# 14. LANGUAGE: MIRACLE AND TYRANNY

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.

I
CHAPTER 14
LANGUAGE: MIRACLE AND
TYRANNY
Give sorrow words; the grief that does not speak knits up the o’er wrought heart and bids it break.
—William Shakespeare, Macbeth
We can hardly bear to look. The shadow may carry the best of the life we have not lived. Go into the basement, the attic, the refuse bin. Find gold there. Find an animal who has not been fed or watered. It is you!! This neglected, exiled animal, hungry for attention, is a part of your self.
—Marion Woodman (as quoted by Stephen Cope in The Great Work of Your Life)
n September 2001 several organizations, including the National Institutes of Health, Pfizer pharmaceuticals, and the New York Times Company Foundation, organized expert panels to recommend the best treatments for people traumatized by the attacks on the World Trade Center. Because many widely used trauma interventions had never been carefully evaluated in random communities (as opposed to patients who seek psychiatric help), I thought that this presented an extraordinary opportunity to compare how well a variety of different approaches would work. My colleagues were more conservative, and after lengthy deliberations the committees recommended only two forms of treatment: psychoanalytically oriented therapy and cognitive behavioral therapy. Why analytic talk therapy? Since Manhattan is one of the last bastions of Freudian psychoanalysis, it would have been bad politics to exclude a substantial proportion of local mental health practitioners. Why CBT? Because behavioral treatment can be broken down into concrete steps and “manualized” into uniform protocols, it is the favorite treatment of academic researchers, another group that could not be ignored. After the recommendations were approved, we sat back and waited for New Yorkers to find their way to therapists’ offices. Almost nobody showed up.
Dr. Spencer Eth, who ran the psychiatry department at the now-defunct St. Vincent’s Hospital in Greenwich Village, was curious where survivors had turned for help, and early in 2002, together with some medical students, he conducted a survey of 225 people who had escaped from the Twin Towers. Asked what had been most helpful in overcoming the effects of their experience, the survivors credited acupuncture, massage, yoga, and EMDR, in that order.1 Among rescue workers, massages were particularly popular. Eth’s survey suggests that the most helpful interventions focused on relieving the physical burdens generated by trauma. The disparity

between the survivors' experience and the experts' recommendations is intriguing. Of course, we don't know how many survivors eventually did seek out more traditional therapies. But the apparent lack of interest in talk therapy raises a basic question: What good is it to talk about your trauma?

## THE UNSPEAKABLE TRUTH

Therapists have an undying faith in the capacity of talk to resolve trauma. That confidence dates back to 1893, when Freud (and his mentor, Breuer) wrote that trauma "immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words."2

Unfortunately, it's not so simple: Traumatic events are almost impossible to put into words. This is true for all of us, not just for people who suffer from PTSD. The initial imprints of the events of September 11 were not stories but images: frantic people running down the street, their faces covered with ash; an airplane smashing into Tower One of the World Trade Center; the distant specks that were people jumping hand in hand. Those images were replayed over and over, in our minds and on the TV screen, until Mayor Giuliani and the media helped us create a narrative we could share with one another.

In Seven Pillars of Wisdom T. E. Lawrence wrote of his war experiences: "We learned that there were pangs too sharp, griefs too deep, ecstasies too high for our finite selves to register. When emotion reached this pitch the mind choked; and memory went white till the circumstances were humdrum once more."3 While trauma keeps us dumbfounded, the path out of it is paved with words, carefully assembled, piece by piece, until the whole story can be revealed.

## BREAKING THE SILENCE

Activists in the early campaign for AIDS awareness created a powerful slogan: "Silence = Death." Silence about trauma also leads to death—the death of the soul. Silence reinforces the godforsaken isolation of trauma. Being able to say aloud to another human being, "I was raped" or "I was battered by my husband" or "My parents called it discipline, but it was abuse" or "I'm not making it since I got back from Iraq," is a sign that healing can begin.

We may think we can control our grief, our terror, or our shame by remaining silent, but naming offers the possibility of a different kind of control. When Adam was put in charge of the animal kingdom in the Book of Genesis, his first act was to give a name to every living creature.

If you've been hurt, you need to acknowledge and name what happened to you. I know that from personal experience: As long as I had no place where I could let myself know what it was like when my father locked me in the cellar of our house for various three-year-old offenses, I was chronically preoccupied with being exiled and abandoned. Only when I could talk about how that little boy felt, only when I could forgive him for having been as scared and submissive as he was, did I start to enjoy the pleasure of my own company. Feeling listened to and understood changes our physiology; being able to articulate a complex feeling, and having our feelings recognized, lights up our limbic brain and creates an "aha moment." In contrast, being met by silence and incomprehension kills the spirit. Or, as John Bowlby so memorably put it: "What can not be spoken to the [m]other cannot be told to the self."

If you hide from yourself the fact that an uncle molested you when you were young, you are vulnerable to react to triggers like an animal in a thunderstorm: with a full-body response to the hormones that signal "danger." Without language and context, your awareness may be limited to: "I'm scared." Yet, determined to stay in control, you are likely to avoid anybody or anything that reminds you even vaguely of your trauma. You may also alternate between being inhibited and being uptight or reactive and explosive—all without knowing why.

As long as you keep secrets and suppress information, you are fundamentally at war with yourself. Hiding your core feelings takes an enormous amount of energy, it saps your motivation to pursue worthwhile goals, and it leaves you feeling bored and shut down. Meanwhile, stress hormones keep flooding your body, leading to headaches, muscle aches, problems with your bowels or sexual functions—and irrational behaviors that may embarrass you and hurt the people around you. Only after you identify the source of these responses can you start using your feelings as signals of problems that require your urgent attention.

Ignoring inner reality also eats away at your sense of self, identity, and purpose. Clinical psychologist Edna Foa and her colleagues developed the Posttraumatic Cognitions Inventory to assess how patients think about themselves.4 Symptoms of PTSD often include statements like "I feel dead inside," "I will never be able to feel normal emotions again," "I have permanently changed for the worse," "I feel like an object, not like a person," "I have no future," and "I feel like I don't know myself anymore."

The critical issue is allowing yourself to know what you know. That takes an enormous amount of courage. In What It Is Like to Go to War, Vietnam veteran Karl Marlantes grapples with his memories of belonging to a brilliantly effective Marine combat unit and confronts the terrible split he discovered inside himself:

For years I was unaware of the need to heal that split, and there was no one, after I returned, to point this out to me. . . . Why did I assume there was only one person inside me? . . . There's a part of me that just loves maiming, killing, and torturing. This part of me isn't all of me. I have other elements that indeed are just the opposite, of which I am proud. So am I a killer? No, but part of me is. Am I a torturer? No, but part of me is. Do I feel horror and sadness when I read in the newspapers of an abused child? Yes. But am I fascinated?5

Marlantes tells us that his road to recovery required learning to tell the truth, even if that truth was brutally painful.

Death, destruction, and sorrow need to be constantly justified in the absence of some overarching meaning for the suffering. Lack of this overarching meaning encourages making things up, lying, to fill the gap in meaning.6

I'd never been able to tell anyone what was going on inside. So I forced these images back, away, for years. I began to reintegrate that split-off part of my experience only after I actually began to imagine that kid as a kid, my kid perhaps. Then, out came this overwhelming sadness—and healing. Integrating the feelings of sadness, rage, or all of the above with the action should be standard operating procedure for all soldiers who have killed face-to-face. It requires no sophisticated psychological training. Just form groups under a fellow squad or platoon member who has had a few days of group leadership training and encourage people to talk.[7]

Getting perspective on your terror and sharing it with others can reestablish the feeling that you are a member of the human race. After the Vietnam veterans I treated joined a therapy group where they could share the atrocities they had witnessed and committed, they reported beginning to open their hearts to their girlfriends.

## THE MIRACLE OF SELF-DISCOVERY

Discovering your Self in language is always an epiphany, even if finding the words to describe your inner reality can be an agonizing process. That is why I find Helen Keller's account of how she was "born into language"[8] so inspiring.

When Helen was nineteen months old and just starting to talk, a viral infection robbed her of her sight and hearing. Now deaf, blind, and mute, this lovely, lively child turned into an untamed, isolated creature. After five desperate years her family invited a partially blind teacher, Anne Sullivan, to come from Boston to their home in rural Alabama as Helen's tutor. Anne began immediately to teach Helen the manual alphabet, spelling words into her hand letter by letter, but it took ten weeks of trying to connect with this wild child before the breakthrough occurred. It came as Anne spelled the word "water" into one of Helen's hands while she held the other under the water pump.

Helen later recalled that moment in The Story of My Life: "Water! That word startled my soul, and it awoke, full of the spirit of the morning. . . . Until that day my mind had been like a darkened chamber, waiting for words to enter and light the lamp, which is thought. I learned a great many words that day."

Learning the names of things enabled the child not only to create an inner representation of the invisible and inaudible physical reality around her but also to find herself: Six months later she started to use the first-person "I."

Helen's story reminds me of the abused, recalcitrant, uncommunicative kids we see in our residential treatment programs. Before she acquired language, she was bewildered and self-centered—looking back, she called that creature "Phantom." And indeed, our kids come across as phantoms until they can discover who they are and feel safe enough to communicate what is going on with them.

In a later book, The World I Live In, Keller again described her birth into selfhood: "Before my teacher came to me, I did not know that I am. I lived in a world that was a no-world. . . . I had neither will nor intellect. . . . I can remember all this, not because I knew that it was so, but because I have tactual memory. It enables me to remember that I never contracted my forehead in the act of thinking."[9]

Helen's "tactual" memories—memories based only on touch—could not be shared. But language opened up the possibility of joining a community. At age eight, when Helen went with Anne to the Perkins Institution for the Blind in Boston (where Sullivan herself had trained), she became able to communicate with other children for the first time: "Oh, what happiness!" she wrote. "To talk freely with other children! To feel at home in the great world!"

Helen's discovery of language with the help of Anne Sullivan captures the essence of a therapeutic relationship: finding words where words were absent before and, as a result, being able to share your deepest pain and deepest feelings with another human being. This is one of most profound experiences we can have, and such resonance, in which hitherto unspoken words can be discovered, uttered, and received, is fundamental to healing the isolation of trauma—especially if other people in our lives have ignored or silenced us. Communicating fully is the opposite of being traumatized.

## KNOWING YOURSELF OR TELLING YOUR STORY? OUR DUAL AWARENESS SYSTEM

Anyone who enters talk therapy, however, almost immediately confronts the limitations of language. This was true of my own psychoanalysis. While I talk easily and can tell interesting tales, I quickly realized how difficult it was to feel my feelings deeply and simultaneously report them to someone else. When I got in touch with the most intimate, painful, or confusing moments of my life, I often found myself faced with a choice: I could either focus on reliving old scenes in my mind's eye and let myself feel what I had felt back then, or I could tell my analyst logically and coherently what had transpired. When I chose the latter, I would quickly lose touch with myself and start to focus on his opinion of what I was telling him. The slightest hint of doubt or judgment would shut me down, and I would shift my attention to regaining his approval.

Since then neuroscience research has shown that we possess two distinct forms of self-awareness: one that keeps track of the self across time and one that registers the self in the present moment. The first, our autobiographical self, creates connections among experiences and assembles them into a coherent story. This system is rooted in language. Our narratives change with the telling, as our perspective changes and as we incorporate new input.

The other system, moment-to-moment self-awareness, is based primarily in physical sensations, but if we feel safe are not rushed, we can find words to communicate that experience as well. These two ways of knowing are localized in different parts of the brain that are largely disconnected from each other.10 Only the system devoted to self-awareness, which is based in the medial prefrontal cortex, can change the emotional brain.

In the groups I used to lead for veterans, I could sometimes see these two systems working side by side. The soldiers told horrible tales of death and destruction, but I noticed that their bodies often simultaneously radiated a sense of pride and belonging. Similarly, many patients tell me about the happy families they grew up in while their bodies are slumped over and their voices sound anxious and uptight. One system creates a story for public consumption, and if we tell that story often enough, we are likely to start believing that it contains the whole truth. But the other system registers a different truth: how we experience the situation deep inside. It is this second system that needs to be accessed, befriended, and reconciled.

Just recently at my teaching hospital, a group of psychiatric residents and I interviewed a young woman with temporal lobe epilepsy who was being evaluated following a suicide attempt. The residents asked her standard questions about her symptoms, the medications she was taking, how old she was when the diagnosis was made, what had made her try to kill herself. She responded in a flat, matter-of-fact voice: She'd been five when she was diagnosed. She'd lost her job; she knew she'd been faking it; she felt worthless. For some reason one of the residents asked whether she had been sexually abused. That question surprised me: She had given us no indication that she had had problems with intimacy or sexuality, and I wondered if the doctor was pursuing a private agenda.

Yet the story our patient told did not explain why she had fallen apart after losing her job. So I asked her what it had been like for that five-year-old girl to be told that something was wrong with her brain. That forced her to check in with herself, as she had no ready-made script for that question. In a subdued tone of voice she told us that the worst part of her diagnosis was that afterward her father wanted nothing more to do with her: "He just saw me as a defective child." Nobody had supported her, she said, so she basically had to manage by herself.

I then asked her how she felt now about that little girl with newly diagnosed epilepsy who was left on her own. Instead of crying for her loneliness or being angry about the lack of support, she said fiercely: "She was stupid, whiny, and dependent. She should have stepped up to the plate and sucked it up." That passion obviously came from the part of her that had valiantly tried to cope with her distress, and I acknowledged that it probably had helped her survive back then. I asked her to allow that frightened, abandoned girl to tell her what it had been like to be all alone, her illness compounded by family rejection. She started to sob and kept quiet for a long time until finally she said: "No, she did not deserve that. She should have been supported; somebody should have looked after her." Then she shifted again and proudly told me about her accomplishments—how much she'd achieved despite that lack of support. Public story and inner experience finally met.

## THE BODY IS THE BRIDGE

Trauma stories lessen the isolation of trauma, and they provide an explanation for why people suffer the way they do. They allow doctors to make diagnoses, so that they can address problems like insomnia, rage, nightmares, or numbing. Stories can also provide people with a target to blame. Blaming is a universal human trait that helps people feel good while feeling bad, or, as my old teacher Elvin Semrad used to say: "Hate makes the world go round." But stories also obscure a more important issue, namely, that trauma radically changes people: that in fact they no longer are "themselves."

It is excruciatingly difficult to put that feeling of no longer being yourself into words. Language evolved primarily to share "things out there," not to communicate our inner feelings, our interiority. (Again, the language center of the brain is about as far removed from the center for experiencing one's self as is geographically possible.) Most of us are better at describing someone else than we are at describing ourselves. As I once heard Harvard psychologist Jerome Kagan say: "The task of describing most private experiences can be likened to reaching down to a deep well to pick up small fragile crystal figures while you are wearing thick leather mittens."[11]

We can get past the slipperiness of words by engaging the self-observing, body-based self system, which speaks through sensations, tone of voice, and body tensions. Being able to perceive visceral sensations is the very foundation of emotional awareness.[12] If a patient tells me that he was eight when his father deserted the family, I am likely to stop and ask him to check in with himself: What happens inside when he tells me about that boy who never saw his father again? Where is it registered in his body? When you activate your gut feelings and listen to your heartbreak—when you follow the interoceptive pathways to your innermost recesses—things begin to change.

## WRITING TO YOURSELF

There are other ways to access your inner world of feelings. One of the most effective is through writing. Most of us have poured out our hearts in angry, accusatory, plaintive, or sad letters after people have betrayed or abandoned us. Doing so almost always makes us feel better, even if we never send them. When you write to yourself, you don't have to worry about other people's judgment—you just listen to your own thoughts and let their flow take over. Later, when you reread what you wrote, you often discover surprising truths.

As functioning members of society, we're supposed to be "cool" in our day-to-day interactions and subordinate our feelings to the task at hand. When we talk with someone with whom we don't feel completely safe, our social editor jumps in on full alert and our guard is up. Writing is different. If you ask your editor to leave you alone for a while, things will come out that you had no idea were there. You are free to go into a sort of a trance state in which your pen (or keyboard) seems to channel whatever bubbles up from inside. You can connect those self-observing and narrative parts of your brain without worrying about the reception you'll get.

In the practice called free writing, you can use any object as your own personal Rorschach test for entering a stream of associations. Simply write the first thing that comes to your mind as you look at the object in front of you and then keep going without stopping, rereading, or crossing out. A wooden spoon on the counter may trigger memories of making tomato sauce with your grandmother—or of being beaten as a child. The teapot that's been passed down for generations may take you meandering to the furthest reaches of your mind to the loved ones you've lost or family holidays that were a mix of love and conflict. Soon an image will emerge, then a memory, and then a paragraph to record it. Whatever shows up on the paper will be a manifestation of associations that are uniquely yours.

My patients often bring in fragments of writing and drawings about memories that they may not yet be ready to discuss. Reading the content out loud would probably overwhelm them, but they want me to be aware of what they are wrestling with. I tell them how much I appreciate their courage in allowing themselves to explore hitherto hidden parts of themselves and in entrusting me with them. These tentative communications guide my treatment plan—for example, by helping me to decide whether to add somatic processing, neurofeedback, or EMDR to our current work.

As far as I'm aware, the first systematic test of the power of language to relieve trauma was done in 1986, when James Pennebaker at the University of Texas in Austin turned his introductory psychology class into an experimental laboratory. Pennebaker started off with a healthy respect for the importance of inhibition, of keeping things to yourself, which he viewed as the glue of civilization.13 But he also assumed that people pay a price for trying to suppress being aware of the elephant in the room.

He began by asking each student to identify a deeply personal experience that they'd found very stressful or traumatic. He then divided the class into three groups: One would write about what was currently going on in their lives; the second would write about the details of the traumatic or stressful event; and the third would recount the facts of the experience, their feelings and emotions about it, and what impact they thought this event had had on their lives. All of the students wrote continuously for fifteen minutes on four consecutive days while sitting alone in a small cubicle in the psychology building.

The students took the study very seriously; many revealed secrets that they had never told anyone. They often cried as they wrote, and many confided in the course assistants that they'd become preoccupied with these experiences. Of the two hundred participants, sixty-five wrote about a childhood trauma. Although the death of a family member was the most frequent topic, 22 percent of the women and 10 percent of the men reported sexual trauma prior to the age of seventeen.

The researchers asked the students about their health and were surprised how often the students spontaneously reported histories of major and minor health problems: cancer, high blood pressure, ulcers, flu, headaches, and earaches.14 Those who reported a traumatic sexual experience in childhood had been hospitalized an average of 1.7 days in the previous year—almost twice the rate of the others.

The team then compared the number of visits to the student health center participants had made during the month prior to the study to the number in the month following it. The group that had written about both the facts and the emotions related to their trauma clearly benefited the most: They had a 50 percent drop in doctor visits compared with the other two groups. Writing about their deepest thoughts and feelings about traumas had improved their mood and resulted in a more optimistic attitude and better physical health.

When the students themselves were asked to assess the study, they focused on how it had increased their self-understanding: "It helped me think about what I felt during those times. I never realized how it affected me before." "I had to think and resolve past experiences. One result of the experiment was peace of mind. To have to write about emotions and feelings helped me understand how I felt and why."15

In a subsequent study Pennebaker asked half of a group of seventy-two students to talk into a tape recorder about the most traumatic experience of their lives; the other half discussed their plans for the rest of the day. As they spoke, researchers monitored their physiological reactions: blood pleasure, heart rate, muscle tension, and hand temperature.16 This study had similar results: Those who allowed themselves to feel their emotions showed significant physiological changes, both immediate and long term. During their confessions blood pressure, heart rate, and other autonomic functions increased, but afterward their arousal fell to levels below where they had been at the start of the study. The drop in blood pressure could still be measured six weeks after the experiment ended.

It is now widely accepted that stressful experiences—whether divorce or final exams or loneliness—have a negative effect on immune function, but this was a highly controversial notion at the time of Pennebaker's study. Building on his protocols, a team of researchers at the Ohio State University College of Medicine compared two groups of students who wrote either about a personal trauma or about a superficial topic.17 Again, those who wrote about personal traumas had fewer visits to the student health center, and their improved health correlated with improved immune function, as measured by the action of T lymphocytes (natural killer cells) and other immune markers in the blood. This effect was most obvious directly after the experiment, but it could still be the detected six weeks later. Writing experiments from around the world, with grade school students, nursing home residents, medical students, maximum-security prisoners, arthritis sufferers, new mothers, and rape victims, consistently show that writing about upsetting events improves physical and mental health.

Another aspect of Pennebaker's studies caught my attention: When his subjects talked about intimate or difficult issues, they often changed their tone of voice and speaking style. The differences were so striking that Pennebaker wondered if he had mixed up his tapes. For example, one woman described her plans for the day in a childlike, high-pitched voice, but a few minutes later, when she described stealing one hundred dollars from an open cash register, both the volume and pitch of her voice became so much lower that she sounded like an entirely different person.

Alterations in emotional states were also reflected in the subjects' handwriting. As participants changed topics, they might move from cursive to block letters and back to cursive; there were also variations in the slant of the letters and in the pressure of their pens.

Such changes are called "switching" in clinical practice, and we see them often in individuals with trauma histories. Patients activate distinctly different emotional and physiological states as they move from one topic to another. Switching manifests not only as remarkably different vocal patterns but also in different facial expressions and body movements. Some patients even appear to change their personal identity, from timid to forceful and aggressive or from anxiously compliant to starkly seductive. When they write about their deepest fears, their handwriting often becomes more childlike and primitive.

If patients who present in such dramatically different states are treated as fakes, or if they are told to stop showing their unpredictably annoying parts, they are likely to become mute. They probably will continue to seek help, but after they have been silenced they will transmit their cries for help not by talking but by acting: with suicide attempts, depression, and rage attacks. As we will see in chapter 17, they will improve only if both patient and therapist appreciate the roles that these different states have played in their survival.

## ART, MUSIC, AND DANCE

There are thousands of art, music, and dance therapists who do beautiful work with abused children, soldiers suffering from PTSD, incest victims, refugees, and torture survivors, and numerous accounts attest to the effectiveness of expressive therapies.18 However, at this point we know very little about how they work or about the specific aspects of traumatic stress they address, and it would present an enormous logistical and financial challenge to do the research necessary to establish their value scientifically.

The capacity of art, music, and dance to circumvent the speechlessness that comes with terror may be one reason they are used as trauma treatments in cultures around the world. One of the few systematic studies to compare nonverbal artistic expression with writing was done by James Pennebaker and Anne Krantz, a San Francisco dance and movement therapist.19 One-third of a group of sixty-four students was asked to disclose a personal traumatic experience through expressive body movements for at least ten minutes a day for three consecutive days and then to write about it for another ten minutes. A second group danced but did not write about their trauma, and a third group engaged in a routine exercise program. Over the three following months members of all groups reported that they felt happier and healthier. However, only the expressive movement group that also wrote showed objective evidence: better physical health and an improved grade-point average. (The study did not evaluate specific PTSD symptoms.) Pennebaker and Krantz concluded: “The mere expression of the trauma is not sufficient. Health does appear to require translating experiences into language.”

However, we still do not know whether this conclusion—that language is essential to healing—is, in fact, always true. Writing studies that have focused on PTSD symptoms (as opposed to general health) have been disappointing. When I discussed this with Pennebaker, he cautioned me that most writing studies of PTSD patients have been done in group settings where participants were expected to share their stories. He reiterated the point I’ve made above—that the object of writing is to write to yourself, to let your self know what you have been trying to avoid.

## THE LIMITS OF LANGUAGE

Trauma overwhelms listeners as well as speakers. In The Great War in Modern Memory, his masterful study of World War I, Paul Fussell comments brilliantly on the zone of silence that trauma creates:

> One of the cruxes of war . . . is the collision between events and the language available—or thought appropriate—to describe them. . . . Logically there is no reason why the English language could not perfectly well render the actuality of . . . warfare: it is rich in terms like blood, terror, agony, madness, shit, cruelty, murder, sell-out, pain and hoax, as well as phrases like legs blown off, intestines gushing out over his hands, screaming all night, bleeding to death from the rectum, and the like. . . . The problem was less one of “language” than of gentility and optimism. . . . The real reason [that soldiers fall silent] is that soldiers have discovered that no one is very interested in the bad news they have to report. What listener wants to be torn and shaken when he doesn’t have to be? We have made unspeakable mean indescribable: it really means nasty.[20]

Talking about painful events doesn’t necessarily establish community—often quite the contrary. Families and organizations may reject members who air the dirty laundry; friends and family can lose patience with people who get stuck in their grief or hurt. This is one reason why trauma victims often withdraw and why their stories become rote narratives, edited into a form least likely to provoke rejection.

It is an enormous challenge to find safe places to express the pain of trauma, which is why survivor groups like Alcoholics Anonymous, Adult Children of Alcoholics, Narcotics Anonymous, and other support groups can be so critical. Finding a responsive community in which to tell your truth makes recovery possible. That is also why survivors need professional therapists who are trained to listen to the agonizing details of their lives. I recall the first time a veteran told me about killing a child in Vietnam. I had a vivid flashback to when I was about seven years old and my father told me that a child next door had been beaten to death by Nazi soldiers in front of our house for showing a lack of respect. My reaction to the veteran’s confession was too much to bear, and I had to end the session. That is why therapists need to have done their own intensive therapy, so they can take care of themselves and remain emotionally available to their patients, even when their patients’ stories arouse feelings of rage or revulsion.

A different problem arises when trauma victims themselves become literally speechless—when the language area of the brain shuts down.[21] I have seen this shutdown in the courtroom in many immigration cases and also in a case brought against a perpetrator of mass slaughter in Rwanda.

When asked to testify about their experiences, victims often become so overwhelmed that they are barely able to speak or are hijacked into such panic that they can't clearly articulate what happened to them. Their testimony is often dismissed as being too chaotic, confused, and fragmented to be credible.

Others try to recount their history in a way that keeps them from being triggered. This can make them come across as evasive and unreliable witnesses. I have seen dozens of legal cases dismissed because asylum seekers were unable to give coherent accounts of their reasons for fleeing. I've also known numerous veterans whose claims were denied by the Veterans Administration because they could not tell precisely what had happened to them.

Confusion and mutism are routine in therapy offices: We fully expect that our patients will become overwhelmed if we keep pressing them for the details of their story. For that reason we've learned to "pendulate" our approach to trauma, to use a term coined by my friend Peter Levine. We don't avoid confronting the details, but we teach our patients how to safely dip one toe in the water and then take it out again, thus approaching the truth gradually.

We start by establishing inner "islands of safety" within the body.22 This means helping patients identify parts of the body, postures, or movements where they can ground themselves whenever they feel stuck, terrified, or enraged. These parts usually lie outside the reach of the vagus nerve, which carries the messages of panic to the chest, abdomen, and throat, and they can serve as allies in integrating the trauma. I might ask a patient if her hands feel okay, and if she says yes, I'll ask her to move them, exploring their lightness and warmth and flexibility. Later, if I see her chest tighten and her breath almost disappear, I can stop her and ask her to focus on her hands and move them, so that she can feel herself as separate from the trauma. Or I might ask her to focus on her out breath and notice how she can change it, or ask her to lift her arms up and down with each breath—a qigong movement.

For some patients tapping acupressure points is a good anchor.23 I ask others to feel the weight of their body in the chair or to plant their feet on the floor. I might ask a patient who is collapsing into silence to see what happens when he sits up straight. Some patients discover their own islands of safety—they begin to "get" that they can create body sensations to counterbalance feeling out of control. This sets the stage for trauma resolution: pendulating between states of exploration and safety, between language and body, between remembering the past and feeling alive in the present.

## DEALING WITH REALITY

Dealing with traumatic memories is, however, just the beginning of treatment. Numerous studies have found that people with PTSD have more general problems with focused attention and with learning new information.24 Alexander McFarlane did a simple test: He asked a group of people to name as many words beginning with the letter B as they could in one minute. Normal subjects averaged fifteen words; those with PTSD averaged three or four. Normal subjects hesitated when they saw threatening words like "blood," "wound," or "rape"; McFarlane's PTSD subjects reacted just as hesitantly to ordinary words like "wool," "ice cream," and "bicycle."25

After a while most people with PTSD don't spend a great deal of time or effort on dealing with the past—their problem is simply making it through the day. Even traumatized patients who are making real contributions in teaching, business, medicine, or the arts and who are successfully raising their children expend a lot more energy on the everyday tasks of living than do ordinary mortals.

Yet another pitfall of language is the illusion that our thinking can easily be corrected if it doesn't "make sense." The "cognitive" part of cognitive behavioral therapy focuses on changing such "dysfunctional thinking." This is a top-down approach to change in which the therapist challenges or "reframes" negative cognitions, as in "Let's compare your feelings that you are to blame for your rape with the actual facts of the matter" or "Let's compare your terror of driving with the statistics about road safety today."

I'm reminded of the distraught woman who once came to our clinic asking for help with her two-month-old because the baby was "so selfish." Would she have benefited from a fact sheet on child development or an explanation of the concept of altruism? Such information would be unlikely to help her until she gained access to the frightened, abandoned parts of herself—the parts expressed by her terror of dependence.

There is no question traumatized people have irrational thoughts: "I was to blame for being so sexy." "The other guys weren't afraid—they're real men." "I should have known better than to walk down that street." It's best to treat those thoughts as cognitive flashbacks—you don't argue with them any more than you would argue with someone who keeps having visual flashbacks of a terrible accident. They are residues of traumatic incidents: thoughts they were thinking when, or shortly after, the traumas occurred that are reactivated under stressful conditions. A better way to treat them is with EMDR, the subject of the following chapter.

## BECOMING SOME BODY

The reason people become overwhelmed by telling their stories, and the reason they have cognitive flashbacks, is that their brains have changed. As Freud and Breuer observed, trauma does not simply act as a releasing agent for symptoms. Rather, "the psychical trauma—or more precisely the memory of the trauma—acts like a foreign body which long after its entry must continue to be regarded as an agent that still is at work."26 Like a splinter that causes an infection, it is the body's response to the foreign object that becomes the problem more than the object itself.

Modern neuroscience solidly supports Freud's notion that many of our conscious thoughts are complex rationalizations for the flood of instincts, reflexes, motives, and deep-seated memories that emanate from the unconscious. As we have seen, trauma interferes with the proper functioning of brain areas that manage and interpret experience. A robust sense of self—one that allows a person to state confidently, "This is what I