sPRING 2004 v 2.qxd 11/26/2006 9:43 AM Page 1

# Stress Points

Newsletter for the
**Australasian Society for Traumatic Stress Studies**

Spring 2004


## Contents


President's Message
page 2

TV Trauma: A Brief History of Hospital Dramas
pages 3 – 7

Trauma in Journalism: The Dart Symposium
pages 7 – 10

The American Nightmare: A Conversation about Horror with Film Maker Adam Simon
pages 12 – 14

Chapter News
pages 15 – 17

Sydney Conference Report
pages 17 – 19

2005 Conference Update
page 20

Trauma Classics
pages 21 – 23

Conference Calendar
page 24


# Editorial

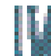
As spring draws to a close summer programming begins on our TV sets. It is a time I often contemplate reading that book on my shelf, "Four Arguments for the Elimination of Television" (Mander, 1977). The argument made is that television is a powerful technology which is used to mediate and colonize experience with inherent bias which will ultimately diminish our physical and emotional health. In the 27 years since his pleading, rather than elimination, we have embraced the revolution of media, multimedia and technology: digital, broadband, satellite, wireless streaming, crossplatforming, handycam, and memory stick. Most of us feel the world on our fingertips. We access information as it happens – trauma as it happens. We can witness trauma fact and trauma fiction twenty-four-seven. So we thought it was time to explore the media and trauma.

In this edition Jason Jacobs talks about the portrayal of trauma in the television hospital drama. In her article on the inaugural Dart symposium on News Media and Trauma, Margie Smithurst reports discussion from Sandy McFarlane, Hugh Riminton, Trina McLellan, Jason South and Tom Burton. Director Adam Simon addresses, in conversation, the multilayered relationship of trauma and the horror film. ASTSS members contribute with Jennifer Davis's film review of "Touching the Void" and Marion Oke's Trauma Classic "Trauma, Narrative and Human Development: the work of Erik Erikson"

The regular features of President's Report, Chapter News, and Conference Calendar return. Lynda Matthews gives an overview of the ASTSS 2004 Sydney conference and Elizabeth Sachse outlines planning for the W.A. 2005 conference.

As always we invite you to submit contributions in the form of short papers (no more than 1,500 words), Book Reviews and Letters which address traumatic stress. Email your contributions to: B.Tarrant@latrobe.edu.au, or mail to

PO Box 4011,
Balwyn East,
Victoria,
Australia, 3103.

Bronwyn Tarrant 

sPRING 2004 v 2.qxd 11/26/2006 9:43 AM Page 2

# PRESIDENT'S MESSAGE

## REPORT TO THE AGM SEPTEMBER 10TH 2004

by John Raftery

2004 has been another year of development for ASTSS. Sometimes we might appear to be struggling along as we try to balance our commitment to the organisation with our complex lives, so it is good at a time like this to remind ourselves of what we have achieved. It is also a good time to remind ourselves that we are building on a foundation of hard work in establishing a structure and procedure to underpin our action. The Strategic Plan serves to remind us of our vision and goals. I believe that we have been refining and focusing on those goals in a gradual process.

As a relatively small organization, we are distinguished by the fact that we have very low fees, ambitious goals and a small infrastructure. We are bound together by our common purpose to see that trauma is a threat to individual and social health, and must be kept on the agenda at all levels – in professional practice, in academic pursuit, in public legislation, and in government policy. In doing this we ensure that there is a focus, not only on effective treatment, but there are prevention and early intervention planks. What we have done in the past year is to continue the implementation of the Strategic Plan.

Towards this end our achievements for 2004 have been:

1. The formation of a new chapter in Western Australia
2. The organisation of another annual conference, which we are now enjoying
3. The commitment to further conferences over the next two years – WA 2005 and SA 2006
4. The orchestration of a very successful national workshop tour by Berthold Gersons in February
5. A successful Management Committee planning weekend in April 2004
6. The revamping of our web site www.astss.org.au
7. The regular delivery of an expanding newsletter
8. The development of a paper for the Management Committee on training in the field of trauma
9. The further development in some chapters especially Victoria
10. The successful implementation of our awards in research and the media and the commissioning of a piece of art work for the media award.



In the future I know we will continue to pursue our goals, whether in partnership with other bodies or alone. I would favour a further exploration of partnerships with appropriate bodies such as ACPMH. I think we have to be ambitious but also realistic in what we can achieve. We need to avoid

sPRING 2004 v 2.qxd 11/26/2006 9:43 AM Page 3

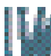
burnout. We all work as volunteers under a great deal of modern pressure from our normal occupations and we cannot do everything. We will continue to rely on the commitment of individuals for the work of the Management Committee and sub-committees. I believe it is timely to consider a revision of our infrastructure and administrative needs.

For the future, I believe we need to consolidate and modestly expand our program in:

1. The WA conference – great opportunity for off shore promotion especially Africa and the Asian region.
2. Continuing development of WA Chapter and support of other chapters.
3. Training policy – exciting possibility to develop ethical standards of practice, influence tertiary curricula; encourage high standards of professional training.
4. A revision of constitution to reflect the status quo in our chapter structure.
5. An expansion of our role in influencing the development of healthy public policy – eg the law and trauma; more efficient ways of dealing with media with Media Award as the flagship; broadening the research base through the Research Award.

I would like to express my appreciation to you all for your contribution to the society, especially the members of the Executive and Management Committees for your support, time and commitment.

John Raftery
President ASTSS



# TV TRAUMA: A BRIEF HISTORY OF HOSPITAL DRAMAS

by Jason Jacobs

In the late 1950s British television began showing a hospital based series *Emergency – Ward 10*, a popular medical soap that ran in various versions for over ten years. Very few patients died in this series and it was rare for the doctors to make mistakes or question the ability of medical science to cure illness and treat trauma. According to the show's medical advisor, Dr Meyrick Emrys-Roberts the important thing was, 'to make sure that the doctors were shown in the best light possible so that the public wouldn't lose their faith in medicine.' Jump forward to the mid-1990s and the first season of *ER*: in the episode 'Love's Labor Lost' we see Dr Mark Greene (Anthony Edwards) battle to save the life of a pregnant young woman with eclampsia. We see him attempt to pull the baby out, we see him pushing it back in, we see him nervously perform an emergency C-section; finally, we see the woman bleed to death. Greene failed to spot a haemorrhage in her uterus; it is his fault she dies.

How can we account for this extraordinary change from a medical show that promoted reassurance in

the medical profession to one that sets out quite explicitly to disturb and unsettle the audience about the abilities of healthcare professionals? Why did the representation of trauma on television become so explicit by the mid-1990s? Today it is commonplace on television to see a range of trauma - both reality shows and fictional programmes are happy to depict injury, wounds, sickness, plastic surgery and accidents in gory detail. Where does the appetite for this material come from?

The changes in the depiction of TV trauma can be explained by considering the history of the hospital drama on television. There are three main phases in this transformation of the genre.

First there is the 'Paternal' phase: a period from the 1950s to the late 1960s which includes shows such as *Medic* (US, 1954-55), *Dr Kildare* (US, 1961-66), *Dr Finlay's Casebook* (UK, 1962-71) and *Ben Casey* (US, 1961-66). These shows were respectful of the growing power of the medical establishment and took care to show that, whatever the outcome in individual cases, medical progress was inexorable. Reassurance was personified in the figure of the infallible, capable doctor and in the early shows the focus was on the individual doctor's role in healing people; typically they were white males at the centre of authority in the hospital or practice. In this way the paternal hospital dramas promoted a reassuring vision of a world healed by a modernising medical practice.

The second period we might call 'Conflict' since the shows in this phase at least acknowledged that society was not necessarily based on a consensus. Beginning in the late 1960s and lasting until the late 1980s this period included shows such as *Medical Centre* (US, 1971), *Marcus Welby* (US, 1969-76), *M*A*S*H* (US, 1972-1983), *Casualty* (UK, 1986 - present) and *St. Elsewhere* (US, 1982-8). These shows acknowledge the impact of the counter-cultural movement and were far more explicit in their subject matter, often using social 'problems' such as abortion, homosexuality, rape, drug addiction and venereal disease, issues that had been excluded from the earlier paternal shows on the grounds of taste and audience sensitivity. We can understand this explicitness in terms of greater cultural liberalisation but it was also part of a desire to map societal anxieties onto the body. In these shows the body was not only a site for the application of benevolent medical science, but also a physical canvas for the display of the consequences of the transgression of traditional morality and mores. Nonetheless, the humanist male doctor remained at the centre and there is no question of our faith in his ability to cure both medical and social ills. The beginnings of doubt about this project are certainly detectable in some shows - *St Elsewhere* in particular would often showcase the 'yuppie despair' of some of its characters, and *M*A*S*H*, although intended as comedy also was often critical of the establishment and dangerous environment in which the doctors were required to work.

Put crudely, the paternal and conflict phases primarily offer reassuring depictions of the medical profession. While the latter acknowledges significant problems there is never any question of the adequacy of ability of the science and doctors involved.

Finally we have the 'Apocalyptic' phase that begins in the 1990s with the explosion of medical dramas such as *ER* (US, 1994-present), *Chicago Hope* (US, 1994-2000), *Gideon's Crossing* (US, 2000-01), *Cardiac Arrest* (UK, 1994-96), and *All Saints* (Australia, 1998-present). These new hospital dramas (since this is the primary setting of medical dramas of the 1990s) capture a sense of cultural despair and exhaustion (rather than, as in *The X-Files*, cynicism) that was organised around anxieties about the body. They exhibited a fascination with disease, injury and mortality as well as the moral and ethical challenges that advances in medical technology have facilitated. Hence, rather than science providing solutions to illness, injury and disease, in these shows that technology is part of the problem. The shift to the apocalyptic is signalled by the end of reassurance and the promotion of the idea that

doctors and science have lost faith in their abilities. They seem to be saying: 'We cannot heal the world, or ourselves.'

The cultural context is crucial to this change, since in terms of health everyone in the world is now healthier than at any other time in human history. We can see in a range of sites how the collapse of traditional politics has meant a greater emphasis on the Self and the Body. With the failure of grand political visions promoting the transformation of society, there seems little left to change except ourselves. At least we can control what we eat, how we look and so on. Several scholars have also noted the rise of the so-called 'therapeutic state' where cultivating the Self is promoted above the building of adult solidarity. As one scholar has argued, contemporary morality has replaced ideas of right and wrong with those of health and illness. The medicalisation of everyday life -with health scares over obesity, SARS, AIDS, CJD and the reclassification of social problems as medical ones (such as shyness being redefined as social phobia) - means that there is a tendency to couch all human behaviour in pathological terms (so any habitual behaviour is now likely to be deemed an addiction). In this context it is not surprising that issues of health become foregrounded in the media, in the arts, in film and television.

The human subject in the 1990s was increasingly depicted as vulnerable and at risk and out of control. The fascination with the human body and its diseases and mortality is directly connected to this increasing sense of risk. That is why the contemporary hospital dramas find their drama not in reassurance - that the doctors will always be competent enough to heal - but in undermining reassurance.

The hospital setting itself, borrowing from *M*A*S*H*, is frequently depicted as a war zone, with busy corridors and the sudden arrival of seriously injured patients, often in groups, bursting through the swing doors on a gurney. Apart from struggling with toxic and often violent patients, the doctors also have to struggle with hostile management and cost-cutting administrators who continually seek to impose market-based models on healthcare and exhibit little compassion for their employees or the patients that they treat (*ER*'s Robert 'Rocket' Romano (Paul McCrane) is a good example).

Linked to the war zone metaphor is the explicit depiction of injury and illness, with blood and wounds depicted in gory detail in a manner reminiscent of a horror movie. Faced with such challenges the doctors themselves often exhibit low self-confidence in their abilities to manage the healthcare nightmare. They are often shown suffering from psychological trauma as they attempt to manage the ethical labyrinths, hostile management and a fast paced workload. Hence these shows have a mode of address to the audience that stresses ambiguity, confusion and no reassurance.

The settings, characters and events are shown to us in highly stylised manner. There are two key features of the new hospital dramas that are pertinent in this respect: action and reflection. The action modes of these shows were strongly influenced by the rise of reality television in the early 1990s, with its stress on the immediacy of events as they happen and its blending of documentary with sensationalism. Another influence was the dominance of Hollywood action cinema during the 1990s, but in the medical shows, the spectacular event is displaced within an interior setting so that the dynamism of the action/spectacle takes place inside, in densely populated emergency trauma rooms. The urgency and pace of these spectacles of medical emergency is often rendered using the Steadicam, a form of camera mounting that allows the cameraman to move around in small spaces allowing long takes, and fluid movement that follows the action. Action scenes typically include an aural dimension too, with the exchange of medical terminology - a kind of 'medi-babble' -between members of the team as they struggle with the ruined body.

Such action sequences are balanced by dialogue-based 'reflection' moments which are shot much more conventionally. Often they come after the action scenes as a kind of debriefing moment when the mistakes of the treatment are mulled over. They can also showcase conflict between the junior and senior staff about correct procedure and the impact

of personal belief on the treatment of patients. The patients themselves also have a narrative function: often they are toxic patients, violent, deceitful or unwilling to receive treatment. Some patients act as 'reflectors' bringing with their injuries a set of circumstances or problems that resonate with the medical professional treating them.

We can see how these elements work together in order to create a disturbing depiction of emergency trauma if we go back to *ER*'s 'Love's Labor Lost.' At this point in the season Mark Greene is facing the possibility that his wife will leave him because he refuses to move from County General where he has just been offered a promotion. The cheerful pregnant couple he meets – Jodi and Sean O'Brien – are therefore a potent reminder of what he stands to lose. After he diagnoses Jodi as having a bladder infection she collapses in the carpark with eclampsia and the rest of the episode depicts Mark's frantic attempts to deliver the baby without killing Jodi.

As the baby's heartbeat drops Mark attempts to deliver it as alarms go off and Jodi screams; the baby is larger than he anticipated and its shoulder is stuck against the pubic bone. There follow several minutes of Mark fighting with Jodi's body to remove the baby using the 'McRoberts manoeuvre' which involves pushing her legs up to her chest; we hear sounds of slick tissue being moved as Mark battles to wrest the baby out without success. Faced with an obstinate vagina he decides to extend the episiotomy but the baby remains jammed in. We see the anxious faces of both Sean and the medical staff as Mark decides the push the baby back in and start a Caesarean. There follows a brief moment of reflection as Mark explains to Sean what is happening and Sean berates him for his apparent inexperience.

The Caesarean procedure is graphically depicted. Although there are no shots of the incision itself the body horror is conveyed by a mixture of sounds, reactions and dialogue. As Mark proceeds his panic and indecision are foregrounded; after he asks the medical team to pull open Jodi's abdomen we get the following exchange between him and Dr Susan Lewis:

> *Mark:* You cut across the lower segment of the uterus.
> *Susan: [looks at him, astonished]* You're asking me?
> *Mark:* I'm asking God.

In the past we might have criticised the depiction of doctors as having God-like powers to heal, but here we are asked to consider the disturbing sight of a doctor who clearly is unsure of what he is doing. He finally pulls the baby out, but Jodi dies because he failed to notice a placental abruption on the ultrasound. As he stands alone looking down at Jodi's torn body, the junior doctor, Carter, comes in and says:

> *Carter:* Dr Greene … I just wanted to say, er, to tell you that, um, I thought what you did was a heroic thing.

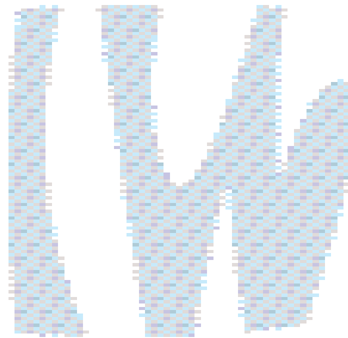
As viewers we may well feel some of Carter's hesitancy since we are caught between competing interpretations with Carter's remark incongruent with our experience of the previous horror and with Mark's own understanding of it (he looks puzzled at the remark and leaves without a word). It suggests a sense of heroism that is a product of failure, the decision to go on when the world cruelly produces unfair and unsurpassable challenges. Jodi's case represents the stubborn intransigence of the body that does not respond to the intervention of advanced medical science and also acts as a surrogate reflector for the doctors in that the failure of the body to recover reflects back on their own diminished potency.

One of the lessons of this generic change on television is that creative innovation in the media can actually anticipate and explore issues and problems that only later become matters of public interest. Since the 1990s matters of ethical responsibility, professional integrity and the impact of high workloads on doctors have become visible aspects of public policy in Europe and the UK. *ER* is even used as a teaching tool by some medical schools in the US who are concerned with

sPRING 2004 v 2.qxd 11/26/2006 9:43 AM Page 7

ethical dilemmas in contemporary healthcare. More important the public audience for these popular shows were exposed to a range of highly disturbing depictions of modern healthcare that, in part, may be responsible for the considerable cynicism that many people now feel about the ability of medical science to cure the world.

Dr Jason Jacobs is Senior Lecturer in the School of Arts, Media and Culture, Griffith University. He is author of **Body Trauma TV: The New Hospital Dramas** which is published by the British Film Institute.



# TRAUMA IN JOURNALISM

## The Dart Symposium

by Margie Smithurst

### Reporting traumatic events

The challenge facing journalists was to adequately describe the trauma and suffering they witnessed, the head of Psychiatry at Adelaide University and world expert in trauma, **Professor Sandy McFarlane** said.

Journalists were part of a long line of writers and artists, who, since humans began recording terrible events, have attempted to communicate the horrors onto the printed page or canvas.

"About suffering they were never wrong, the old masters", English poet W.H. Auden said. Professor McFarlane took as an example Brueghel's painting *The Death of Icarus*, which shows Icarus drowning, burned and unnoticed, while the villagers continue their lives around his death, oblivious of his plight.

"Such is the nature of traumatic events that without coverage or depiction in some way by someone, they too would pass us by," he said.

Arguably, the bigger the event, the more important it was for the depiction to rise to the occasion.

Sadly, many events made words inadequate, such as the uncovering of the Nazi concentration camp atrocities in 1945 or the mass slaughter in World War I trenches.

But journalists who surrendered the task, or were hindered by censorship were not performing their roles as the initial arbiters of history.

Traumatic events in themselves had the power to change history, he said, citing the example of the devastating Tangshan earthquake which brought to an end the cruel and stifling rule of the Gang of Four in China.

Journalists played a great role in translating these events, in their ghastly entirety, to the rest of the world. Their ability to be 'on site', to witness the extent of the victims' plights, to react with compassion, and to report with integrity was what made their position

unique.

How this was done with words and images was vital to alerting others to injustices or humanitarian crises and triggering empathy.

"Empathy is a challenge that defeats most people," McFarlane said. "If we haven't lived through the distressing, disturbing experience of another, the more removed we are from understanding or relating to it."

Putting the reader, the listener or the watcher as close to the experience without being harmful was then the delicate task of the journalist.

Would support for a war continue if the journalist's most painful descriptions, or the photographer's more grisly photos were published?

Triggering empathy, and thereby inciting compassion and ultimately, action, was at the very heart of the journalist's job.

## Trauma management in the media

How often should an editor send out a young recruit on gruelling stories? How old is too old to send someone on an assignment that might require legging it, fast, out of a tight spot? What's the closest a photographer should be allowed to come to a raging bushfire? How can a busy editor know just who is finding the job too tough and ought to be taken off it?

Questions like these are what editors at Fairfax published papers in Australia are seriously examining in their determination to bring a new code of best practice to the media industry here.

Managing journalists holistically, not just via their deadlines, was the aim, the *Sydney Morning Herald's* executive director **Tom Burton** said.

He accepted the changes were overdue and the effects of journalists' exposure to trauma has been regarded as a secondary, almost derisory, concern. Mr Burton was confident the industry was ready for such a 'sea-change' and would be joined by other media organizations, if only because the costs of doing otherwise in Australia were unfeasible in our increasingly litigious society.

Creating a bottom up framework for managing the risks of the jobs journalists were assigned was Burton's intention. Self-care, where peers looked out for each other, has been used successfully in the ambulance and police services in Australia for a number of years now and could be applied effectively to media staff.

Fairfax publications have already rolled out such a scheme - indeed, just weeks before the tragic Bali bombing. Reports suggest success, with potential breakdown cases averted by peer-to-peer management.

The industry had to accept the changes and act, with the task at hand for media executives everywhere, to develop the most effective programs for their staff and those they report on.

While still "in the sandpit stage", Fairfax and he were not short of ideas, but suggestions were always welcome, Burton said.

## Reporting trauma can be addictive but also harmful

**Hugh Riminton** of Channel Nine knows what steady gunfire sounds like. He has seen bloated corpses and just killed. He has reported stories on the wounded and sick, and in unthinkable numbers, and covered events most Australians have been fortunate never to witness first-hand.

He has covered so many of these

assignments that he earned the title, 'Master of Disaster'. But he wasn't sure whether he had mastered his own response to such disasters.

Reporters were victims of the disasters too – not in immediate, on-site ways, but victims after the fact, suffering classic distress-type symptoms not dissimilar to war veterans.

Riminton said recognising when to draw back and discontinue was critical and every reporter/photographer had to learn to identify the point when the job was impacting badly on their lives.

The negative impacts were failing relationships, deteriorating health, substance abuse, anger, feelings of hopelessness, isolation or powerlessness, and obvious stress. These were significant signs the job was doing more harm than good.

Trauma wasn't predictable, he said. Out in the field, the job which caused the most damage may not be the big one, rather it could be the smaller, more personalized experiences that triggered a breakdown.

For him, seeing severely wounded children in the overflowing hospitals of Kosovo was more distressing than a river in Rwanda filled with thousands of genocide victims' corpses. For each person, the trigger would be different, he said.

****

*"When the guns are going, you just hear white noise. It goes absolutely quiet. You don't hear the de-de-de, what you hear is almost music. When I heard that music, I thought, ooh, this is going to be good…"*

These are not the words of a reflecting, returned soldier but from award-winning press photographer, **Jason South**, of *The Age* newspaper, speaking of his time in East Timor.

East Timor, a hotbed of violence and militia rampage, left him high on the adrenaline and the daily survival of it all. On his return to Australia, he took two months off, refused counselling, and tried to transfer the 'high' of the experience in Timor to everyday life in Melbourne. It didn't work.

Bridging the two separate worlds was important to adjusting after difficult assignments, he said. This was known as 're-entry'.

"If you don't take the time to process what you've just been through – whether with an understanding colleague or a professional – it isn't going to go away."

Most likely, it would play itself out in what South, speaking from personal experience, described as 'non-career enhancing behaviour'. Being known for keenness to get into a punch-up at the local pub wasn't likely to get you the next job.

He said a way to avoid this was to return to work quickly and accept counselling even a month after the assignment. This may then be the right time for the flood gates to open.

Journalists took these extreme jobs out of curiousity, and would be passionate about what they were witnessing. There was an undoubtable rush in reporting on disaster and being the reporter/photographer on the spot.

But with the role came responsibility, firstly, to the victims and their families and also to yourself.

Being responsible with yourself meant the chance to stay around a lot longer.

## Journalists need to 'do no further harm'

Journalists and news bosses should take on the mantra of 'do no further harm' in their news practice, said **Trina McLellan**, researcher and

journalism lecturer at the University of Southern Queensland.

In an age of increasing litigation, major broadcasters were liable for large payouts to victims where courts accepted that the victim could be traumatized by inappropriate broadcasting.

The media environment needed to wake up to itself and listen.

Doing no further harm applied specifically to the victims of trauma, who suffered most in the journalists' daily pressure to get a deadline, she said.

In a demanding job with constant exposure to victims to get the stories, journalists suffered 'compassion fatigue', meaning they became desensitized, felt they had seen it all and pushed the boundaries, making inappropriate choices of what to report.

Alerting journalists and newsrooms to this insensitivity was the result of Ms McLellans' research. She said a journalist's priority should be to be consistently respectful and sensitive to victims' plights. Many victims did not believe this had happened.

She talked to numerous victims in Australia, including the Port Arthur shootings, and developed a check-list of ethics-based criteria from victims on what they wanted from journalists covering traumatic events.

The stories had to be accurate as victims often used media footage and reports to piece together the events afterwards. Inaccurate reporting was a distressing contributor to further trauma.

Traumatic stories were often repeated to a public supposedly desperate for pictures or footage of the occurrence. If this had to happen it should be done with care and sensitivity to the plight of the people in the pictures, who were often unknown and unrelated to a majority of viewers.

Research has shown there were also significant numbers who could relate and be seriously distressed by repetitive airings of similar events and explicit coverage.

As well, why put dramatic music with an obviously traumatic story?

Complaints mechanisms had to be amended to align with patterns of trauma sufferers' behaviour. It could take some time before victims felt they had the control necessary to take on a major broadcasting organization and voice their distress on reports.

News personnel needed training about trauma. People react differently to trauma and how such events were reported in their initial stages needed to change to respect a victim's crisis.

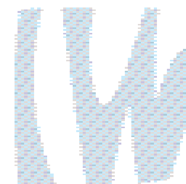
Consent should be obtained for delicate footage where possible, and care was needed with editing.

Organizations like Dart Australasia had commenced educating and assisting journalists and media employees in their work on trauma to improve the standard of care.

It was obvious journalists needed to take care of themselves, but they also needed to be careful with their 'victims'.

It was possible to perform to a deadline and yet act with respect and understanding, she said.

The inaugural Dart Symposium was held in Melbourne, September 28, 2004



# TOUCHING THE VOID:

## A FILM BASED ON THE TRUE STORY OF BRITISH MOUNTAINEERS JOE SIMPSON AND SIMON YATES

BY JENNIFER DAVIS

Many of those interested in the field of Trauma will have seen Touching the Void. It is in its tail-end period of showing at the cinemas as this goes to press, having been simply reviewed as "Not to be Missed", by the Sydney Morning Herald. I saw it at the Australian premier – a fundraiser for the Australian Himalayan Foundation.

I was introduced to the book (written by Joe Simpson) by a climber friend many years ago – being, in fact, the first of many climbing books I would devour as an armchair professional! It is one of the only books I can say that I read in one sitting – finishing it at around 3am. It was published in 1988 and won the Boardman Tasker Award later that year. Presenting Simpson with the 1989 NCR Award, Magnus Magnusson said "It is not just a book about mountaineering. Ultimately it is about the spirit of man and the life-force that drives us all."

In an age where we are cynical about how Hollywood presents complex Psychological processes (e.g. The Manchurian Candidate), this is a film which just simply tells the story. It is in the simplicity of the storytelling that the anguish and power of the trauma emerges. Actors are used to portray the younger Simpson and Yates in the re-creation, however, this is interspersed with comment by both men as they are today.

The two British mountaineers were attempting the first ascent of the West Face of Siula Grande in the Peruvian Andes. They were fit and well prepared – except that they decided to travel light and leave some of their oxygen tanks behind. It proved to be their near-fatal mistake. As they were descending down the mountain by a different route, Joe slipped. "I lifted my head from the snow and stared, up across my chest, at a grotesque distortion in the right knee, twisting the leg into a strange zigzag." (p72)

Without giving away the critical elements of the story – Simon, who, could have "gone for help", lowered Joe down the mountain until an unthinkable conundrum occurred. At that point the two climbers became separated and Simon returned to Base Camp alone, assuming Joe was dead.

Joe had to get himself down the mountain, starving and dehydrated, with a severely broken leg. He had no idea at any stage whether Simon would still be there to meet him, as he assumed that Simon thought he would be dead. Joe became delirious at the end of his tortuous trip out from inside of, and down, the mountain, however made it far enough for Simon, after some delay, to hear him calling against the howling wind and was thrown onto the back of a donkey and taken to Lima for surgery. Joe was convinced he would make it until he cried out for Simon and there was no answer. He then assumed he had been left for dead and that Simon had packed up and gone home. So near and yet so far. It was then that the nightmares and hallucinations became more intense.

Joe was rescued, but the psychological damage had been done. He had believed for that short period of time that he was going to die – after putting in a super-human effort to survive. He had indeed touched the void, and would never return completely from it.

In the making of the film, he was interviewed by the filmmaker in order to capture the most authentic version of events possible. Simpson described that time as one of opening Pandora's Box and not being able to get the lid back on again. He had to return home and have a few months of therapy in order to get the lid back on – and put the padlock back in place (as he described it in a SMH interview). He said that he never wanted to return again to the feelings he had at the foot of the mountain.

The film reminded me very much of the interview at the ASTSS conference in Melbourne where Brian Keenan was interviewed by Bessel van der Kolk. For me, a moment in time not to be missed. Despite the audio being very difficult to pick up, I was able to hear of the experience of another kind of trauma. It was deemed at this event that no questions be allowed, due to the intense nature of Keenan's experience whilst a captive in Beirut.

Both these events raise questions about the necessity and efficacy of people being required to frequently recount their traumatic experiences in a public arena. Simpson now does motivational speaking (and has continued writing – the sequel is This Game of Ghosts), but describes himself as totally divorced from the feelings of the event. Keenan lives quietly on the wild, west coast of Northern Ireland with his wife and child, and focuses on writing about other, more easily recountable, adventures.

Let it raise its own questions for you.

# THE AMERICAN NIGHTMARE: A CONVERSATION ABOUT HORROR WITH FILM MAKER ADAM SIMON

by Bronwyn Tarrant

*The American Nightmare* opens with a montage of images from both horror movies and news footage, so well edited that if you're unfamiliar with the horror genre it is impossible to separate reality from unreality. "Even real horror buffs, even some of the guys who made those movies, when they watch the sequence couldn't pick out what was their footage, from what was the real footage" says Adam Simon. Those "guys" include: Wes Craven (Scream), George Romero (Dawn of the Dead), Tobe Hooper (Chainsaw Massacre), John Carpenter (Halloween) and David Cronenberg (Rabid). Horror films from 1968 to 1978 are the focus of Simon's *American Nightmare*. The opening sequence establishes this as a film essay on trauma: Vietnam War, Kent State University police shootings, the murder of Bobby Kennedy and the assassination of Martin Luther King Jr. **Would we have horror movies in that decade without those traumas?** Simon quickly answers, "We wouldn't have those particular horror movies".

**So how is a horror movie different from a Hitchcock movie?**

Hitchcock is generally considered the great genius of the pure suspense thriller. But within that context, he also created the two critical works of modern horror, "Psycho" and "The Birds". The whole tradition of horror post 1960 is completely altered by those two films, both of which are entirely up the alley of what we're talking about.

The alley we're talking about is the impact of trauma in the development of horror films. For example, Alfred Hitchcock pioneered the crane shot, and all the directors who pay him homage shoot the trauma from high above – replicating the dissociative phenomena for protagonist and audience. Terr writes, "Hitchcock takes the camera up high – high, high above the set – so high that the full-grown actor looks like an errant five year old alone, confined, and utterly overwhelmed in his cell" (1990:51) Maybe this famous camera technique was born when WIlliam Hitchcock arranged for his pre-latency aged son to be thrown in a prison cell, for "this is what we do to naughty boys". Hitchcock's "The Birds" was the location for two traumatic meta-narratives: (1) In order to capture utter terror from the victim-heroine, Hitchcock organized for taxidermied birds to be hurled by a surrounding crew at actress Tippi Hedren, (causing injuries that delayed filming), and (2) Hitchcock gave Hedren's six-year-old-daughter a birthday gift of a toy coffin with a custom-made portrait doll of her mother lying inside (Anger, 1990). Hitchcock told Associated Press: "Tippi Hedren is really remarkable. She's already reaching the lows and highs of terror" (Dec. 4, 1962). Therefore, the audience's ornithophobia is merely one of "The Birds" traumas.

The horror film can't exist without suspense, yet it is only one portion. Generally in a Hitchcock film there is a more coherently pleasurable frightened experience because of the sense of mastery around us, as opposed to the sense in most horror films that the directors are not to be trusted and are out of control. The experience of a horror film aims to be more traumatic. It aims to scar you in a way that a suspense film doesn't. A suspense film takes you right to the edge, holds you in that edge as long as it can, and then ... basically makes things okay. At best the horror at the end of a horror movie is not over, it's just beginning – and moving out of the small community it began in, into the rest of the world. Meaning out into us.

**Jason Jacobs identifies "3 phases in hospital dramas": paternal, conflict, and apocalyptic. He hallmarks the apocalyptic phase "by the end of reassurance". Would it be fair to say that the horror movie is about the subversion of reassurance?**

Historically the horror genre presented a hardy band of the righteous to stop the forces of chaos and horror – in Dracula (the archetypal example) it is a real estate man, a doctor, a journalist, and an American cowboy. But instead, in the horror movies in *American Nightmare*, we have a small band of hapless ordinary individuals trapped between a rising source of chaos or evil (zombies), and an almost equally horrific force of order attempting

to stop it. Here it becomes hard to distinguish which is worse, which are the monsters, and our heroes (that is our victims; that is us) are trapped in between.

It's always been viewed both politically and socially as a very reactionary genre. It tends to be xenophobic, fearful of difference and change, and having a more conservative notion that civilization is a thin veneer over a primal chaotic reality and that what is repressed better stay repressed or it will destroy us all. So some may say that the horror movie then is the ultimate existential genre in which it is teaching us how to live in a world of ongoing horror. Versus, it's a reminder of the never ending archaic battle between absolute good and absolute evil – a kind of Bush doctrine in effect – where the fight is never over and the evil-doers are always out there and must always be stabbed through the chest with a cross, or whatever it will take to keep it down.

The classic end to a suspense – such as in "North by Northwest" when Eva Marie Saint is lifted off Mount Rushmore into the arms of Carey Grant – things aren't just over, they're going to be much better. Whereas in "Carrie" the hand shoots up out of the grave, and literally right up into us. The goal of the suspense is to take you on a controlled rollercoaster ride. The goal of the horror is to give you nightmares. It is actually to make something happen long after the movie is over. In the apocalyptic phase the crisis is never ending.

**What is the American nightmare?**
Nightmare is the key phrase. To ask what is the origin of horror movies is homologous to asking where nightmares come from. No one is utterly immune to nightmares. Whereas we know that there are some people who can't have anything but nightmares. A traumatized person is precisely the person who is terrorized by nightmares. The language of the nightmare is always going to be drawn from the world both inner and outer. The opening of The American Nightmare and the title is: (1) a pun on the American dream, (2) to say here was a particular American nightmare, and (3) to say here is my American nightmare (I tried to create the texture of one of my personal nightmares at the age of about nine).

The group of horror films that bears looking at in this context is Wes Craven's "Nightmare on Elm Street" which is a pure distillation of the theory and practice of the nightmare. The imagery of that film is so powerful. We could probably understand much about the 80s by studying that series as this movie tries to understand the 60s and 70s. In particular, what the condition of the youth must have been at that time, that they could so embrace, as a heroine, a girl whose nightmares are literally killing her friends. She is self mutilating to desperately not succumb to the nightmare. To try and pull apart where the metaphor ends and reality begins there is tricky: What nightmare are they fending off? This aligns with what Wes Craven says in the movie, that teenagers in particular administer horror movies to themselves as a kind of controlled substance.

The moral panic that society has about horror films is precisely about protecting the children. Wes Craven says we have to accept these movies are for adolescence especially, that they are in some way "boot camp for the ego" and that we have to look more honestly at adolescence. There is something about adolescence itself which is horrific. Adolescence is traumatic. Adolescence as a topic is traumatic. It's an awkward period where everything that was sweet and loveable about childhood turns ugly. Bodies that have been safely beautiful because they are precisely not desirable start to become something else. On every level from the purely physical to the social – this is a period of horror. It just seems natural that one of the main modes of expression, about and for this period, be the horror movie.

**Every Saturday night growing up I used to watch The Night Stalker by facing away from the TV with my head buried in a cushion asking my older sister when it was safe to look, which of course she unreliably did. What is our role as an audience of a horror film?**
Almost everyone can describe something like that. My girlfriend and her brother used to watch "Dr Who" from behind the couch. I would insist on going to the movies, and then create this elaborate apparatus with my hands that would have my thumbs at my ears and my fingers laced over my eyes, so that at the critical moment with one quick movement I could cut off what I was seeing and shut off what I was hearing. It's about learning these weird methods of coping, for making it through. In her book "Men, Women and Chain Saws" Carol Clover (1992) argues the core position of the horror movie spectator is not voyeuristic, is not the eye of the

killer, it's the next to be killed. It's not sadomasochistic, it's a position of quasi-safety where you are not the victim but you're next in line so you have to see in order to prepare. The movie which explores that most clearly after the fact is "Blair Witch".

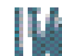
**We concluded the interview discussing Tom Savini's statement at the beginning of The American Nightmare: "I went from being the scared kid to the kid that scares".**

That might be an aphorism for the best and the worst of what happens to us. In the worst case, those who've been traumatized and don't have any means to deal with it, will themselves become purveyors of trauma. And, maybe in the best case scenario (like Tom Savini) the person finds a way to simulate and control his trauma and share it with us – in ways that is traumatic but healthy. That may speak to the simultaneous necessity for the sharing of that which has hurt us, with the process of creating metaphor for it, as much as developing the community to share in witnessing it.

**And without the metaphor we run the risk of acting it out literally?**

That's right, shifting from the abused who becomes the abuser instead to the kid who was scared being the kid who scares in a good way. The great bane of all of our existences, especially now, are the metaphorically challenged, the literalists, the fundamentalists among us. Those who take a text like the Bible and don't recognize metaphor but think it's literal. Who equally take a horror film and want to ban it because they cannot perceive its metaphoric nature. The inability to perceive metaphor is dangerous, and what does it say that our airwaves and media (which used to be dominated for years by drama and comedy) is now dominated by this new form that is called "reality show" which can only make things utterly literal which is in no way reality? Maybe that's the message, that the literalists are the danger and those who make metaphor are important even if it's ugly.

Adam Simon is a writer, director and actor. His film credits include, *Bones*, the award winning *The Typewriter, the Rifle and the Movie Camera*, *Paranoia*, and *Bob Roberts*. *The American Nightmare* is rated R (its historical footage both real and unreal is shocking and violent). It is distributed through Umbrella Films.



Last year Tom Savini received a lifetime achievement award for his work in the horror genre. He has directed four horror films, including "Night of the Living Dead". He has acted in 31 films since 1977; he has 25 film credits for make-up, and 16 for special effects – all horror. He's also been on the "Simpsons", playing himself. Yet, his appearance in *The American Nightmare* is the most powerful, as he gives testimony about his Vietnam War experience and its impact. Tom Savini "enlisted in the army to avoid going to Vietnam". He undertook study at the Army's photography school, was given a camera, and sent to Vietnam as an ordinary grunt. Tom speaks of using the camera to cope, when it was through the lens it was a special effect, it wasn't real. Tom practiced theatre make-up in Vietnam after battles – recreating wounds and scars he'd seen. Tom describes the overwhelming fear of being in a war – "I know my hands were constantly shaking ... especially after an attack, 'cause you didn't know if there was going to be an attack the next day, or the next day, or ..." – and his use of horror to defend against the trauma – "So here I was looking at what I thought was effects 'ie real gore' and actually studying them, thinking if I had to create this what would I do?". In the process of the interview Tom remembers, "when I was a kid watching Frankenstein, the Wolfman, I'd go home and try to recreate these guys". The strategies he developed to cope with horror movies were enlisted in war and became a career. His mastery in special effects and make-up in the horror genre is explicit: "If it's going to be horrible, it's going to be horrible the way I saw it. But they'll never see it the way I saw it, which is out of absolute fear"

# CHAPTER NEWS

## NEW SOUTH WALES

The NSW Chapter will meet on Tues, Nov 23, at 7 pm. Suite 6 /201 New South Head Rd, Edgecliff. Instructions are on the web site or call Beth 9326-2036 or 0414-710-101. It will be a get together to plan 2005.

Here is a tentative agenda:
(1) Do we want to put on a small NSW CONFERENCE? We have the funds. If you are in favor of this action, what focus do you want for the conference?

(2) Are you interested in a social get together to meet and have a speaker?

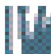
(3) Do we want to continue with discussions and case presentations on a regular basis? If so, how often would you come? Sunday brunch has been suggested. Would you prefer that time to an evening?

(4) Ron Cox from the South Coast has suggested we organize an audio-visual hooK up across NSW for meetings. He has a list of the equipment needed. Do you agree with the idea? If so, who would like to help organize that?

Please email me your thoughts and PLEASE LET ME KNOW IF YOU ARE COMING.

The Aboriginal and Torres Strait Islander Interest Group of the APS reorganized at the October Annual APS Conference. As we know there are particular historical and current trauma issues for indigenous people. I have joined the interim Committee. The Committee would like others who are interested to contact them through the APS.

Beth Stone
beths@psych.usyd.edu.au

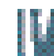


## QUEENSLAND

The Queensland Chapter is planning to have a seminar/workshop in late February or March 2005, and would appreciate feedback from members regarding the choice of topic that may appeal, and any particular speakers you might suggest. We are also exploring the possibility of conducting a similar event in Northern Queensland. Again feedback would be appreciated from our Northern members.

The Chapter was represented by Gwen Roberts (Chairperson) at the National Refugee Health Care Conference in Brisbane in October. This was a stimulating day attended by a range of health professionals - doctors, nurses and allied health professionals - exploring the present health needs of refugees and asylum seekers in Australia. Much discussion covered the proposal to establish a National Network of health care providers for these people in Australia.

Gwen Roberts
gwen.roberts@uq.edu.au



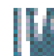
## WESTERN AUSTRALIA

There has been a great deal of interest about our conference on child abuse. This has increased the numbers of people attending our monthly open forums with associated requests to join ASTSS.

However, there are many members in W.A. with whom we have little contact. In order to bring about more activity we are proposing a chapter dinner. We are hoping to advertise this in a local newsletter which will deal mainly with social activities and local meetings.

I am grateful to all our committee members who are encouraging a variety of activities and local support.

Dulcie Veltman
dveltman@upnaway.com



## WESTERN VICTORIA

At our recent AGM the Western Victorian Chapter ASTSS banner was proudly unfurled. Office Bearers for the next 12 months have remained unchanged but there are a couple of new members on the horizon and one member has come from another country region. President – Dan Torpy; Treasurer– Claire Ryan; Secretary–Dave Hyatt. Members of the executive are Fran McPhee – Allan and Margot Murphy. At all times throughout the past year each of these executive members have been instrumental in organising our activities.

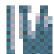
Also at the AGM we were addressed by Louise Boyne, a neuropsych clinician who graphically illustrated how the brain is effected through physical trauma incidents.

Our Chapter was well represented at the Sydney Conference with Caroline Taylor from Ballarat University as a keynote speaker and four other members present for the proceedings. It was a very successful conference and thanks go to Lynda and Faye and John for the excellent venue, catering and choice of speakers.

We need to be on full alert as there is a proposal for the 2007 conference to be held in the Ballarat region.

I am indebted to the strong work of the members of the executive committee and local members. We are a small group but the effect of the work that we do in the local community is staggering. May we continue to be facilitators in enhancing life and responsible choices for our local communities.

Daniel Torpy
Torpy.daniel.d@edumail.vic.gov.au



## VICTORIA

Over the past few months we have focused our attention on a number of special events and on developing new strategies to connect with Vic Chapter members.

**September 2004** The DART CENTRE for News Media and Trauma – Australasia, held a Symposium in Melbourne to launch their entry into the Australasian region in conjunction with other global networks. The event was well attended by journalists and healthcare practitioners who were taken through a riveting three hours of salient, thought provoking and at times very moving presentations by journalists and a news photographer. Their personal accounts and evocative visual images gave us a taste of what it may be like to look through the lens of a camera and to report from a scene of devastation while remaining coherent and responsible as they bear witness to the horrors of war, cruelty, natural disasters and human inequities.

Sandy McFarlane gave an interesting overview on the field of trauma, impressing the need for journalists to re-think their reservations over benefits to be gained from counselling. One theme of the Symposium was to highlight possible dilemmas facing journalists returning from the field, the impact on their families, personal relationships and work environment. How do they cope, who do they share their experiences with? Is a more pro-active, even if unwanted, intervention from their managers preferable to being dragged from the gutter in a drunken state of emotional wipe out as one journalist described.

Cait McMahon a new Vic. Chapter Committee member was highly praised for her major part in coordinating the launch of Dart Centre in Australasia. ASTSS committee members assisted with registrations and it was very rewarding to see that our joint DART/ASTSS advertising had reached other ASTSS members who were present at the Symposium. Please visit www.dartcenter.org/australasia for more news on this very worthwhile project.

**October 2004** ANNUAL DINNER The theme of this occasion was to give a well deserved tribute to Ruth Wraith who is a co-founder of ASTSS and Head of the Department of Psychotherapy at the Royal Children's Hospital, Melbourne. Her work and research continues to highlight the unique experience for children when exposed to traumatic situations which differs from that experienced by adults.

The dinner was held in Cambodian Style at Ta-Prom Restaurant in Camberwell. Rob Gordon, consultant in the area of Trauma and Critical Incident Response was as ever, entertaining and spoke of his ground breaking professional journey with Ruth and of her achievements, Andrew Coghlan from Emergency Management Australia gave a less known, engaging perspective of Ruth's' work and commitment, including the more recent Canberra bush

fires. Paul Valent, Traumatologist and writer spoke warmly of Ruth's indefatigable life force, her humour and diplomacy with immovable human bureaucracies. The evening was hosted by President Jitka Jilich who added a touch of colour and spontaneity to the evening.

Ruth was more than a little overwhelmed by the tribute and her appreciation was palpable. The evening was a reminder of the generosity in time and content to ASTSS Vic. Chapter from Ruth Wraith, Rob Gordon, Paul Valent, Di Clifton and many others over past and more recent years.

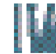
The Annual Dinner is now set to be in fact, an annual event. Please keep a spot in your diaries for October/November of each year. We hope to canvass speakers also from the arts, writers, journalists and lawyers as guest speakers, to share their perspectives on trauma and the medium in which they have chosen to express themselves.

**Connecting with Members:** Some of you will be aware that we have recently initiated a more direct communication with members by email. Whilst a number of incorrect addresses bounced back, and we are attempting to redress this, we have not received any unfavorable responses to communicating with members in this way. Our intention is to inform members of events of interest, ASTSS activities and to hear from you but we do not want to bombard with unwanted emails. We are thinking of emailing a small survey which will assist us to obtain a clearer overview of Vic. Chapter Member's views and needs with respect to local activities, seminars, education, and so forth. Please take the time to complete this, if this proposal is put into action. **It would be of great assistance if members would confirm their correct email address to: fmair@ozemail.com.au**.

**Planning Day:** This has been moved from November 2004 to January 2005. Fixed events for next year will hopefully provide a workshop/seminar given by a guest speaker and the Annual Dinner. Proposals for other activities include study/discussion groups on neuroscience and trauma; the impact of trauma on children, a training course. If you would like to run a seminar or to participate in perhaps a 'one-off' event, please let us know.

Please visit the Vic. Chapter section of the ASTSS Website for updates. On behalf of the Vic. Chapter Committee I wish you a relaxed and pleasant end of year break.

Felicity May
Acting State Representative.
fmair@ozemail.com.au



## Advancing Traumatology: from violence, trauma & human suffering to healing and hope
## 2004 Sydney Conference Report

by Lynda Matthews

The 11th Annual ASTSS conference was held in Sydney on 10th -11th September 2004 at the Marriott Hotel, College Street. One hundred and fifty nine delegates attended the meeting, some travelling from Western Australia and New Zealand to participate, and reports indicated the atmosphere was very warm and congenial. As anticipated, the dynamic program of invited speakers stimulated much thought in a number of areas where violence and trauma has resulted in human suffering. There were many opportunities for delegates to chat with speakers both in the allocated question time and afterwards in the breaks. Many of these conversations were continued with colleagues in the 'cocktails & conversation' and 'farewell' social events.

ASTSS was honoured that Her Excellency Professor Marie Bashir AC, Governor of New South Wales agreed to assume two official roles at the Conference: to officially open the conference and to present the 2003 ASTSS Media Award. Her opening speech set the context for the Keynote Address by Paul McGeough, winner of the Media Award, who enthralled the audience by painting a very clear picture of the human and security crisis that continues to exist in Baghdad today. The Governor on presenting the Award to Paul was able to reflect

on her own earlier experiences in Iraq.

The overseas speakers were well received and added an international perspective to the meeting. Mary Harvey's talk presented sections from a number of personal narrative interviews with women who had experienced abuse. She walked us through the 'turning points' in the stories that identified transitions in the narratives from stories of powerlessness and shame to stories of hope and agency. Mary made available a copy of her interview protocol and supporting articles to ASTSS. Copies can be obtained through Faye Cameron (02 9449 5279).

Ulrich Schnyder presented information on accident victims and the predictive role of active coping in the development of PTSD. He informed us of the low PTSD rate in his sample and of the role of cognitions in the number of sick-leave days post-accident. We did wonder, however, where he obtained his photo of Edvard Munch's 'The Scream' which was stolen earlier this year…

A number of speakers presented information on post-trauma interventions. Stephanie Hodson explained the ADF Critical Incident Mental Health Support framework using Operational Bali Assist as a case study of the approach. Grant Devilly provided a concise account of evidence for CISD. He suggested that post-traumatic interventions need to be evidence-based and that currently there is little evidence for debriefing as a practice. Richard Bryant emphasised that the majority of people will recover from critical incidents over time and there is little to support a focused debriefing protocol. He suggested that there should be a screening protocol for those at risk, and that CBT be offered to those who are identified with PTSD or ASD. Colleen Jackson offered an alternative model to the organisational debriefing CISD or CISM, but prefaced this with the view that there is significant terminology slippage, which needed to be clarified - people still confused counselling with debriefing.

An alternative is a Salutogenic Model, which is based on an assumption that people are resilient and most will not develop pathology. The model focuses on support and information, as well as empowering those directly involved. A protocol has been developed for this, with a card for distribution to people at a site. All speakers supported a DO NO HARM approach and cautioned against many of the current practices in systematic debriefing.

For those intrigued by the neurosciences, Sandy McFarlane and Kim Felmingham provided very informative sessions that examined neuroimaging data and various abnormalities in functioning in people with PTSD. Sandy's talk walked us through neuroimaging data that investigated particular difficulties in working memory experienced by those with PTSD, and discussed ways of improving function in this area. Kim's presentation examined neuroimaging data that explored neural reactions to emotional facial expressions, and explained from this the dysregulation in similar networks to fear and angry faces.

Sandy McFarlane also presented research findings on the criminal victimisation and perpetration amongst psychiatric inpatients at a public hospital facility. Significant percentages of the sample had experienced sexual or physical assault and Sandy discussed the potential impact of these experiences on symptomatic presentation and outcomes of these groups.

Janet Haines talked about psychophysiological data from research conducted using a personalised, staged guided imagery methodology. She demonstrated how this approach allows reactions to a traumatic experience to be tracked as the event develops and in its immediate aftermath, and for factors associated with a psychpathological or resilient response to be identified.

The consequences of violence and trauma within the Indigenous Community were discussed by Judy

Atkinson. Judy stressed the need within Indigenous communities for a healing response to individual, family and community pain from traumatic impacts of trans- and intergenerational experiences and legacies of colonisation. The processes and impacts of trauma across generations, and the cultural and spiritual tools for healing from trauma were presented.

Caroline Taylor provided a thought-provoking session on child sexual abuse and the traumatising influences of the sociolegal response. She offered examples of how legal processes continue to de-authorise voices of survivors, and talked of the courage and tenacity of spirit demonstrated by both child and adult survivors despite their experiences. Caroline urged us to respond in ways that build on the positive survival strengths, to recognise the courage and the journey, to help survivors create and strengthen a healing path.

The final session invited a panel that comprised Judy Atkinson, Mary Harvey, Sandy McFarlane and Ulrich Schnyder to answer the following question: *If you had a year off from normal duties and significant resources, what would you do to make a difference to the effects of violence and trauma, and give hope to those working in the field?*

Sandy would adopt a whole of government approach and lobby all levels to change policy and implement a more effective system of early intervention and prevention. This would focus on a reduction of the incidence of traumatic events, provide more effective treatment programs, and equip mental health systems to recognise and respond to traumatic damage.

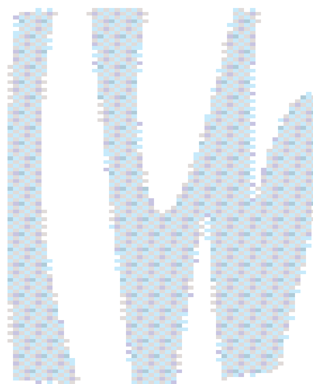
Judy would like to continue and expand current research and effect policy change, provide better evidence, change paradigms of understanding about indigenous trauma, focus on resilience and improving resources, partnerships with agencies would be forged with a heavy emphasis on educating to heal the broken spirit.

Ulrich would travel to other countries and explore inter-cultural ways of understanding and responding to traumatic experience. A question would be 'why do some cultural groups have greater resilience and what are the risk and protective factors?' He would also find out about traditional non-medical ways of healing and would also spend at least 10% of the time healing and restoring himself.

Mary would celebrate difference as a value and find ways of reducing dehumanisation. She would campaign for understanding of others on the ground that you cannot dehumanise what and whom you know. She would explore settings for apology for harm and emphasise accountability and restitution. She would work towards social change and increasing social competencies.

If you are interested in accessing speaker abstracts and biographical information, they have been posted to the ASTSS website - www.astss.org.au

Thanks to all those who contributed to the wonderful success of this conference -advisors, organisers, providers, supporters, chairs, speakers, and delegates - and the hotel staff who made us all feel like VIPs.



# 2005 ANNUAL ASTSS CONFERENCE COMMITTEE REPORT

As many members may have already heard at Sydney, the 2005 Annual Conference will be held in Perth, WA. The theme of the conference is "The Impact of Childhood Trauma Over the Lifespan: Historical Denial - Current Challenges". Due to unforeseen clashes, the finalized and confirmed dates for the conference are Friday 16th and Saturday 17th September, 2005, with pre-conference workshops on Thursday 15th.

The theme of this conference has been developed to address issues associated with both adult survivors of childhood trauma and children recently exposed to trauma. By focusing on these complimentary areas we aim to raise awareness about issues such as the impact of trauma on psychosocial development of those traumatized during childhood; the range of diagnoses post-trauma syndromes attract; effective intervention; acknowledgment of the range of traumatic events which may occur during childhood; and disclosure and personal-legal resolution. Many of these issues are the same for adults and children, however they may manifest in different ways.

The structure of the conference will consist of plenary sessions, concurrent sessions, and mini-workshops. Thus we hope to meet the specific needs of those working with children or adult survivors of childhood trauma, whilst facilitating increased connection and dialogue. Breaking the cycle of trauma through the generations remains a key challenge today. I am sure we will identify many more during the course of this conference. Poster sessions will also be held during the conference.

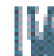
The conference venue is the Hyatt Regency Perth, on the foreshore of the Swan River. Accommodation has been secured at special rates for delegates. Alternative accommodation is available nearby, from apartments to backpackers. A few extra days to enjoy Western Australian hospitality is highly recommended, and we are happy to advise delegates about local attractions and nearby holiday destinations.

Final negotiations are underway with International Presenters. We are officially calling for the submission of abstracts from potential speakers. The official deadline for submissions is 27th February, 2005. Conference updates are available via the ASTSS web-site and Stress Points. Specific information is available via contacting me

Email: waconferenceorganiser@astss.org.au
Fax: 08 93899922

We are delighted to extend this invitation to you to attend what is sure to be a dynamic conference.

Elizabeth Sachse



ASTSS 2005 Conference Committee Chair

sPRING 2004 v 2.qxd 11/26/2006 9:44 AM Page 21

# Trauma, Narrative and Human Development: The Work of Erik Erikson

## TRAUMA CLASSICS

by Marion Oke

Narrative researcher and theorist John Kotre (1984) in his focus of generativity and psychiatrist Judith Herman's (1992) work on trauma and recovery, both draw from the work and theory of developmental psychologist Erik Erikson (1977). A number of the first-person stories in John Kotre's collection of generative narratives, *Outliving the Self, Generativity and the Interpretation of Lives* (Kotre, 1984), contain themes of surviving trauma, violation, oppression and loss. The stories include accounts of holocaust experiences, war trauma and domestic violence. Kotre describes the aim of his project as being "To shed light on generativity".

Erikson's stage theory of human development conceptualises related but distinct stages over the life span from birth to death, with particular tasks or conflicts which must be mastered or resolved at each stage before moving on to the next. For example, the tasks or crises of achieving identity and intimacy must be mastered or resolved before moving on to the task of generativity—the caring for and passing on of wisdom to the next generation (Erikson, 1977: 222-247).

Many authors, including Kotre (1984), have commented that such a fixed-stage theory of development tied to age norms does not fit with reality; individuals' lives are much more varied, messy and much less linear than this. Seemingly flying in the face of the linear nature of his theory, it appears that Erikson developed it in the context of hearing the stories of many individuals dealing with profound life crises and trauma. Prior to being a psychologist he was an artist, leading him to paint "contexts and backgrounds" rather than "point to facts and concepts" (Erikson, 1977:14), perhaps reminiscent of narrative therapist Michael White's concepts of "landscapes of consciousness and action" (White, 2004).

Erikson's career as a child analyst began in Vienna. Later he moved to America where he continued his psychoanalytic work, first conceiving his ideas on child development through a research project he was involved in at Yale University. He describes the psychoanalytic method as "essentially a historical method", interpreting present problems as a function of past experience. As does the narrative researcher or practitioner, Erikson perceives the psychoanalytic process as a relational one, that the researcher/therapist is not separate from the process he/she is attempting to understand: "the psychoanalyst is an odd, maybe, a new kind of historian . . . he becomes part of the historical process which he studies" (Erikson, 1977:14).

Erikson's work (encompassing clinical work, research and theory) is focused on the resolving of life crises. He gives accounts of several individuals in very different social contexts, dealing with and later reflecting on and giving meaning to life crises. The stories or "specimen situations" he relates are all of individuals dealing with traumatic life situations. He tells not only of war veterans, but also of a young child traumatised by believing he caused the death of his grandmother at which he was present. He tells of Native Americans traumatised by the imposition of white culture, the loss of their traditional culture and the impossibility of living up to the expectations of both the old and the new cultures. All these individuals, Erikson explains, experienced conflict and resulting "mental disturbance" (Erikson, 1977:13).

Erikson tells the story of an unarmed medical soldier who found himself forcibly armed with a sub-machine gun by an abusive

medical officer and forced into battle. He did not remember what happened after this, but the following morning found himself in the improvised army hospital suffering intestinal fever. An air attack ensued and whilst all the able-bodied men were able to help each other and find shelter, he was immobilised and terrified. He was evacuated the next day and thought he felt better until the first meal was served: "The metallic noise of the mess utensils went through his head like a salvo of shots. It was as if he had no defence whatsoever against these noises, which were so unbearable that he crawled under a cover while the others ate" (Erikson, 1977:34).

In telling the story of the traumatised soldier, Erikson describes how talking with him about his fears and anxieties associated with the war, led to the re-surfacing of traumatic memories created much earlier in his life, when at the age of 14, his mother in a drunken rage, pointed a gun at him, "He had grabbed the gun, broken it, and thrown it out the window. Then he had left for good" (Erikson, 1977:35). After this the 14 year old met a man who served as a protective father figure, to whom he made a promise ". . . never to drink, swear, or to indulge himself sexually—and then, never to touch a gun. He had become a good student and a teacher and an exceptionally even-tempered man . . . until that night on the Pacific beachhead, when amidst the growing anger and panic of the men, his fatherly officer had exploded with a few violent oaths, and when immediately afterwards someone had pressed a sub-machine gun into his hands" (Erikson, 1977:35).

Erikson interprets the soldier's earlier experience with his mother as the "seat of his neurosis". However, another understanding is that life, through the linking of memories, particularly traumatic memories, turns back on itself. One traumatic event is not necessarily more salient than another, they virtually become fused into the one mental and bodily experience defying the linear concept of time. The earlier trauma is reexperienced, as all its associated feelings, including bodily sensations, are occurring in the present. Through the vehicle of narration, the two traumatic events will likely become separated in time, but remain linked in meaning.

Erikson talked with many traumatised war veterans, he describes typical posttraumatic symptoms, including constant panic, palpitations and a sense of helplessness. "Childlike anger and anxiety without reason were provoked by anything too sudden or too intense, a perception or a feeling, a thought, or a memory . . . . Worse, these men were unable to sleep and to dream well" (Erikson, 1977:35). These men had thus lost their sense of trust and safety in the world. However, what impressed Erikson most was their loss of a sense of identity (Erikson, 1977:36). Thus Erikson seems to have come to his theory of resolving certain crises at particular life stages, by hearing the stories of individuals dealing with extreme past crises and trauma.

Part of Judith Herman's explanation of the effects of trauma involves a developmental approach which reflects Erikson's theory. Describing the state or experience following trauma which she names "disconnection", Herman refers to the traumatised individual as losing touch with important qualities gained through the developmental process, in particular the loss of a sense of safety, security, identity and meaning: "Traumatic events destroy the victim's fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation" (Herman, 1992:51).

In the first year of life, according to Erikson's theory, the child learns to trust, to feel safe in the world. If a child is abused and/or terrorised during this early stage, this sense of trust is likely not to be gained; for those traumatised in later childhood or adulthood it is likely to be lost. Also in jeopardy is the traumatised person's sense of identity, usually gained, according to Erikson, during adolescence. The abused person is often no longer able maintain intimacy, a quality or ability usually acquired

according to Erikson, during early adulthood. The ability to be generative, to care for and give to the younger (and perhaps older) generation may also be diminished (Erikson, 1977); (Herman, 1992).

Erikson's developmental tasks can also be seen to parallel the tasks or processes of recovery from trauma. According to Judith Herman these broadly include regaining a sense of safety in the world; a period of remembrance and mourning; and a sense of reconnection, including reconnection or reconciling with oneself, a regaining of intimate and family relationships and friendships, a reconnection with the world of work and study and/or an involvement in political activity, particularly political work associated with helping other survivors (Herman, 1992). The final stage of recovery, Herman names commonality: "Commonality with other people . . . means belonging to society, having a public voice, being part of that which is universal . . ." (Herman, 1992:235-236).

Erikson's crisis or task of older adulthood, the gaining of integrity as opposed to falling into despair, could be seen to parallel this process, as well as reflecting the narrative focus of meaning and context. He explains "integrity" as being "the ego's accrued assurance of its proclivity for order and meaning . . . an experience which conveys some world order and spiritual sense, no matter how dearly paid for . . ." (Erikson, 1977: 241).

Consistent with a narrative understanding, in addressing the issue of recovery, Erikson describes a process which retrospectively makes the trauma or catastrophe meaningful and understandable, "intelligible, retrospectively probable" (Erikson, 1977), (p. 32). We cannot undo what has happened, what we can do is to ". . . understand a continuum, on which the catastrophe marked a decisive event, an event which now throws its shadow over the very items which seem to have caused it. The catastrophe has occurred, and we must now introduce ourselves, as a curing agent, into the post-catastrophic situation" (Erikson, 1977:32).


References:

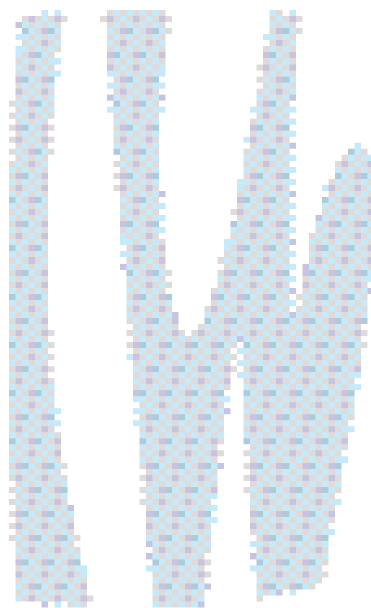
Erikson, E. (1977). Childhood and Society. St Albans (U. K.): Triad/Paladin.

Herman, J. L. (1992). Trauma and Recovery. New York: Basic Books.

Kotre, J. (1984). Outliving the Self: Generativity and the Interpretation of Lives. Baltimore: John Hopkins University Press.

White, M. (2004). Working with people who are suffering the consequences of multiple trauma. The International Journal of Narrative Therapy and Community Work(No. 1), 45-76.


Marion Oke is a counselling psychologist in private practice, who also works at Relationships Australia and completing her PhD at La Trobe University (Bouverie Centre Campus)



sPRING 2004 v 2.qxd 11/26/2006 9:44 AM Page 24

# Conference Calendar

**November 20, 2004**
FVSAI Training: Demystifying Ritualized Trauma: Laying the Foundation for Understanding in Biology, Psychology and Culture Training
(Part 1) Trauma: Scientific, Cultural and Personal Perspectives; (Part 2) January 15th: Ways to Work with Triggering of Dissociated States; (Part 3) March 5th: Recovery, Peer Support, Institutional Response to Childhood Sexual Trauma
San Diego, California, USA
Phone: 858-623-2777, ext. 442
E-mail: fvtrain@alliant.edu

**November 29 – December 12, 2004**
APSAC's 2nd Annual Trauma Treatment Clinic
Maui, Hawaii
Web Site: http://www.apsac.org/trauma/2004Brochure.pdf

**December 3-5, 2004**
Bindung, Trauma und soziale Gewalt
Psychoanalyse, Sozial- und Neurowissenschaften im Dialog
Frankfort am Main, Hessen, Germany

**December 7-11, 2004**
Models for Healing Multicultural Survivors of Historical Trauma Conference
Santa Ana, New Mexico, USA
E-mail: TakininetConf@aol.com

**January 7, 2005**
Effects of Trauma on Youth
Cambridge Health Alliance, Division of Continuing Education in Psychiatry
Boston, MA
Email: CME@challiance.org

**January 31-February 4, 2005**
Seeking Safety: Research-Based Treatment for PTSD & Substance Abuse
Puerto Vallarta, Mexico
http://www.amigabc.com

**February 16 – 20, 2005**
8th World Congress on Stress, Trauma and Coping
Crisis Intervention: Best Practices in Prevention, Preparedness and Response
Baltimore, MD
E: scohen@icisf.org
http://www.icisf.org/8WC/

**March 3-4, 2005**
Mindfulness
Heywood, Greater Manchester, United Kingdom
British Association for Behavioural & Cognitive Psychotherapies [BABCP]

**April 6-9, 2005**
ATSS 13th Annual Conference on Stress and Trauma
Staying Balanced in a Merry-Go-Round World
Dallas, Texas, USA
www.ATSS-HQ.com

**April 8, 2005**
Risking Connection
Traumatic Stress Institute [TSI/CAAP]
Unspecified, VT
http://www.tsicaap.com

**April 08-16, 2005**
Healing Chronic Traumatization: a two-day conference tour with Dr. Ellert Nijenhuis
MELBOURNE: 08/04 to 09/04. SYDNEY: 11/04 to 12/04. BRISBANE: 15/04 to 16/04
The Delphi Centre
Email: info@delphicentre.com.au
Website: www.delphicentre.com.au

**April 18 – 23, 2005**
15th National Conference on Child Abuse and Neglect
Supporting Promising Practices and Positive Outcomes: A Shared Responsibility
Boston, Massachusetts
Email Contact: 15thconf@pal-tech.com

**April 21-22, 2005**
(April 23-24: Advanced Clinical Training)
IMHCA's Spring 2005 Conference:
The Body Remembers: The Psychophysiology of Trauma
Boise, Idaho, USA
www.idahomentalhealth.org

**April 22, 2005**
The Time Bomb of Terrorism
Greater London, United Kingdom
http://www.roysocmed.ac.uk/