Trauma - the search for a poisoned chalice?

Niklas Serning, January 2024

Introduction

Helicopters are terrifying when under threat – the noise, the too-small windows, the erratic movements side-to-side then up – and worst of all, rapidly down. We were given three minutes' warning to evacuate our outpost due to an incoming threat, the helicopter barely touched the ground as we jumped in, but as we tried to get altitude something went wrong. The pilot shouted something about the strong wind and lift, the engines were maxed out, lights flashed and we were being tossed about in the back. I will never forget that morning in Timor L'Este. But it was only that – terrifying. The idea that it would be traumatising never occurred to us.

I was a humanitarian working in war zones before I retrained as a psychologist and subsequently Officer in the British Army. At that time, my humanitarian colleagues and myself did not use the term 'trauma' to describe the sometimes quite intense adverse events that befell us, such as that near miss in the helicopter, assaults, or the loss of colleagues by violent means. I therefore noted with curiosity and some surprise that the psychological literature and broader therapeutic discourse on humanitarians often focused on trauma.

Intrigued, I investigated the area for my doctoral dissertation (Serning, 2011) and found that none of my research participants – humanitarians recently returned from complex emergencies – saw themselves as traumatised. Adverse events were not seen as trauma, nor necessarily as having effects beyond the immediate agitation and subsequent sense making.

My objective with this chapter is to zoom in on what happens when a client begins – and ceases – to see an adverse event as a trauma. I will examine the phenomenology of applying a trauma label to an event or oneself. I will draw upon my doctoral research into humanitarians as well as case studies from my clinical private practice in order to do so.

Periadversarial growth in humanitarians

The first thing you do when you have decided to research something is to review the literature already created on the topic. Humanitarians and war was all about adverse events and trauma, with a smattering of posttraumatic growth (Barron, 1999, Downie, 2001, Ehrenreich, 2002, Eriksson et al

2001, Jessen-Petersen, 2001, Larson, 2006, McFarlane, 2004, Reyes and Jacobs, 2006). There were some dissenting voices, for example Thomas critiqued the broad brush with which traumatization is liberally applied to suffering humanitarians, where more existential issues may be more useful to highlight. "*The central discourse in most research on the mental health of humanitarian workers has been characterised by a preoccupation with risks, stress and trauma as it emphasises illness as opposed to health and well-being.*" (Thomas, 2008, p70). It seemed as if my old colleagues and I must have been outliers in our non-traumatised experiences, since the psychologists were pretty much agreed that warzones leave these fundamentally different imprints.

As I moved to the next stages of my research, interviewing humanitarians recently returned from complex emergencies, they sounded more like my old colleagues than what the psychologists described. There were accounts of hardship and fear for sure, and a good half of the participants mentioned persistent bodily discomforts that they linked to experiences in war zones, one of them for example mentioning: "*an underlying level tension in my gut*". There was a sense that these bodily symptoms were more automatic, more background experiences. They happened and gradually faded away – as one explained: "*whenever I hear certain noises, I assume it's a mortar, obviously only for about three seconds, and I think it will probably just take some time for that to go away*", whilst the more emotional responses to the difficulties of coming back were in the foreground of the participants' experiences.

Of perhaps equal or greater importance was the worry of being traumatized or suffering from PTSD – illustrated by another participant: "*it's quite possible [ ] to be suffering from a mild form of post traumatic stress. [ ] there is a concern that there is an underlying long term effect that you can't quite put your finger on [ ] there's a big black hole about – was there any permanent effect?*". Note how the topics of traumatization and PTSD, so prevalent in the media and aid organizations' support agendas, did not seem to pertain to the participants. If anything, it was the worry that one had 'got PTSD' rather than any traumatization in itself that proved anxiety provoking. Looking at the above, we have a group of humanitarians that do experience distress whilst in extreme situations, but we never have any symptoms of PTSD, only the worry about catching it. One participant mentioned a colleague being a bit shaky, but nothing more than that: "*There was a member of my team who was getting a bit shaky and she was getting incredibly jumpy when there was explosions, and she was going through a bit of a rough patch*". In summary, these events did not permanently stain the subsequent experiences of my participants.

The most difficult experiences were around reconnecting with the home that they had left behind. Having transformed during this intense time away, home did not feel like home anymore, and the mission country could not serve as a home either. The distress was existential, not physiological or

traumatic. In their words: "*Not important that the counsellor knew about Afghanistan, since the issue wasn't Afghanistan, the issue was coming home. Even the issues that did originate in Afghanistan was more about missing the place rather than being traumatized by it.*"

In terms of posttraumatic growth, given that my participants didn't see themselves as traumatised in the first place, my first thought was that it wouldn't apply. However, a different label could be constructed where we replace the *post* with *peri* in order to make it in the now, and *traumatic* with *adversarial* to indicate that the event wasn't necessarily traumatically impacting but certainly adversarial and difficult. There was plenty of *periadversarial* growth – growth during adversity – as my participants faced their challenges. What would be deemed traumatising by many outsiders was actually described as exciting: "*The first time it was a rocket siren and maybe the first few times I was scared and they all happened in my first week so it was good kind of initiation ahh but then after that there was, I mean yeah there was fear whenever there was a rocket siren I guess there was fear but generally you know my, when we were going down town for example you know on the helicopter. The first time I went in the helicopter I was scared but then gradually it just became excitement…".*

The allure of trauma in clinical practice

More than a decade later, with part of my working week in clinical private practice, I notice two distinct versions of discourses around trauma. The first is represented by the clients that come to me having attached notions of trauma to themselves. These self-conceptions of trauma arise out of a breadth of situations, spanning those conventionally understood as traumatic as well as events that might be viewed by many as falling within the ordinary sphere of human experience. The second is the group of clients for whom trauma is the elusive Answer – the seekers that suffer and wish to find the reason for this suffering in a trauma long forgotten and hidden in their depths. For both categories, my challenge in therapeutic practice is opening up a space to examine and interrogate these ideas: for some clients, this has resulted in conflict. That conflict has sometimes developed into a productive and empowering period of growth, and it has sometimes failed to resolve.

Commencing with the first category, those that have experienced deep suffering and characterise this suffering as traumatisation, my first task is to truly listen, truly understand their experience. The event may be too charged to detail in initial sessions, and one tool is to see it as sealed in a box – whatever happened in that crashing helicopter is in that box – we may or may not open it, but we can discuss how you are here today, and what stories permeate your daily life. Inevitably, a client's lifeworld is far larger than the part relating to the adverse event, their personalities far wider and richer than simplistic products of a trauma. This is where existential therapy shines, in the mapping out of broad swathes of clients' lives – their meanings in life, their relations, their stories, their self-

images – and also where the deepening effects of phenomenology can allow us to truly stare hard enough at a grain of sand to see the world.

Once we have situated them in a rich setting (or at least a rich understanding of a bleak setting), the focus on entrenched, stuck narratives begins. Traumatisation is most usually presented as an unassailable, concrete fact, and this is where I need to be respectful. If someone brings a firm conviction of their religion, politics or the genesis of their suffering, it is not for me to deny it. But it is for me to offer the possibility to open up the conviction in order to transform it from a sedimented, inert past choice and into a living choice in the now. If you are committed atheist or Christian, and this causes you much suffering, have a long hard look at this tension. I need to respect the conviction as well as the person, and they are sometimes at odds – by opening up fixity, new ways forward can emerge. Are there less dogmatic ways to follow Jesus, are there more awe-inspiring ways to be an atheist? Is there any wiggle room in the traumatising effects of the trauma, is there any freedom or opportunity for a different choice that millisecond that you get triggered?

This dance of truthfully and genuinely holding both scepticism and affirmation for the narrative that the client has created within their culture is one of the most difficult and satisfying parts of my job. Any disingenuousness is immediately picked up by the client – if I secretly think that they are underplaying or exaggerating their experience, they will know. At the same time, the narrative needs to be worked with. My answer is to work at the very edges of the client's narrative – the pregnant liminal zones where fixity blurs. My client may know that what happened was horrendous and has debilitated them forever, and I want to truly understand this core of their narrative, but once I understand it, I move to the edges and enquire into what parts of them aren't debilitated, and whether forever has to mean always. This is especially true when the trauma label has been applied by outside mores – when an event like an explosion, an assault or a sexual event has taken place and our culture insists that it be traumatising. Sometimes this extraneous narrative resonates and provides a sense of relief, but in other instances disagreement and refusal of the label can lead to judgement from others, as the victim is seen as being in denial or not 'sitting with their feelings'. Just like some people blame victims, others judge those that refuse to be victims.

I usually fail – but more often momentary stumbles rather than permanent crashes. Perhaps my queries in the liminal zone sound too much like the queries of those that deny my client's experience, perhaps my exploration of 'what works well' sounds like 'stop thinking about the bad stuff and move on'. On a good day, I catch this stumble and examine how this is for my client, how it is to be denied one's suffering. This can be beneficial, in that it loosens the hold and resistance against anything that queries the trauma narrative – it ceases to be either affirmation or denial, it becomes affirmation and growth. I remember with great fondness and admiration clients that have

travelled this journey from either self-imposed or culturally-imposed paralysis in trauma narratives, how they first insisted on unequivocal affirmation and got it, how they were curious about slightly different narratives as an exception, and how they at the end grasped the free choice to fully own exactly who they are, including the fact that they have learnings derived from terrible experiences.

Moving on to the second case, those that look for the trauma that is the Answer, it is something that I have noticed increasingly over the past five years, possibly as a result of recovered memory ideas, hidden trauma narratives and psychedelic therapies. A case study that Nina Lyon and I wrote in Re-visioning existential therapy (Lyon & Serning, 2021) may illustrate it:

> Edward had tried everything – from the standard NHS treatments of CBT and counselling, to going further via EMDR and psychodynamic therapies, and ending up in the domains of the psychospiritual and psychedelic. He tried CBT, hypnotherapy, EFT, rebirthing, trauma-focused body psychotherapy, transpersonal therapy. He attended a series of ayahuasca ceremonies which he hoped would bring him breakthrough, and was disappointed to not find the relief that he had been expecting. He nonetheless felt that important unconscious transformations must have taken place, even if he was not yet consciously aware of them. His aim was to cut to the heart of his pain, find that nugget of trauma at the core of him that, once discovered and dealt with, would liberate him and allow him to live a good life. He was shy and timid, with low drive, and believed this to be a result of trauma due to early parental separation. This was how he had always been.
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> His was a genuinely impressive and moving account of hard work at finding a better way to live. However, I could not escape the feeling that he was looking for a singular trauma to explain his problems. As his account unravelled, I became increasingly convinced that this was mistaken. The nugget he was aiming for, whether it was an insecure core attachment, conditional love, or maladaptive core belief, didn't exist. Personality and social systems don't work like that: they are too complex and messy…
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> Maybe Edward could have changed into an extraverted, jovial and happy man, but after twenty years of trying, I doubted it. Much to his disappointment, I tried to focus on how it would be to be as he was, what options he still had within the scope of his low drive and shyness. Did I give up on Edward? I'd rather say that I gave up on the imaginary Edward and worked with the real Edward that was sitting in my room. He never came back, and I will always hope that I was wrong, and that perhaps for him, there was this one thing that could be found, understood and worked through in order to bring radical change. Failing that, and more likely in my view, I hope that he would learn to accept his situation and being, and learn to choose ways to enjoy life within these confines.

We want a coherent story and we want a good life without suffering, but rarely do we get either. The new trauma narratives, especially in conjunction with the latest hyperbolic claims of psychedelics, form a child's religion version of good and evil. This comic book depiction of the Baddie (The Trauma for Maté, Thanos in Marvel) and the Goodie (Ayahuasca for Maté, The Avengers for Marvel) makes for great entertainment, but real life needs more subtlety. I have yet to succeed in providing clients such as Edward definitive Answers, but occasionally I have made them curious about the more winding road less travelled, the messy reality of a million reasons that in some way lead to who you are, and the million choices that you can make to gradually adjust who you will be.

What do we mean by trauma and traumatisation?

As we delve deeper into the label of trauma, it may be pertinent to examine what trauma actually is. Given the subjective, popularised and politicised nature of the social sciences, such an examination is complicated. Originally meaning 'wound' in Greek, it has gradually become reified as a categorically different wound, and I believe that the issue lies therein.

If we disregard the West and the last thirty years and survey the millennia of recorded history for psychic wounds and responses to them, there is little support for any categorical difference between trauma and regular suffering. Our own history and non-Western cultures seem to agree that suffering is the result of the event coupled with the person experiencing the event inside a culture. Being in a snake pit would be terrifying for me, intimidating for Crocodile Dundee, and delightful for a snake lover. The event (snakes or helicopters) is experienced through an individual in a culture, and the kind of and amount of suffering depends on the mindset of the individual as well as their surrounding culture.

We can see this in the radically different ways that people in different cultures indicate high levels of suffering – soldiers in the American Civil War experienced a sense of a weak heartbeat, Salvadorian women escaping civil war spoke of *calorias* which was a sense of heat in the body, WW1 shell shock was largely physical tics and pains, whilst today's Western PTSD is characterised by dissociation and flashbacks (Watters, 2010). Do note that these experiences are fully real to the victim – they are not made up – but they are entirely culturally determined. Just like culture teaches us how to express most of our other emotions and needs, it teaches us how to express suffering. 'Trauma' is not a physiological biological linear brain process that can be remedied by codified and measured 'trauma therapies'. As therapists we therefore need to understand the event, the experiencer and the

culture – this is hopefully what this book will achieve in terms of delving deeply into different kinds of difficult situations and having a phenomenological rather than reductive take on suffering.

Greek heroes and regular folk experienced niggles and catastrophes, and suffered accordingly in proportional amounts. Shakespeare's characters lament and gnash their teeth, but they don't dissociate or have flashbacks. The often brutal existence of regular folk in the Middle Ages and the routine torture and sexual violence of war created vast amounts of suffering, it even broke some people beyond recovery, but again the relationship between impact and effect seemed continuous.

We see this in non-Western cultures today as well, where catastrophes like tsunamis in Sri Lanka certainly cause suffering but not traumatisation. I had been working for the United Nations in Sri Lanka until merely a week before the tsunami in 2004, and my old colleagues recounted in consternation how a virtual army of Western counsellors descended upon the island, all intent on finding and curing trauma and labelling kids that would rather go back to school than do trauma therapy as being in 'denial'. A letter from the University of Colombo at the time firmly requested Western agencies to cease to treat suffering yet coping survivors as psychological casualties. According to this letter, seeing the effects of trauma as a physiological reaction in the brain rather than a cultural communication was not only incorrect, but deeply undermining of their resilience (University of Colombo, 2005). If Western ideas of trauma are so disabling and also so different from all other cultures in time and location, why do we even have these ideas?

I believe that it was the birth of psychotherapy in Europe a hundred years ago that also gave birth to a very uniquely Western take on suffering called trauma theory. Discussed by Freud (1896/1962) and Ferenczi (1933/1955) amongst others, extreme events were thought to be so unbearable that they became repressed, only to resurface as psychological symptoms. This hydraulic theory of the pressures of the mind is still only a theory with little backing in modern science, and most practitioners of therapy have now moved on from the complicated warrens of psychoanalytic thinking, but the separation between regular suffering and trauma remains. Trauma theory really took off with the work of van der Kolk in the eighties, along with his intense lobbying for these ideas to be made official in the Diagnostic and Statistical Manual of Mental Disorders.

The therapeutic community has a tendency to take on the theory that resonates with it, not what has scientific backing, and it is the clients that suffer the effects. Even the most easily refuted theories and contentious authors are widely accepted. One example is polyvagal trauma theory (Porges, 2011), a neurobiological and evolutionary theory about trauma and its treatment that is fully refuted by basic neurobiology – the nervous system simply doesn't work like that (Grossman and Taylor, 2007, Grossman, 2016).

In terms of authors, Maté and van der Kolk are the main pillars in the area. Maté argues that pretty much everything stems from trauma (even cancer! (Maté, 2021)) and most can be healed with psychedelics - his simplistic and politicised theories are undermined by his over-reliance on early childhood attachment (attachment theory has largely been refuted by twin studies – Knopik, 2017, Harris, 2010, Serning, 2019) whilst neglecting more parsimonious genetic impact. Van der Kolk (2015) was the original and main proponent of the separation of trauma from other suffering, responsible for decades of moral panics, recovered memory hoaxes and pseudoscientific treatment forms (Carr, 2023)).

Despite the lack of evidence (and sometimes solid evidence against these theories), the community takes them at their word without query or critique. Our schools and governing bodies would do well to mandate basic scientific grounding in their members. Such grounding should include the differentiation of correlation and cause – so that when Maté claims that racism increases asthma because of trauma (Maté, 2022), the reader should immediately start thinking about differential hypotheses – victims of racism are more likely to suffer from poverty, this is in turn linked to unhealthier homes, areas with increased pollution, less access to good health care et cetera – the preferred hypothesis is not always the true one.

Training improvements should also stress the importance of drawing from a wide array of sources – the hippocampus seemed smaller in those diagnosed with PTSD from Vietnam, but this wasn't replicated in subsequent research (Jatzko et al, 2006). Finally, a solid grounding in statistics reduces the likelihood of being misled – Maté claims that there is a clear deterministic link between being a victim of abuse and injecting drugs (2012), yet only 3.4% of victims of repeated abuse inject drugs (Felitti, 1998).

But does it really matter what the therapists believe in terms of the aetiology of trauma? At the end of the day, therapy is about talking and understanding your client, something that can be done whether you believe that trauma is just another form of suffering, 'held in the body', or indeed karmic effects of naughtiness in previous lives. A good therapist brackets their assumptions, and the only effect these theories would have is the administration of some breathing exercises or EMDR, both as harmless and useful as regular therapy. This is all true, however what therapists think has an effect on how we manage our countries and people – for example the US Army has spent half a billion dollars to combat PTSD with their Comprehensive Soldier Fitness programme, with no measurable effect whatsoever (Singal, 2021). Furthermore, the discourses that permeate therapy seep out into mainstream culture, furthering victimhood, defeatism and objectification. It is to these issues we will now turn.

What happens when we apply labels of trauma?

Nassim Taleb famously distinguishes between fragile, robust and antifragile (2012). Entities in the last category are characterised as becoming stronger when stressed, like a muscle that gets more powerful after receiving micro-tears in the gym, like the fire that wants the wind rather than the candle that gets snuffed out by it. Such antifragility is the story of all our lives – the stress of times tables and Chaucer made us count and read better, the stress on the football field made us run faster, the insistence to do better when we failed our friends made us better friends.

Western culture (Holland, 2019) is actually founded and thoroughly interwoven by a singular account of antifragile suffering. The greatest posttraumatic growth story ever told must be how Jesus' suffering on the cross led to a new covenant with God. This narrative served as the foundation for ideas about individualism, progress and charity leading to the Enlightenment, the welfare state and yes – psychotherapy. Jesus' resolve falters as he bemoans his situation, yet he prevails and does in the end grow and transcend, becoming our culture's core example for how to grow from adversity. Granted, this is a difficult example to follow, and there have surely been occasions when the pressure got too high and we hit the wall, but this learning about ourselves and the world, coupled with recalling how others had endured that specific trial, and how we had endured other trials, hopefully got us to where we are today – stronger, wiser and with increased freedom.

An individual convinced of their own resilience doesn't see themself as likely to be traumatised and is hence less inclined to interpret adverse experiences as traumatic, and is thus less psychologically vulnerable to them. By contrast, many of today's clients are enmeshed in narratives of trauma. These narratives have proliferated in online psychotherapeutic and quasi-therapeutic discourse and are characterised by a subjective concept creep in which any adverse experience is traumatic if it is individually deemed to be traumatic. As such, no trauma can be said to be more traumatic than any other trauma, indeed insisting that one is worse than another is claimed to be re-traumatising. Whilst this trope abounds, a seemingly opposite one manages to co-exist with it, one of competition in how bad one's situation is, a deeply distressing form of victim Olympics where occasional validation is quickly invalidated by someone else's worse experience. To paraphrase Orwell (1945), all traumas are equal, but some traumas are more equal than others.

Other characteristics of this conception of trauma are its anti-agentic quality and the particular moral universe it operates in, which is anticipated in part by Nietzsche's Genealogy of Morality (1887/1994). To be traumatised is to be largely helpless against one's own emotional responses, and to have the right to be taken care of by others in the world. Much of this care-taking of the traumatised is done by psychological professionals, who do so with genuine compassion and desire to help the wounded. However, the concept creep of the contemporary trauma narrative has

recruited a sizeable new cohort of people into identifying with it, and in doing so sacrificing their own self-efficacy. The concept creep also creates opportunity for therapists believing themselves to be uniquely able to care for, heal and hold the traumatised – often for generous remuneration.

What was it about the humanitarians I interviewed that enabled them to survive adverse events intact? It might be that they happened to share fortuitous neurological traits, but it might also be the case that they shared a worldview about the nature of their work that led them to process those events differently than they might have had they taken a more trauma-centric mindset. If narratives and social constructs can shape our perceptions and experiences in one direction or another, it seems desirable to examine which ones that are likely to be psychologically helpful in adverse conditions, since adverse conditions are an unfortunate and inescapable part of human experience. To identify into the trauma category is to place oneself in a class with little agency or freedom, undermining the possibility of growth when faced with these adversities. It is the essence of resentment, where we refuse the world as it is, where we insist on our rights whilst knowing that they can never be fulfilled – I am in pain, it is unfair, and I cannot do anything about it. By contrast, to paraphrase Scruton (2014), if we see the resentment of traumatisation as the curse that we put upon ourselves, then radical forgiveness of the world and its actors, and letting go of our right not to suffer, is the sacrifice that we make to absolve us of this curse.

My final point on the effects of labelling ourselves as traumatised relates to an understandable yet deeply problematic hybrid between full trauma victimisation and full ownership of what life has thrown at us. Posttraumatic growth should signify something positive arising from something negative, but looking closer at popular social media accounts, also occasionally mirrored in my practice, a different picture emerges. This is not Nassim Taleb's antifragile muscle becoming stronger through stress, this is the eternal tragedy of the heroic underdog. The focus is the trauma, the vulnerability and the special care and dispensations requested by the victim, and the assertions that they have 'learnt so much' and 'become stronger' are foregrounded against an overarching backdrop of victimhood. Sadly, it seems that the 'growth' part is far too often there in order to make victimhood seem more heroic.

How do we reframe the trauma discourse in order to produce genuine, untainted growth? It is possible – but it takes solid commitment from both client and therapist to step past the poisoned narratives in this new culture of resentment. It was evident in my research and I see it clearly with my colleagues in the Army, where many have experienced situations that would be generally described as traumatic. As a general rule, impact increases unit cohesion, sense of resilience and willpower – even after the most gruelling of events (Jennings, McRandle, 2011). There are occasional

individual descents into collapse, yet the aforementioned cohesion, resilience and willpower allows the soldier or officer to 'crack on', often with stronger and deeper resolve.

Ways forward

Given how the inscription of trauma seems to create great risk of invalidating and disempowering us, how do we move forward in a more skilful way? Shall we jettison the term and simply talk about experiences of adversity and our reactions to it? This may seem radical, but the concept of trauma as a distinct form of suffering with categorically different effects is a very new one.

Moving away from the label, we could return to the consensus of other cultures and times where life happens and we do our best to learn from it. This book would then need to be revised as there would be no post trauma to grow from. There would only be experience, some clusters of which are generally troubling for the individual, but all of which must be endured and learnt from with acceptance, resolve and future focus. Our jobs in the caring professions would be to care and leap ahead to indicate antifragile ways of dealing with difficult experiences. Spurious theories would cease to tempt individuals to categorise their suffering as something different from suffering, requiring special treatment.

Maybe there really is such a thing as PTSD that happens in the most extreme of events. Maybe the amygdalae really can flood the hippocampus so that memories get encoded in the eternal present (Rothschild, 2000, p71). Were this the case, I don't know how we could have mentally endured hundreds of thousands of years as a species on the savannah, being hunted by hyenas, hunger and each other, but maybe the shamans then were better than us therapists now. Or maybe the body keeps the score differently for humans in the modern West. I really don't know. But what I do know from my travels in clinical practice, war and research, is that the trauma label is a double-edged sword to be used with extreme caution. If at all possible, see your suffering as something to endure, avoid, fight, resign yourself to, transform or ignore. If this book can teach you to grow from it, we have done our job right. If it only validates your suffering and supports you in creating an identity around your suffering, we have failed.

There is no reason to query the intentions of most proponents of contemporary trauma culture as anything other than honourable. But what I have seen is that these good intentions have been a road to many of my clients' hell. Marx (1844) famously referred to religion as the opiate of the people - a soothing balm that allows relief yet thwarts the revolution. Perhaps we can see the current tendency towards the designation of much adversity as trauma as that. Comforting yet disabling - a poisoned chalice.

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