Response to the Multidisciplinary Roundtable Soldiers' Tales (Un) told: Perspectives on trauma and narrative in the consideration and treatment of PTSD (and pre-TSD)

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The papers by Michael Kilburn, Samata Sharma, Nathalie Saltikoff, Dana Modell, Scott Rothermel and Sandra Gasana offer a variety of perspectives about the effects of violence and inclusion of narrative methodologies for treatment. Of particular focus in the collection is the use of narrative approaches, especially with those who have experienced what is called complex trauma, defined as multiple physical and mental assaults and/or chronic assaults that have occurred early in life. In contrast, simple trauma refers to one episode. In particular, war and the experience of soldiers in war are considered by these authors. The collection starts with a paper by Samata R. Sharma who describes the physiological brain changes accompanying the experience of being traumatized and pharmacological and psychotherapy treatment approaches to alleviate symptoms. Here her emphasis is on Post-Traumatic Stress Disorder (PTSD), a condition that is referenced in the papers that follow. Nathalie Saltikoff and Dana E. Modell consider narrative psychotherapy approaches and how narrative content is embedded in many psychotherapy treatments. Their paper is followed by one by Scott Rothermel, who explores administrative systems problems in the U.S. Department of Defense that disrupt, de-legitimize and impede efforts of returning soldiers to express their encounters with violence and find ways to heal. In a fourth paper, Sandra Gasana examines community healing efforts in Montreal, offering a rich and multi-level perspective about individual and community healing for traumatized individuals and groups. In the last article of the collection, Michael Kilburn, hypothesizing about pre-Traumatic Stress Disorder (pre-TSD), explores how national violence grows and potentially could be stopped, thus disrupting a cycle of escalating suspicion, hostility, and aggression. In his closing remarks about the roundtable collection, Michael Kilbrun suggests the importance of a multidisciplinary team approach for addressing violence at all levels of society, from that affecting the individual to peoples and countries. He also proposes that oral historians may contribute in some fashion to healing combatants and noncombatants who have PTSD.

The papers are interesting and provocative, offering means by which disabling reactions to extreme trauma may be understood, managed, lessened and possibly eliminated. Prevention and treatment, Kilburn argues, are essential areas

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requiring exploration. Limitations of our present knowledge in the area of complex trauma are considered and the collection concludes with a challenge to take on the next steps toward healing. Those steps could include the incorporation of oral historians in multidisciplinary teams, a novel approach that Kilburn agrees requires careful thought.[1]

What is missing in the collection, however, are the connections between oral history both as a methodology and a discipline and their relationships to the prevention of structural violence, the violence emanating from the organization of the culture itself that results in systemic violence, especially toward those who are marginalized and underserved. In addition, how oral historians, because of their own expertise, could contribute to reversing those structural aggressions goes unaddressed. Also missing is a connection between trauma and how the oral historian may aid healing.

Before I proceed further, I would like to describe my professional background. I am a clinical psychologist who works in my community with individuals, families, and larger groups experiencing internal rifts and perceived attacks coming from outside their group. I treat clients and families with complex trauma. I also am a peace psychologist, that is, one who explores ways to change how societies work. How political/social systems can change in ways that further peaceful interaction is a part of my exploration. In addition, I am an oral historian who studies the impact of violence on those who experience it, namely the narrators and the interviewer(s) and on those who listen to or read the accounts of trauma. Here I refer to those who do not conduct the interviews with the narrator but rather listen to or read the dialogue.

The concerns I have about the roundtable include the leap from establishing that the narrative method is legitimate and a useful intervention in many psychotherapy treatment approaches, especially those concerned with the treatment of PTSD, to the assertion by Kilburn, in his concluding remarks, that oral historians may become part of the treatment, healing, and rehabilitation of individuals experiencing severe trauma. Moreover, Kilburn wonders whether practices of oral historians may help with the development of training that increases resilience and rehabilitation of soldiers experiencing trauma, another questionable contention that raises ethical issues as well. And finally, Kilburn asks how it is possible to lessen cultural violence in the first place, enlisting oral historians in this quest. The question itself is broad and leads to a further set of complicated questions and research, which, unfortunately are outside the scope of the multidisciplinary roundtable discussion.

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[1] M. Kilburn, S. Sharma, N. Saltikoff, D. Modell, S. Rothermel and S. Gasana, "Multidisciplinary roundtable: Soldiers' tales (un)told: Perspectives on trauma and narrative in the consideration and treatment of PTSD (and pre-TSD)," *Oral History Forum d'histoire orale* 33 (2013), Special issue 'Confronting Mass Atrocities: 1-26.

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A review of the trauma and treatment literature suggests that a promising treatment of PTSD is narrative exposure therapy, one that links incomplete and recovered memory to one's narrative, in order to create a consolidated sense of oneself within a story of one's life.[2] At the same time, there is research questioning under what conditions to use this technique and the possible negative consequences.[3] Moreover, while other methodologies may be helpful, those studying effectiveness of this treatment reason that it may be more difficult to tease out the impacts of other treatment approaches because they are not as well described and documented, that is, are not using empirically standardized protocols and quantitative methods to study outcomes. The research to date that attempts to substantiate a narrative exposure therapy approach compare its methodology to psychoeducational interventions and general counselling approaches, or with a no treatment condition.[4] However, Hogue points out that there are a number of therapies that may be helpful in treating war-related PTSD, according to the US Preventive Services Task Force criteria, but that those that are effective include five key factors: narration, cognitive restructuring, in vivo exposure, stress inoculation, and psychoeducation.[5] Hogue goes on to say that narration may be the most effective therapeutic aspect.

To return to narrative/exposure techniques that look promising for work with traumatized children and adults, especially those in other parts of the world who experience ethnic/political conflict, research into treatment does not begin to address what would be the best approach to use in the United States with respect to returning veterans of war. As Scott Rothermel points out, while the Pentagon is slowly establishing outreach programs based on narrative methods for soldiers and civilians, the effort has not been "in a consistent or well researched way that would allow their efficacy to be measured scientifically."[6] Moreover, those soldiers from the United States with diagnosed PTSD from exposure to war on foreign ground are reported in much greater numbers than those suffering from

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[2] J. M. Hall, "Narrative methods in a study of trauma recovery," *Qualitative Health Research* 21, no.1 (2011): 3-13.

[3] L. De Haene, H. Grietens, and K. Verschueren, "Holding harm: Narrative methods in mental health research on refugee recovery," *Qualitative Health Research* 20, no. 12 (2010): 1664-1676.

[4] V. Ertl, A. Pfeiffer, E. Schauer, T. Elbert, and F. Neuner, "Community-implemented trauma therapy for former child soldiers in Northern Uganda: A randomized control trial," *JAMA* 306, no. 5 (2011): 503-512.

[5] C. W. Hoge, "Editorial: Interventions for war-related Posttraumatic Stress Disorder," *JAMA* 306, no. 5 (2011): 549-551. For another recent review, see B.E. Karlin and G. Cross, "From the laboratory to the therapy room: National dissemination and implementation of evidence-based psychotherapies in the U.S. Department of Veterans Affairs Health Care System," *American Psychologist* 69, no. 1 (2014): 19-33.

[6] M. Kilburn, S. Sharma, N. Saltikoff, D. Modell, S. Rothermel and S. Gasana, "Multidisciplinary roundtable," 13. Here he cites the U.S. Department of Veterans Affairs, National Center for PTSD, his footnote 29.

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war and ethno/political conflict in other parts of the world, raising issues about the virulence of the exposure and the nature of concomitant factors that affect this population.[7]

The numbers of soldiers and civilians in the United States with PTSD, when these are compared to the number of those in other countries, also raise questions about whether expressions of trauma, as defined by PTSD, are universal, or conversely, whether reactions to violence and rifts are experienced differently in various parts of the world, depending upon how cultures handle distress, the amount of individual and societal fragmentation resulting from the events, and what meanings are associated with war and participation. Perhaps what is construed as PTSD is more a Western construct that best defines the reactions of westerners who confront war and other trauma but has less utility in other parts of the world. There are questions raised about whether PTSD can be considered an independent, unique diagnostic entity, even in the U.S., because of the overlap between PTSD and other Axis I psychiatric disorders.[8]

To proceed further, the collection of Kilburn et al. focuses on the symptoms of American soldiers returning to the United States after wars in Iraq and Afghanistan. The returning warrior, well-suited for combat by personality and training, returns to civilian life only to find that his/her exquisitely fine-tuned reactions to war have little place stateside. Remember that PTSD, the diagnosis, was developed from the symptoms of veterans returning from Viet Nam in the 1970s, where American soldiers fought an unpopular and demoralizing war in a place far from home. Warriors from more recent international conflicts also come home to the United States, a country that is now war-weary and wary about war as a solution. How much is the symptom complex of PTSD the result of the specific beliefs and about circumstances in which soldiers fight? Perhaps it is important to raise questions about best practices that depend on culture, meanings, local methods of healing, and the kind of society to which people return.[9] How efficacious are narrative approaches practiced in the United States and to what degree must other societal conditions and supports be in place in order for healing to occur? Karlin and Cross raise issues about the lack of dissemination of highly recommended evidence-based practices and strategies, including prolonged exposure therapy and cognitive processing therapies for PTSD, within the Veterans Affairs Health Care System (VA) as well as in public community

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[7] L.K. Richardson, B.C. Frueh, and R. Acierno, "Prevalence estimates of combat-related PTSD: A critical review," *Australia and New Zealand Psychiatry* 44, no. 1 (2010): 4-19; F.H. Norris and L.B. Slone, "Understanding research on the epidemiology of trauma and PTSD," *PTSD Research Quarterly* 24, nos. 2-3 (2013): 1-13.

[8] See Richardson et al., "Prevalence estimates," 1-13.

[9] J. M. Levitt. (2011). "Post-Traumatic Stress Disorder and peace," in *The Encyclopedia of Peace Psychology*, ed. D. J. Christie (Malden: Blackwell, 2012), n. pag.

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practice and private mental care systems.[10] There are several cultures interacting that may affect the availability of good practice, including the VA as a system-wide entity, mental health practitioners within the VA's many centers, and the veterans themselves who might be reluctant to seek treatment.

Some traumatologists, working in Africa and in the Middle East, employ brief training in the narrative exposure technique in order to facilitate soldier and civilian healing. The circumstances prompting intervention are trauma associated with both forced migration and resettlement and ongoing trauma to those continuing to live in war-torn communities. Interviewers are either graduate students in psychology or related disciplines and/or members of local groups. Then, local interviewers, in turn, train other interviewers from their communities. The local healers are carefully screened and their credentials evaluated. Some primary education is expected. The treatment approach is highly structured and frequent oversight is built-in to the methodology. Success using this method has been documented.[11]

What is the relevance of the narrative exposure approach in general and the brief treatment approach described above to the potential involvement of oral historians in the healing of PTSD? The therapeutic techniques described above are different from oral history interviewing in which there is much more leeway about how interviews are conducted and where the objective is to get personal history while not focusing on healing as a primary objective. Moreover, with respect to working with those with symptoms of trauma, Western-trained psychotherapists are encouraged to remain vigilant about the emotional impact of the narrative process on their clients and themselves. The goals with respect to their dialogue with their clients include providing a safe place in which the client can reveal, learn, and grow. Trauma comes in many forms and clients move at varying paces throughout their treatment, with progress sometimes advancing in spurts, counterbalanced by regression or retreat. Client vulnerabilities, in general, and at certain intervals during the healing cycle, may prevent steady progress.[12]

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[10] Karlin and Cross, "From the laboratory to the therapy room,"19-33.

[11] F. Neuner, M. Schauer, C. Klaschik, U. Karunakara, and T. Elbert, "A comparison of Narrative Exposure Therapy, Supportive Counseling, and Psychoeducation for treating Posttrauma Stress Disorder in an African refugee settlement," *Journal of Consulting and Clinical Psychology* 72, no. 4 (2004): 579-587; and L.P. Onyut, F. Neuner, E. Schauer, V Erti, M. Odenwald, M. Schauer, and T. Elbert, "Narrative Exposure Therapy as a treatment for child war survivors with posttraumatic stress disorder: Two case reports and a pilot study in an African refugee settlement," *BMC Psychiatry* 5, no. 7 (2005): n. pag. For a review of the technique's effectiveness, see K. Robjant and M. Fazel, "The emerging evidence for Narrative Exposure Therapy: A review," *Clinical Psychology Review* 30 (2010): 1030-39; and L. De Haene, H. Grietens and K. Verschueren, "Holding harm: Narrative methods in mental health research on refugee trauma," *Qualitative Research in the Health Sciences* 20, no. 12 (2010): 1664-76.

[12] J. Herman, *Trauma and recovery: The aftermath of violence from domestic abuse to political terror* (New York: BasicBooks, 1992).

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Reactions to hearing about trauma second-hand, as the therapist does, also must be embedded in the treatment. Listening to stories containing horror require that the therapist carefully monitor his/her own responses. This attunement with one's own reactions as a therapist is considered a good practice regardless of the content of the sessions and the purpose of the treatment.

To continue, not only are interview methods in psychotherapy different from those interview techniques employed by oral historians but the pace, the interventions and the objectives of sessions also are dissimilar. Both psychotherapist and oral historian seek the story, the narrative, but in different ways, for different purposes, and with the expectation of different outcomes.

However, there also are common threads in oral history and psychotherapy. Narratives are key in both methodologies, especially narratives that create a comprehensive, integrated story, which then is believed to move toward a personal truth and a psychological integration for the client/narrator. The relationship of the storyteller or the client and the interviewer is one that is built on some degree of trust—the interviewer becomes the "public", the agent through which secrets, perhaps never before articulated memories associated with unease and shame, guilt and fear, may be disclosed and in turn, legitimized. The oral historian, like the therapist, must be mindful of her/his own reactions to disclosure, especially when trauma is part of the narrative, as these emotions serve as feedback and as opportunities to question one's objectivity, raising questions about one's conscious and less conscious reactions and agendas. The experience of revealing and then organizing memory can be healing for the narrator. This may be so regardless of context, for example, as part of a public performance (see Sandra Gasana in this collection) a recreational experience, a therapy session, and within an oral history can be healing for the narrator. [13] Conversely, as mentioned in the collection, the retelling of the story also can be disorganizing and lead to exacerbation of symptoms and herein lies the rub—a requirement for therapy. When the story telling is generally a positive experience, adding a supportive community that accepts a person who previously has felt unworthy, confused, and isolated can further facilitate healing and growth both in the individual and in the community. However, the mere opportunity of simply sharing memory with only one other may be sufficient. Telling one's story with only one witness, the interviewer or therapist, may begin a personal feedback system within the narrator, one that does not require further outside intervention. The individual, through further discovery, may find new ways to organize parts of a story that before was experienced only as disjointed fragments or not recalled at all.

[13] For example, see R. A. Mowatt and J. Bennett, "War narratives: War stories, PTSD effects, and therapeutic fly-fishing," *Therapeutic Recreation Journal* 45, no. 4 (2011): 286-308; and A. R. Denham, "Rethinking historical trauma: Narratives of resilience," *Transcultural Psychiatry* 45 (2008): 391-414.

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Through training in working with memories involving horror and with supervision by trained psychotherapists, the oral historian may in the process of interviewing start a process of healing. Here I mention my own experience studying the reactions of interviewers working with WW II Jewish survivors. How the interviewers responded to content filled with horror and the incorporation of team oversight, which included a psychologist with years of experience working with trauma survivors, were essential for the interviewers to proceed.[14]

Or perhaps, conversely, the oral historian may enter the healing process at a later time, after the completion of psychotherapy addressing the trauma, further helping the narrator to complete a recovery. In either time interval of the healing process, the oral historian may help the wounded to develop a cohesive story based on insights. However, bringing the disjointed pieces of the narrative together and working with the side effects resulting from disclosure become the territory of the psychotherapist. It is the oral historian who makes the memoire with the narrator but it is the psychotherapist who engages with the individual to enable him/her to become more whole or psychologically integrated so that the story, now more cohesive, can begin to flow and become a new reality. It is possible that psychotherapy, regardless of the techniques employed, may to some extent promote healing and then perhaps the telling or declaring one's story to others, when one is ready, becomes a function of the oral history experience, after memories are further congealed in psychotherapy. Conversely, it may be an oral historian who discovers that the narrator would benefit from treatment, that telling the story is insufficient, and it is he or she who through observations and work with trainers and/or supervisors facilitates the narrator's work with a psychotherapist and/or other trained specialists, such as psychopharmacologists. Of interest is that veterans returning from recent wars may tend to prefer psychotherapeutic interventions to medications and this also speaks favorably to the employment of narrative approaches. The Veterans Administration encourages presenting choice of treatments to its patients.[15]

I add here that there may be multiple ways in which people are healed, including through writing, performance, and music, all of which can be joined to the narrator's story, as Sandra Gasana, in her article, attests. Regardless of the entry point for intervention, however, it must be understood that any one healing approach may not be correct and may even be harmful. In addition, it is crucial to

[14] J. M. Levitt, *Interviewer reactions to World War II holocaust stories and effects on the interviewer.* Paper presented at the meeting of the Oral History Association, Oklahoma City, OK, October 2014.

[15] See G. M. Reger, T. L. Durham, K.A. Tarantino, D.D. Luxton, K.M. Holloway and J.A Lee, "Deployed soldiers' reactions to exposure and medication treatments for PTSD," *Psychological Trauma: Theory, Research, Practice, and Policy* 5, no. 4 (2013): 309-16.

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base one's entry point on the present needs and comfort level of the narrator or client. If the narrator is having difficulty with the interview process, it is important to consider deferring an oral history interview or the telling of the story through performance as part of a community experience. In the case of psychotherapy treatment, when there is regression, it becomes necessary to rethink the treatment modality or to take a recess from the process. Here, therefore, both oral historian and therapist have roles to play in thinking through the healing process.

With respect to violence that is embedded in our community structures, a theme in the collection, the oral historian may be effective in a number of ways. Through the study of history, we can track how practices involving dialogue are more or less efficacious. That is, by following the experiences of people who have experienced trauma the oral historian is able to identify the influences of various forces on and by individuals and larger groups that, in turn, contribute to societal positive change and/or to continued dysfunction. Understanding and development of constructs can be facilitated by documenting detailed accounts of a narrator's behavioral interactions and remembered outcomes, a function of the oral history method. The oral historian also can interview segments of the population that have not spoken out before and add their voices to the discussion. Identifying needs of and opportunities for societal participation of traumatized individuals and groups may develop from these exchanges. The very recording of experience, especially those experiences associated with horror and dehumanization and making those experiences publically accessible, lend legitimacy to those needing and/or seeking service and press societal leaders to take note and act.

In conclusion, oral history methodologies can be constructive for the narrator when there is a story he/she wants to tell. Moreover, storytelling can be healing. However, experiences associated with complex trauma, PTSD, and pre-TSD must be approached with great care because such trauma-related expressions may be deeply embedded in a storyteller's psyche. Proceeding with caution is necessary, with an appreciation that what appears to be just part of the story may be associated with meanings and manifestations that are painful, primordial, and fixed. When telling the story is insufficient to promote healing, psychotherapy and other treatment may be advisable. We as facilitators of story-telling always must be mindful of that.

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