



The Trinity of Trauma: Ignorance, Fragility, and Control

The Evolving Concept of Trauma /
The Concept and Facts of Dissociation in Trauma



Ellert R. S. Nijenhuis

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Vandenhoeck & Ruprecht

With 26 figures and 12 tables.

Bibliographical information published by the Deutsche Nationalbibliothek

The Deutsche Nationalbibliothek lists this publication in the Deutsche Nationalbibliografie; detailed bibliographic data available online: <http://dnb.d-nb.de>.

ISBN 978-3-525-40247-4

You can find alternative editions of this book and additional material on our website: www.v-r.de

Cover image: Balancing of pebbles on the top of a triangle stone/shutterstock.com

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Vandenhoeck & Ruprecht LLC, Bristol, CT, U.S.A.
www.v-r.de

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Printed in Germany.

Typesetting: Satzspiegel, Nörten-Hardenberg

Managing Editor: Joseph A. Smith

Printed and bound in Germany by © Hubert & Co., Göttingen

Printed on non-aging paper.

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Volume I

The Evolving Concept of Trauma

Preface

One of the pitfalls of childhood is that one doesn't have to understand something to feel it. By the time the mind is able to comprehend what has happened, the wounds of the heart are already too deep.

Carlos Ruiz Zafón (2005, p. 33)

The trinity of trauma is a trilogy: Volume I, *The Evolving Concept of Trauma*, and Volume II, *The Concept and Facts of Dissociation in Trauma*, are predominantly conceptual, theoretical, and empirical in nature. Volume III, *Assessment and Treatment of Dissociation in Trauma*, which builds on the first two volumes, addresses clinical practice.

The first seven chapters of Volume I present a selective history of the concept of trauma, revealing the capricious understanding of trauma and trauma-related disorders from ancient to modern times. It also identifies several recurrent and persistent conceptual flaws that have plagued the issue. Chapters 8 and 9 reveal that these relate in part to philosophical matters that have hardly, if at all, been considered or realized in the trauma field. Philosophical wisdom – mainly but not exclusively treated in Chapter 10 – shows that (1) there are *intrinsic* relationships between the brain, the body, and the environment, that (2) subject and object are co-constitutive, co-dependent, and co-occurrent, that (3) causation is dynamic, and that (4) matter – hence neuroscience – cannot explain consciousness and will outside of experience. All science and clinical practice depends on two irreducible fibers: will and consciousness. Any human action starts and ends with consciousness and is propelled by will such as desires to live, love, explore, care, dominate, compete, play, and defend. Grounded in these insights, Chapter 11 fulfills the primary aim of Volume I: to formulate new definitions of trauma and traumatic experience, traumatic events, traumatizing events, and traumatic memory.

The secondary aim of Volume I – one closely related to its primary aim – is to demonstrate and critique the age-old 'dissociation' of two groups of disorders that are more alike than different. In the course of medical and psychiatric history these two have been described and contrasted using a wide variety of names, such as 'melancholia' versus 'hysteria,' or 'traumatic neurosis' versus 'traumatic hysteria.' In the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013), the two are now called (1) trauma- and stressor-related disorders, which prominently includes acute stress disorder and posttraumatic stress disorder (PTSD), and (2) dissociative disorders. Another 'dissociation' in the DSM-5 that should be rejected and mended is the division of dissociative disorders and conversion disorders.

The reasons for proposing a single category of trauma-related disorders to capture the trauma- and stressor-related disorders, dissociative disorders, and conversion disorders of the DSM-5 are conceptual, theoretical, and empirical. Whereas these various disorders are not identical, they do have the classic causes in common that Aristotle formulated many ages ago: material, efficient, formal, and final causality. Their common efficient causes include particular patterns of psychophysiological and brain activation, and the material causes include common structural brain abnormalities. Their common formal cause is a more or less complex dissociative organization of the personality, that is, a division of this biopsychosocial system in two or more conscious and self-conscious subsystems or 'parts.' This dissociative organization is intimately related to two common final goals: the desire to live (a happy) daily life and the desire to survive adverse events. Children have an evolutionary-grounded, deep-felt need to attach to their parents, other important caregivers, or relatives on which they depend. Children are also defined by an equally natural and strong urge to defend themselves against individuals who molest, harass, rape, hit, kick, confine, betray, manipulate, degrade, and/or neglect them. These two very different wills are exceptionally hard to integrate when the will to attach and the will to defend themselves pertain to the same individual(s). In this light, it is easy to understand that these conflicting wills can fissure the developing child's personality.

Postulating that the formal causality of these disorders involves a dissociation of the personality requires a solid definition of the concept of dissociation (Chapter 13). The definition provided balances the clinical and scientific interests of sensitivity and specificity, and thus includes phenomena that characterize individuals whose personality is dissociated and excludes phenomena that also typify individuals with other mental disorders. The distinctive features of the dissociative parts is that they are both conscious and self-conscious. They include the unique conceptions of who they are ('I'), what the world is like, and how their 'I' relates to itself ('me, myself, mine'), to other people ('You'), and to 'things' and 'events.' In other words, what distinguishes dissociative parts is that they include their own person perspectives. To get a firm grip on the nature of these perspectives, Chapter 12, the opening chapter of Volume II, analyzes the concepts of consciousness and self-consciousness, and examines the differences between the two in individuals with and without dissociative disorders. To substantiate the concept of dissociation of the personality, the chapter also includes an analysis and definition of the concept of personality.

Chapter 13 presents a meticulous definition of dissociation in trauma. Several authors have criticized the proposal to delimit the concept of dissociation to a division of the personality and the manifestations of this partition, but their objections are less than persuasive (Chapter 14). Another criticism implies that the dissociative parts of the personality are artifacts rather than natural, trauma-related phenomena. These parts stem from factors such as suggestibility as well as self-suggestion and hetero-suggestion, fantasy proneness and engagement in fantasy, and prescribed and enacted social roles. Chapter 15 formulates and examines the contrasting hypotheses of these 'sociocognitive models' of dissociation and

trauma-related views of dissociation, particularly those that emerge from the theory of (trauma-related) structural dissociation of the personality (TSDP; Nijenhuis, Van der Hart, & Steele, 2002; Van der Hart, Nijenhuis, & Steele, 2006). The empirical evidence generally supports the trauma models and rejects the sociocognitive models. In fact, the scientific base of TSDP has strengthened with every new study exploring its hypotheses.

Chapters 16–19 present, examine, and test several biopsychosocial hypotheses of the theory of structural dissociation of personality. The findings are consistent with the essential formulations of this perspective regarding the material and efficient causality of this dissociation. Chapters 16–18 present the psychophysiological and neurophysiological research; Chapter 19 details structural brain abnormalities. The empirical evidence gathered to date contradicts the sociocognitive models and clearly strengthens the stance that PTSD in its various forms (APA, 2013) and complex dissociative disorders are indeed one of a kind. The crucial conceptual, theoretical, and empirical link lies in the common dissociation of personality as a whole ‘embrained,’ embodied, and environmentally embedded system. This system does not exist and function, and cannot be comprehended, at the exclusion of a material and social environment, as explained in Volume I. The division of this organism-environment system in conscious and self-conscious biopsychosocial organism-environment subsystems is simple in PTSD (APA, 2013) and intricate in more complex dissociative disorders, particularly in dissociative identity disorder (DID).

This division of the personality in trauma involves a trinity, that is, three major prototypical subsystems or parts of traumatized individuals’ personality: more or less trauma-ignorant and trauma-ignoring apparently normal parts (ANP), fragile emotional parts (fragile EP), and controlling emotional parts (controlling EP). The core theme of Chapter 20 is that this trinity, these three major modes of existence and functioning, also seem to characterize perpetrators and their partners in crime: professionals such as physicians, psychologists, and psychiatrists, and the general public when it comes to trauma, particularly chronic childhood traumatization. The link, thus, lies in the difficulty to integrate and realize traumatic experiences and their consequences, particularly when it comes to the immense problem of chronic childhood traumatization.

The various concepts developed, and the insights gained, in the first two volumes are then applied in the third. This volume presents and analyzes in detail the different phases of assessment and the treatment of chronically traumatized individuals. Several strategies and interventions are suggested, analyzed, and discussed at a microlevel. One major theme is the continual challenge of helping the different dissociative parts – each involving person perspectives that are unique in at least some crucial regards – to recognize, acknowledge, understand, and accept each other. It is also a demanding task to get these different parts to cooperate with each other. Healing requires an individual who, in manageable steps, as a whole organism-environment system learns to integrate his or her different dissociative parts:

1. the first-person perspective, the unreflected ‘I’ with a point of view that involves *past and present phenomenal experience*;

2. the quasi-second-person perspectives, the ‘I-me, myself, mine’ relationships that involve *past and present phenomenal judgment*;
3. the second-person perspectives, the ‘I-You’ relationships that also involve specific *past and present phenomenal judgment*, as well as
4. the third-person perspectives, the ‘I-object’ relationships that involve *past and present physical judgment*.

Therapists help patients to initiate, execute, and complete these integrative actions. In order to be effective, therapists must pursue and model the integration of their own different person perspectives:

1. the first-person perspective (e.g., “I feel apprehensive”),
2. the quasi-second-person perspective (e.g., “My body tells me I’m stressed”; “I’m pleased with the result of my intervention”; “Was my judgment correct?”),
3. the second-person perspective (e.g., “I like her”; “He resists my good intentions”; “How does she perceive me?”; “I find it hard that she still mistrusts me”), and
4. the third-person perspective (e.g., “The patient has a dissociative disorder”; “The way the patient reacts to me suggests she is re-enacting the traumatic relationship with her mother”; “What intervention could lessen the self-cutting?”).

In this context, therapists become attuned to their patients’ phenomenal experiences and judgments. They meticulously and empathically pace their patients’ dissociative part-dependent conceptions of the self, the world, and the self-of-the-world in order to achieve a consensus how ‘things are.’ They join their patient’s conceptions, but they do not give up their own. Rather, they aim at integrating the two. This ongoing integration process constitutes the relational foundation for therapeutic stimulation, for inviting the patient to engage in new, more efficient actions that are within their reach. The actions proposed are more efficient, are better suited, because the execution thereof fulfills the patient’s desires (e.g., to reduce or end their suffering) more than the ones they replace. Therapy, thus, concerns the stepwise improvement of the patient’s actions effecting the gradual realization of their goals.

The joint enterprise called therapy may be seen in fact as ‘therapeutic dancing.’ This creative action comprises three levels of action:

1. the therapist’s ongoing attunement to the patient’s phenomenal experience and phenomenal conceptions of him- or herself, of the world, and of his or her being a part of that world;
2. the therapist’s ongoing effort to reach a consensus regarding these phenomenal realities; and
3. the therapist’s invitations to the patient to make a particular ‘move’ in a direction defined by the patient’s interests, not by those of the therapist. The trauma therapist is thus a guide and model, not a controlling authority.

Healing trauma involves two interacting persons: the ‘dividuum’ injured by adverse life circumstances but willing to mend the division; the blessed, or in any case less unfortunate, ‘individuum’ willing to guide whatever actions this recovery may take.

I am most grateful to Arne Blindheim, Stephen Braude, Fredrik Garpe, Onno van der Hart, Annica Ljung, Isabel Lopez-Fiestas, Timo Järvillehto, Sebastian Lorenz, Winja Lutz, Klaus Matthes, Yolanda Schlumpf, Simona Seidmann, Hans Peter Sondergaard, Sander van Straten, Esther Veerman-Renkema, Ekaterina Weder, and Fabian Wilmers for their thoughtful comments on the original version of the current text, their discussions with me on the themes of the present two volumes, and for their sympathy.

Joseph Smith’s linguistic and technical corrections of the original text have been invaluable. It was great working with you, Joe, thank you very much. It is an immense privilege that Vandenhoeck & Ruprecht was willing to accept my lengthy text for publication. Franco Biondi and Inge Liebel-Fryszler paved the way to the V&R author Rainer Schwing, who helped me persuade Günter Presting and his V&R team that publishing the *Trinity of Trauma* might be a worthwhile venture.

I sincerely thank the deeply wounded individuals I have encountered for their eventual trust in me and for everything I learned from them. The thoughts on the ‘trinity of trauma’ would not have evolved without the many hours we shared together. The book could also not have been written had not participants in courses on trauma and dissociation and other colleagues shown an eager interest in my ideas. Like anyone else, I am indeed an organism-environment system. Rainy, my beloved wife, even though contemporary philosophers doubt essences exist, love is all.

Westerbork, The Netherlands; Cuidad Quesada, Spain, Fall 2014

Chapter 1

A Horrible Kind of Melancholia

Trauma tends to exceed human understanding. It disrespects boundaries, interrupts all kinds of units and makes them blend, it disrupts bodily and psychic organisms and upsets social and historical organizations.

Esther Fischer-Homburger

The beginning of wisdom, Socrates taught us, lies in the definition of terms. Since terms point to concepts, to ways of grasping something, defining terms yields conceptual clarity. Establishing a clarity of complex concepts can be an intellectual and, as the history of trauma illustrates, emotional struggle as well. Part of the challenge is that thought is subject to perspective, interest, and ongoing development. How we as individuals, groups, nations, and indeed as a species perceive and understand our world and ourselves is influenced by many different and ever evolving personal, social, political, cultural, and historical contexts. For these reasons our concepts may tend to drift. The goal, then, is less the love of wisdom – the literal meaning of the term ‘philosophy’ – than the desire to gain wisdom. The Dutch word for philosophy *wijsbegeerte* aptly expresses this insight. *Wijs* means wise and *begeerte* a desire or urge. *Wijsbegeerte* thus means the desire or will to gain wisdom. The 19th-century German philosopher Arthur Schopenhauer (1958, 1813/2007) taught that will is extremely powerful and everlasting, including the desire to explore. Indeed, the quest for wisdom is eternal, and the invention and definition of terms a continual venture. Originally, the term ‘trauma’ pertained to an open physical wound or a violent rupture to the surface of the skin, and carried no psychological meaning. Although the concept of ‘physical trauma’ had been around since the ancient Greeks, the concept of ‘psychic trauma’ was proposed only in the last quarter of the 19th century (Eulenburg, 1878). Psychic trauma has been defined in a variety of ways during its relatively brief history, and as we shall see different perspectives have persevered. The concept and its derivatives such as ‘traumatic experiences’ and ‘traumatic events’ continue to be used in a confusing variety of ways in the general, clinical, and scientific literature and discourse. The historian Donna Trembinski (2011, p. 82) observed that “the terminology and theoretical parameters of trauma theory have never been definitively settled and differ from scholar to scholar.” Whereas achieving a consensus definition of trauma is essential for

progress in the field of traumatic stress (Weathers & Keane, 2007), the definitions offered to date are, as leading traumatologists Julian Ford and Christine Courtois (2009) remarked, not particularly clear.

One major reason for the difficulty in making progress, I admit, is that the conceptualization – and hence the definition of trauma – relate to basic, albeit unresolved philosophical conundrums as well as to some ‘tough’ themes in psychology and psychiatry. Daunting questions include the following:

- Are traumatic experiences caused by inherently traumatizing events? Or are they rather due to subjective features? In other words, do particular events cause trauma-related disorders and diseases by their very nature – or does the impact of events relate foremost to personal, social, cultural, political, and historical features?
- Do events exist objectively, that is, do they exist at all independent of experiencing and knowing subjects? Is our whole world, including traumatizing events, perhaps in essence just an idea? Is it but a shadow of something else that we cannot perceive or know – much as Plato contended?
- Is there a natural class of events that are inherently traumatizing? Or is any category of trauma necessarily a human, and hence an artificial, construction?
- Is trauma and are human experience, thought, and behavior generally more fully explicable in terms of the brain (at least in principle)? Will we come to understand trauma in all respects the day we know everything about the brain? Or is this hope a mere tragic illusion?
- Is the mind simply an epiphenomenon of the working brain? That is, is the mind a secondary phenomenon caused by, and thus unable to affect, the brain? Is its activity a primary phenomenon, and is therefore the study of the mental features of trauma in the end irrelevant?
- Or is the mind different from the brain? Does the mind constitute a different substance altogether than brain matter? Does it possess properties that are different from those of the brain? Can we therefore understand trauma in full only by also considering the mind?
- Or are the brain and the mind perhaps in fact identical? Applied to trauma, would a complete description of the brain in trauma be identical to a complete description of the mind in trauma?
- Is the head the seat of the mind? Does trauma thus lie between the ears? Or is our mind somewhere out of our head? Is trauma as much a phenomenon beyond our head and body as within it?
- Is our body (minus the brain) sufficient unto itself? Or can it be understood only in relation to the brain as well as in relation to the individual’s current and past experience and environment?
- Is it possible to understand and change human experience and thought, including trauma, in terms of the classic Western methods of science, that is, from an ‘objective’ third-person perspective? Or must we explore the first-person perspective, that is, the sub-

jective experience, using, say, Buddhist methods? Or would it be possible and necessary to use a combination of these traditions?

Any attempt to develop definitions of trauma and related concepts must consider these puzzles, which have been and still are often cast in terms of dichotomies. Is trauma best understood in terms of

- philosophical *materialism* (= all that really counts is matter; physics and biology, notably including materialistic neuroscience, suffice) or philosophical *idealism* (= all that exists are ideas; the world is like a dream)?
- philosophical *realism* (= there is an objective, knowable world with eternal laws that can be directly known [naïve realism]) or philosophical *constructionism* (= all we can experience and know are our own constructions of reality)?
- philosophical *dualism* (= matter – hence body – and mind are different substances or have different properties) or philosophical *monism* (= matter and mind are different attributes of a single substance)?
- *natural and universal laws* (= trauma has always existed among all cultures and is here to stay) or as a *product of modern culture* (= the phenomenon did not exist prior to the ‘modern’ invention of trauma, the disorder is culturally bound)?
- *exogenesis* (= trauma, understood as a psychic injury, is caused primarily by objectively existing events that are like a sharp knife inducing multiple cuts to the skin) or *endogenesis* (= trauma, the mental wound, is essentially due to subjective factors)?
- *genuine effects* (= trauma involves a real injury) or *artifacts* (= ‘trauma’ is about matters such as attention seeking, avoiding responsibility, seeking economic gain, suggestion, simulation, and fantasy)?

Or would some of these matters, or perhaps even all of them, somehow be simultaneously entangled?

To get a deeper feel for the conceptual and definitional problems at hand as well as for their clinical, scientific, and societal relevance, in the first chapters of this book I sketch the history of trauma (this history is thus not presented solely for its own sake). This history shows that the struggle to conceptualize, understand, and define trauma has often strongly pertained to the puzzles and apparent dichotomies mentioned above.

Within this framework, I examine in the present chapter whether in the course of written history it has been recognized that particular environmental events can cause, co-determine, or at least crucially relate to a particular kind of psychopathology? Has it been postured that psychopathology involves exogenesis (= external event induces pathology) or has the focus regarding psychopathology typically been on matters internal to individuals, thus on endogenesis (= internal condition induces pathology’) rather than on environmental influences (cf. Fischer-Homburger, 1999)? Was it thought in former times that the world can be an injurious, unbearable place? Or was it rather believed that some peo-

ple – whether men, women, or children – are incapable or unwilling to cope with common life and with environmental conditions that seem not to trouble other individuals?

A second issue I explore in the present chapter is whether the core features of the pathology, which according to contemporary insight are often related to experiencing adverse events, have remained relatively stable across time? And if so, have these features been associated with one disorder or rather with various disorders, whether across historical time and/or within a particular historical phase?

Still another matter that demands attention from the start is whether throughout the ages trauma-related symptoms and disorders have been foremost seen as *psychopathology*, thus as a pathology of the mind, or whether they have been more commonly understood as *biopathology*, for example, as an imbalance of humors or neurotransmitters?

Trauma Through the Ages

Do we function today as our ancestors once did? Is trauma the same at all times and at all places? Some philosophers, anthropologists, and psychiatrists doubt it and instead contend that trauma is a culture-bound phenomenon (Bracken, 2001; Hacking, 1995, 2002; Jones et al., 2003; Young, 1997). Within the wider debate in the history of psychology, they variously emphasize that applying modern psychological categories to individuals from the past is most problematic. In their view, trauma-related disorders came into existence only in the last decades of the 19th century. They claim that this was the time when the concept and the diagnosis of psychic trauma and its symptoms were ‘invented’ or at least formalized, and that a language of trauma developed. Other authors maintain that, although our experiences are colored by cultural beliefs, our ancestors were no different from us in psychological, biological, and social regards (Trembinski, 2011). They thus assert that trauma is quintessentially a phenomenon of all times and all places.

Even in remote times, it was recognized that there are relationships of all kinds between adverse events, body, and mind. However, the various ideas that scholars, survivors, and laymen have crafted regarding the kind of relationships that apply have sometimes been as capricious as the symptoms of the individuals injured by the hardships they met up with. The current selective review of the history of melancholia and hysteria attests to this. I start with melancholia, a disorder that, from the 18th century and in particular from the 19th century onward, became defined ever more in terms of sadness and depression, thus preparing the way for our contemporary understanding (Jackson, 1987). However, originally and for many ages after its first appearance in written history melancholia also captured a condition of intense anxiety.

Traumatic Melancholia

Throughout history, melancholia has been associated with any number of causes, some of which were largely endogenic in nature: The disorder was caused by factors residing within the affected individual. Other explanations focused more on changes in the environment leading to intense fear and deep sorrow. The melancholia of present interest is (1) a mental disorder that, by whatever name we call it, was or is no longer classified as hysteria or by some other name with the same referents, which includes (2) overwhelming fear or other vehement emotions (3) during and after experiencing, witnessing, or hearing about one or more adverse events, as well as (4) a subjective inability to overcome the experience, which (5) exhibits in a variety of often long-lasting physical and mental symptoms. In this sense a number of disorders that went or go by various other names – some of which refer to the kind of adverse event under consideration (e.g., “a horrible kind of melancholia,” irritable heart, railway spine, traumatic neurosis, war neurosis, battered child syndrome, PTSD (American Psychiatric Association (APA), 1994, 2013) – are intimately related. While they capture at least highly similar, if not identical, conditions, it seems warranted to conveniently collect them under the label ‘traumatic melancholia,’ even though experiencing highly adverse events and a lack of integration of these experiences was not instantly, consistently, or uniformly seen in all cases as a main or contributing causal factor of the disorder.

Suffering from an Excess of Black Bile, Strong Emotions, and Dissociation of the Personality

The foundational works of the Hippocratic School documented that leading ancient Greek philosophers and physicians understood the body and mind as inseparable entities. This philosophical monism also applied to prominent Roman doctors such as the physician and philosopher Galen of Pergamum (129–199/217?) and medieval philosophy and medicine. Illness, it was felt, affected the body and the soul (= mind) in equal measure. The received idea was that physical and mental health was achieved by balancing the four humors: blood, phlegm, black bile, and yellow bile. In addition to this endogenic physiological interpretation, Galen and other physicians from late antiquity also believed that mental health was supported by avoiding all overwhelming emotions because these could cause a humoral imbalance. Whereas this psychological advice disappeared in medical literature by the 5th century, it would later reappear, among others in the seminal works of Spinoza in the 17th century. Spinoza may have been the first to emphasize the importance of symbolizing intense emotional experiences (“passions”), of putting them in words or other symbols (“clear and distinct ideas”) rather than re-enacting them recurrently. As he stated in his magnum opus *Ethica* (Part V, proposition 3): “An affect that is a passion ceases to be a passion as soon as we form a clear and distinct idea thereof.” Because Spinoza thought affects are intrinsically related to environmental influences, which means that the one (affects) cannot exist without

the other (environmental events), his understanding of passions involved a mixture of endogenic and exogenic influences that presuppose each other. As I shall detail later, this view reemerged in the work of some 19th-century thinkers and has been taken to its deep implications in the writings of a number of contemporary authors.

The *Internal Affections*, a collection of works by different authors, published under the name of Hippocrates (circa 400 BC), was known to Galen and copied and commented on throughout the Middle Ages. It describes the symptoms of a ‘thick disease.’ Black bile, it was said, initially collects in the liver, then moves upward, and finally reaches the head. The initial headache might later become complicated by a loss of clear vision and hearing as well as by hallucinations, nightmares, the inability to stand and speak, heavy breathing, and bouts of somnambulism. Yet periods of melancholic madness could be interrupted by periods of lucidity, showing that the disorder involved transitions between quite different ways of being. With respect to our understanding of trauma, these shifts in the way and level of functioning will be a recurring and essential theme. Melancholia, it was further claimed, could eventually evolve into a still graver condition called mania.

Greek, Roman, and medieval thinkers (e.g., Vincent of Beauvais, circa 1190–1264) suggested that melancholia involves an excess of black bile (melancholia literally means an [over]abundance of black bile) that might result from an individual’s constitutional temperament, illness, or strong emotions. Vincent of Beauvais believed that individuals suffering from melancholy sometimes feared death – and sometimes desired it – and often killed themselves. This changeability and other capricious symptoms of melancholia Vincent observed indicate that the disorder apparently implied profound shifts between opposite affects, desires, and actions.

These shifts may have related – and continue to be related – to a crucial observation by Magister Lorentius near the end of the 13th century. He suggested that the interior, intellectual soul wanders during night terrors (Lawn, 1979). The part of a human’s soul that resembles the souls of animals controls the individual’s movements. Yet the intellectual soul does not wake up and indeed remains completely unaware of the bodily movements. Cast in modern terms, Lorentius thus felt that melancholia involves a dissociation of the whole, normally integrated system of biopsychosocial functions that constitutes an individual’s personality. The division was between a terrified dissociative part of the personality with strong sensorimotor and emotional features, and a dissociative part that was more cognitively and less physically and emotionally oriented.

Suffering from Terror

The Ancient Greeks and Romans recognized that emotional shocks may have lasting effects. Herodotus (*The History of Herodotus*, 440 BC, Liber 6, caput 117, translation by George Rawlinson) recorded how an Athenian soldier became permanently blind after the following incident during the Battle of Marathon:

Epizelus, the son of Cuphagoras, an Athenian, was in the thick of the fray, and behaving himself as a brave man should, when suddenly he was stricken with blindness, without blow of sword or dart; and this blindness continued thenceforth during the whole of his after life. The following is the account which he himself, as I have heard, gave of the matter: He said that a gigantic warrior, with a huge beard, which shaded all his shield, stood over against him; but the ghostly semblance passed him by, and slew the man at his side. Such, as I understand, was the tale which Epizelus told.

According to Plutarch (46–120 CE), such events as war scenes can elicit vehement fear. This terror, he contended, is most usually caused from some imminent danger, when a terrible object is at hand, heard, seen, or conceived, whether physically present or in a dream.

Ancient Arabic physicians and psychologists agreed on this matter. They categorized melancholia, which they called *huzn*, as a disease that included mental symptoms such as sadness, sorrow, and mental pain (e.g., Radden, 2000). Al-Kindi (circa 801–873 CE) linked melancholia with intense emotions such as anger, passionate love, hatred, and depression; and for Ibn Sina (980–1037 CE), known in the Western world as Avicenna, the various causes for melancholia included catastrophic events such as intrigues surrounding one's life and lost love.

Several centuries later the Oxford University scholar Robert Burton (1577–1640) would also link melancholia, at least in a number of cases, with catastrophe. In his *Anatomy of Melancholia* (1621), he emphasized that “many times the more sudden the accident, it is the more violent.” Plutarch and Burton thus realized, very independently, that particularly sudden, imminent, and recurrent danger may elicit dramatic physical and emotional reactions that can take the form of melancholia.

But not just the events involved are of a special kind, Burton emphasized. The overwhelming fear that horrific events may trigger is in some regards also different from other fears. Burton reminded us that Cicero and Patritius had distinguished between fears that can arise from observing or hearing about terrible events and other fears. He quoted the Swiss physician and Basel professor Felix Plater (1536–1614; *Praxis Medica*, 1602–1608, cap. 3, de mentis alienatio), who observed that

[of] all fears they are most pernicious and violent, and so suddenly alter the whole temperature of the body, move the soul and spirits, strike such a deep impression, that the parties can never be recovered, causing more grievous and fiercer melancholy, than any inward cause whatsoever, and imprints itself so forcibly in the spirits, brain, humours, that if all the mass of blood were let out of the body, it could hardly be extracted.

It is this type of melancholia, which relates to dreadful environmental conditions and involves the whole human organism, that I refer to as *traumatic melancholia*.