falsity.
"There is a strangeness, bizarreness to this dual existence. I tire of it. Yet I cannot give up on life, and I cannot delude myself into believing that if I ignore the beast it will go away. I've thought many times that I had recalled all the events around the surgery, only to find a new one.
"There are so many pieces of that 45 minutes of my life that remain unknown. My memories are still incomplete and fragmented, but I no longer think that I need to know everything in order to understand what happened.
"When the fear subsides I realize I can handle it, but a part of me doubts that I can. The pull to the past is strong; it is the dark side of my life; and I must dwell there from time to time. The struggle may also be a way to know that I survive—a re-playing of the fight to survive—which apparently I won, but cannot own."
An early sign of recovery came when Nancy needed another, more

extensive operation. She chose a Boston hospital for the surgery, asked for a preoperative meeting with the surgeons and the anesthesiologist specifically to discuss her prior experience, and requested that I be allowed to join them in the operating room. For the first time in many years I put on a surgical