

THE TRAUMA INDUSTRY

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Can we be held emotionally hostage by an earlier - or even recent - event or trauma? Today trauma counselors rush to plane crashes, shootings, fires, earthquakes - disasters - to get victims to talk about what they saw, what they heard, and what they felt. These counselors tell us that the victim must be debriefed as soon as possible to prevent the onset of post traumatic stress disorder (PTSD) now, in the near future, or - in the worst case - years later. PTSD is spoken of with such a certainty of occurring and as such a threat that we must wonder how a responsible health worker, employer or victim could deny the help being offered.

But how did this disaster strategy begin? What fuels its momentum?

One soldier described trauma this way: "...it required a mental readjustment to face the stark fact that I had been scared. Scared not only psychologically but physiologically, for my pulse rate had gone up, digestion had stopped, and the adrenal glands -- sensitive to all degrees of fear -- had constricted my blood vessels to produce a dry tongue with an almighty thirst..."⁽¹⁾

Maybe you had to run for your life from a firestorm. Or the police have just told you that your spouse, child or parent was dead on arrival after a car accident. Or you witnessed your child hit by a car. Or you have just escaped a tornado, breaking loose from being sucked from your home or struck by flying debris. No one can remain neutral and in control in dire circumstances. Everyone reacts to extraordinary events.

The American Psychiatric Association's Diagnostic Criteria Manual defines PTSD as caused by "an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone..." PTSD can lie dormant, according to Dr. Koop, the former U.S.A. Surgeon General, and may not "...show up until years after the traumatic event." These authorities acknowledge the magnitude of such an event, then assign emotional shock and the depressive reaction that often follows an horrific event to the realm of disease. They classify PTSD as a medical problem.

Let's say I arrive home after jogging 10 miles, sweaty, heart pounding, to finding a dead chicken hung over my front door. My anger will surge and display with increased breathing rate and higher blood pressure. I will be in a dynamic physical state. Am I displaying symptoms of a physical illness? Are my emotional reactions, which may manifest such exaggerated symptoms because of my run and the dead chicken, a disease? Consider a policeman, who has been pursuing a suspect on foot, and then finds a dead body. Is his or her reaction the presentation of symptoms of a disease? If I or the policeman show physical signs of shock and then manifest any signs of depression, APA and Dr. Koop will answer yes.

Those who apply this disease logic to PTSD assume that the medical treatment of physical illnesses also apply to

non-physical functions such as emotional reactions. This cross-over is a misapplication. No universal law of human behavior supports the notion that human emotional behavior follows a predictable course. Grief is a classic example of the misapplication of the disease model to human emotional behavior. The so-called stages of dying so popular with grief and trauma counselors were introduced by Swiss psychiatrist, Kubler-Ross, in her book On Death and Dying. She declared that dying patients move through five emotional stages--denial, anger, bargaining, depression and acceptance. Soon her model was taught in medical school and seeped into mental health treatment. Then it appeared in everyday language; everyone from columnists to bankers to school teachers were talking about stages of grief. Her model has become more than a model. People, professionals and lay alike, adopted it as the prescribed, that is the correct way to grieve.

Superimposing the disease model upon human emotional behavior from trauma projects a false impression of predictability. Is a suggested model just an hypothesis or is it a universal law of behavior applicable to all humankind? Are we again allowing an interesting premise, perhaps valuable in developing new conjectures, to become the only and truthful way to view and heal the effects of trauma?

In fact, research at universities including Harvard and University of California have found no "normal" grief cycle, no "healthy" way that most bereaved persons behave.⁽²⁾ Rather, people show a great variety of responses to loss, as many as the 6 billion of the earth's population. In short research proves what we already know -- we are not emotional clones of one another. We respond as individuals.

Now too the claims of debriefing are being contested. Debriefing -- talking about what you saw, what you heard, and what you felt -- may have no impact on or, at worst, encourage dire consequences, consequences practitioners could not want. In adults, research shows that the debriefing method, also called Critical Incident Stress Debriefing (CISD), exacerbated depression in road accident victims and in emergency workers attending serious bus crashes. Those "debriefed had significantly higher scores for morbidity and distress ..." Similar findings occur in studies of earthquake victims, burn victims, car accident victims and Gulf War veterans.⁽³⁾

Furthermore, grief counseling in which children draw, talk or act out their feelings can exacerbate depression later on in their adulthood, according to The Royal Society of Medicine.⁽⁴⁾ The fact is that children notice adult behavior, absorbing adult emotional cues to the catastrophe. What the child notices then propels the youngster's own emotional response.⁽⁵⁾ If instead of releasing children from their trauma, debriefing could be etching horrific images into these young memories so that they cannot forget, why would we use such practices? Could reliving the horror be hitching youngsters to a trailer full of upsetting scenarios to drag throughout life? Is that what we want for our children? Anybody's children?

Post traumatic stress disorder is fostered by the wide-spread belief that horrible events can be repressed, stuffed away, pushed down, until they "break through" the memory, as if the memory is a catchment facility. If efficacy is so questionable, why is debriefing and the notion of PTSD so popular? The answer lies within Freud's speculations.⁽⁶⁾ According to Freud, childhood trauma is the basis for chronic flaws revealed in adulthood. The adult is held hostage to earlier traumas. And a leap in logic from Freudian theory of memory repression becomes the foundation for emotional behavior as pathology, the scientific study of the nature of disease.

Freud's speculation that memory houses repressed remembrances waiting to erupt has victimized patients and therapists alike. The most recent example is the proliferation of Repressed Memory Syndrome. Therapists attributed all the problems of their adult patients to sexual abuse. The flaw with this therapeutic deduction was that many patients didn't recall any abuse until the therapist's intervention. Next came proponents of False Memory Syndrome who contested the truth of repressed memory recall. The irony, of course, is that true victims

of abuse wish their memories were lost, repressed or gone forever. Unfortunately, they are plagued with ghastly images from the past, their torment trivialized and invalidated by all the suspicion over who is telling the truth.

Freud, a physician, could only proceed from the disease model. He sought the source of his patients' hysteria and attempted to excise it. He proceeded as if memory lies dormant like the tubercle bacillus waiting for the physical decline of its host to erupt into tuberculosis. He used talk therapy to release his patients' memories of childhood sexual abuse. The more talk focused on childhood memories, the less, Freud believed, the events held any power. [\(7\)](#)

PTSD is treated with this same logic, treated as if it were pathologically based - diseased. PTSD is an illness, claims DrKoop's website, that may not show up until many years later. Supposedly, PTSD is a mental and emotional time bomb ticking away in the memory catchment, until and unless you excise it. That is, once you've been traumatized, you remain so unless and until you relive the trauma. "Relive or suffer" is exactly what the trauma counselor warns disaster victims.

Still, researchers, from psychiatrists to geneticists, have searched many decades for that elusive disease connection, the physical determinants of aberrant emotional behavior. They have pinpointed none.

I asked psychiatrist Peter R. Breggin, M.D., "Are you saying no pathogen has been identified that causes emotional distress?"

"We've seen patients who get depressed when they have certain hormonal disorders," he answered. "Sometimes people get depressed when they're just plain sick. Sometimes people get depressed when they have head injuries. " But," he continued, "there's never been a particular pathogen or process clearly identified with depression, except, interestingly enough, with psychiatric drugs, which muck about with the neurotransmitters. It is clearly established, that for example, Prozac and Halcion can cause depression." [\(8\)](#)

Even proponents of the human genome project caution against leaps of logic that declare a physiological origin for emotional problems. Mapping the billions of cells comprising DNA is a long stretch to assigning a causal relationship between one gene and complex emotional behavior. While geneticists claim to have found genes for Duchenne muscular dystrophy, cystic fibrosis, and Huntington's Disease (a degenerative brain disease), they have found not one from the 30,000 genes in DNA directly, i.e. alone or singularly, causes emotional behavior. Nor has a pathogen been identified that directly causes anxiety, depression, schizophrenia, or post traumatic stress disorder. [\(9\)](#) [\(10\)](#)

Before the 70s, little or no attention was given to the human reactions of emergency workers, firefighters and such. Mental health professionals assumed that their training and "psychological profiles" firefighters made them immune from ordinary emotional reaction to catastrophe. Jeffrey Mitchell Ph.D., a former firefighter, and others saw need to care for his fellows suffering from emotional shock.

The "Mitchell Model" began with the Freudian hypothesis that by reliving trauma, the victim eliminates it. Next that notion was mixed with the 12-step group process and named Critical Incident Stress Debriefing (CISD). CISD includes intense re-exposure to the incident through reliving what one saw, heard, and felt. Debriefing, the shortened term for CISD, was supposed to mitigate the harmful effects of traumatic stress and lessen subsequent traumatic symptoms. (CISD or debriefing as used is not to be confused with the military method of debriefing, a necessary step for improving rescue skills.)

Social scientists took a closer look at Mitchell's claims. They wanted to know if CISD lessens consequences of

trauma but found his claims anecdotal and lacking in scientific rigor.⁽¹¹⁾ "Given the illusion of science and precision, through claims of theoretical roots and empirical evaluation, [an idea] readily transforms something with a life and momentum all its own."⁽¹²⁾ In fact, researchers called the popularity of debriefing, the "Barnum Effect" -- the pretty packaging and clever marketing of a nice idea -after "the master showman who built an empire on the premise that a little gullibility can be taken a long way."⁽¹³⁾

But the damage was done. Old methods had been wrapped up and decorated with a new name. Sensitivity training of the 60s and 70s was folded into the burgeoning Recovery Movement of the 80s and 90s, known today as support groups. These support groups hold in common many characteristics, including peer pressure, confession and conformity of thought and conformity of autobiographical memories, the same tactics applied during the communist revolution in China, brainwashing of Korean POWs, and here in the U.S. by communist cells during the 30s, 40s and 50s. Today's variations include the Recovery Movement slogan, "Think with your heart, not with your head"⁽¹⁴⁾ and autobiographical stories about how bad parents, insensitive spouses or slave-driving bosses make life miserable. Social scientists call this effort "ideological re-education or a modest form of elective brainwashing."⁽¹⁵⁾

Whatever way CISD is researched, analyzed or investigated, the end result is the same. If a firefighter, for example, witnesses a traumatic event, he or she is presumed to be on the road to PTSD and must be debriefed. Yet no one except the trauma counselors will claim that this strategy prevents PTSD or heals anyone, much less without possible harm attached to the process.

Unfortunately, the Western-European medical community has long accepted, almost as a divine-decree, that there is such a sickness as repressed emotions and memories, and the only way to a healthy life is to relive the traumatic event. "By medicalising what is a non-medical condition and introducing therapy subject matter that is vastly abused, medicine is propping up a lot of dwindling careers," Prof. McEwan told a European trauma conference.⁽¹⁶⁾ Despite substantial research debunking the claims of CISD proponents and challenging PTSD as a medical label, the trauma industry goes on. After all, the whole of psychiatry, psychology, and counseling is embedded with Freudian speculations.

By law, the workplace is held responsible for the health and safety of its employees. Therefore, management seeks to ensure health safety of employees and avoid legal fallout from a traumatic incident. CISD proponents claim that without CISD, employees will suffer PTSD at some future time. When this illness will attack, however, is unpredictable. As author and psychologist Tana Dineen said, "Under the guise of science, [trauma industry] pretends there are typical ways that people react to tragic or violent situations and some formula or standard for handling them. The message is: If you don't deal with this the 'right' way, you will get sick from it."⁽¹⁷⁾ ⁽¹⁸⁾

Management, therefore, must protect employees against the so called "pathology" of PTSD or risk litigation. In the United States, psychological debriefing after an emergency is mandatory in many occupations, even in emergency services. Police departments require their officers to undergo CISD after violent events. One police officer told me, after his car hit and killed a homeless pedestrian running across the San Francisco Bay Bridge. "I'm required to meet with the shrink, but me and my partner talked about it. The shrink doesn't tell me anything I don't already know."

The policy of most fire departments is to retain the crew after a "critical incident" such as an unusually dangerous fire. The crew is told to "share what they saw heard and felt" because supposedly reliving their emotional experience will lessen the firefighter's risk of recalling, for instance, going through the motions of resuscitating a

dead child while the child's mother watched expectantly. Or lessen the ever-plaguing question firefighters ask themselves, "Did I do enough?"

While the Recovery Movement method receives accolades from the firefighter administrators, front line personnel find it intrusive and unnecessary. One firefighter told me, "The Chiefs like to advertise what they are doing for us, but most of us think it's a joke." I asked one fire captain how his crew saw mandatory CISD. He answered by telling me about a firefighter who was rescued from inside a burning crack house, hot bullets exploding around him. The firefighter's shift was over, and he didn't want to hang around for CISD. He wanted to go home. "I can't force them to talk," the captain told me, " but I couldn't allow him to leave, so I told him to go to sleep." Aren't we contradicting and undermining our training that an individual has the wherewithal, the personal tools, to manage his life? Are we sick and feeble unless given a pass by an authority figure?

Crisis Management formalizes, that is institutionalizes, and makes mandatory activities that people do naturally, i. e. spontaneously, after they have endured a shocking event. Jolted by an extraordinary event we generally do the following:

- 1) We're gregarious by nature. We gather on street corners, in bars, in grocery stores to trade stories and talk about what we saw, heard and felt. Neighbors ask each other: Where were you when (fill it in) happened? Did you hear the explosion? See the flames?
- 2) We try to make sense of our surroundings. From city meetings to church pulpits to casual gossip, we examine and explain why the sensational event, the hurricane, shooting, or car accident happened.
- 3) We comfort each other, driven by our human compassion, for we can't sit by and watch others suffering without attempting to alleviate their pain. Neighbors deliver food to each other; parents and children cradle each other; strangers donate medical supplies and money.
- 4) We may feel guilty that the other guy got hit and we survived. For example, one house stood among a neighborhood of burned out homes. Inside the owner brought out champagne glasses while his friend popped the cork and poured. The owner left his glass untouched, unable to celebrate his good luck while his neighbors sifted through ashes and mourned.

When we humans share a common experience, we convene of our own accord. We are a social species. For centuries we turned to houses of worship seeking comfort and care, seeking commiseration and rebuilding. But today, with our fluid, less defined social structures, a confluence of business, law, and psychology has created the Crisis Management Industry --administrators and professionals who will impose on us a structure, without respecting or believing in what is a part of each of our human natures, our own unique and singular ability to adapt and rejuvenate to our ever-changing circumstances.

The Crisis Management Industry has turned a service of solace and benevolent emotional support, once the domain of established religions and stronger communities, into a business, a business supported by "the psychology industry's view that everyone needs help whether they know it or not."⁽¹⁹⁾

The human behavior model describes PTSD as a condition manufactured by the disaster industry, for PTSD is no more than the acute emotional/mental shock followed by depression that varies according to personal mental style. The human behavior model holds that emotional reactions result from ordinary human characteristics, not pathogens; that each emotional reaction system of the six billion of us is unique from any other. Humans do not

follow a formula in their pattern of reacting, as each is singular to one's own self.

The human behavior model subscribes to the position of famed anthropologist Ashley Montagu: "The one thing characteristic of human nature, is, surely, its changeability under changing conditions. The one characteristic of man as man is his ability to make all the necessary changes within himself to meet the demands of a changing environment. This trait, plasticity or educability or adaptability, is the one which, in the human species as a whole, has had the greatest demands made upon it by natural selection. Survival of the human species and its progress has depended upon this ability of human nature to change in adaptation to changed conditions." ⁽²⁰⁾

ADDENDUM

For more on how to take care of yourself and those you love after a trauma see the author's book Emotional Recovery After Natural Disasters: How To Get Back To Normal Life. ⁽²¹⁾ This easy to read, book offers solutions, not philosophy and is founded in the following facts and three decades of experiential research at the Center for Counter-Conditioning Therapy®.

A. There are 6 billion sets of human reactions, not just one. A person doesn't work at behaving uniquely, for each reacts to his or her surroundings, catastrophic or not. This reality, that 6 billion humans react singularly and uniquely, has been overlooked by those industries seeking to homogenize human behavior.

B. Acute shock lasts from 10 days to two weeks. (Confirmation of this fact goes as far back as the 1800s ⁽²²⁾.) How you fare after two weeks depends in great part upon how you've taken care of yourself during that initial shock.

C. After the initial shock you can go on with the business of life -- reorganizing yourself within your new circumstances - unless you become preoccupied with the trauma.

D. If you remain preoccupied with horror, chances are good that you'll get depressed. We need look no further than recent wars in Yugoslavia, Rwanda, or the Balkans. Refugees have no respite from their preoccupations with disaster. Look at the Kosovo refugee camps where the unrelenting distress of ghastly preoccupations fuels the refugees' mental turmoil. "When the refugees come across the border here they're still in shock," said Roger Lake, a Canadian doctor in Kukes, Albania. "They can't sleep, or they wake up at 3 in the morning, and circular thoughts go around and around in their head. They lose their appetite; they're crying all the time; they have no energy... They've been here a month now, and [they've come to the point] where life isn't worth living." ⁽²³⁾ Forced to live under continued mental turmoil, "[They're] replaying and replaying [what happened] because [they're] trying to make sense of it. You can get stuck in that, and it can make you feel very ill," Lynne Jones, a British psychiatrist said. ⁽²⁴⁾ Depression is a usual and normal response to emotional shock.

Endnotes

