Multidisciplinary Roundtable: Soldiers' Tales (Un)told: Perspectives on Trauma and Narrative in the Consideration and Treatment of PTSD (and pre-TSD)

Michael Kilburn, Samata Sharma, Nathalie Saltikoff, Dana Modell, Scott Rothermel and Sandra Gasana

This interdisciplinary roundtable discussion examines the function of narrative in the context of structural violence, both preemptively and in its aftermath. It considers various functions of storytelling, reintegration and reconciliation from a variety of disciplinary perspectives and approaches: clinical/physiological; psychological/human services; cultural/sociological; public health and health administration; and historical/political. While the initial focus is current research and treatment of PTSD (Post Traumatic Stress Disorder) among combat veterans and other victims of conflict, the discussion necessarily engages larger issues of trauma, memory and history: the social and political responsibilities of bearing witness to traumatic histories; the ethics and protocols of interviewing survivors; and the broad relation of narrative and storytelling to social reconciliation, restorative justice, and historical truth. Particular consideration is given to the possibilities and dilemmas of applying oral history methods to the consideration and treatment of trauma. From talk therapy to Truth and Reconciliation Commissions, various narrative strategies have shown promise for mitigating the psychological and sociological traumatic disorders of conflict and atrocity. A greater understanding of the function of narrative in healing the wounds of war may also suggest preemptive strategies to the political (meta)narratives that frame, provoke, and legitimize organized violence in the first place.

Introduction

Michael Kilburn, *Endicott College*

My interest in trauma and narrative, and the genesis of this collaborative working group, all started with a chance encounter in 2008. I had just founded the Endicott Center for Oral History and became interested through my teaching and research on human rights in exploring the ways that storytelling might be used for social justice, such as juridically as in the *gacaca* trials which were then still happening in Rwanda, or even therapeutically, as with the programs for supporting torture survivors and refugees run by the School of Public Health at Boston University. Then I met Shaw Pong Liu, a Boston based composer who had just written -

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decomposed, really- a version of Stravinky's 1918 *L'histoire du soldat*, [*The Soldier's Tale*]. She had introduced passages of silence, atonality, and improvisation into the musical score and incorporated fragments of testimony from American Vietnam and Soviet Afghanistan veterans suffering their own difficult journey home. I invited her to premiere the piece at my college as part of a program with Dahr Jamail, one of the few unembedded journalists in Iraq, and representatives of the Boston chapter of *Iraq Veterans Against the War*. In 2009, we teamed with Scott Rothermel, a colleague working as a behavioral health care consultant for the US Department of Defense and Veterans Affairs, to present our work at the *Remembering War, Genocide and other Human Rights Atrocities: Oral History, New Media and the Arts* conference at Concordia University in Montréal.[1]

With the addition of a psychiatrist (Dr. Samata Sharma at Brigham and Women's Hospital), a team of licensed clinical social workers (Dr. Nathalie Saltikoff and Dana Modell), and a community oral historian (Sandra Gasana, who led the Rwandan working group of the recently completed Montréal Life Stories project at Concordia University), the project has evolved to examine the relationship of narrative and trauma in a multidisciplinary and interdisciplinary way.

The different disciplines approach the question of trauma and narrative on a variety of scales and in different ways: from the micro (the self-referential stories the brain tells itself); through to the clinical environment of psychotherapy and other narrative based interventions; to the systems level of behavioral health care administration; to the community cultural level, which considers second degree and intergenerational trauma; and, finally, to the macro level of historical and political metanarratives that create the context within which organized mass violence happens. Together, we explore the roles and responsibilities of oral historians and narrative practitioners in dealing with traumatic effects of conflict and atrocity.

Drawing on a roundtable discussion at the 2011 Oral History Association annual meeting in Denver and a presentation at the "Beyond Testimony and Trauma: Oral History in the Aftermath of Mass Violence" conference at Concordia University in March 2012, the following reflections summarize an ongoing collegial conversation outlining our responses to the question of the role of narrative as it relates to the study and treatment of Posttraumatic Stress Disorder (PTSD) among combat veterans and other victims of conflict. While the initial focus was PTSD among survivors of war, both combatant and civilian, the discussion necessarily engages larger issues of trauma, memory and history,

[1] A review of this part of the project was published in the journal *alt.theater* in Spring 2011 and as a chapter in *Remembering Mass Violence: Oral History, New Media, and Performance*, ed. Steve High, Ted Little and Thi Ry Duong (Toronto: University of Toronto Press, 2013, forthcoming).

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including: the social and political responsibilities of bearing witness to traumatic histories; the ethics and protocols of interviewing survivors; and the broad relation of narrative and storytelling to social reconciliation, restorative justice, and historical truth. Particular consideration is given to the possibilities and dilemmas of applying oral history methods to the understanding and treatment of trauma.

This ongoing collaborative dialogue is an attempt to not only map the many ways narrative functions (and malfunctions) within the social matrix of PTSD, but also to begin to frame an interdisciplinary dialogue that can try to address it in a more holistic and concerted way.

Cognitive Neuroscience and Narrative
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In the following section, psychiatrist Samata Sharma, outlines the physiological impact of trauma on the brain and the function of narrative in a medical setting, discussing current clinical understandings and treatment options.

The psychiatric approach to trauma and narrative is distinguished by its empirical grounding of narrative function in the physiological processes of the brain. Memory, stories, and narrative tend to be described in terms of neurobiological and chemical structures and processes: protein chains, neural networks, electrical activity and blood flow. From this perspective, narrative apparently functions internally to structure cognition. As George Lakoff succinctly puts it: "Narratives are brain structures… the mind is the brain."[2] Any connection that forms between your thoughts simultaneously forms between your neurons. As you internalize a metaphor or story, a circuit in your brain physically constitutes it.

Aided by ever more sophisticated imaging technologies, cognitive neuroscience has begun to disprove centuries of assumptions both scientific and popular about how memory functions. Apparently, it works less like a document retrieval system, with fixed impressions and experiences filed away in folders or on shelves, and more like a print on demand service, or short order cook. According to this emerging model, memories are always already fragmentary. They must first be disassembled for storage and then are reconsolidated upon recall; literally re-collected. Brain scans of individuals in the act of remembering show a seemingly random process of bricolage. Thus, remembering is an act of creation, with the neural substrates of memory – specific areas of the brain that are activated and deactivated depending upon the event being experienced or

[2] George Lakoff, *Don't Think of an Elephant* (White River Junction, VT: Chelsea Green Publishing, 2004), 1.

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recollected - under constant reconstruction. (This is my grandfather's axe, my father replaced the head and I replaced the handle, but this is my grandfather's axe.) Ironically, in some sense, we must forget in order to remember.

At least, that is the way it is supposed to work. Injury, disease, chronic or severe stress, however, can cause changes in biological markers in the body and brain that lead to manifestations of both physiological and psychological symptoms. Trauma can disrupt the normal process of memory dis/integration. Some experiences are so shocking, so outside the realm of ordinary experience and context, that they resist the deconstructive process of memory storage and formation. The impressions remain "undigested and unassimilated and like a shard of glass."[3] The counterintuitive implication is that traumatic memories may be truer to the original experience, but because of their impossible truth, remain inaccessible to normal processes of memory recall. Since traumatic experience cannot be dismembered, it cannot be remembered. Victims of trauma are unable to forget, therefore unable to recount, much less able to testify. As forgetting helps us make sense of the world, for sufferers of PTSD, the world can seem incomprehensible.

In psychiatry, mental illness generally may be conceptualized as a breakdown in the normal neural circuitry in one or more of the following areas: Language or Thought Processing; Emotional Processing; and Memory Processing. Each of these functions is associated with particular regions of the brain. The frontal cortex modulates language, executive function, top down processing, including the suppression of inappropriate affect, or maintenance of socially appropriate behavior. The amygdala, neural clusters deep within the medial temporal lobe, are responsible for emotional processing, especially fear. Hyperarousal of this region can overpower the moderating influence of the frontal cortex. Memory, the *sine qua non* of cognition, is modulated by the hippocampus, one of the deepest structures of the brain. Both emotional memory and declarative memory are processed here, so it, along with the amygdala, is particularly relevant to narrative processing of emotional memories[4].

While all mental illness involves some dysfunction in the relation of these three region/structures of the brain, PTSD – and particularly combat PTSD – has specific implications for narrative processing[5]. The repeated stress of combat, exacerbated by the ambiguous nature of counter-insurgency, the types of weapons

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[3] Jad Abumrad and Robert Krulwich, **"**Memory and Forgetting," Radiolab, season 3, episode 4, 14 February 2013, www.radiolab.org/2007/jun/07.

[4] See Larry Cahill, et al., "The Amygdala and Emotional Memory," *Nature* 377, no. 6547 (1995): 295-296; and James L. McGaugh, **"**The Amygdala Modulates the Consolidation Of Memories Of Emotionally Arousing Experiences," *Annual Review of Neuroscience* 27 (2004): 1-28.

[5] Lisa M. Shin, Scott L. Rauch, and Roger K. Pitman, "Amygdala, Medial Prefrontal Cortex, and Hippocampal Function in PTSD," *New York Academy of Sciences* 1071 (2006): 67–79.

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and tactics encountered, repeated deployments, the rapid transition between the crisis mode of the front and the normalcy of home, conspire to undermine the very cognitive processes needed to cope with the situation.

Many returning veterans have symptoms of PTSD or TBI (Traumatic Brain Injury).[6] Often, aspects of both conditions are present, complicating diagnosis and treatment. Apparently PTSD can replicate the physiological effects of Traumatic Brain Injury (TBI) and vice versa. Damage to the frontal cortex, whether caused by explosive concussions or repeated stress, diminishes the capacity for language, attention and executive processing, as well as self-control, leading to an inability to articulate, communicate, and maintain social relationships. Chronic hyperarousal of the sympathetic nervous system leads to extreme vigilance, paranoia, and a violent fight or flight response, now unchecked by a compromised frontal cortex. Both the ability to recall the emotional event as a coherent memory and the ability to relay it in a way that evokes social empathy are affected. The vicious cycle of incapacity, alienation, and inarticulate rage and depression spirals downward, a process that can now be mapped by dynamic MRIs and other imaging technologies. Images of the brains of sufferers of PTSD show increased blood flow and neural activity in the regions associated with fear and emotional arousal, while decreasing activity of brain structures involved in the inhibition of affect and the translation of experience into communicable language.

Despite the empirical emphasis and Foucauldian discipline of psychiatric institutions, narrative plays an important role in both diagnosis and treatment of PTSD symptoms. However abbreviated and circumscribed, storytelling facilitates treatment by clarifying the communication between patient and physician. Even the implied narrative structure of the diagnosis and treatment plan may already have a reassuringly palliative effect on the symptoms themselves.[7]

Still, narrative function is usually bound by certain constraints within the psychiatric environment. A brief and pointed initial intake interview, considering presenting and perpetuating factors, quickly outlines the current symptoms within the context of the life history to aid in diagnosis and treatment. Despite its brevity, doctors note the narrative structure and process of the testimony as well as its content. In addition to gathering information on the symptoms and background,

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[6] A 2009 CBO report cites 28% of those treated by Veterans Health Administration (VHA) between 2004 and 2009 with diagnoses of PTSD or TBI and estimates a 5-25% prevalence rate among the entire Iraq and Afghan veteran population, though unofficial and more recent estimates are much higher. See Congressional Budget Office, "The Veterans Health Administration's Treatment of PTSD and Traumatic Brain Injury among Recent Combat Veterans" (2009), http://www.cbo.gov/sites/default/files/cbofiles/attachments/02-09-PTSD.pdf.

[7] See Erin Finley, *Fields of Combat: Understanding PTSD among Veterans of Iraq and Afghanistan* (Ithaca: Cornell University Press, 2011), 95-98, for a discussion of the paradigm shift in the decision to include PTSD in DSM III.

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including previous incidents and medication profiles, a key question concerns plans and hopes for recovery, as hope and future orientation have proven to be key variables in the recovery process.

Psychiatric treatment options for PTSD and many other forms of mental illness usually involve some form of narrative therapy (the traditional "psychotherapeutic" setting) in combination with a pharmacological regimen. But while drugs can be quite effective in alleviating the worst symptoms in the short term, a full recovery is often obtained only when using both psychopharmacological as well as psychotherapeutic approaches. Drugs can blunt emotions, disrupt the autocatalytic spiral, possibly even erase certain associative memories, but new pathways to help the victim navigate the trauma can only be built and managed by processing traumatic experience through a structured narrative practice in a psychotherapeutic setting.[8] For Freud, "the possibility of integrating the lost event into a series of associative memories, as part of the cure, was seen precisely as a way to permit the event to be forgotten."[9] We must remember in order to forget.

With the advent of functional neuroimaging, biological markers and genetic studies, new theories regarding the role of the oral historical tradition as a therapeutic tool, particularly in times of war, are evolving. Some evidence suggests that the personal retelling of one's story may induce changes, over time, in the hippocampus and other area of the brain involved in memory processing and storage which may allow for a therapeutic "reprocessing" of the traumatic memory. This may, in turn, aid in normalizing neural circuits and decreasing both the physiologic and psychological behavioral symptoms associated with PTSD. This, then, has certain parallels with the goals of psychotherapy and psychopharmacology in treating such disorders. Yet, caution must be taken when proceeding: the retelling of one's story may be very therapeutic for one person, and yet may lead another towards further dysregulation. Therefore, if it is to be used as a therapeutic tool, it is best done so in conjunction with ongoing structured psychiatric care. Nonetheless, such theories do raise compelling possibilities for the role of the personal narrative as a therapeutic tool and for the human voice in healing the wounded mind.

Advocates of narrative medicine, such as Rachel Naomi Remen and Rita Charon, go further, claiming that no real healing can take place without a story.

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[8] Experiments involving the protein synthesis inhibitor anisomycin have successfully disrupted both memory formation and recollection in rats. See H. Cohen, Z. Kaplan, M.A. Matar, U. Loewenthal, N. Kozlovsky, and J. Zohar, "Anisomycin, a Protein Synthesis Inhibitor, Disrupts Traumatic Memory Consolidation and Attenuates Posttraumatic Stress Response in Rats," *Biological Psychiatry* 60 (2006): 767-76, http://www.ptsd.va.gov/professional/newsletters/research-quarterly/V20N1.pdf.

[9] Cited in Cathy Caruth, *Trauma: Explorations in Memory* (Baltimore: Johns Hopkins Press, 1995), vii.

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Developing "narrative competence"[10] on the part of both doctors and patients can improve all aspects of the medical process: diagnosis, treatment, therapy, education and research. In each case, stories help order the mind, suggest analogies, reveal and explore telling discrepancies, and comfort the afflicted by giving larger meaning and context to particular situations.

While narrative approaches are relatively new in western psychiatry, which still tends toward empiricism and the individual patient focus of dominant biomedical discourse,[11] oral traditions and practices are deeply rooted in the healing traditions of many cultures. The Maori of New Zealand, for example, have traditionally performed cleansing rites incorporating music, dance and religious elements to create a cathartic and integrative experience for those returning from battle.[12] The singing of the *Iliad* and the *Odyssey*, in ancient Grecian times, long before they were ever put on parchment, is another example of this. The Hmong chant their personal trauma in public (in the first person plural); improvising their personal testimony within a loose, but culturally predetermined poetic and musical structure.[13] New directions in psychiatric research are beginning to investigate these and other therapeutic applications of narrative and musical structures, though the established medical paradigm of psychiatry can sometimes be resistant to non-clinical applications. Fortunately, new brain imaging technologies are gradually enabling a more sophisticated understanding of the dynamic interrelationship of cognitive structure and narrative function and opening up possibilities for research and treatment.

Narrative Therapy in the Clinical Setting
Nathalie Saltikoff and Dana E. Modell, *Licensed Independent Social Workers (LICSWs), Endicott College, Beverly, MA*

Unlike traditional psychiatry, narration -the dialectical process and the creation of joint meaning- are at the heart of most common forms of psychotherapy that patients pursue after a psychiatric diagnosis. In the next section, Nathalie

[10] Rita Charon, "Narrative Medicine: Form, Function, and Ethics," *Annals of Internal Medicine* 34 (2001): 83.
[11] Normand Carrey, "Practicing Psychiatry through a Narrative Lens: Working with Children, Youth, and Families," in *Narrative Therapy: Making Meaning, Making Lives*, ed. Catrina Brown and Tod Augusta-Scott (Thousand Oaks, CA: Sage, 2007), 77-101.
[12] Jean Smith, "Tapu Removal in Maori religion," *Supplement to the Journal of Polynesian Society* 83, no. 4 (1974): 1-42.
[13] Personal communication during roundtable discussion for "Soldiers' Tales Untold: Oral History, Trauma and Reconciliation" at *Memories of Conflict and Disaster: Oral History and the Politics of Truth, Trauma, and Reconciliation*, the Oral History Association annual conference in Denver CO, 12-16 October 2011. See also L.J. Moore and J. K. Boehnlein, "Treating psychiatric disorders among Mien refugees from highland Laos," *Social Science & Medicine* 32 (1991): 1029-1036.

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Saltikoff and Dana E. Modell (LICSWs, Endicott College) discuss narrative therapy options adapted for PTSD and trauma.

In a psychotherapeutic setting, the process of hearing one's own voice and telling one's own story can help counter the symptoms of isolation, alienation, and disempowerment. From the initial contact with the therapist throughout the working relationship the client creates and re-creates herself as she is known by her therapist. The therapist's office is a stage for enactment of the self, and it is a stage where the client and the therapist co-create the patient's story. Often, the access the therapist has to information about the client from the outside world is limited to medical reports, or is absent altogether. The therapeutic relationship represents one of the few instances in the client's life where she can choose how to present herself to another person with limited input from other sources. In a sense, because of the uniquely isolated and protected environment of therapy, the therapist is a new slate upon which the client narrates, with input only from the therapist and client. This is the case for most forms of psychotherapy. Narrative therapy takes this basic aspect of the psychotherapeutic relationship and evolves it into a specific therapeutic technique of self-narration.

Trauma survivors differ from the other types of clients seen by psychotherapist because of the frequency with which shame, secrecy, and the inability to recall or speak about their experiences affects them. Furthermore, trauma survivors are frequently isolated by their traumatic experiences. These experiences feel un-relatable and survivors often choose not to share these experiences with people in their lives. "I have never told this to anyone…"; "I don't know how to talk about this…"; "This is not how my family thinks of me as…"; "Now that I have told you, what do you think of me?" These types of statements are common to clients when they initially begin to reveal their stories and, more importantly, reveal themselves in the role of trauma survivor to another person. Here begins the work of narrative. And even here, the choice of the word *survivor*, in place of the word *victim*, is a narrative choice. We distinguish the survivor – a person who continues to live, function, or prosper – from the victim, a person who is the object of a negative action. The client, thus emerging - "I have lived through this…"; "This is what happened to me…"; "I will never be the same. It changes you…"; "I will never forget…" - begins the slow process of defining for themselves who they are in the context of their trauma. As Judith Herman has argued,

> Sharing the traumatic experience with others is a precondition for the restitution of a sense of a meaningful world. In this process, the survivor seeks assistance not only from those closest to her but also from the wider community. The response of the community has a powerful influence on the

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> ultimate resolution of the trauma. Restoration of the breach between the traumatized person and the community depends, first, upon public acknowledgment of the traumatic event and, second, upon some form of community action…These two responses-recognition and restitution, are necessary to rebuild the survivor's sense of order and justice.[14]

Remembering is a dialectical act of (co)creation in search of tolerable meaning. To understand narrative therapy in treating trauma, we can start with the context of PTSD. We will review the diagnosis, but as early as the informal rap groups of veterans who came together during the Vietnam War, which predate the current diagnosis of PTSD, veterans who had been through the trauma of war were gathering to retell their stories in an attempt to find solace from their experiences.[15] Evolving from the study of the experiences of Vietnam Veterans in the 1970s, the diagnosis of PTSD was added to the Diagnostic Statistical Manual (DSM) in 1980. Shortly thereafter, studies conducted in the 1970s and early 1980s of women and children who were victims of sexual assault yielded the understanding that victims of those experiences presented the same symptoms as veterans, and survivors of sexual assault and domestic violence were added to the list of those commonly developing PTSD.[16]

As defined by the DSM IV, one of the hallmarks of PTSD is that a person lives through a nearly incomprehensible event and that a fear of death is part of that experience. Memories of trauma are often stored in images and are thereby not accessible in words. This often results in the person's memory of what happened not being readily and/or voluntarily accessible to them. In PTSD, we talk about the triggers that lead to people experiencing flashbacks, and survivors not having control over these flashback sensory events. The flashbacks often occur as images, and these images start and stop whenever they are triggered by the client's internal or external environment. This causes the survivor to re-experience an event that others do not have access to. The survivor is isolated by these internal and horrifying experiences, and is unable to share them because they do not have the narrative ability to do so. Survivors often spend time and energy avoiding triggers to these flashbacks, further exacerbating the problem and isolating themselves. This behavior also conditions and reinforces the fear response in the brain, further embedding the problem outside of the client's conscious grasp.

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[14] Judith Herman, *Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror* (Basic Books, 1997), 70.
[15] Ibid., 27.
[16] Ibid., 32.

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This is where the work of narrative and narrative therapy comes in. The deceptively simple act of "telling" the story, of simple narration, can be healing.[17] Narrative therapy takes the foundational act of telling and creates a framework for recalling, telling, reworking, and finding meaning through a guided therapeutic process that creates a sense of community by co-authorship. Herman tells us: "From those that bear witness, the survivor seeks not absolution but fairness, compassion, and the willingness to share the guilty knowledge of what happens to people in extremity."[18]

Narrative therapy is a strengths-based collaborative approach that focuses on empowering the client and helping them identify a sense of self beyond the problem that they have struggled with. The therapeutic approach is a relational style that values: a) encouraging; b) social responsibility; c) empowerment; d) respecting personal knowledge and lived experience; and e) mutual collaboration. At the core of narrative therapy lies the "deconstruction" of problematic stories and the creation of cognitive space for an alternative narrative construct.[19]

Working alongside the narrative therapist, the client finds words for, authors and re-authors the story of their experience. "Stories" are viewed as a selected gathering of information arranged in a specific manner with attached meanings. "Problem stories" arise when survivors do not know how to explain their experiences and are forced to live with interpretations that are invalidating and shaming. In order to "deconstruct" a problem story, the narrative therapy begins by "externalizing" the problem. This technique separates the identification and definition of a "problem" from the identity of the survivor.[20] Externalization takes shame away from a survivor's identity and invites the client to stand apart from the problem and begin a dialogue about their relationship to the problem.

Herman identifies three protective components to resiliency in trauma survivors as "active, task oriented coping strategies, strong social ability, and internal locus of control."[21] Narrative therapy engages active coping and an internal locus of control. The process itself builds sociability between the client and the therapist and then later, using the skills learned in this process, the survivor can use narrative to build or rebuild connection to their social supports.

In narrative therapy, the therapist takes on the role of the witness and co-creator rather than the expert; listening to the client's voice in determining the meaning of his or her experiences. The therapist supports the client in re-claiming

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[17] Nader Amir, Jane Stafford, Melinda S. Freshman, and Edna B. Foa, "Relationship between Trauma Narratives and Trauma Pathology," *Journal of Traumatic Stress* 11, no. 2 (1998): 385-392.
[18] Herman, *Trauma and Recovery*, 68.
[19] Michael White and David Epston, *Narrative Means to Therapeutic Ends* (New York: Norton, 1990).
[20] Ibid.
[21] Herman, *Trauma and Recovery*, 59.

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authorship of his or her identity away from the "problem" filled story of victimization. The therapist works transparently, allowing the client access to the therapist's thoughts and interpretations, which in turn allows the client to choose how they wish to incorporate these thoughts into their story. The therapist functions as an assistant editor, but the client remains the author, empowered with a sense of naming, mastery, and choice. The resulting story is a co-created and the client's experience of victimization is re-written as a story of survival, empowerment and authorship, with strengths and resiliency based on the clients' values and beliefs about the world. In addition, this story, like all of the stories we tell ourselves, now has the flexibility of narrative, instead of the rigidity of images, and can be changed and retold in different settings and to different people, as the client chooses to use it to connect with others. At this point in the process clients will often begin to make statements such as "Maybe I could tell my parents…"; "Maybe I can tell them what I have been through…"; "How would I talk about it to them…" The ability to build these bridges between the survivor and their family and community is a necessary component to healing from the trauma.

Narrative therapy explores both the subjective meaning ascribed by an individual, as well the subjective meanings and values that are influenced by cultural narratives of a given society.[22] "If clients are able to understand their experience of trauma in context they are less vulnerable to pathologizing their identity."[23] Michael White suggests that clients should also be guided to understand their own experience in the larger context of culture, history, and politics. By doing so, they may further externalize their experiences and understand themselves and their reactions in the context of their interactions with the greater world.

This is a particularly promising approach for veterans, whose self-perception was intimately bound up in allegiance to, even identification with unit, branch, and nation, and whose trauma was initiated in the line of duty. After the intense cohesion, fraternity, and mortal intimacy of combat, however, many veterans feel particularly isolated and abandoned after demobilization. They often struggle to reframe and understand their war experiences as meaningful in a civilian context that lacks the immediacy, intensity, order, and mission of deployment. As Ernest Hemingway described his own post war reorientation,

[22] Michael White, "Deconstruction and Therapy," in *Experience, Contradiction, Narrative, and Imagination-Selected Papers of David Epston and Michael White, 1989-1991*, ed. Michael White and David Epston (Adelaide: Dulwich Centre Publications, 1991), 109-151.
[23] Marie-Nathalie Baudoin, "Agency and Choice in the Face of Trauma: A Narrative Therapy Map," *Journal of Systemic Therapies* 24, no. 4 (2005): 43.

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> We have come out of the time when obedience, the acceptance of discipline, intelligent courage, and resolution were most important, into that more difficult time when it is a man's duty to understand his world rather than simply to fight for it.[24]

The stress and alienation of post-deployment is sometimes compounded by feelings of grief for lost comrades, guilt, and shame, as veterans are often both the survivors and the perpetrators of trauma.[25] Narrative therapies show great promise in helping veterans begin to author a world that can account for the larger meaning and context of their experience and allow for a meaningful reconnection with civilian life. Unfortunately, this is sometimes hampered by a lack of clear communication, efficiency, and empathy within the bureaucracy of veterans' health administration.

Narrative Breakdown in Systems of Care
Scott Rothermel, *Rothermel and Associates, Inc*.

Scott Rothermel is a behavioral healthcare consultant who has worked with the U.S. Department of Defense and the National Institute of Mental Health to support the design and administration an effective system of care for the mental health care needs of the hundreds of thousands of veterans suffering symptoms of PTSD and TBI. Addressing the potential and logistics of narrative based therapies for veterans from a systems perspective, the question of narrative competency impacts many aspects of his work, from the efficacy and provision of psychotherapeutic services, to the navigation of language of veterans benefits and services, to the resistance to dialogue within military culture.

PTSD presents as a breakdown in the structures of the brain that enable processing, recounting, empathy, and reintegration. When the treatment of veterans suffering PTSD is viewed from a macro perspective, however, the miscommunication between narrative and metanarrative becomes tragically apparent.

Despite the fact that the Veterans Health Administration[26] (VHA) is the largest health care system in the United States, the behavioral health care benefits provided to returning soldiers are widely perceived as systemically, economically, and morally inadequate, both in terms of individual treatment options as well

[24] Ernest Hemingway (1946), quoted in Ashley B. Hart II, *An Operator's Manual for Combat PTSD: Essays for Coping* (Lincoln, NE: Universe, 2000), 101.
[25] Herman, *Trauma and Recovery*, 67.
[26] The VHA is the integrated health care system for the US Department of Veterans Services, providing medical and behavioral services for more than 8 million veterans annually.

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from an administrative standpoint. While the quality of care was ranked among the highest in the nation in 2003[27], the VHA has been overwhelmed by the volume and nature of illness and injury characteristic of the wars in Afghanistan and Iraq.

The incorporation of narrative approaches – talk therapy, narrative therapy, exposure therapy, writing and art therapy – is promising, both in terms of the efficacy of individual and group treatment compared to other approaches, as well as increasing administrative efficiencies.[28] Narrative approaches are also being considered outside the clinical setting to improve resilience and reintegration both before and after deployment. Combat units have not yet been assigned embedded poets and orators as in Homer's time, but the Pentagon is gradually implementing outreach programs for soldiers and the public that incorporate narrative strategies, though not in a consistent or well researched way that would allow their efficacy to be measured scientifically.[29] In 2009, for example, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury awarded a $3.7 million contract to Theater of War for public readings and discussions of Sophocles' *Ajax*. In response to an epidemic of suicides among its ranks (between 2008 and 2010, the 850 confirmed suicides in the U.S. military represented 1 out of every of 5 active duty military deaths[30]), the army implemented the "shoulder to shoulder" suicide prevention program that emphasizes the importance of peer mentoring and talk therapy.[31]

Despite these efforts, the administration and efficacy of veterans' health care benefits are widely seen as failing the overwhelming demand. One of the problems is the sheer scale of the need for services. There are currently more than two million active duty and reserve military personnel. Including veterans and dependents, 20% of the US population is connected in one form or another to the military; comprising approximately 60,000,000 people. Despite this broad social impact, the professional military has become increasingly disconnected from

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[27] According to the National Committee for Quality Assurance, quoted in Erin P. Finley, *Fields of Combat: Understanding PTSD Among Veterans of Iraq and Afghanistan* (Ithaca, NY: Cornell University Press, 2011), 120.

[28] D. M. Sloan, et al. "Written Exposure as an Intervention for PTSD: A Randomized Clinical Trial with Motor Vehicle Accident Survivors," *Behaviour Research and Therapy* 50 (2012): 627-635. See also Frank Neuner, et.al. "A Narrative Exposure Treatment as Intervention in a Refugee Camp: A Case Report," *Behavioural and Cognitive Psychotherapy* 30 (2002): 205-209, http://kops.ub.uni-konstanz.de/bitstream/handle/urn:nbn:de:bsz:352-opus-43573/Neuner_etal_NET_Macedonia_BP.pdf?sequence=1.

[29] See U.S. Department of Veterans Affairs, National Center for PTSD, http://www.ptsd.va.gov/professional/pages/survivors-aftermath-trauma.asp.

[30] Defense Manpower Data Center, "Defense Casualty Analysis System: Active Duty Military Deaths by Year and Manner," (2011), https://www.dmdc.osd.mil/dcas/pages/report_by_year_manner.xhtml.

[31] See Army Suicide Prevention Program, http://www.armyg1.army.mil/hr/suicide/default.asp.

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society, comprising less than 1% of the population serving active duty. This makes it harder for veterans to reintegrate and easier for politicians to commit troops without due diligence.[32] Since 2001, more than 2 million troops have served in Afghanistan and Iraq, approximately 37% of whom having served multiple deployments.

With a majority of returning veterans expected to exhibit some expression of PTSD or TBI, and a limited number of behavioral health care providers, access to care is a major issue that the rhetoric of "supporting the troops" does little to address. Although the expected standard wait time is 14 days for an initial evaluation, many veterans routinely wait a month or more for an initial assessment, much less treatment. And even when treatment is available, many veterans must first self-identify and then fight for access, often on their own and with diminished capacity, navigating a bewildering bureaucratic system. Those who manage to access care can expect to wait 3-6 months before they see any alleviation of symptoms. The bureaucratic and logistical delays have no doubt contributed to the alarming rise in suicide rates among veterans. Eighteen veterans commit suicide every day, and suicide has become the leading cause of death in the US Armed Forces.[33]

While suicide rates among veterans in Canada remain relatively low compared to the United States[34] (though still 50% higher than the non-veteran population and female suicide rates are elevated[35]) the rates of PTSD and psychiatric disability are by some measures even higher. A 2011 Parliamentary report found 26% of Canadian veterans suffered "operational stress injury" with 11% displaying severe symptoms of PTSD. Of veterans enrolled in VAC (Veterans Affairs Canada) rehabilitation programs, more than half suffered from a service related psychiatric injury and 70% had mental health care needs.[36]

In addition to the narrative aspects of treatment options, diagnosis and delivery of care, a narrative-based approach to trauma also has important implications at the systems level. Narrative competencies and attention to the

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[32] See Andrew Bacevich, *Breach of Trust: How Americans Failed Their Soldiers and Their Country* (New York: Metropolitan Books, 2013).

[33] Rick Maze, "18 Veterans Commit Suicide Each Day," *Army Times*, 22 April 2010, http://www.armytimes.com/news/2010/04/military_veterans_suicide_042210w/.

[34] Stephanie Levitz and Murray Brewster, "Canadian Military Revises 2011 Suicide Stats, Raises Tough Questions," *CTV News*, The Canadian Press, 17 July 2013, http://www.ctvnews.ca/canada/canadian-military-revises-2011-suicide-stats-raises-tough-questions-1.1371783#ixzz2eJJo3Hz6.

[35] Colin Perkel "Elevated suicide rate for female soldiers, veterans: study," *CTV News*, The Canadian Press, 19 April 2011, http://www.canadianveteransadvocacy.com/blog/?p=692.

[36] Jean Rodrigue Pare, "Post-Traumatic Stress Disorder and the Mental Health of Military Personnel and Veterans," *Parliamentary Research Division, Internal Affairs, Trade and Finance*, 14 October 2011, http://www.parl.gc.ca/Content/LOP/ResearchPublications/2011-97-e.htm#a18.

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dialogic narrative rather than linear dictation could improve the administration of behavioral health care in the following ways:

- The use of storytelling (in contrast to forms and questionnaires, for example) could be more efficient, nuanced, and sensitive in collecting information from the patient, understanding the presentation of symptoms holistically and in context, and defining the need for services. The empathy and active listening of an engaged interlocutor could alleviate some of the alienation and disregard veterans seeking services currently perceive from the system. A narrative approach to the collation and processing of information might reveal inconsistencies in the bureaucratic management structure and nomenclature. Context rather than key-term based information management could reduce redundancy and seal the "cracks" that veterans often describe falling through.

- In some ways, the diagnosis of PTSD is itself a kind of narrative conceit, what Finley calls an "illness construct," and those seeking care must learn to frame the story of their individual suffering in terms that the disability claim adjudication boards can recognize.[37] Narrative counseling at an administrative level may help veterans communicate more effectively, though it runs the risk of coaching them to misrepresent their story to fit an official diagnosis.[38]

- Consideration of narrative flow and process might enable scaling up and down the system, revealing redundancies and improving communication between the administration and delivery of treatment. The patients could be seen as protagonists following a storyline of care within a coherent narrative structure, rather than depersonalized objects or data points within a bureaucratic matrix.

- A serious consideration of narrative would do much to improve cohesion and resilience at the every level within the VHA system: from the psychic health of the individual soldier, through unit cohesion and morale, to the health, safety and integrity of veterans' families and communities. A narrative medical approach employing dialogue rather than directive, and systems management as a two way collaborative process, would facilitate communication, access, and the quality and efficiency of care.

[37] See Finley, *Fields of Combat*, 123, 127 and 164-65, for a critical view of PTSD diagnoses.
[38] Finley, *Fields of Combat,* 167. Here Finley relates a story of how some veterans began carrying blankets because of a typo in official literature that a sign of PTSD was carrying "survivor quilt."

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Unfortunately, these proposals contradict the instincts of military culture, which is based on a top down, monological chain of command and control. The mission is clear and the need acute, but incoherence of the bureaucratic narrative is exacerbated by a warrior's code of toughness and sacrifice, an emphasis on mission rather than personal integrity, a culture of obedience and silence, and a rigid command system that often sees innovation and initiative as insubordination. Even more than the rigid protocols and empirical culture of psychiatric institutions, the military is based on a strict hierarchy and unambiguous directives. A macro view of the military industrial healthcare complex reveals narrative dysfunction, incoherence, and a lack of responsiveness and accountability at every level. Despite recent efforts at reform, the system is overwhelmed, with the specific care needs of veterans and their families, and the economic, social, and moral integrity of the system itself in a state of triage.

From a systems perspective, it is clear that combat PTSD, while understood and treated as an individual disability, is also a symptom of a larger social dysfunction related to a breakdown in communication. The social impact of combat trauma is evident not only through the sheer scale of its manifestation, but also in the way it metastasizes throughout families, communities, and society as untreated trauma which, in turn, begets domestic violence, anti-social behavior, and suicide, creating second generation trauma among the victims and survivors.[39] Reestablishing social bonds and communication is not only beneficial to the patient, but to society at large.

Given the immense and growing backlog of cases and the demands of long-term treatment, much thought has gone into reducing the psychiatric casualties by leveraging resilience.[40] Here, too, narrative strategies can play a part. If storytelling can play an effective role in processing trauma after the fact, perhaps a stronger sense of narrative structure and process would equip soldiers to deal more effectively with the moral and situational ambiguities of combat and reduce the incidence of PTSD. Soldiers could be trained in both storytelling and listening, and encouraged to make sense of their role in the larger story of the mission. In the field, troops could be given time and structure, possibly including archetypal literary or dramatic structures, to transform their experiences into narratives. [41] Until the late 20th century, troops often spent weeks or months in

[39] Tara Galovski and Judith A. Lyons, "Psychological Sequelae of Combat Violence: A Review of the Impact of PTSD on the Veteran's Family and Possible Interventions," *Aggression and Violent Behavior* 9, no. 5 (2004): 477-501.
[40] Petra M Skeffington, Clare S. Rees, and Robert Kane, "The Primary Prevention of PTSD: A Systematic Review," *Journal Of Trauma & Dissociation* 14, no. 4 (2013): 404-422.
[41] See Shay's use of classic Greek tropes in processing combat PTSD; Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York: Simon and Schuster, 1995); and Jonathan Shay, *Odysseus in America: Combat Trauma and the Trials of Homecoming* (New York: Scribner, 2003).

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transit post conflict and were able to collectively process their experience. Now wounded or rotated troops can be home in hours and are usually discharged within 24 hours of their return home. The sudden transition and isolation appears to exacerbate the onset of depression, PTSD and problems of reintegration.[42]

Of course, participation by oral historians in programs to build resilience raises a number of ethical issues, including the question of whether more resilient soldiers would be protected from harm, or simply deployed to more dangerous missions. Despite these ambiguities, resilience is a promising field of research, if somewhat narrowly focused at present on training individual soldiers. From a systems perspective, resilience should be built throughout the health care bureaucracy, and a dynamic narrative theory could help strengthen the requisite dialogical structures, processes, and feedback.

The shocking numbers of veterans suffering from PTSD and the inadequacies of care are an urgent and growing issue. But soldiers are themselves a tiny minority compared to the global victims of war, violence, and human rights atrocities. If the United States, with all its resources and expertise, cannot adequately provide for the care of its veterans, the situation is infinitely more dire, in terms of treatment, reintegration, and reconciliation for the civilian population of war ravaged societies.

Life Stories in the Community
Sandra Gasana, *Concordia University, Montréal*

Sandra Gasana was Associate Director of the Center for Oral History and Digital Storytelling at Concordia University and senior researcher for the Rwandan working group of the Montréal Life Stories Project. She also served as a researcher for Peacekeeping Studies at the University of Montréal. In this section, she reflects on the role of narrative and especially "shared authority" in the Community-University Research Alliance project, "Life Stories of Montréalers Displaced by War, Genocide, and other Human Rights Violations."
For the Montréal Life Stories project, a five year joint Community-University Research Alliance (CURA) sponsored by the Canadian Social Sciences and Humanities Research Council to explore the experiences and share the stories of Montréalers displaced by large scale violence, narrative was both means and ends, process and product. Based at the Center for Oral history and Digital Storytelling at Concordia University, it comprised collaborative working groups in the Cambodian, Haitian, Rwandan, and Jewish Holocaust refugee and survivor

[42] For issues of post-deployment reintegration of veterans, see Nina Sayer et.al., "Reintegration Problems and Treatment Interests Among Iraq and Afghanistan Combat Veterans Receiving VA Medical Care," *Psychiatric Services* 61, no. 6 (2010): 589-597, http://www.research.va.gov/media_roundtable/reintegration_problems.pdf.

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communities in Montréal, as well as groups focused on refugee youth, education, and oral history performance. The CURA project was conceived as a true partnership between university researchers and community members with full collaboration in all aspects of the project. The initiative produced a remarkable archive of stories, performances, and other collaborations and partnerships. Perhaps more importantly, it also lived out the true meaning of its creed of "shared authority": every stage of the process was informed by a consensual dialogic. The thoughtful, rigorous, and democratic process of informed consent built trust and rapport, and the empowerment of participants gave them agency over the stories they told and the opportunity to share and collaborate within their community.[43]

After members of the various communities were invited to participate, a pre-interview consultation set the parameters and protocols, and the interviewee was given full control over the length, direction, and content of the discussion. Participants were invited and trained to participate in the post-production processing, mediation, and dissemination of the material. Many have since used the resources of the research and documentation centers for their own projects. The aim was not just to help witnesses tell their story (much less to "give survivors voice") but to provide them the opportunity and the tools to make their own stories and use them for self-expression and community empowerment. The aim was to explore, create, and practice concrete ways of transmitting the unspeakable and rebuilding community.

Significantly, the transmission between the participant and the oral historian was only the first of several narrative iterations. Stories were not only collected and archived, but were also used in playback theater[44], interactive new media applications, podcasts, documentary film, radio plays, and other creative interpretations. The reproduction and circulation of survivors' stories in various media and contexts served to animate - in some cases to re-animate - community dialogue, interaction, and reconciliation both within the various cultural communities, and throughout the broader multicultural cityscape. Documentation centers established by and for the survivor communities in Montréal and Kigali became both a site and a means for intergenerational and intercultural understanding.

The intergenerational aspect was particularly important in the Rwandan working group. One of the main objectives of the research was to allow survivors of ethnic and political violence to tell their stories, often for the first time. Among Rwandan Canadians who had been born in Canada, there was the pervasive sense that their parents and grandparents never spoke of ethnic and political violence

[43] See Steven High, "Sharing Authority: An Introduction," *Journal of Canadian Studies* 43, no.1 (2009): 12-29.
[44] See http://www.lifestoriesmontreal.ca/en/playback-theatre-1.

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that led them to flee Rwanda, rendering the younger generations alienated from both their parents and their Rwandan heritage and history. This perspective demonstrates how PTSD can disrupt narrative function not only within individuals and families, but longitudinally as well, affecting the transmission of identity and culture between generations. Such continuity is particularly important in the diaspora, and Rwandan youth were most engaged in the project, hoping to break the cycle of silence. As Lisa Ndejuru, a Rwandan community organizer, participant, and researcher put it,

> Initially, I had thought that dialogue about or out of genocide would breach an "ethnic" divide, but instead there were many groups even within the "same" group, and dialogue first ended up being about breaching the silences among us.[45]

The dialogic, multimedial, and community-based structure of the Life Stories project enabled the process of narrative reconstruction to disseminate back into the community, providing content, form, and will to facilitate the reintegration of traumatized members within a community and greater collective self-understanding. This illustrates how narrative is a social act, animating, rather than simply recalling, meaning. Traumatic stories are not simply forensic evidence or archival records, but realize their full meaning in social context and use.

The therapeutic aspects of narrative in the interview process were implicit, and participants were given access to counseling services if necessary, but the scope of the project revealed how individual life stories both contribute to and derive meaning in the larger context of the community. Life histories linked psychology, sociology, geography and history. This multidisciplinary approach allowed the participants to express the complexity and contradiction of the personal, and find reassurance in the knowledge that, however compromised or fragmentary their own traumatic stories, the metanarrative within which, they played out, had meaning and value. The temporal scope of the project also incrementally gave some community members the courage and confidence to participate (in some cases, years after they were first contacted) as they saw the integrative capacity and resilience of the community restored. Though the grant-driven phase of the project is now over, the community research and documentation centers in Montréal, Kigali, and elsewhere have been designed to be self-sustaining and hopefully the narrative process will continue.

The social commitment and orientation of this project illustrates that PTSD is not just an individual affliction, but radiates throughout communities

[45] Lisa Ndejuru, "Sharing Authority as Deep Listening and Sharing the Load," *Journal of Canadian Studies* 43, no.1 (2009): 6.

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spatially and intergenerationally. Sharing authority and responsibility for a dialogic process of re-engagement can help reintegrate shattered communities and histories and help individual sufferers find a voice and a place. The Montréal Life Stories project seems to have most fully realized the possibilities of a serious commitment to the principles and practice of narrative, from its expression as a verb, its exercise as both means and ends, and its capacity to integrate individuals, communities, societies, and generations past and future within a coherent and meaningful story. The Community-University alliance provided the structure, tools, and resources for the social integration and beginning of the healing process for traumatized refugee communities. A stronger community and engaged host society can better care for those individuals suffering from PTSD as a result of war, genocide and other human rights violations.

Politics by Other Means: Narrative and Civic Responsibility
Michael Kilburn, *Endicott College, Beverly, MA*

Michael Kilburn is a political scientist and oral historian and coordinator of the Soldiers' tales Untold working group on trauma and narrative. He frames the relation of trauma, memory, and reconciliation in terms of political sociology and discusses the civic and ethical implications of traumatic history, justice, and reconciliation for veterans and other victims of PTSD. He suggests that a greater understanding of the function of narrative in healing the wounds of war might also imply preemptive strategies to the political (meta)narratives that frame, provoke, and legitimize organized violence in the first place.

All political societies are built on an interlocking foundation of myths, legends, histories, and cultural reference points: a shared language and common story that create national/communal identity, social cohesion, a common weal, and a vision of the future. This collective narrative, civic identity, or democratic self-understanding is an ongoing dialogical process of political socialization. At best, these narratives provide consensus, security, meaning, and common purpose; at worst, they can be used to justify injustice, oppression, and collective violence. Ideology, the story that we tell ourselves about ourselves and our world, functions to maintain narrative continuity and provide a guide for behavior. When functioning smoothly, it is transparent, implicit, and self-evident. But when the contradictions become too obvious, political systems can exhibit irrational and even self-destructive behaviors. Whether by design or default, trauma happens for a reason, and usually a political one. Atrocities may be designed and implemented, or merely allowed to unfold through criminal or benign neglect, but given a failure of political vision and will to prevent atrocities, they are inevitable.

From the socio-political perspective then, the nexus of trauma and

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narrative consists in the construction of an ideological framework -a *meta*narrative- within which organized violence takes place. Whether the aim is manufacturing consent to a murderous policy or provocation to murder itself, politicians are well versed in the demagogic rhetoric and narrative conceits that frame, provoke, and legitimize organized violence against "others" who allegedly threaten the social order. Systems of injustice, oppression, slavery, war, etc., are inevitably justified or rationalized with reference to an overarching national narrative.. As such metanarrative constructs are a necessary and deliberate precursor to the social, cultural, economic, and political conditions conducive to trauma - be they systematic oppression like slavery, apartheid, and gender/class divisions or more episodic expressions of atrocity such as genocide, war, or "ethnic cleansing"- they might be termed "preTSD".

The ideology of "manifest destiny," for example, tapped into the exceptionalist millennial faith and racist "civilizing mission" of Euro-Americans to justify westward expansion/imperialism and genocide against Native Americans. Jim Crow and apartheid were not just legal systems of privilege and exclusion, but cultural paradigms deployed through story, song, and language itself to reinforce and culturally embed an oppressive political order. Genocides are always preceded by identifiable stages of rhetorical and symbolic dehumanization. The 2008 conviction of Rwandan singer Simon Bikindi for incitement to commit genocide is testament to this strategic power of narrative.[46] War itself, as Hermann Goering noted in his famous aphorism, must always be preceded by the cultivation of a patriotic groundswell of support and obedience. [47] Narrative choices by policy makers can dramatically impact the life experience of their constituents. For Cathy Caruth, the bearers of trauma, the foot soldiers, survivors, victims and witnesses, are the collateral damage of such political demagoguery. "If PTSD must be understood as a pathological symptom," she writes, "then it is not so much a symptom of the unconscious, as it is a symptom of history."[48]

The Bush administration's decision to frame the attacks of 9/11 as a declaration of war, for example, rather than an international crime as Colin

[46] The Prosecutor v. Simon Bikindi, ICTR -01-72-T, http://www.unictr.org/Portals/0/Case%5CEnglish%5CBikindi%5Cjudgement%5C081202eJudgement.pdf.

[47] "Why of course the people don't want war… But, after all, it is the leaders of the country who determine the policy and it is always a simple matter to drag the people along, whether it is a democracy, or a fascist dictatorship, or a parliament, or a communist dictatorship. Voice or no voice, the people can always be brought to the bidding of the leaders. That is easy. All you have to do is tell them they are being attacked, and denounce the peacemakers for lack of patriotism and exposing the country to danger. It works the same in any country." Hermann Goering, interview by Gustave Gilberg, 18 April 1946, Nuremberg, http://www.snopes.com/quotes/goering.asp.

[48] Cathy Caruth, *Trauma: Explorations in Memory* (Baltimore: Johns Hopkins Press, 1995), 5.

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Powell, in his capacity as Secretary of State, had advocated, led to a series of policies, postures, and doctrines with traumatic consequences for soldiers, civilians, and societies. There is typically no collateral damage in a detective story, no airstrikes, occupation or torture, but war stories are awash in blood, trauma, and carnage. Bush's semiotic coup established a narrative framework permitting, even encouraging, a range of human rights violations and indignities: from widespread prejudice and violence against visible minorities; surveillance and curtailment of civil liberties; illegal war and occupation; rendition, torture and indefinite detention; the wholesale destruction of Iraqi society, and drone warfare. In deliberately creating the preconditions for a range of traumatic experiences throughout society (both domestically and in the various fronts of the "global war on terror,") such a provocative rhetorical framing –whether in the buildup to war, revolution, or incitement to genocide – is a clear example of "PreTSD."

When President Bush addressed a joint session of Congress shortly after the attacks, he claimed that 9/11 was not a singular act of terrorism, but the latest chapter in a millennial struggle of good versus evil, an attack on civilization and "freedom itself." To claim that the Al Qaeda terrorists were "heirs of all the murderous ideologies of the 20th century, follow(ing) in the path of fascism, Nazism, and totalitarianism"[49] makes sense only in terms of a simplistic mythic narrative, not historically, politically, ideologically or even logically. Bush's singular talent as president was a charmingly compelling, if incurious, self-confidence and the American people, in their ignorance of history, politics, and civics, were reassured by a storyline that cast them as innocent victims and heroes (indeed the two were conflated in the telling) faced with an evil, implacable and irredeemable foe who had to be utterly destroyed. It was a classic, almost Hollywood, script: a narrative framing resonant with American ideological self-conception that allowed the people to make at least symbolic sense of their trauma. Bush's approval ratings soared to among the highest in US history and inconvenient questions about his legitimacy and competence were buried in the rallying cry. Despite a quick and decisive victory against the Afghan regime, counterinsurgency against Taliban remnants, Al Qaeda, and former warlords dragged on, and the post-conflict reconstruction and transition to civilian rule was riddled with corruption and ambiguity. The complex situation on the ground undermined and even contradicted the political rhetoric and the war expanded to match the expansive rhetoric of a "global war on terror."

If Afghanistan was a tragedy, Iraq was a farce. While the war against the Taliban was at least grounded in historical events and sanctioned by international law, the 2003 invasion of Iraq was a product of neo-Conservative wishful

[49] George W. Bush, "Address to a Joint Session of Congress," 20 September 2001, par. 13, http://www.americanrhetoric.com/speeches/gwbush911jointsessionspeech.htm.

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thinking and imperial ambition. The premise for "Operation Iraqi Liberation" only made sense in terms of the Manichean neo-conservative worldview wherein "evil-doers" of any description were enemies alike. Terms like "axis of evil," "Islamofascism" and the claim that Hussein was the "new Hitler"[50] framed the conflict with the moral clarity of World War II. The fact that no evidence linked Saddam Hussein to Al-Qaeda was seen by an increasingly isolated and delusional national security team as a plot spoiler to be overwritten by metaphor, metonymy, and propaganda. The constant rhetorical conflation of the two campaigns was so successful that to this day, in the absence of any evidence, significant numbers of Americans still believe Hussein was involved in the 9/11 attacks.[51] Anything or anyone that contradicted the increasingly self-referential narrative – absence of WMDs; absence of uranium procurement from Niger; criticism of torture-induced testimony – was isolated, discredited, and dismissed. The administration's preference for story over facts was on full display in the stagecraft of Colin Powell's testimony before the UN Security Council, which relied on assertions, computer simulations and props.[52] When the Security Council declined to endorse the war plans for lack of evidence, President Bush dismissed the United Nations as "irrelevant." Perhaps the most transparent example of the Bush administration's predilection for narratology over epistemology is Karl Rove's dismissive quip to Ron Suskind on the limits of enlightenment principles and empiricism among the "reality based community," those who,

> …believe that solutions emerge from your judicious study of discernible reality. That's not the way the world really works anymore. We're an empire now, and when we act, we create our own reality. And while you're studying that reality -- judiciously, as you will -- we'll act again, creating other new realities, which you can study too, and that's how things will sort out. We're history's actors . . . and you, all of you, will be left to just study what we do.[53]

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[50] Anne Kornblut and Charles Sennott, "Saddam the New Hitler, Bush tells Europeans," *Boston Globe,* 22 November 2002, http://www.smh.com.au/articles/2002/11/21/1037697805270.html.

[51] At the time of the invasion, 69% believed he was personally responsible. The number declined to 41% by 2007 and 38% by 2011. See Nick Rivera, "Ten Years Later, Belief in Iraq Connection With 9/11 Attack Persists." *The Moderate Voice*, 9 September 2011, http://themoderatevoice.com/121921/ten-years-later-belief-in-iraq-connection-with-911-attack-persists/. See also Amy Gershkoff and Shana Kushner, "Shaping Public Opinion: The 9/11-Iraq Connection in the Bush Administration's Rhetoric," *Perspectives on Politics* 3, no. 3 (2005): 525-537, for an overview of the rhetorical strategy.

[52] Tellingly, a tapestry of Picasso's *Guernica*, that visceral artistic testament to the brutal reality of war, which hung outside the Security Council chambers, was covered with a blue cloth during his testimony.

[53] Quoted in Ron Suskind, "Faith, Certainty, and the Presidency of George W. Bush," *New York Times Magazine,* 17 October 2004,

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A compelling story, it seems, trumps inconvenient truth. The policy that grew out of this narrative, however tenuous its connection to reality, had very real consequences for those swept up in its blood-thickened plot. Despite attempts by the Bush administration to keep their war in the realm of the virtual – keeping its cost off the books through supplemental funding, for example, and out of the newspapers by censoring photographs of the caskets at Dover Air Force base; refusing to count civilian casualties; and routinely denying service for claims of PTSD – the chickens eventually came home to roost.

For the architects of the policy, the self-evident righteousness of the cause led to arrogance and a tragic miscalculation of its implications and consequences when events when off script. The exigencies of the war (exacerbated by Secretary of Defense Donald Rumsfeld's insistence on a lighter military and widespread use of private contractors) increased the potential for trauma among soldiers and civilians alike. Underequipped troops without body armor, desert camouflage, or cultural literacy confronted a reality on the ground far more complex than the narrative they had been given. The ambiguity of the mission; repeated and stop-loss deployments (including National Guardsmen as well as active duty soldiers); the widespread use of improvised explosive devices and suicide attacks; and the unpredictability of counterinsurgent warfare, including a spate of "green on blue" attacks[54]; have all led to increasing levels of PTSD, depression, and suicide. For civilians caught in the crossfire, the situation was worse, with daily random violence by insurgents and occupation troops, their social and economic networks destroyed, heritage looted, neighborhoods and families dispersed, and access to care virtually non-existent.

When young men and women are tasked with executing policies that are coherent and correspond to an ideological narrative of national identity and purpose, resilience and morale improves.[55] When the troops, as well as civil society, have solidarity, trust, and the opportunity to share their experiences and make collective sense of them, they are more likely to survive the horror of war. But when the narrative is incoherent, when the ideological justification unravels, when they are confronted with the "Catch 22" of impossible policies, when they are disabled from processing the inherent contradiction of ideology and practice,

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http://www.nytimes.com/2004/10/17/magazine/17BUSH.html?_r=0, and attributed in Mark Danner, "Words in a Time of War: On Rhetoric, Truth and Power," in *What Orwell Didn't Know: Propaganda and the New Face of American Politics*, ed. András Szántó (Philadelphia: Public Affairs Reports, 2007), 17.

[54] Referring to the color assignments in tactical combat displays, "green on blue" refers to (allegedly) friendly forces firing on international coalition troops.

[55] Paul T. Bartone, "Resilience under Military Operational Stress: Can Leaders influence Hardiness?" *Military Psychology* 18 (Supplement) (2006): S131-S148.

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they can suffer consequences on a psychological and physiological level.[56] These victims may manifest symptoms of PTSD –depression, withdrawal, violence, suicide- that in turn traumatize their families and communities. Traumatized communities may succumb to fear and internal division. At best the capacity of the community to care for and reintegrate its members is compromised. At worst, society descends into balkanization that perpetuates the cycle of violence and trauma. The traumatized are witnesses to political and ideological failure, victims of what Cathy Caruth calls an "impossible history."[57] And in our complicity, if we take shared authority and civic responsibility seriously, then, as Hank Greenspan says, "we are implicated."[58]

But if trauma ultimately results from a failure or misuse of political narrative, there may also be a talking cure. Recognizing early on the narrative strategies of PreTSD suggests opportunities for civic countermeasures. Politicians can work to restore narrative coherence and rebuild legitimacy. Civil society, from national and international NGOs to the Habermasean micro public sphere of neighborhood associations, can discuss and debate public policy, creating counter narratives and demanding transparency and accountability. Citizens can speak with their representatives and each other, demanding that their voices be incorporated into the national narrative and that the victims of trauma, both soldiers and civilians, be given their due. Media, mass, social, and creative, can help frame and reframe political issues in a way that promotes critical understanding and coherence and avoids war. Civil society initiatives such as Susan Benesch's "Dangerous speech project"[59] can monitor inflammatory public speech, while new social media, such as Kenya's ushahidi.com - activist mapping software used to track, publicize, and prevent post-election violence - can endeavor to reclaim public space from the hate-mongers. By speaking and listening to each other, we can begin to recognize our mutual implication. A strategy of civic-literary deconstruction might pre-empt politicians from getting away with ideologically driven narrative choices and tactically driven narrative strategies that create the conditions for the diffusion and persistence of trauma within a polity. If the conditions of trauma are narratively constructed, they might be preemptively deconstructed as well.

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[56] Allison Whitesell and Gina P. Owens, "The Impact of Patriotism, Morale, and Unit Cohesion on Mental Health in Veterans of Iraq and Afghanistan," *Traumatology* 18 (2012): 1-7.
[57] Caruth, *Trauma*, 5.
[58] Hank Greenspan, *On Listening to Holocaust Survivors* (Westport, CN: Praeger, 1998), xx.
[59] For an overview, see "Dangerous Speech along the Path to Mass Violence" World Policy Institute, http://www.worldpolicy.org/content/dangerous-speech-along-the-path-to-mass-violence.

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Conclusion

Michael Kilburn, *Endicott College, Beverly, MA*

The experience of trauma is intensely personal and so intimate that it defies communication, but it derives from and radiates through all levels of society. At each level – individual/psychic, clinical/therapeutic, administrative, community, policy – trauma induces a breakdown in the processing of experience into memory and collective understanding. Narrative competency may help restore coherence and communication within and among individuals, communities, and societies. Moreover, attention to the various disciplinary perspectives engaged in trauma work – psychiatry, human services, oral history, cultural studies, sociology, politics – suggests that there are benefits for the individual, the community, the polity, and the integrity of the story itself by focusing on the collaborative dialogic process, rather than just the product of narrative.

Practiced in the art of soliciting and collecting stories, listening empathetically, and inductively co-creating narratives from fragments of memories, oral historians would seem well suited to participate in the vast work of comprehending and addressing trauma in its individual, community, social, political and historical aspects. Oral historians can contribute in some ways to the care, recovery, and reintegration of victims, both combatant and noncombatant. But direct engagement in the treatment of veterans and others suffering symptoms of PTSD raises a host of logistical, methodological, and ethical issues.

What role can we responsibly play in the treatment of veterans and others suffering symptoms of PTSD? What does this role suggest about the relationship between individual experience, cultural narrative, and historical truth? Might music, art, or poetic archetypes facilitate the narrative processing of trauma? Can methods and practices of oral history be incorporated into training to improve the psychological and social resilience and reintegration of soldiers? And should they be, or would such complicity violate professional ethics and standards? How can family and community members participate in the healing and reconciliation process, and can society reintegrate returning veterans and refugees without also integrating their impossible stories? What are the historical, legal, and policy implications? What is the moral and political accountability (and liability) of narrativizing the trauma of combat veterans, not to mention the overwhelming civilian casualties of military conflict?

Finally, we should recognize that even if we leverage our narrative practice to improve the quality, efficiency, and delivery of trauma care, we are still only treating a symptom. From a civic perspective, we need to interrogate, critically analyze, and if necessary dissent from policies that put individuals in potentially traumatic situations in the first place.

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