

**MAPPING TRAUMA AND
ITS WAKE:
AUTOBIOGRAPHIC
ESSAYS BY PIONEER
TRAUMA SCHOLARS**

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It is not an easy task writing an autobiographic essay of a career in traumatology – or more correctly, the evolution of understanding trauma and posttraumatic stress disorder (PTSD). Looking backwards is the nature of autobiographical work and one is never sure how well focused the binoculars are when covering a long trail and wide field of professional endeavors. When it comes to this autobiography, I've often wished that someone would have invented a neurological probe, a device like an old-fashioned thermometer, that could be inserted painlessly into the brain and extract perfectly preserved memories that could be 'downloaded' to print out the exact details of one's life experiences. Or better yet, the probe device could be inserted into a monitor screen and we could view in three-dimensional holographic color imagery the chapters of life. Who knows, maybe this is what happens automatically in spiritual consciousness when we exit this life to the next level of being.

HISTORICAL FRAMEWORK

To frame some kind of historical perspective, I have to go back to my graduate school years at Michigan State University in 1969 – 1973. It is here that there were two diverse pathways that laid a foundation for my later work in PTSD. First, my academic interests at that time were in the study of personality processes and their relationship to altruism. I wanted to know how personality characteristics were associated with altruism under different types of social situations and conditions of need. In a series of studies I explored a 'person by situation' interactional model of prosocial behavior and discovered that persons with high self-esteem were more consistently helpful across different

situations requiring assistance than were insecure, anxious, safety-oriented persons (Wilson, 1976). These studies directed my attention to the larger question of why people fail to act in situations where there are clear-cut needs for intervention without moral conflict about doing the right thing, as seen in historical examples such as My Lai in Vietnam; the Holocaust; ethnic and genocidal massacres in Rwanda, Cambodia and the former Yugoslavia. On the other side of the coin was the question of the victim. What happens to victims in different types of everyday life situations and how strong does their personal need for help have to be before others will act in prosocial ways? These questions were of strong interest to me during the years of my graduate training and the early part of my academic career. Eventually my laboratory studies led me to want to understand what had happened to men who served in Vietnam, as the war raged on unabated during this time period (1969-1973).

On a personal level, several of my closest life-long buddies enlisted in the U.S. Marine Corps after high school and served in Vietnam in 1966-1967. They were never the same afterwards. And despite my most sincere attempts to “re-connect” with them after coming home from the war, they were angry, alienated, short-tempered and refused to talk about their experiences. I lost my best friend to a war and his only comment to me for 13 years was, “fuck you, you wouldn’t understand, you weren’t there.” As a historical footnote, he called me at midnight after I appeared on the television program 60 Minutes with Mike Wallace in 1979-1980 to talk about PTSD in Vietnam veterans. My life-long buddy said, “Jack, ol’ bud, I need to talk to you. Can we meet somewhere?”

The second historical thread which extends back to my graduate school years relates to four years of work in a crisis intervention center in East Lansing, Michigan. It

was there, on a daily basis, that I cut my teeth working with a wide range of psychological emergencies. Many of those who telephoned for help or walked in had been traumatized: rapes, drugs, divorce, abuse, assaults, suicide attempts, chronic incurable illnesses or severe mental disorders. I learned a lot from doing crisis intervention and little did I know at that time that it was going to be my clinical ‘boot camp’ for the work with Vietnam veterans that was soon to follow.

In 1973 I accepted a position at Cleveland State University where I reside today. I was attracted to the newest school in the Ohio system and turned down a three-year post-doctoral fellowship at Harvard Medical School to begin my career here. The university offered to support my research interests, build me a laboratory and give me nearly unlimited support to pursue my research program. It was an exciting environment in which to work.

During my first year, 1973-1974, I unwittingly encountered the first of many Vietnam veterans attending the urban university and who sought out my help. I did not know it at the time, but there were nearly 1,900 Vietnam veterans attending the University in the early 1970’s and many of them made their way into my psychology classes and office. This was to be the beginning of a relationship that changed my life forever.

There are so many stories of importance that happened between 1973-1976, that it is hard to know which ones to tell you about. There are a few vignettes that I want to share because they represent so many others like them that I came to know – Vietnam veterans struggling to come home from the war.

During the first week of my teaching, a youthful, blond, curly-haired Irishman,

John Burke, walked into my life. He introduced himself as a psychology major and told me rather quickly that he was trying to get his life together and had no place to live. He stated without reservation that he was a recovering heroin and alcohol addict who was estranged from his Irish-Catholic family and needed a place to 'crash' for a week or so until he could find a job and place to live. I was impressed by John's intelligence, sincerity, intensity and understated desperation. Having just purchased a large, old colonial home, I invited him to stay with my wife and I until he could get himself situated. He indicated that he was handy with his hands and could fix things that needed repair. John said he'd stay no longer than two weeks and be on his way.

John moved in and quickly went about his endeavors. Always polite, courteous and intellectually engaging, he set about fixing cracked windows, leaky toilets and broken door locks. I was impressed with his 'handyman' skills and willingness to help us fix up our old house. Time went by and John stayed on, continuing to help with repairs, demanding nothing other than a place to sleep. He usually took his evening meal with us before leaving every night for what he called his 'cookies and coffee' club meeting. He never mentioned the name Alcoholics Anonymous (AA), but eventually I figured out that is where he went to meetings at a nearby St. Ann's Catholic Church.

One night, while working late in my study, John asked me if we could talk. I said sure and sat back to listen. For the next five hours he told me for the first time that he was a combat medic, with the 101st Airborne Division in Vietnam. He talked about his war experiences and how they led to his use of heroin before the end of his second tour of duty. He explained that he had never discussed his war experiences with anyone and appreciated my willingness to listen. For the next six months, we talked about Vietnam

every night. John seemed to feel better and looked much more relaxed. His two-week stay extended to 9 months and he moved out at the end of the school year and had done well in his studies and personal life. Four years later, he graduated from the University as a Presidential Scholar with a 3.98 GPA and the most distinguished student. He went on to obtain his Master's degree and today is an international director of programs concerning refugees, war and torture victims in different parts of the world. He has a wonderful family and remains sober and an active member of AA, despite additional traumatic losses in his life.

John Burke's life and story about Vietnam moved me deeply as a person. Soon, I was meeting other Vietnam veterans in my classes who would introduce me to others outside the university community including Cleveland's tough inner city ghetto, Hough, the site of race riots in 1966. The process snowballed in 1974. I began conducting informal interviews in a pilot study to learn more about the impact of the Vietnam war in their lives. The format was simple: "Tell me about what you were like before Vietnam; what happened in Vietnam; and how have you changed since coming home from the war." I interviewed several hundred men, kept notes, and then began to tape record sessions with their permission. Soon, the men requested an opportunity to get together with other 'Nam vets' to talk. I started holding 'rap groups' at the university on Tuesday and Thursday evenings. These were intense, emotionally powerful experiences. What I encountered in the way of raw emotional intensity surpassed anything I'd ever experienced in my life. I had many personal reactions, including the feeling that the real story of what actually happened in Vietnam had never been told to the American people. I identified with the veterans' pain, suffering, alienation, anger, rage and feeling

‘forgotten’ and abandoned by the government and people that sent them to war. The guys in the group reminded me of my lost life-long buddy, Willie, whose personal well-being had been snatched in combat with the 3rd Marines in Vietnam. I began to sense the uniformity and common suffering of their post-war lives; the nightmares, flashbacks, isolation, anger, loneliness, loss of identity, binge drinking and feelings of betrayal and abandonment. In varying degrees, they all shared a ‘syndrome’ of sorts which was worse for those with hard-core combat, blood and guts experiences, senseless killing of villagers, and the repeated witnessing death, dying, destruction and atrocities. I often had the feeling that I was looking at the tip of an immense iceberg whose depth of dimensions scared me. But, there was no denying its existence. It was there and about to erupt like a glacier cutting loose and creating a deafening roar in the silence of nature. Along with other professionals working in isolation, I began speaking of the ‘post-Vietnam syndrome’ and coined the term ‘delayed stress reaction’ to characterize the pattern of symptoms that develop following attempts at re-adjusting to American society after Vietnam.

By 1975 I felt the need to study more systematically the phenomena of post-Vietnam adjustment among war veterans. I began writing research proposals and over the next two years, had at least a half-dozen rejected. Interestingly, the feedback was always the same, “this is a timely and important subject but not one that is our priority for funding at this time.” The message could not have been clearer: America was not ready to take a self-effacing look at the Vietnam War and what it did to the men who fought there.

The U.S. left Vietnam in 1973 and the war ended in the spring of 1975 when

North Vietnamese troops and tanks rolled into Saigon. To the men I was working with, the war wasn't over and in their minds they were still there. By now, I was working alongside them in spirit and commitment. It was then that the 'Nam vets' started calling me 'Doc' and soon my colleagues at the university addressed me in the same manner. Today, 30 years later, no one calls me John, Professor, Dr. Wilson or anything else...just 'Doc.' Some of the vets still call me by the Vietnamese name for doctor, "Hey, Bac Si."

The rejection of the grant proposals to study the re-adjustment problems of Vietnam veterans was discouraging. By 1976, I had just about decided to leave this new research interest and return to my laboratory studies of altruism. But, that was not to be. One day a disabled veteran came in for an interview in my pilot study. His name was Henry Vasil, an engineering student at the university.

Hank was hit at point-blank range by a rocket propelled grenade (RPG) while manning an M-60 machine gun on the back of an armored personnel carrier (APC) on November 11, 1969 while serving with E-troop, 1st Cavalry, 11th Brigade, Americal Division. The impact of the RPG blasted him off the APC and blew away parts of his hands, arms, legs, head and chest. When I met him, he was noticeably scarred with shrapnel marks from his head to his knees. Hank spent time in the hospital in Japan for his burns and had multiple surgeries before being transferred to Walter Reed Army Hospital for the next two years of additional surgeries and treatments. Hank was a power weightlifter and state champion athlete in track prior to enlisting in the U.S. Army. When he returned home to his high school sweetheart and loving wife, Sharon, he was a frail, emaciated, tattered and torn shell of his 6' 4" stature; half of his top athletic weight and physical condition. Today, Hank remains married to Sharon and has two strong,

handsome sons, Scott and Philip.

Hank asked me on many occasions how the grant proposals were progressing. I told him that they had been rejected and that I was discouraged and ready to give up. By now it was 1976 and I was about to leave for summer vacation when Hank said, “Doc, have you tried the Disabled American Veterans?” I told him ‘no’ and with that he picked up the telephone and dialed the National Commander, Dale Adams, in Washington. Hank spoke with Mr. Adams, informed him that he was a member of DAV, and 100% disabled. He told him about my work and need for research funding and handed me the phone. I remember that Mr. Adams asked smart, insightful questions about my proposed project, The Forgotten Warrior, and asked me how much money I needed to complete the first phase of the project. I told him and he promised to get back to me. I left to attend the 1976 Fourth of July celebration in Boston to visit a college friend. When I returned home, there was a stack of pink phone messages on my desk marked ‘urgent.’ I contacted the director of research services who informed me that they had received a check for \$50,000 from the DAV. The Forgotten Warrior project was now a reality. Just at the point where I thought I would quit and return to laboratory research, the tip of the iceberg popped up to greet me and the in-depth study of Vietnam veterans took center stage.

One year later, I testified before the U.S. Senate for the first of six times on my research findings. The day after the testimony, Walter Cronkite’s CBS Evening News telephoned to make plans to come to Cleveland to do a documentary. Two weeks later, the White House telephoned and asked me if I would be interested in developing an outreach program for the Veterans Administration (VA) and informed me of President Carter’s interest in the work. Shortly after that, I met another disabled veteran and

quadriplegic named Max Clelland who was the director of the VA in Washington and later, U.S. Senator from Georgia. At the same time, the DAV decided to launch a 66 city national outreach program to assist Vietnam veterans. I helped designed and implement it over the next several years (1977-1980). The idea was simple: create a one-stop service center staffed by Vietnam veterans for Vietnam veterans that could provide assistance and counseling for war-related stress problems (i.e., PTSD, education, jobs, health care and assistance with obtaining service connected benefits from the VA). Much of what developed through the DAV's national outreach program carried over to the design of the VA's Vietnam Veteran Re-Adjustment Counseling Program (RCS) which began in West Los Angeles in late 1979 under the nurturing eye of Senator Alan Cranston, chairman of the Senate subcommittee on veteran's affairs. On August 15, 1979, the congress passed a law (S.7) enabling a veterans health care act which appropriated funds to finance the VA's new program dedicated to establishing national outreach counseling centers in satellite locations outside VA medical centers and hospitals. I was surprised and overwhelmed when I received a letter of commendation from President Carter who gave me the pen that he used to sign the bill and an original copy of the bill itself on behalf of my efforts to aid Vietnam veterans. One month later, I received the George Washington Honor Medal from the Freedom Foundation at Valley Forge, Pennsylvania.

The pilot studies begun in 1973, in which I recorded the accounts by Vietnam veterans of how they had been affected by the war, produced a rich amount of material. Using a simple method of open-ended interviews, the men poignantly and painfully described what happened to them in Vietnam. The scheduled two-hour sessions often lasted much longer. Virtually all of the participants disclosed that they had never talked

about their combat and war zone experiences. The sessions were emotionally powerful and interrupted by periods of sadness, crying, anger, rage and quiet, unspoken pride. I found myself becoming more absorbed into their experiences and disturbed by their narratives of guerrilla warfare and the senseless things that happened during the war. There were accounts of search and destroy operations, long-range reconnaissance patrols, the burning of villages, confusion about terrain objectives and who was the enemy, the horrors of mortar and sniper attacks at night, the accounts of being in formidable jungles and rice paddies, and what it was like to be a helicopter door gunner and crew chief, swift boat sailor in the “brown river” navy or ‘point man’ on patrol in an infantry unit. Especially important were the descriptions of how difficult it was for a 19-year-old to sort out what was happening in Vietnam, trying to understand such things as a free-fire and no-fire zones; the omnipresence of Viet Cong soldiers, night and day; the killing, death and the demand for body counts in a war of attrition. So often, the same themes emerged from the interviews: Why did my buddies die? What’s this war about anyway? Why are we rejected by American society? Why can’t I sleep? Why can’t I relax? Why do I need to have a weapon at all times? Why can’t I “fit in” now? How come I’m not the same person I was before going to Vietnam? Why am I so jumpy? Why don’t I trust anybody now? How do I know whom to believe anymore? They lied to us in Vietnam about the war and about what was happening in Vietnam. Why do I feel most secure when I am alone and drinking my Bud and Jack Daniels?

By the time the Forgotten Warrior project began, the themes which emerged from the open-ended interviews were clear and beginning to make sense. The war experience produced a great deal of ideological and attitudinal change. Red-blooded 18 and 19-year-

old boys fresh out of high school were sent to the other side of the world to fight a war against the possible spread of communism, the dreaded 'red hoard' we'd been taught about in high school during the 1960's. At that time, the justification for the war was barely credible in an era of cold war politics and the halo effect of John F. Kennedy's credo: "Ask not what your country can do for you, but what you can do for your country." Like my life-long buddy from Columbus, Ohio who went off to become a U.S. Marine, he didn't know what he was getting into in Vietnam. And within a year, the men who survived had their worlds turned upside down by the horrors of war, assaults on the truth, political and military betrayal and the absence of a genuine homecoming and appreciation of their service by the American society. There was no doubt that this wasn't the war our dads fought in WWII and neither was the country dedicated to the G.I.'s and their lack of clear-cut victory in America's longest war.

The changes I was observing in belief systems, attitudes and political orientation were surface manifestations of a larger inner struggle with identity. Time and time again I would hear the men say, "Doc, I'm not the same person who went to Vietnam, I've changed. I'm not sure who I am anymore." This theme was so prevalent that it became readily apparent that the stressors of war had intensified and taxed the young adult developmental task of establishing a sense of personal identity in preparation for future roles. There was an internal set of changes stirring about in the newly returned veterans of America's most unpopular war. They were trying to sort everything out and at the same time find a place in the American society in which they could live and get on with life. Feelings of alienation, estrangement, cynicism, and doubt were predominant as the men looked around at successful, prospering peers and mainstream American society

unaffected by the war. The war traumatized veterans had existed in a strange land and surreal world of madness of death, dying and destruction in the darkness of the abyss of human suffering. And for what?, was the unanswerable question for many of these men.

There was uniformity of concerns expressed by the men about their post-Vietnam life. There was confusion about changes in personality and behavior. Reports of sleep disturbance, startle response, anger, irritability, jumpiness, and flashbacks to scenes of combat were universal. The reticence of talking about the true nature of events in Vietnam was paramount with fears of being misunderstood and disbelieved. Accounts of hyperaroused, “wired up” behaviors were particularly evident among those who engaged in infantry patrols, search and destroy operations and fire-fights in the jungles and rice paddies. The “wired up” behaviors included sleeping with weapons, booby-trapping property, nighttime perimeter patrols of property and backyards with weapons, suspiciousness, being on guard for possible attack by the V.C. or ‘enemy’ forces, and a strong need to make sure that loved ones and children were protected against possible harm. There was tentativeness in asking me about upsetting and strange behaviors that included flashbacks, nightmares, traumatic memories, periods of acting without knowing what happened (i.e., dissociative flashbacks), the sudden onset of heart palpitations, sweating and emotional states of anxiety, fear and intense anger. Accounts of self-medication with alcohol or marijuana were common and most men traced the use of substances to the need to “come down” after combat operations in Vietnam. There were also changes in perception of self-in-the-future. Men would say, “Doc, I was 19 when I went to Vietnam in 1967 and now I feel as though I’m 60 years old. I don’t know if I’ve got much of a future or even want one.” The confusion about the amount of viable time

left to sort out the impact of the Vietnam experience carried over to problems in intimate relationships. Many reported feeling numb and an inability to sustain close, intimate relationships. There were accounts of difficulties in friendships and attempts to express inner feelings to others. The usefulness of combat hardened numbing was now causing difficulties in social relations. There was fear that to 'let go' of the numbed outer psychic skin developed in Vietnam would have bad consequences. It was safer not to feel and to maintain automatic states of vigilance and hypervigilance. The result was increasing degrees of isolation, estrangement and alienation. Soon, many men were existing in cocoon of isolated numbing and felt trapped in the psychic trauma of their war experiences. It was a dark place that was difficult to share with anyone, except for the 'band of brothers' who walked together in harms way.

By the time I testified before the U.S. Senate subcommittee on veterans affairs in 1977, the post-Vietnam pattern of psychological reactions was very clear to me. There was no doubt that it was a multifaceted process which cross-cut different dimension of psychosocial functioning: identity formation, prolonged stress reactions, psychobiological disruptions associated with nervous system functioning (e.g., startle, hyperarousal, sleep disturbances), social alienation, and disillusionment. I knew that this was more than just a 'post-Vietnam syndrome' and that there were variations in the presentation of war-related changes in behavior. I also knew that there were degrees of severity in the condition and that some symptoms were debilitating and led to disruptions in daily living. I began speaking of the delayed stress syndrome and shortly thereafter by the more generic term, posttraumatic stress disorder (PTSD). The symptoms and behaviors fit a pattern which I began to classify by categories in 1978. I drew up several lists of

symptoms and organized them for brochures published by the Disabled American Veterans to aid veterans. At the same time, work on constructing the VA's re-adjustment counseling program (RCS) continued in meetings in Max Clelland's office in Washington, D.C. It was there that I met Dr. Arthur Blank, Shad Meshad M.S.W., Dr. Charles Figley, Dr. Frank Ochberg, Dr. Arthur Egenderf and others who worked primarily with Vietnam veterans. We exchanged observations and to no one's surprise we all were like the blind men trying to describe the proverbial elephant. By then we had a good sense of the phenomena of PTSD which was soon to become a new diagnostic category in the DSM-III, which was first published in February, 1980. Once PTSD was included in the official bible of the American Psychiatric Association (APA), the doors of science, law and social policy were opened in ways that few could have envisioned at the time. I believe that the advent of PTSD as a diagnostic category was a critical turning point for both science and the humanitarian treatment of trauma survivors. On a spiritual level, I believe that the power and energy from centuries of human trauma and suffering finally got an official mouthpiece and spokesperson with the PTSD diagnostic category. The ghosts of the past had arisen to set in motion a process of discovery that would transform the scientific and spiritual understanding of trauma forever.

THE PEOPLE WHO INFLUENCED MY WORK

My graduate and post-graduate education during the late 1960's and early 1970's did not include courses on stress, trauma, and coping. There simply were no courses in the curriculum on the subject. Moreover, in terms of the clinical understanding of traumatic reactions, the DSM-II (1968) classified stress reactions under the rubric of

transient adult personality disorders (code 307.3) with a sub-category of adjustment reaction of adult life. In fact, the DSM-II went so far to say that the category was to be used as a temporary diagnosis and that if symptoms persisted, another diagnosis was warranted. Of course, the other diagnosis 'warranted' were limited to psychoses, neuroses and character and behavior disorders. The point that I am making is that the understanding of psychological trauma was limited. Theoretically, the classificatory scheme could be traced to Freud's (1916) explication of the traumatic neuroses. In retrospect, I had no professors in university studies who could have provided tutorial since the study of trauma and PTSD did not exist in mainstream psychology at the time.

Looking back on the period of my earliest work, 1973-1980, there are several people who were influential in my work and are friends and colleagues today.

First, I want to acknowledge Robert Jay Lifton, M.D. Bob was a distinguished professor at Yale University when I first telephoned him about the work I was doing with Vietnam veterans. I had read his book, Death in Life: The Survivors of Hiroshima (1967), and felt that it was one of the most important books of the 20th Century. It was clear to me that Lifton was a compassionate, courageous and creative person. His account of the posttraumatic effects of the first atomic bomb were profound and frightening in their implications. Through his extensive interviews with the A-bomb survivors (cf. Hibakuska), Lifton laid out the entire phenomena of PTSD in remarkably clear ways. Today, part of our nomenclature and diagnostic criteria for PTSD originate from his research on A-bomb survivors. Terms like psychic numbing, survivor guilt, death guilt, posttraumatic neurosis, involuntary re-living phenomena, active and passive avoidance of situations that trigger reminders of the trauma, etc., were incisively

described by Lifton in 1967.

If I remember correctly, my first contact with Bob Lifton was in the fall of 1976 as the Forgotten Warrior project began. He was kind, supportive and encouraging of the research project. Bob left the door open for me to contact him and gave generously of his time and insights for the next several years. We met in person at the First National Symposium on the Issues of Vietnam Veterans held in Santa Rosa, California in 1979 and I found a kindred spirit; a man of enormous integrity, dedication and unflinching moral character to stand up for what is wrong, even if politically unpopular. To give one poignant memory, I remember Bob telling me that when it comes to work with victims of extreme trauma, there can be no moral neutrality. It was an important lesson and one that I have reflected upon many times when fighting in different arenas for the rights of trauma victims.

Throughout the mid to late 1970's, there were several others who influenced my work in different ways. Charles R. Figley has been a friend and collaborator since 1977. Charles is a natural born leader and had established a role as 'point man' on issues pertaining to war veterans and later, trauma victims in general. As early as 1979 we discussed the idea of creating a society for traumatic stress studies (STSS), which became a reality in 1985. Charles and I shared many common views about what was needed for the newly emerging field of trauma studies which included journals, books, professional societies, advocacy, and social policy changes by legislative acts.

At the University of Cincinnati, Bonnie Green and Jack Lindy were heavily involved in the 1972 Buffalo Creek Dam disaster research and later clinical studies of psychotherapy outcome with Vietnam veterans. Bonnie is a first rate methodologist and

researcher with a keen mind. I learned a great deal from her about the intricacies of disaster research and the limitations of psychological questionnaires.

Jack Lindy is a world-class psychoanalyst with a truly unique ability to understand how trauma affects the inner psychic life and unconscious processes. No one has influenced my intellectual thinking about the dynamics of PTSD more than Jack Lindy. The creative processes that Jack and I shared along the way gave birth to the ideas in the book, Countertransference in the Treatment of PTSD (Wilson and Lindy, 1994) and my most recent book, Empathy in the Treatment of Trauma and PTSD (Wilson and Thomas, 2004).

In reviewing the first decade of my work in the field of traumatology, I would be remiss if I did not mention the names of colleagues who conducted the Legacies Study on Vietnam Veterans in New York City in the 1970's. The late Bob Laufer was a brilliant sociologist who helped me think about the interface between social forces and traumatic consequences. Dr. Arthur Egendorf is a gifted clinician and was co-director of the Legacies project. Art, a Harvard graduate and Vietnam veteran, had a fine-tuned mind regarding the dynamics of PTSD in combat veterans and their intricacies in personality functioning.

As a final word about the people who influenced me to make contributions in the field of traumatology, I have to acknowledge Sigmund Freud and Erik Erikson. For years I have poured through Freud's writings on psychological trauma looking for his insights, which are numerous and dispersed throughout the standard edition of his collected works. Freud understood PTSD as early as 1916, as discerned succinctly in The Introductory Lectures on Psychoanalysis (Chapter XVIII) and in later elaborations in Beyond the

Pleasure Principle (1920). It is my personal belief that had Freud lived through World War II and witnessed the mass destruction, killings, the Holocaust and the first atomic bomb at Hiroshima, that he would have revised his theory to incorporate ideas of how the ego can exhibit prolonged absorption in the traumatic material without predisposing vulnerabilities from repressed psychosexual conflicts of childhood development.

Erik Erikson's life work on the epigenesis of identity has had a strong influence on my thinking. As noted by Lawrence J. Friedman (2001) in his biography of Erikson, the central theme of his work was the formation and change in identity across the life-cycle. Although it rarely appears in college text books on the eight stages of life-span development, Erikson's insights about identity-confusion and the loss of a sense of self-sameness and continuity came from his clinical work with repatriated WWII veterans seeking help in San Francisco in 1944 and with his psychoanthropological work with Native Americans living on U.S. government reservations. Erikson understood that traumatic experiences and cultural uprooting could impact the inner world of identity formation. Moreover, Erikson's work implied that trauma could impact at any stage of life-cycle development, from infancy to old age, with discernable effects depending on what stage of ego development was predominant. Nowhere was this insight more relevant than to my early work with Vietnam veterans who were 18-20 years old in Vietnam, the precise age at which early adult identity formation begins to firm up in anticipation of adult roles and responsibilities. As I sat and listened to the participants in our earliest pilot studies, the resounding theme which occurred over and over again was, "Doc, I'm not the same person I was before I went to Vietnam. I've changed. I don't fit in anymore. I don't know where I'm going now. I was 19 in Vietnam, now I feel 60. I

don't know whom to trust or what to believe and I don't know what I'm going to do.”

These statements were clear evidence of identity confusion and a loss of self-sameness and continuity. Since first hearing those words coming from the dispirited souls of Vietnam veterans, I have heard them expressed all over the world: Bosnian refugee and torture victims; returning Iraqi war veterans; displaced and homeless soldiers in Croatia; asylum seekers and refugees from Iran, Turkey, Cambodia, Armenia, El Salvador and other countries in the world. So powerful is the impact of trauma to the inner world of experience, that my forthcoming book is focused on The Posttraumatic Self: Restoring Meaning and Wholeness to Personality (Wilson, in progress, Brunner-Routledge Press).

CONTRIBUTIONS TO THE FIELD

In reflecting on my achievements in the field of traumatic stress studies, I find it necessary to divide them into four areas which are interrelated: (1) written works; (2) humanitarian work; (3) program and organizational development; and (4) forensic/legal contributions.

Scholarly Publications

There is a chronology to my scholarly work which begins with the Forgotten Warrior project which culminated in a three-volume series published by the Disabled American Veterans (1977-1980). Out of that work grew a chapter written for Charles R. Figley's (1980) book, Strangers at Home: Vietnam Veterans Since the War, entitled *Conflict, Stress and Growth: The Effects of War on the Psychosocial Development Among Vietnam Veterans*. In this chapter, I synthesized a psychodynamic perspective of war stressors on ego-identity formation and PTSD was presented. Three additional

chapters followed in Figley's 1985 and 1986 books, Trauma and Its' Wake. These chapters focused on conceptualizing a theoretical framework of PTSD and comparative analyses of PTSD in different trauma populations. At the same time, research on the factors predictive of PTSD among Vietnam Veterans was published in Bill Kelly's 1985 book, Posttraumatic Stress Disorder and the War Veteran Patient. The chapter was entitled *Predicting PTSD Among Vietnam Veterans*. The findings from this research have since been replicated many times showing the strength of war zone stressors as primary factors in statistical predictions of PTSD symptoms. This chapter was one of the first to empirically examine the role of pre-morbid personality disorders in relation to PTSD symptoms. Similarly, this same research data led to the an empirical study of PTSD in relation to criminal behavior and was published under the title, *PTSD and the Disposition to Criminal Behavior*. Among other findings, the results established a significant relationship between combat roles and war zone exposure to criminal activity of a violent nature as measured by the Vietnam Era Stress Inventory (Wilson and Kraus, 1979). The chapter also included a typology of 9 different forms of PTSD as complex syndromes. It was here that I spelled out the multidimensional nature of PTSD and identified three specific forms of survivor mode behavior associated with PTSD and the disposition to criminal behavior (i.e., sensation seeking, dissociative flashbacks, depression-suicide).

In the spring of 1986, the second annual meeting of the Society for Traumatic Stress Studies (STSS) was held at Cleveland State University which was titled, From the Holocaust to Vietnam. In 1988, the proceedings were subsequently published by Plenum Press under the title Human Adaptation to Extreme Stress: From the Holocaust to Vietnam (Wilson, Harel and Kahana, 1989).

Charles Figley asked me to pull together some of my work in one volume and Trauma, Transformation and Healing was published by Brunner-Mazel in 1989. There are three chapters in this book which I regard as important achievements. The first is a 'person by situation' theoretical model of traumatic stress. This chapter, entitled *A Person-Environment Approach to Traumatic Stress Reaction*, was an outgrowth of my book with Joel Aronoff entitled Personality in the Social Process (Erlbaum, 1985). *The Sacred Pipe Revisited* examined Native Americans and cultural rituals in relation to the recovery and healing from profoundly traumatic experiences. To date, this remains one of the most requested articles that I have published and drew attention to non-traditional and culture-specific ways of dealing with the aftermath of trauma. The first psychological study of Pearl Harbor survivors was entitled *The Day of Infamy: The Legacy of Pearl Harbor*. This study was based on in-depth interviews with men attending the 45th reunion of Pearl Harbor in Honolulu in 1986. A follow up study was later published under the title War and Remembrance (Harel, Kahana and Wilson, 1993).

In 1988 the first European conference on Traumatic Stress was held in Lincoln, England under the stewardship of Roderick Orner. It was there that the need for broader international cooperation in the field of trauma studies became evident and gave birth to the idea of producing an international handbook to cross reference studies worldwide. In 1989, I was a visiting scholar at the Royal Brisbane Hospital in Australia and together with Professor Beverly Raphael, M.D. edited the first International Handbook of Traumatic Stress Studies which contained 83 chapters and nearly 1,000 pages of text. This labor of love took five years to complete and was published in 1993 by Plenum Press. I believe that this book is particularly important because it attempted to define the

domain of inquiry into traumatic stress phenomena (theory, assessment, research methods, victim populations, treatment methods, social policy issues, etc.) from an international perspective.

While actively working on The International Handbook, I became aware of the impact of the work on therapists, counselors, researchers and crisis responders. It was at that time that I began sketching models of countertransference processes in professional work with trauma populations. I contacted Jack Lindy and we began collaborating on the book Countertransference in the Treatment of PTSD (Guilford, 1994). I consider our collaborative work to be a break-through in identifying the mechanisms which underlie a complex matrix of emotional reactions which exist when working with trauma patients who are suffering from PTSD. Among other advances, we identified Type I and Type II countertransference and four different modalities of empathic strain experienced during clinical work.

The research on the International Handbook of Traumatic Stress Syndromes also made it clear to me that the field of traumatology had not yet standardized assessment instruments and technologies. In 1993 I began collaboration with Terrence M. Keane to produce a reference book, Assessing Psychological Trauma and PTSD (Guilford Publications, 1997). The second edition of the book will be published in 2004 and reflects the exponential growth of knowledge in psychological assessment of trauma and PTSD. I consider this book to be an important step forward in having a gold standard reference volume for clinicians and research throughout the world. In the second edition, for example, there are new chapters on neuroimaging, pharmacological probes, standardized methods of forensic assessment, physical health, and substance abuse.

My experience as a “PTSD expert” has taken me to many ‘hot zones’ and crisis situations which include wars and disasters: rescue operations of American personnel under siege in Kuwait in the first days of Iraq’s invasion of Kuwait in August 1990; and humanitarian work for the World Health Organization (WHO) and United Nations High Commission on Refugees (UNHCR) in former Yugoslavia. I spent months in Bosnia and Croatia working with war victims and providing psychological first aid, crisis debriefings and training. These and other experiences shaped awareness of the need for a book that would help to standardize research and training on crisis debriefings. Spearheaded by Beverly Raphael, we produced the book Psychological Debriefings (Cambridge University, 2000) as an attempt to synthesize the literature on acute interventions following trauma.

Work with war victims, refugees and displaced persons in Bosnia led to a greater awareness to bring attention to the special needs of traumatized asylum seekers and refugees. A lecture tour in Holland and Sweden impressed me with the innovations developed in these countries to treat refugees and victims of war trauma. In Holland, I met Dr. Boris Drozdek in Hertogenbosch and collaborated on Broken Spirits: The Treatment of Traumatized Asylum Seekers, Refugees, War and Torture Victims (Brunner-Routledge, 2004). This critically needed professional reference book will help standardize the care for victims of terrorism, war and political oppression.

There are three additional books which have been published in recent years that relate to each other and reflect the growth of my work. On September 11, 2001, Treating Psychological Trauma and PTSD was published by Guilford Press. The publication date was serendipitous but perhaps not by chance alone. In this book, Matthew J. Friedman,

Jack Lindy and I attempted to develop a comprehensive psychobiological framework by which to understand the different treatment approaches to PTSD. We developed a tetrahedral model of PTSD and dissociative processes which enables the precise specification of target goals for symptom alleviation. It also attempted to provide a critical analysis of treatment approaches and where they succeed or fail. The Posttraumatic Self: Restoring Meaning and Wholeness to Personality (Brunner-Routledge, in preparation) examines how trauma impacts the inner world of psychological experience. Empathy in the Treatment of Trauma and PTSD (Wilson and Thomas, Brunner Routledge, 2004) explores the matrix of empathy and its relation to the psychotherapy of PTSD. In this book empathy is analyzed as the key to facilitating the transformation of trauma in patients and expands into new areas the insights gained from empirical research studies based on the book, Countertransference in the Treatment of PTSD (Wilson and Lindy, 1994).

Forensic Contributions

The advancement of understanding PTSD as a complex stress response syndrome has had application in many new areas of science and society, including in the legal area. During the course of my career, I have been asked many times to serve as an expert witness in legal cases. At first, the nature of the involvement in litigation was focused on Vietnam veterans who were charged with criminal activity (i.e., drug smuggling, assault, murder, etc.). With the advent of PTSD as an Axis I mental disorder, its existence as a psychiatric entity could be used by attorneys in civil and criminal cases. In civil cases, PTSD has been used in personal injury cases or in determining injuries and damage associated with employment, duty, or accidents. In criminal cases, PTSD has been used

as a mental state defense, mitigation defense or in other respects.

From 1978 to the present, I have worked in cases in which the proper use of PTSD as a psychiatric phenomena was employed successfully in over 15 precedent cases involving civil and criminal law. This includes the first federal criminal precedent case in 1980, the U.S. vs. Tindall. In that case, a jury in Boston, Massachusetts found Michael Tindall, a former highly decorated Cobra helicopter pilot in the Vietnam war, not guilty by reason of insanity (NGRI), in a case alleging the illegal transportation of hashish. In 1979, a jury in Philadelphia, Pennsylvania found Michael Mulchay not guilty by reason of insanity for shooting and killing a man he never met during a dissociative flashback episode to his war experiences in Vietnam. In 1981 a jury found Ngo Nghia, a former Vietnamese Vietnam veteran and prisoner of war (P.O.W.) not guilty by reason of insanity of attempting to assault a police officer at Harvard University. Mr. Nghia had commanded a naval vessel during the war and had been subjected to massive war trauma and torture as a P.O.W. by the conquering North Vietnamese Army until his daring escape and journey of asylum seeking to the U.S. Mr. Nghia experienced a dissociative flashback to his P.O.W. experience during a lecture on the Harvard Campus by a Vietnamese lecturer recently returned from Vietnam whom he misperceived as the communist commandant of his P.O.W. camp. In 1987, John Goodman, a Korean War Veteran, was found not guilty by reason of insanity for murdering his wife in a dissociative flashback to his war experiences as a U.S. Army infantry flame thrower during the Korean War. On the anniversary of his disabling war injuries in combat caused by his flame thrower and subsequent explosion of a large cache of hidden enemy weapons, Goodman acted in an irrational manner and 'torched' his wife to death with

gasoline.

These cases not only set legal precedent, they opened the door to a broader use of PTSD in litigation. I have written two chapters about these forensic cases entitled, *In the Arms of Justice* (Trauma Transformation and Healing, 1989) and the *Forensic/Clinical Assessment of PTSD in Legal Settings* (Assessing Psychological Trauma and PTSD, 2004, 2nd Edition).

As the awareness of PTSD grew in the American society, so did its application to legal issues in an increasingly broad domain of cases ranging from airplane crashes, hotel fire litigation, exposure to HIV infected blood, wrongful conviction and incarceration, the Exxon Valdez oil spill and acts of terrorism. These legal cases were important learning experiences about the nature of PTSD and its relation to behavioral manifestations. It also raised the larger question of justice for victims of trauma which result in life-long injuries. Perhaps because fate placed me at the advent of PTSD in 1980, I came to understand how the lives of ordinary people are affected by the “scales of justice” in such cases as State of Louisiana vs. Charles Heads; People vs. Eric and Lyle Menendez; State of Ohio vs. Dr. Sam Sheppard; Exxon Valdez litigation; American Airlines Flights 102, 1029 crash litigation in Cali, Columbia and Little Rock, Arkansas; U.S. Air Flights 405, 1016 crash litigation in Cleveland, Ohio and Columbia, South Carolina; the Amtrak “Sunset Limited” train crash litigation in Mobile, Alabama where the train fell off a bridge into a bayou; the DuPont Plaza Hotel fire in San Juan, Puerto Rico; the wrongful conviction and 18-year imprisonment of the “Chicago Four” in Illinois; the airline hijacking and terrorism case of Mohammed Ali Rezag in federal court in Washington, D.C.; sexual assault case of William Kennedy Smith in West Palm Beach, Florida; and

the murder case of former political prisoner and torture victim of Fidel Castro, in the State of Florida vs. Raul Gomez in Miami Florida. Each of these cases were unique and unveiled the intricate and complex ways that PTSD effects human behavior. It also made clear that our system of justice is an important arena for victims of trauma, no matter which side of the legal fence they find themselves on.

As Bob Lifton taught me decades ago, there is no moral neutrality when it comes to understanding trauma's effect on the psyche. It is important to fight for justice in the courts for genuine cases of PTSD and trauma related injuries. My experience has also convinced me that it is equally important to stand up against the improper use of PTSD in litigation, as in the Exxon Valdez oil spill case in which hundreds of claims were being filed for PTSD from seeing an oil spill in a pristine environmental setting. In my view, it would weaken and diminish the scientific value of PTSD as a psychiatric diagnosis if persons claiming to suffer PTSD from relatively minor stressor experiences were to receive financial compensation in the same manner as victims of the Holocaust, disabled war veterans, rape victims or survivors of the terrorist attacks on the World Trade Center in 2001. In the courts of justice throughout the world, the stakes are high for victims of trauma who suffer from PTSD and associated psychiatric maladies. They need the finest possible representation and serving as an expert witness is a privilege and challenge of the highest order. It is imperative to preserve the integrity of the PTSD diagnosis in litigation.

Service

When asked to discuss the greatest achievement to the field of traumatology, most

people think of published scholarly materials since they are lasting works in print. To me, service to others ranks as important as the written word.

First, the Forgotten Warrior project led to responsibility for designing and assisting in the implementation of two national outreach programs for Vietnam veterans between 1977-1980. The Disabled American Veteran National Outreach Program and the Veterans Administrative Re-adjustment Counseling (RCS) program afforded me the opportunity to teach, train and collaborate in efforts to bring badly needed assistance to Vietnam veterans. In this capacity I traveled extensively across the country from 1980 - 1986, setting up storefront outreach centers in over 80 cities. Similarly, from 1979-1982, I worked closely with the newly founded Vietnam Veterans of America (VVA) and its director, a disabled former U.S. Marine Corps Officer, Bobby Muller, to prepare educational materials on PTSD and provided congressional testimony of re-enduring war related problems of Vietnam veterans. From 1984-1987 I served on the DSM-III-R task force of the American Psychiatric Association to revise the diagnostic criteria for PTSD. From 1989-1991 I traveled extensively throughout Australia under the sponsorship of the Departments of Health and Veteran Affairs to assist the Australia Vietnam Veteran Counseling Service (VVCS) in its national outreach efforts to develop treatment programs for its 50,000 men who fought in Vietnam alongside U.S. military forces. This effort in Australia taught me that psychological trauma knows no cultural, racial or ethnic boundaries.

From 1990-1995 I served as director of emergency services for the Cleveland, Ohio chapter of the American Red Cross and developed a Trauma Action Team comprised of mental health professionals, clergy, and Red Cross professional staff who

were cross-trained in crisis interventions, debriefings, and psychological first aid to assist victims of disaster. In 1994-1995 I served during the Balkans War in former Yugoslavia with the United Nations to develop mental health programs for non-military victims of war. Under the auspices of the World Health Organization (WHO) and the United Nations High Commission on Refugees (UNHCR), I worked throughout Bosnia and Croatia to train physicians, psychologists, social workers, etc. about PTSD and to set up community-based humanitarian programs. In Bosnia, I worked in Sarajevo, Tuzla, Mostar, Bihac, Zenica and other areas while the war was going on. To this day, I can see clearly the freshly killed persons on the trauma line, the look on the faces of the traumatized children, adolescents, women and elderly who were left destitute and bereft by the horrors of ethnic cleansing and scorched-earth policy of total destruction. The ongoing siege of Sarajevo will never be forgotten and the personal witnessing of people killed by Serb snipers. After the Dayton, Ohio peace accords in 1995, I returned to Croatia for nearly a decade to continue providing humanitarian services, education and training to agencies and organizations seeking to address the wounds of war. In 2003-2004, I received a Fulbright Scholarship and taught at the Clinic for Psychological Medicine at the University of Zagreb Medical School. Young medical students, who were children during the war, received education about PTSD, disabled war veterans, asylum seekers, torture victims and refugees for the first time.

BUILDING FOR THE FUTURE AND LOOKING BACKWARDS

In the task for this chapter assigned by Dr. Figley, the question of how current or future scholars might build upon the work accomplished to date is posed. This question

is interesting because it necessitates a look backward and forward at the same time.

Twenty-four years after the advent of PTSD as a diagnosis, we still do not have an integrative meta-theory of PTSD. I have attempted to construct several theoretical models of PTSD (e.g., Green, Wilson and Lindy, 1985; Wilson, 1989; Wilson, Friedman and Lindy, 2001) that are variants on a psychobiologically based, 'person by situation' interactional model of trauma and the development of PTSD. As the field progresses, we need a comprehensive theoretical model which specifies the relevant variables and processes, and their interactive effects on patterns of posttraumatic adaptation. The advances in the neuroscience of PTSD, assessment technologies, and life-span study of the vicissitudes of prolonged stress response patterns will permit the creation of a unifying theory of posttraumatic stress disorder and its effects on all psychological systems of behavior.

We have come full-circle in a century of studies on traumatic stress. The seminal insights of Pierre Janet, Sigmund Freud and Carl G. Jung showed that trauma effects unconscious mental processes in discernible ways which include repression, dissociation and injuries to the self. Future work is critically needed to understand more precisely how trauma effects the inner world of experience in terms of ego-identity, the self-structure and personality processes. The inner and outer worlds of posttraumatic adaptation are interrelated. Neuroscience studies of brain-behavior linkages will enable a deeper understanding of the inner world of trauma in terms of learning, memory, information processing, personality development, affect regulation and behavioral dispositions.

Understanding trauma's impact on the processes and vicissitudes of life-span

development is in its infancy. How does trauma effect the epigenesis of identity across the life-cycle? How does trauma shape the trajectory of ontogenetic development? What factors determine human resilience to catastrophic trauma?

The questions associated with the treatment of PTSD are currently paramount in clinical outcome studies. Future therapeutic treatments will move beyond the current trend of using a method or technique (e.g., cognitive behavioral therapy, psychodynamic, EMDR, pharmacological) of psychotherapy to treat PTSD symptoms as a unidimensional entity. Future treatment techniques will be geared to identifying target objectives in terms of specific symptom clusters and applying a range of clinical procedures to address their psychobiological origins and how they were encoded through learning and memory into complex repertoires of behavior shaped by cultural influences. Since PTSD is a multi-dimensional phenomena of prolonged stress response patterns, clinical studies will lead to new treatments that are analogous to current medical procedures for treating cancer and heart disease. Underlying psychobiological disruptions in neurohormonal and physiological processes will be known and clinical interventions will use specialized techniques to target the behavioral manifestations of these disrupted processes.

Today we recognize that traumatic stress reactions are more than a set of psychobiological mechanisms located in the brain and sensory nervous system. The human element of empathy and compassion in the treatment process is critically important. We need systematic studies of transference and countertransference, the matrix of empathy, and the role of the therapists' personality processes in clinical treatments. We need to study the processes of posttraumatic therapy and the inner world of the therapist with the same degree of rigor as we do to the PTSD patient or research

subject. Future research will refine levels of understanding, applying state-of-the-art scientific techniques to the *in vivo* study of therapist during psychotherapy. For example, what would PET scans, MRI's, or other types of physiological monitors tell us about the emotional processes of therapists during treatments? For example, are there psychobiological profiles of high empathy therapists? Are the brain processes of highly empathic therapists in different states of functioning than those of low empathy therapists?

Gaps in the knowledge base concerning areas of study critically needed for the field of traumatology will be filled. As the field continues to evolve, that new areas will be identified and scientific knowledge will fill the gap, raise the bar on “gold standards” of excellence and facilitate progress in knowledge.

FLASHBACK AND FLASHFORWARD

As a final note, I think that it is important to reflect back on the days prior to 1980 when PTSD became a worldwide reality because of its classification as a separate disorder in the DSM-III of the American Psychiatric Association (APA).

At that time, we had no professional journals, reference or textbooks in the field of traumatology. We had no national or international societies concerned with the study of trauma and PTSD. We had no databases like P.I.L.O.T.S (published international literature on traumatic stress; www.ncptsd.org). We had no national or international centers to study PTSD. We had no international centers to treat victims of torture, trauma or assist refugees, asylum seekers and victims of political oppression and terrorism. We had no political advocacy organizations for victims of crime, rape, violence or sexual

assault. We had no private or governmental hospital programs dedicated to the treatment of PTSD. We had no professional societies dedicated to crisis interventions, psychological debriefings and training programs to assist in times of disaster or emergency. We had no treatment techniques tailored to posttraumatic stress disorders. We had no scientific studies of the brain and trauma responses in PTSD. We had no books on the psychological assessment and treatment of PTSD. We had no programmatic social policy or legislative initiatives in the U.S. Congress, the United Nations and other governmental agencies. We had no awareness of the prevalence and ubiquity of psychological trauma in the daily lives of people throughout the world. We had no media coverage of worldwide traumatic events such as the September 11, 2001, terrorist attack on the World Trade Center Towers in New York; or the recent earthquake in Bam, Iran that killed nearly 50,000 people. We had no daily news coverage on CNN of deaths of civilian and military persons in the current war in Iraq due to terrorist attacks and guerrilla warfare. We had few avenues of justice to address the wrongs created by trauma in courts, tribunals or judicial processes since PTSD did not exist prior to 1980 as a legal entity. We did not have 'PTSD' as part of the household vocabulary of people throughout the world. We did not have the collective consciousness that we live in a world of trauma and human suffering and that peace remains elusive throughout the world.

If there is an overarching humanitarian mission for future scholars, it is to find a way to prevent the conditions in the world that produce trauma, violence, war and human suffering. Until that occurs, the scientific knowledge about trauma and PTSD is critical for the evolution of the species.