Sidran Institute
TRAUMATIC STRESS EDUCATION & ADVOCACY

No Escape from Philosophy in Trauma Treatment

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Long known by his colleagues for being an independent thinker, Jonathan Shay asked that this paper be kept in the voice in which it originated; readers will notice immediately that it is a transcript of a spoken work. The paper, printed here in a slightly altered form, was originally given at the 1994 International Society of Traumatic Stress Studies meeting. In his talk, as well as in this paper, Shay challenges us with his clarity of vision of what the classics can teach us about trauma. It is a unique perspective, one that has received much acclaim in Shay's 1994 book, Achilles in Vietnam: Combat Trauma and the Undoing of Character *(Simon & Schuster, available in paperback, 1995), and in his later book* Odysseus in America: Combat Trauma and the Trials of Homecoming*(Scribner, 2003). It takes us from our usual modes of thinking into a new and invigorating perspective.*

The conference organizer told me I have 20 minutes for all of philosophy. Great! Considering the amount of time most people devote to the voluntary study of philosophy as adults, that's probably *far* too much time. My goal for this talk is to make a number of appeals:

- To recall that virtually all of our academic disciplines evolved out of and differentiated from philosophy within the last few centuries—*often from only one side of an unsettled philosophical dispute*. The fact that one side won, institutionally speaking, does not necessarily mean that it had the stronger case and the dispute was settled by victory for that side. Never forget the power of a social group [and academic and professional disciplines are indeed multigenerational social groups] to construct a reality for its members.
- To accept as a lifelong task strengthening capacities for ethical perception and deliberation;

- To skeptically monitor the social construction of reality in our own worlds;
- To become more alert to those ideas that are so pervasive as to be invisible;
- To take our own lives seriously and not leave these tasks to the “experts” and the “professionals.”

Some writers, following the line of Aristotle’s famous lecture series “Ethics,” say that it is the branch of philosophy that deals with how to live well, how to achieve human flourishing (Nussbaum, 1986, Broadie, 1991). When someone gives such a definition, readers generally glaze over and nod and pay not the slightest attention to the fact that just yesterday, we might have heard that a colleague was hauled before a professional ethics board—I guess by that definition to be sternly admonished that he or she had not been living well, had failed to flourish.

The internationally prominent French philosopher Paul Ricoeur wants us to reserve the word ethics for philosophizing about living well and the word morals for philosophizing about our duties. But as Ricoeur also points out the Greek word *ethos* and the Latin word *mores* mean exactly the same thing—the customs, habits, way of life of an individual or group (Ricoeur, 1992, 170). So this does not really help at all. If I succeed at what I am doing, you will leave this chapter with not one piece of philosophical jargon, with no hundred-dollar words like *deontology* or *deictic*, nor with hair-splitting distinctions between the words *ethics* and *morals*, but rather with a greater curiosity to just plain figure out what people are talking about when they throw these words around.

Long-dead philosophers are usually the source of pervasive, invisible—therefore unconscious—“truths” that get built into our institutions, our “common sense,” and our emotional reactions to events. Controversies as fresh as whether to admit to the possibility of post-traumatic personality changes in the DSM-IV version of PTSD goes back to ancient roots. (This was, as you know, *rejected* by the Anxiety Disorders Committee and thus does not appear in the DSM-IV).

So that this sweeping claim doesn’t hover in the bloodless world of abstraction, I want to give you this example that is central to the field of trauma, particularly to severe, prolonged trauma under effective conditions of captivity, such as political torture, domestic battering, combat, incest—trauma bad enough to produce what Judy Herman (1992) calls “complex PTSD,” what the DSM-IV Field Trials awkwardly called Disorders of Extreme Stress Not Otherwise Specified [DESNOS], and what ICD-10 calls “Enduring Personality Change after

Catastrophic Experience" (W.H.O., 1992). Here is this example, in the form of a question: *Can any workings of bad luck produce cruel or evil actions in a good person?*

Plato (*Apology*, 41d) has Socrates say, in his famous defense before the court that condemned him to death, "nothing can harm a good man either in life or after death," and again in the *Republic* we hear extensively argued that the good person cannot be harmed by the world. For Plato, the notable quality that a good man has is inextricably bound up with good breeding, in particular aristocratic lineage. By the time we get to the Roman Stoics, however, this possibility of unshakable goodness, now called virtue, has been democratized so that even a slave could possess it, having acquired it by good upbringing in childhood. In this form Christianity took up the idea and clothed it with the doctrine of God's grace. By the late 18th Century it had been set in stone by Immanuel Kant, who said that which is truly deserving of ethical praise, blame, or true moral worth cannot be augmented or diminished by fortune. In the 20th Century, psychoanalysis offered us as a "scientific" result what the culture had already embraced, that no bad events could shake good character, once formed in childhood. When a previously good person engages in horrible acts, we must have been deceived; there had been a hidden flaw, a *diathesis*— give it a Greek name and that makes it more true than if you say it in plain English—a word incidentally that harks right back to Plato's *Republic*.

Because of the presence of such "heavies" as Plato, the Stoics, and Kant, you may be wondering—well, maybe they're right after all, maybe it's "truth." It's hard to buck that kind of authority, especially if you are unaware of the fact that this reflects only *one* tradition and don't know who's on the other side of the issue or what they have to say.

Plato's contemporaries thought of him as a crank, not a philosopher, a word they reserved for the tragic poets like Sophocles, Euripides, Aeschylus, and above all, Homer. All of the tragic poets presented the destruction of good character by external events, particularly betrayal and bereavement. Among those whom subsequent ages also called philosophers, Aristotle undercut Plato's position most powerfully, although there are times that Aristotle appears to endorse it, and people argue and argue about where he really stood.

So as much as I hate to, I'm going to have to drop this line of discussion and move on because of time and just leave you again with slogans:

- No escape from philosophy!
- There are many unsettled questions in ethical philosophy.
- Let's learn to recognize when one side of an unsettled philosophical controversy is presented as conclusive truth.

Now I want to direct your attention to Table 1 (below).The ethos or value pattern of the professions (Parsons, 1951) you see laid out in Table 1 represents the product of millennia of philosophic and social struggle. This value pattern is deeply embedded in our common sense, our institutions, our social ideologies. The final two rows of the table point out that this value pattern often leads us astray in our work with trauma survivors and in our practices of self-care in doing this work.

Table 1. The Professional Value Pattern in Our Society

	Universalism	**Functional Specificity**	**Collectivity Orientation**	**Achievement**	**Affective Neutrality**
Definition of Pattern Variable Now Normative For the Professional	Rule-based orientation to patient as subsumable example of abstractly defined category; relationship based on transcendent standard	Significance of patient limited to diagnosis and specific role in treatment; discipline-based orientation toward patient; division of labor; specialization	Defines role/value in relation to institution and profession; fear of institutional sanctions; legitimate gratifications only from institutional and professional rewards, including pay and public esteem	Professional's role/value based on performance competency conceived as learnable, transferable technique, not as personal to the professional	Personal detachment; situation assessed in light of reason, not emotion; delay and restriction of gratifications to those given by the institution and profession
Dichotomous Opposite	PARTICULARISM	DIFFUSENESS	SELF-ORIENTATION	ASCRIPTION	AFFECTIVITY

Definition of Dichotomous Opposite	Orientation to patient on the basis of the particularity of his/her situation, history; immanence	Whole patient seen as significant; no prior limits to interest or concern for patient	Role/value defined in relation to patient; satisfaction derived from relation to patient	Professional's role/value based on personal characteristics	Situation assessed in light of emotions and personal gratifications
Institutionalization of Pattern Variable	Diagnosis-based access, treatment, work organization, claims on resources	Licensure, departmental and professional organization along disciplinary lines	Titles; institutional power; differential compensation	Credentials; licensure examinations; training program criteria; training program curricula	Disciplinary codes against exploitation and abuse of patients
Voice of Common Sense	"If we don't know the diagnosis, how are we going to know what to do?"	"You do your job and I'll do mine, and together we'll get the job done." "I'm the doctor, so shut up."	"You've lost your objectivity." "Get with the program." "Everyone wants to get ahead [in their institution or profession]."	"Of course you can trust me; I've trained many years for this work." "I'm the doctor, so shut up."	You can't let your feelings get involved." "Just stick to the facts." "Don't drag your personal stuff into this."
Advantages of Currently Normative Professional Value Pattern	Predictability; fairness; elimination of nepotism, bribery, exploitation; organizational discipline	Predictability; fairness; goal-attainment, insofar as competency is real; is claimed to promote efficiency	Predictability; is claimed to prevent exploitation, but may just shift beneficiary of the exploitation; is claimed to put patient's needs first	Predictability; fairness; is claimed to promote competency; elimination of hereditary, racial, ethnic, gender privilege	Personal self-discipline; is claimed to put patient's needs first; prevents exploitation and abuse of power
Examples of How Norm Obstructs Trauma Recovery	Rules were often the direct source or legimitization of the trauma; survivor can't trust rule-dominated person	Promotes splitting	Careerism sometimes source of trauma; requires that patient trust the institution, not the person; promotes splitting	Confusion of credentials with competence; abuse of institutional power was source of trauma	No communalization of trauma; obstructs trust; blocks awareness of important clinical information

Examples of How Norm Obstructs Therapist Self-Care	Normative failure to attend to particularity of therapist's own experience of the patient's narratives and reenactments; "I'm fully trained, so…"	Limits growth and job satisfaction; can obstruct team community building; reduces team communication	Normative illusion that institution and profession provide all the social support that is needed to do the work safely; myth of professional invulnerability	Normative illusion that technical proficiency is adequate to hearing trauma narratives and engagement in trauma reenactments; myth of professional invulnerability	Myth of professional invulnerability; loss of signal function of emotions; blocks necessary social support; feared loss of colleague esteem; feared loss of job

Each component of the professional value pattern has a long history and is the product of many centuries-long struggles that we take pride in as social progress. They are not only deeply rooted in ourselves as internalized ideals, but are just as deeply institutionalized in the formal structures and processes of our mental health workplaces. These value orientations speak to us usually in voices of "common sense," so pervasively "true" that that we often fail to notice their presence. The professional value pattern contains many solid virtues, which when absent we note to our horror as exploitation, corruption, and abuse. The positive side of these value orientations is given in the top row labeled "advantages of currently normative professional value pattern." The two final rows sketch out the obstacles that these value orientations throw up to our clinical work and describe how they obstruct therapist self-care.

I want briefly to draw your attention to a number of very interesting questions about how we know what we know and what degree of trustworthiness and permanence we attribute to this knowledge. Here are some of the questions that seem important to me:

- Is it possible to escape the moral dimension of trauma in our "scientific" studies of it?
- When we demonstrate that something has "psychometric properties" does this mean that we have discovered something that is "real?" In what sense is it real— does this mean not culturally and historically constructed? There is an important sense in which the human heartbeat (or the feline heartbeat, for that matter) is not culturally constructed, likewise the mineral, bauxite. When we demonstrate that something has "psychometric properties" have we discovered something like bauxite?
- Is there a conflict in trauma research between the epistemological standard of the double blind study and the ethical requirement for informed consent? Can someone whose capacity for social trust has been destroyed by repeated betrayal and prolonged abuse give informed consent?

Each of these questions could be a chapter in itself.

Therapist self-care is the final topic that I want to devote time to before I stop—*what is the ethical standing of the needs of the trauma therapist?* Let us take an undramatic and familiar example: What ethical standing does the good of my night's sleep have when set against the good of my patient's finding comfort when he (all of my patients are men) feels despair in the middle of the night? In fact, our philosophical tradition is extraordinarily weak in its ability to deal with the problem of competing, incommensurable goods. Utilitarian ethics, institutionalized in modern America as cost/benefit analysis, is genuinely useful when you can meaningfully define competing goods in a common coinage, but leaves you utterly at sea when no common coinage can be found. I challenge you to find a convincing way to make the good of my patient's comfort in nocturnal despair commensurable with the good of my night's sleep. We have many rich and varied ways of thinking about conflicts of good and evil, but few to help us in conflicts of good and good. So in our practical deliberations, such as what to do when called in the middle of the night, we tend to fall back on notions of moral duty, and on Christian praise of self-sacrifice.

Duty entered Hellenistic philosophy through the Stoics and then merged very powerfully with the stream of Thou Shalts and Thou Shalt Nots from the Bible. In modern times Immanuel Kant set the question, What is my Duty?, at the top of everyone's agenda.

We ask, what is our duty when a patient calls in the middle of the night? What I want you to notice here is that there is a large void when we attempt to answer the question of the affirmative ethical standing of the self, the self of the therapist, in this situation. By framing it in terms of duty, we are usually pushed to a limited number of alternatives:

- We can deny that the telephone call really represents a good for the patient, or is such a negligible good that the patient's ethical claim is negligible. Therefore we have no duty to pick up the phone.
- We can admit that it *is* a good for the patient, but declare that good to be tainted by illegitimate means, such as lying about suicidal intent to gain comfort in despair. This allows us to redefine the conflict from being the clash of two goods to being the clash of good and evil.
- We convince ourselves that refusing the patient's phone call promotes a *higher* good of the patient, and that thus refusing it becomes part of our duty as therapists. Much supervisory instruction is devoted to the subject of "setting limits," "role-modeling appropriate boundaries" for the benefit of the patient, etc.

- We shift the duty to someone else through “coverage” arrangements in the form of phone answering machine instructions to call someone else.
- We perceive some threat to health or safety (Kant, 1991, no. 5, 19–20) in accepting the phone call, which for the first time gives the therapist any ethical standing and allows the mobilization of righteous indignation at the violation of rights, shifting somewhat the perspective away from duties.

In general we lack confidence of our capacities for practical deliberation in situations of conflicting goods. Very possibly you have paid a therapist or outside supervisor for years in search of this confidence. I’m here to tell you that the lack, dear reader, is not necessarily in yourself, but in our philosophical heritage.

What is notably absent from all of the alternatives we come up with in the middle of the night is the calm, assured, affirmative respect accorded to the self of the therapist that therapists routinely accord to patients. The pressures that our patients mobilize in the middle of the night depend to some extent on the ethical vacuum that our culture creates around the self of the therapist.

So that I can perhaps dispel suspicions that professional philosophers would hold their noses at this account, I just want to briefly quote from a recently published symposium of ethical philosophers: *over a large range of cases our ordinary thinking about morality assigns no positive value to the well-being or happiness of the moral agent of the sort it clearly assigns to the well-being or happiness of* ***everyone other than the agent.*** (Slote, 1993, p. 441). And *if I am faced with someone who has a valid claim of need, I cannot appeal to facts of self-interest in deliberating whether I should offer help, because self-interest* ***per se*** *cannot rebut a moral presumption* (Herman, B., 1993, p. 319).

This is an unresolved issue—the ethical standing of the self—in our philosophy, an invisible lacuna, if you wish. I make no claim to fill it here today, but merely to point it out, to make the invisible visible. However, I want to close by pointing to the obvious fact that therapist self-care most readily acquires an affirmative ethical standing if it is strongly valued and supported by a *community*, in particular, the community of the therapist’s co-workers. This positive value is raised to an exponent if there is actual community among the *patients*, and if that community of patients values and supports therapist self-care as very much in its self-interest. However much of the ethos of the professional presumes, and frequently promotes, an isolated *individual* as the patient, and contemplates neither the

existence nor ethical standing of community among patients.

References

Broadie, S. (1991). *Ethics with Aristotle*. New York: Oxford University Press.
Herman, B. (1993). Obligation and performance: A Kantian account of moral conflict. In O. Flanagan and A. O. Rorty (Eds.), *Identity, character, and morality: Essays in moral psychology*. Cambridge: MIT Press.
Herman, Judith (1992). *Trauma and recovery*. New York: Basic Books.
Kant, E. (1991). *The metaphysics of morals* (M. Gregor, trans). New York: Cambridge University Press.
Nussbaum, M. (1986). *The fragility of goodness: Luck and ethics in Greek tragedy and philosophy*. New York: Cambridge University Press.
Parsons, T. (1951). *The social system*. New York: Free Press.
Plato. *Apology*. 41d.
Ricoeur, P. (1992). *Oneself as another* (K. Blamey, trans). Chicago: University of Chicago Press.
Slote, M. (1993). Some advantages of virtue ethics. In O. Flanagan and A. O. Rorty (Eds.), *Identity, character, and morality: Essays in moral psychology*. Cambridge: MIT Press.
World Health Organization (1992). *The ICD-10 classification of mental and behavioral disorders*. Author.