

## Traumatic Encounters: Reading Tim O'Brien

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In the introduction to his groundbreaking work *Achilles in Vietnam*, Jonathan Shay recalls listening to Vietnam veterans and being “struck by the similarity of their war experiences to Homer’s account of Achilles in the *Iliad*.” He quickly realized that Homer’s descriptions might help those who have not been in battle understand the “bitter experiences” common to “continuous, heavy combat.” Only much later did he also come to appreciate that readers of some kinds of literature “would be better able to interpret” these works “if they listened to combat soldiers” (xiii). Shay’s thesis need not be limited to the classics, however. As the most evocative re-creation of Vietnam’s traumatic combat experience, Tim O’Brien’s fiction seems emblematic of this literature. Considering O’Brien’s works through the lens of trauma theory simultaneously enhances our understanding of form and content and increases our sensitivity to the struggles of those suffering from PTSD.

In some ways, trauma is the most literary of psychological experiences. Trauma inflicts upon the brain a story which, by definition, it cannot understand, cannot process, cannot move beyond. Mired in a continuing attempt to comprehend that liminal experience, the brain retells the story, compulsively repeating it in hallucinations, flashbacks, and nightmares in a determined but hopeless quest for understanding.

In other words, the traumatic experience never really ends. In *Unclaimed Experience: Trauma, Narrative, and History*, her seminal work on experiencing, describing, and witnessing trauma, Cathy Caruth explains:

what seems to be suggested by Freud in *Beyond the Pleasure Principle* is that the wound

of the mind—the breach in the mind’s experience of time, self, and the world—is not, like the wound of the body, a simple and healable event, but rather an event that [...] is experienced too soon, too unexpectedly, to be fully known and is therefore not available to consciousness until it imposes itself again, repeatedly, in the nightmares and repetitive actions of the survivor. (4)

Each attempt to imagine trauma “engages, in some way, a central problem of listening, of knowing, and of representing that emerges from the actual experience of the crisis [...] a crisis marked, not by simple knowledge, but by the ways it simultaneously defies and demands our witness” (5). Because the actual experience itself resists interpretation—Caruth notes that “the painful repetition of the flashback can only be understood as the absolute inability of the mind to avoid an unpleasurable event that has not been given psychic meaning in any way” (59)—stories about the experience of trauma become “a kind of double telling, the oscillation between a *crisis of death* and the correlative *crisis of life*: between the story of the unbearable nature of the event and the story of the unbearable nature of survival” (7).

This double telling seems central to Tim O’Brien’s work. Readers of *The Things I Carried*, for example, immediately encounter the insistent repetition of combat trauma, from the “Boom-down” of Lavender’s death in the title story to the “star-shaped” wound in “The Man I Killed,” to cite just two obvious instances. Indeed, repetition structures the work itself, both within individual stories and across repeated stories (e.g., “Ambush” and “The Man I Killed”).

O’Brien’s work also reflects Freud’s belief that consciously retelling the traumatic event in a controlled environment might allow the brain to process the experience, the basis of both the so-called “talking cure” offered to World War I shellshock victims and the (hopefully) more sophisticated therapy provided to veterans returning from chaotic experiences in Iraq and

Afghanistan. In “The Man I Killed,” for example, Kiowa comes to understand that his friend Tim O’Brien needs to talk about death, moving gradually from rationalizing his actions to urging him forward before simply inviting, even demanding, his story. And elsewhere, other characters express their envy of O’Brien’s career as a writer, precisely because it allows him to retell their shared stories in ways that seem, to them at least, healthier than those available to themselves. Indeed, in “Notes” and elsewhere, O’Brien, the narrator, seems to agree, citing the guilt he feels for finding a way forward that his buddies cannot follow. Of course, Shay insists that such retelling can be “catastrophic” if approached as mere debriefing or if undertaken without necessary precautions, which might account for the seeming fragility of O’Brien’s first-person narrator (and perhaps even of the author himself).

Because trauma and its aftermaths are central to any full understanding of Tim O’Brien’s works, encountering O’Brien on the page can become an unexpectedly unsettling experience. I say experience because, in addition to enlightening our understanding of the literary works themselves, trauma theory explores how the reader inescapably becomes a kind of witness to the explosive events described in O’Brien’s stories and novels.

Here the “listener to trauma” runs into one fundamental problem of testimony: by its very nature, as Shoshana Felman and Dori Laub argue in *Testimony: Crises of Witnessing in Literature, Psychoanalysis, and History*, testimony indicates a “crisis of truth” (6):

texts that testify do not simply *report facts* but, in different ways, encounter—and make us encounter—*strangeness*; how the concept of testimony, speaking from a stance of superimposition of literature, psychoanalysis and history, is in fact quite unfamiliar and *estranging*, and how, the more we look closely at texts, the more they show us that, unwittingly, we do not even know what testimony is and that, in any case, it is not simply

what we thought we knew it was. (7)

Listening to trauma, then, destabilizes readers in ways much more limited than yet still suggestive of Elaine Scarry's description of the direct experience of pain. This destabilization leads Felman and Laub to describe mass trauma—events like genocide and slavery as well as war—as “history which is essentially *not over*” (xiv).

Grounded in the recognition that reading O'Brien's work can be—indeed should be—a difficult experience for students and instructor alike, this essay will survey trauma theory both to summarize relevant issues for instructors unfamiliar with the field and to direct those wishing to expand their own understanding.

### ***Defining Post Traumatic Stress Syndrome***

After decades of study and discussion going back to psychiatry's earliest days—both Freud and Janet significantly contributed to our current understanding of experiencing trauma—PTSD was first included as an official diagnosis by the American Psychiatric Association in 1980, with the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III). The definition relied heavily on a revealing phrase, defining trauma as “an experience ‘that is outside the range of usual human experience and that would be markedly distressing to almost anyone.’” While this phrase was dropped in the substantially revised definition of PTSD in DSM-IV (1994), what Mark Heberle calls its “paradoxical combination of the abnormal and the universal” remains useful in understanding the condition (11).

According to DSM-IV—the entire PTSD entry is included in Appendix I—PTSD involves “characteristic symptoms” that develop “following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.”

More specifically:

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. [...] Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. [...] The disorder may be especially severe or long lasting when the stressor is of human design (e.g. torture, rape). The likelihood of developing the disorder may increase as the intensity of and physical proximity to the stressor increase.

While this list of experiences may sometimes seem within “the range of usual human experience,” the definition continues to list a crucial requirement: “The person’s response to the event must involve intense fear, helplessness, or horror.”

Unable to adequately process such extreme experiences (for reasons I will explore below), people who suffer from PTSD develop a range of potentially debilitating symptoms that largely involve unwillingly repeating the traumatic event (e.g., flashbacks, nightmares,

hallucinations) or relentlessly avoiding, willingly or not, anything that might recall the traumatic event. (See the Appendix for a full list of characteristic symptoms.) In her groundbreaking work *Trauma and Recovery*, Judith Herman categorizes these symptoms as “hyperarousal, constriction, and intrusion.” As Heberle summarizes:

The chronic and debilitating nervousness, irritation, and sleeplessness of [hyperarousal] reproduces states of self-protective vigilance associated with the original trauma but now maladaptive; at its most destructive, hyperarousal can trigger frenzied homicidal and suicidal episodes. This disorder directly contrasts with the shutting down of physiological, emotional, and cognitive responses typical of constriction, which resembles affectless hypnotic trance states in which time and self-consciousness seem to dissolve. While constriction blocks painful and unbearable trauma-related responses and even effaces memory of the trauma itself, intrusion breaks through the repression, forcing the survivor to relive the horror through fragmentary, asynchronous images and sensations of the original experience, often in the form of nightmares. Constriction and intrusion are intimately linked, as trying to bury a soul-shattering experience simply increases the pressure to resolve it. (12)

While such symptoms are experienced individually in ways that are by definition at the limits of human experience, some collective experiences—genocide, combat, natural disasters—leave whole groups of survivors vulnerable to PTSD. Heberle notes that “Vietnam combat veterans, who may have been no more than 20 percent of the total American military personnel in Southeast Asia, constitute another such group [in which traumatization has become the “usual experience”]: by the late 1980s, 35.8 percent met all APA diagnostic criteria for PTSD, and more than 70 percent had suffered at least one of the primary symptoms” (11, see also Shay 167-169).

Shay translates the DSM's diagnostic description of these primary symptoms into a more easily understood list:

- Loss of authority over mental function—particularly memory and trustworthy perception
- Persistent mobilization of the body and the mind for lethal danger, with the potential for explosive violence
- Persistence and activation of combat survival skills in civilian life
- Chronic health problems stemming from chronic mobilization of the body for danger
- Persistent expectation of betrayal and exploitation; destruction of the capacity for social trust
- Persistent preoccupation with both the enemy and the veteran's own military/governmental authorities
- Alcohol and drug abuse
- Suicidality, despair, isolation, and meaninglessness (xx)

Given that many of those who suffer from PTSD experience multiple symptoms, it is little wonder that Shay claims the condition “can devastate life and incapacitate its victims” (xx).

Such symptoms may identify the effects of PTSD, but Cathy Caruth warns us that they do not define the condition itself. Despite our desire for a simple formula for PTSD, Caruth insists: the pathology cannot be defined either by the event itself—which may or may not be catastrophic, and may not traumatize everyone equally—nor can it be defined in terms of a *distortion* of the event, achieving its haunting power as a result of distorting personal significances attached to it. The pathology consists, rather, solely in the *structure of its experience* or reception: the event is not assimilated or experienced fully in time, but only

belatedly, in its repeated *possession* of the one who experiences it. To be traumatized is precisely to be possessed by an image or event.

(Caruth, "Part I" 4-5)

Caruth's phrasing hints at the gothic nature of PTSD: the event quite literally haunts the survivor (a fact to which Toni Morrison draws our attention so devastatingly in *Beloved*). In O'Brien's fiction, the best example of this haunting may come in John Wade's inability to escape his past in *In the Lake of the Woods*. Wade's story reminds us that while PTSD symptoms reflect the myriad ways the disorder attacks survivors' lives, they all stem from the fundamental inability to comprehend the traumatic experience itself.

### ***Experiencing Trauma***

Perhaps the crucial fact in understanding trauma involves recognizing that not only is the traumatic incident, by definition, not normal, "outside the range of usual human experience," but also that the brain's experience of that event is itself abnormal, radically unlike our own experience of everyday events. As Judith Herman explains, "People in a state of terror are not in a normal state of consciousness. They experience extreme alterations in arousal, attention, and perception" (6). She elaborates, "When people are in a state of terror, attention is narrowed and perceptions are altered. Peripheral detail, context, and time sense fall away, while attention is strongly focused on central detail in the immediate present." This narrow focus leads to "the state we call disassociation" (the early psychologist Janet "first coined the term" after studying "state-dependent memory and abnormal retrieval" (7)), in which the individual experiences

“profound perceptual distortions, including insensitivity to pain, depersonalization, derealization, time slowing and amnesia” (6).

Interestingly, Herman suggests that this reaction can become a learned response not just to trauma but even to the expectation of trauma. While “[s]ome people disassociate spontaneously in response to terror,” Herman notes, “[o]thers may learn to induce this state voluntarily, especially if they are exposed to traumatic events over and over. Political prisoners instruct one another in simple self-hypnosis techniques in order to withstand torture” (7). For those of us who, thankfully, have never experienced trauma, such examples help illustrate why the brain might spontaneously disassociate with confronted with the traumatic event.

Regardless of the particular individual experience, such hyperarousal leaves marks on the brain: the “activation of trauma-specific memories in combat veterans with PTSD produces highly elevated physiologic responses that fail to extinguish even over periods of half a lifetime” (Herman 6). It is precisely the long-lingering effects of these elevated responses that manifest themselves as the PTSD symptoms summarized above.

For a sense of what such a traumatic experience might be like, consider a passage from O’Brien’s *In the Lake of the Woods*. Immediately following the sudden death, by sniper fire, of a sergeant in his unit, John “Sorcerer” Wade recalls “shivering”:

The cold came from inside him. A deep freeze, he thought, and then he felt something he’d never felt before, a force so violent it seemed to pick him up by the shoulders. It was rage, in part, but it was also illness and sorrow and evil, all kinds of things.

For a few seconds he hugged himself, feeling the cold, and then he was moving.

There was no real decision. He’d lost touch with his own volition, his own arms and legs, and in the hours afterward he would remember how he seemed to glide toward

the enemy position—not running, just a fast, winging, disconnected glide—circling in from behind, not thinking at all, slipping through a tangle of deep brush and keeping low and letting the glide take him up to a little man in black trousers and a black shirt.

He would remember the man turning. He would remember their eyes colliding.

Other things he would remember only dimly. How he was carried forward by the glide. How his lungs seemed full of ashes, and how at one point his rifle muzzle came up against the little man’s cheekbone. He would remember an immense pressure in his stomach. He would remember Kathy’s flat eyes reproaching him for the many things he’d done and not done.

There was no sound at all, none that Sorcerer would remember. The little man’s cheekbone was gone. (40)

Here Wade’s description of this experience strikingly parallels Herman’s explanation of hyperarousal and dissociation. The way Wade “glides” through dense underbrush reflects his claim that he “lost touch” with his own body. The language helps transmit this sensation to the reader as Wade “glides, “slips,” wings”—the action even elides into passivity as he “is carried along.” Not just insensitive to pain, Wade unconsciously blocks all sensation save that necessary to find and kill the sniper. Clear evidence of what Herman terms perceptual distortion includes losing his sense of hearing and narrowing his perceptual field down, eventually, to focus only on the man’s cheekbone. (Note too the troubling intermingling of Wade’s later experience—“Kathy’s flat eyes reproaching him for the many things he’d done and not done”—with his description of the event itself, a detail to which I will return below.) And, in a characteristic feature of experiencing trauma, Wade seems to lose his awareness of sequence, to lose track of time.

## *Fracturing Time*

The effects of disassociation and hyperarousal suggest that, in the body's response to the traumatic event, some senses become heightened while others deaden, less important, perhaps, to survival in that awful moment. One common feature of the traumatic experience seems to be that the brain's attention to sequencing events in time breaks down, or, perhaps more accurately, is simply switched off. The characteristic "blur" many survivors describe seems just as linked to this absence of sequence as it is to the narrowing of perception. Some theorists speculate that the brain's astonishing ability to register some details comes at the cost of others. For example, Herman suspects, "because of the narrow focusing of attention, highly specific somatic and sensory information may be deeply engraved in memory, while contextual information, time sequencing and verbal narrative may be poorly registered. In other words, people fail to establish the associative linkages that are part of ordinary memory." This failure to create necessary linkages may account for the way we "find abnormalities not only in storage of traumatic memories, but also in retrieval" (7).

Crucially, this inability to order the event properly in time is not just a feature of the "storage and retrieval" of memory, but actually a constitutive part of the traumatic experience itself. As Cathy Caruth attempts to explain, "Unlike the body, [...] the barrier of consciousness is a barrier of sensation and knowledge that protects the organism by placing stimulation within an ordered experience of time. What causes trauma, then, is a shock that appears to work very much like a bodily threat, but is in fact a break in the mind's experience of time" ("Departures"

32). In effect, the traumatic event ruptures consciousness, just as the brain's ceaseless repetition of the event attempts to suture the break back together.

Another way to understand this failure to structure this event in time was suggested by Freud. As we saw earlier, the DSM's definition of trauma relies less on the event itself than on the individual survivor's response to the event, which "must involve intense fear, helplessness, or horror." Exploring Freud's struggle to analyze what he called "war neuroses" in *Beyond the Pleasure Principle*, Caruth notes:

Trauma comes not from over stimulation, according to Freud, but from 'fright,' the lack of preparedness to take in a stimulus that comes too quickly. It is not simply, that is, the literal threatening of bodily life, but the fact that the threat is recognized as such by the mind *one moment too late*. The shock of the mind's relation to the threat of death is thus not the direct experience of the threat, but precisely the *missing* of this experience, the fact that, not being experienced *in time*, it has not yet been fully known.

("Departures" 32)

Without the sequencing of time, in other words, the traumatic event cannot be understood. The event cannot be understood because, in this most literary of psychological experiences, without time, there can be no coherent narrative, no story.

### ***Denying Story***

Dr. Dori Laub, a child survivor of the Holocaust who has done monumental work in recording survivors' testimonies, explains:

Massive trauma precludes its registration; the observing and recording mechanisms of the human mind are temporarily knocked out, malfunction. The victim's narrative [...] does

indeed begin with someone who testifies to an absence, to an event that has not yet come into existence, in spite of the overwhelming and compelling nature of the reality of its occurrence. (57)

Without a narrative of the event, the brain has not really experienced the event. The traumatic moment has indisputably happened, and yet it has not truly been experienced, because it cannot be understood. Freud, Caruth reminds us, thought of “trauma as a theory of the peculiar incomprehensibility of human survival” (“Departures” 30).

This incomprehensibility troubled early psychiatrists. In his 1919 volume *Psychological Healing*, Janet writes:

Memory [...] like all psychological phenomena, is an action; essentially it is the action of telling a story.... A situation has not been satisfactorily liquidated ... until we have achieved, not merely an outward reaction through our movements, but also an inward reaction through the words we address to ourselves, through the organization of the recital of the even to others and to ourselves, and through the putting of this recital in its place as one of the chapters of our personal history.

(qtd. Herman 9)

The story, in other words, must be complete and coherent to be appropriately placed in “our personal history,” and yet completeness and coherence are precisely impossible in the traumatic event.

No story, Janet suggests, no memory. Given the break in time sequencing, in the brain’s ability to order events, this absence may be the central feature of experiencing trauma. As Judith Herman finds:

Disturbances of memory are a cardinal symptom of post-traumatic disorders. They are found equally in the casualties of war and political oppression: combat veterans, political prisoners, and concentration camp survivors, and in the casualties of sexual and domestic oppression: rape victims, battered women, and abused children.

These disturbances have been difficult to comprehend because they are apparently contradictory. On the one hand, traumatized people remember too much; on the other, they remember too little. They seem to have lost authority over their memories.

(5)

In the absence of story, the survivor may fixate on a single iconic detail (the “star-shaped wound” of “The Man I Killed,” for example). Or the survivor may launch into creating some explanatory story to displace the traumatic event that cannot be understood. Dr. Dori Laub tells of an experience from his own life, when therapy forced him to recognize that happy childhood memories of summer camp were a false attempt to reorganize actual details (recalled from his experiences during the Holocaust) into an acceptable narrative. O’Brien’s fiction offers many examples, from virtually all the events in *Going After Cacciato* to the multiple versions of similar stories in *The Things They Carried* (to cite just one example, note the variations in “Ambush” and “The Man I Killed”). Not even such imaginative retellings, however, can overcome the brain’s relentless need to understand, the need that forces survivors to constantly reexperience the traumatic event.

### ***Reliving Trauma***

It may be inaccurate to call those with PTSD “survivors,” since, for them, the traumatic events are not yet over. As we have seen, “post-traumatic stress disorder reflects the direct imposition on the mind of the unavoidable reality of horrific events, the taking over of the mind—psychically and neurobiologically—by an event it cannot control” (Caruth, “Departures” 29). This possession, this haunting, of the mind troubled Freud, as Caruth explains:

the war neuroses [of WWI triggered] Freud’s perplexed observation of a psychic disorder that appears to reflect the unavoidable and overwhelming imposition of historical events on the psyche. [...] The returning traumatic dream perplexes Freud because it cannot be understood in terms of any wish or unconscious meaning, but is, purely and inexplicably, the literal return of the event against the will of the one it inhabits.

(“Departures” 30)

Given this “literal return,” Caruth notes, “the painful repetition of the flashback can only be understood as the absolute inability of the mind to avoid an unpleasurable event that has not been given psychic meaning in any way. In trauma, that is, the outside has gone inside without any mediation” (“Departures” 30).

In a way, this process seems difficult to understand. The traumatic event is not repressed, in any strict sense (Caruth points out “the ever-surprising fact that trauma is not experienced as mere repression or defense, but as a temporal delay that carries the individual beyond the shock of the first moment” (“Part I” 10)), which may be part of why the war neuroses perplexed Freud. After all, as Herman reminds us, “The ordinary human response to atrocities is to banish them from consciousness. Certain violations of the social contract are too terrible to utter aloud: this is the meaning of the word unspeakable.” And yet, for many people, trauma seems impossible to banish: “Atrocities [...] refuse to be buried” (4). This tension, Herman suggests, offers one way

to understand PTSD, since “The conflict between the will to deny horrible events and the will to proclaim them is the central dialectic of psychological trauma” (5)

Freud was certainly puzzled by the flashback, which Caruth terms “an enigma of survival” (“Departures” 29). In *Beyond the Pleasure Principle*, Freud writes:

[People] think the fact that the traumatic experience is constantly forcing itself upon the patient even in his sleep is proof of the strength of that experience: the patient is, as one might say, fixated to his trauma.... I am not aware, however, that patients suffering from traumatic neurosis are much occupied in their waking lives with memories of their accident. Perhaps they are more concerned with *not* thinking of it.

(13, qtd. Caruth, “Departures” 31)

Of course, merely trying “not thinking of it” does not work. Because, as Herman notes, “trauma simultaneously enhances and impairs memory” (5), memory of the event seems beyond control of the survivor, “a form of recall that survives at the cost of willed memory or of the very continuity of conscious thought,” as Caruth puts it (“Part II” 152). Without effective narrative, without necessary associative links, trauma seems to leave its marks on the brain in unique ways. Neither amnesia nor repression, alternately resisting both direct and indirect access, traces of the traumatic event remain as “an impossible history inside [the traumatized]” (“Part I” 5). As Caruth speculates, “The ability to recover the past is thus closely and paradoxically tied up [...] with the inability to have access to it. And this suggests that what returns in the flashback is [...] is itself constituted, in part, by its lack of integration into consciousness” (“Part II” 152).

For Freud, the key to trauma’s repetition seems to be the brain’s encounter, after the fact, of the threat of its own death. As Freud notes, “These dreams are endeavoring to master the

stimulus retrospectively, by developing the anxiety whose omission was the cause of the traumatic neurosis” (32, qtd. “Departures” 32). Caruth elaborates:

The return of the traumatic experience in the dream is not the signal of the direct experience, but, rather, of the attempt to overcome the fact that it was not direct, to attempt to master what was never fully grasped in the first place. Not having truly known the threat of death in the past, the survivor is forced, continually, to confront it over and over again. [...] It is because the mind cannot confront the possibility of its death directly that survival becomes for the human being, paradoxically, an endless testimony to the impossibility of living.

(“Departures” 32-33)

This explanation hints at the horror faced by survivors: the repeated experience, not just of the terrible details of the event itself, but more accurately, and more excruciatingly, of the fright central to trauma.

Not surprisingly, reexperiencing such extreme fright imposes costs on the brain. Caruth explains:

As modern neurobiologists point out, the repetition of the traumatic experience in the flashback can itself be retraumatizing; if not life-threatening, it is at least threatening to the chemical structure of the brain and can ultimately lead to deterioration. And this would also seem to be the cause with the high suicide rate of survivors. [...] who commit suicide only after they have found themselves completely in safety.

(“Departures” 33)

The disproportionate suicide rate of those (like O’Brien’s Norman Bowker) who make it seemingly safely out of trauma seems difficult to understand without recognizing what may be,

in overly simplistic terms, a kind of solitary, self-directed survivor's guilt. Drawing on Freud's work, Caruth notes:

What is enigmatically suggested, that is, is that the trauma consists not only in having confronted death, but in having survived precisely, without knowing it. What one returns to, in the flashback, is not the incomprehensibility of one's near death, but the very incomprehensibility of one's own survival. Repetition, in other words, is not simply the attempt to grasp that one has almost died, but more fundamentally and enigmatically, the very attempt to claim one's own survival.

(“Departures” 33)

In other words, “the trauma of the nightmare does not simply consist in the experience within the dream, but in the experience of waking from it” (“Departures” 34). No wonder that, for so many, survival is only temporary.

O'Brien's fiction offers numerous examples of the way the flashback retraumatizes by effectively layering newer terrors within the experience of the original event. A useful example comes in the passage from *In the Lake of the Woods* we examined earlier, in the disturbing way John Wade's later experience—“Kathy's flat eyes reproaching him for the many things he'd done and not done”—becomes inextricably interwoven with his understanding of the event itself. While such a detail may unsettle readers expecting an unmediated version of the event, the elusive “true story,” it also forces us to recognize the way the traumatic moment is repeatedly experienced by Wade. When this story intrudes into the novel, in other words, Wade is not so much recalling the event as he is reliving the event. (Those familiar with Toni Morrison's *Beloved* might recognize here what she terms rememory, Morrison's supernaturally spatial metaphor for the lingering truth of the traumatic event, such that anyone—not just the survivor—

might unaccountably run into the experience at any time.) Examples like Wade's remind us that, for survivors, the present and future might be just as terrifying as the past.

### *Recovering Narrative*

Given the horrifying fact that trauma ceaselessly repeats, many survivors become understandably desperate for some way to stop the experience. (Not all, however: some fear that healing will change them or be somehow disloyal to those who did not survive. As Caruth notes, "To cure oneself—whether by drugs or the telling of one's story or both—seems to many survivors to imply the giving up of an important reality, or the dilution of a special truth into the reassuring terms of therapy" ("Preface" vii).) The difficulty of overcoming trauma seems precisely linked to the lack of narrative, without which fully experiencing, and thus moving beyond, trauma becomes impossible: "Not having been fully integrated as it occurred, the event cannot become, as Janet says, a 'narrative memory' that is integrated into a completed story of the past" (Caruth, "Part II" 153).

Transforming incomplete memories of trauma into narratives requires overcoming daunting obstacles related to the very nature of such memories. Like Freud, Caruth finds, "modern analysts have remarked on the surprising *literality* and nonsymbolic nature of traumatic dreams and flashbacks, which resist cure to the extent that they remain, precisely, literal" ("Part I" 5). Just as difficult, memories of trauma seem to have no audience, as van der Kolk and van der Hart explain: "in contrast to narrative memory, which is a social act, traumatic memory is inflexible and invariable. Traumatic memory has no social component; it is not addressed to

anybody, the patient does not respond to anybody; it is a solitary activity” (163). Along with the incompleteness of the traumatic memory itself, distorted by hyperarousal and disassociation, such obstacles to narrative too often become barriers.

And yet such transformation, thankfully, is possible under the right conditions. While it seems like any attempt to retell the traumatic event might work, simplistic approaches (like mere debriefings) risk triggering the sensations and emotions associated with the event itself; like the flashback or hallucination, misguided attempts can retraumatize. But in carefully controlled settings, such transformation can work, as therapists have long known. As Herman explains, starting with Janet, “psychiatrists who treated men in combat [...] found that traumatic memories could be transformed from sensations and images into words, and that when this happened, the memories seemed to lose their toxicity” (9). “The purpose of therapy,” Herman elaborates, is “not simply catharsis, but rather integration of memory. [...] In this slow and laborious process, a fragmented set of wordless, static images is gradually transformed into a narrative with motion, feeling, and meaning. The therapist’s role is [...] to bear witness as the patient discovers his or her own truth.” (9-10)

Perhaps, for Tim O’Brien, writing offers such a controlled space for confronting trauma. Certainly his fiction bulges with individuals—often seeming stand-ins for himself—telling stories as a way at least to cope and at best to heal. Noting the way “O’Brien’s fictional narratives are organized as retrospective meditations or reflections by deeply traumatized figures,” Heberle argues, “these traumatic fictions [often] function as therapy for their subjects [...]; in short, they replicate trauma therapy, which relies on an attempt to communicate to others an ineffable wounding so that the posttraumatic survivor’s life can be repaired and resumed” (xxi). Whether O’Brien is addressing himself, his peers, or us in such narratives can be difficult

to determine, but again and again he constructs story as the only healthy response to trauma. The end of O'Brien's story "The Man I Killed" perhaps best encapsulates this opposition:

Kiowa covered the body with a poncho. [...]

Then he said, "Man, I'm sorry."

Then later he said, "Why not talk about it?"

Then he said, "Come on, man, talk."

He was a slim, dead, almost dainty young man of about twenty. He lay with one leg bent beneath him, his jaw in his throat, his face neither expressive nor inexpressive.

One eye was shut. The other was a star-shaped hole.

"Talk," Kiowa said.

(130)

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## APPENDIX I

### DSM-IV PTSD ENTRY

#### **309.81 Posttraumatic Stress Disorder**

##### *Diagnostic Features*

The essential features of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (Criterion F).

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened violence or assault. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. The disorder may be especially severe or long lasting when the stressor is of human design (e.g. torture, rape). The likelihood of developing the disorder may increase as the intensity of and physical proximity to the stressor increase.

The traumatic events can be reexperienced in various ways. Commonly the person has recurrent and intrusive recollections of the event (Criterion B1) or recurrent distressing dreams during which the event is replayed. (Criterion B2). In rare instances, the person experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relived and the person behaves as though experiencing the event at the moment (Criterion B3). Intense psychological distress (Criterion B4) or physiological

reactivity (Criterion B5) often occurs when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g., anniversaries of the traumatic event; cold, snowy weather or uniformed guards for survivors of death camps in cold climates; hot, humid weather for combat veterans of the South Pacific; entering any elevator for a woman who was raped in an elevator).

Stimuli associated with the trauma are persistently avoided. The person commonly makes deliberate efforts to avoid thoughts, feelings, or conversations about the traumatic event (Criterion C1) and to avoid activities, situations, or people who arouse recollections of it (Criterion C2). This avoidance of reminders may include amnesia for an important aspect of the traumatic event (Criterion C3). Diminished responsiveness to the external world, referred to as “psychic numbing” or “emotional anesthesia” usually begins soon after the traumatic event. The individual may complain of having markedly diminished interest in previously enjoyed activities (Criterion C4), of feeling detached or estranged from other people (Criterion C5), or of having a markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness, and sexuality) (Criterion C6). The individual may have a sense of a foreshortened future (e.g., not expecting to have a career, marriage, children, or a normal life span) (Criterion C7).

The individual has persistent symptoms of anxiety or increased arousal that were not present before the trauma. These symptoms may include difficulty falling or staying asleep that may be due to recurrent nightmares during which the traumatic event is relived (Criterion D1), hypervigilance (Criterion D4), and exaggerated startle response or difficulty concentrating or completing tasks (Criterion D3).

### *Specifiers*

The following may be used to specify onset and duration of the symptoms of Posttraumatic Stress Disorder:

**Acute.** This specifier should be used when the duration of the symptoms is less than 3 months.

**Chronic.** This specifier should be used when the symptoms last three months or longer.

**With Delayed Onset.** This specifier indicates that at least 6 months have passed between the traumatic event and the onset of symptoms.

### *Associated Features and Disorders*

**Associated descriptive features and mental disorders.** Individuals with Posttraumatic Stress Disorder may describe painful guilt feelings about surviving when others did not survive or about the things they had to do to survive. Phobic avoidance of situations or activities that resemble or symbolize the original trauma may interfere with interpersonal relationships and lead to marital conflict, divorce, or loss of job. The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse), domestic battering, being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture): impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained

beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics.

There may be increased risk of Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Social Phobia, Specific Phobia, Major Depressive Disorder, Somatization Disorder, and Substance-Related Disorders. It is not known to what extent these disorders precede or follow the onset of Posttraumatic Stress Disorder.

**Associated laboratory findings.** Increased arousal may be measured through studies of autonomic functioning (e.g., heart rate, electromyography, sweat gland activity).

**Associated physical examination findings and general medical conditions.** General medical conditions may occur as a consequence of the trauma (e.g. head injury, burns).

### *Specific Culture and Age Features*

Individuals who have recently emigrated for areas of considerable social unrest and civil conflict may have elevated rates of Posttraumatic Stress Disorder. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political status. Specific assessments of traumatic experiences are needed for such individuals.

In younger children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Young children usually do not have the sense that they are reliving the past; rather, the reliving of the trauma may occur through repetitive play (e.g., a child who was involved in a serious automobile accident repeatedly reenacts car crashes with toy cars). Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents, teachers, and other observers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult. There may be “omen formation”—that is, belief in an ability to foresee future untoward events. Children may also exhibit various physical symptoms, such as stomachaches and headaches.

### *Prevalence*

Community-based studies reveal a lifetime prevalence for Posttraumatic Stress Disorder ranging from 1% to 14%, with the variability related to methods of ascertainment and the population sampled. Studies of at-risk individuals (e.g., combat veterans, victims of volcanic eruptions or criminal violence) have yielded prevalence rates ranging from 3% to 58%.

### *Course*

Posttraumatic Stress Disorder can occur at any age, including childhood. Symptoms usually begin within the first three months after the trauma, although there may be a delay of months, or even years, before symptoms appear. Frequently the disturbance initially meets criteria for Acute Stress Disorder (see p. 429) in the immediate aftermath of the trauma. The symptoms of the disorder and the relative predominance of reexperiencing, avoidance, and hyperarousal symptoms may vary over time. Duration of the symptoms varies, with complete recovery occurring within three months in approximately half of cases, with many others having persisting symptoms for longer than 12 months after the trauma.

The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing this disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development of Posttraumatic Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

### ***Differential Diagnosis***

In Posttraumatic Stress Disorder, the stressor must be of extreme (i.e., life-threatening) nature. In contrast, in **Adjustment Disorder**, the stressor can be of any severity. The diagnosis of Adjustment Disorder is appropriate both for situations in which the stressor does not meet the criteria for Posttraumatic Stress Disorder (or another specific mental disorder) and for situations in which the symptom pattern of Posttraumatic Stress Disorder occurs in response to a stressor that is not extreme (e.g., spouse leaving, being fired).

Not all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to Posttraumatic Stress Disorder. **Symptoms of avoidance, numbing, and increased arousal that are present before exposure to the stressor** do not meet criteria for the diagnosis of Posttraumatic Stress Disorder and require consideration of other diagnoses (e.g., a Mood Disorder or another Anxiety Disorder). Moreover, if the symptom response to pattern to the extreme stressor meets criteria for **another mental disorder** (e.g., Brief Psychotic Disorder, Conversion Disorder, Major Depressive Disorder), these diagnoses should be given instead of, or in addition to, Posttraumatic Stress Disorder.

**Acute Stress Disorder** is distinguished from Posttraumatic Stress Disorder because the symptom pattern in Acute Stress Disorder must occur within 4 weeks of the traumatic event and resolve within that 4-week period. If the symptoms persist for more than 1-month and meet criteria for Posttraumatic Stress Disorder, the diagnosis is changed from Acute Stress Disorder to Posttraumatic Stress Disorder.

In **Obsessive-Compulsive Disorder**, there are recurrent intrusive thoughts, but these are experienced as inappropriate and are not related to an experienced traumatic event. Flashbacks in Posttraumatic Stress Disorder must be distinguished from illusions, hallucinations, and other perceptual disturbances that may occur in **Schizophrenia, other Psychotic Disorders, Mood Disorder with Psychotic Features, a delirium, Substance-Induced Disorders, and Psychotic Disorders Due to a General Medical Condition**.

**Malingering** should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role.

### ***Diagnostic criteria for 309.81 Posttraumatic Stress Disorder***

A. The person has been exposed to a traumatic event in which both of the

following were present:

- (1) the person experienced witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others
- (2) the person's response involved intense fear, helplessness, or horror.  
**Note:** In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

- (1) recurrent and distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- (2) Recurrent distressing dreams of the event. **Note:** in children, there may be frightening dreams without recognizable content.
- (3) acting or feeling if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
- (4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three or more of the following:

- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
- (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
- (3) inability to recall an important aspect of the trauma
- (4) markedly diminished interest or participation in significant activities
- (5) feeling of detachment or estrangement from others
- (6) restricted range of affect. (e.g., unable to have loving feelings)
- (7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger

- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Specify if:*

**Acute:** if duration of symptoms is less than three months.

**Chronic:** if duration of symptoms is three months or more

*Specify if:*

**With Delayed Onset:** if onset of symptoms is at least 6 months after the Stressor

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