Work, War, and Rape:
Is a Comprehensive Trauma Diagnosis Possible in a Free-Market System?

by
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I certify that I have read this paper and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a product for the degree of Master of Arts in Counseling Psychology.

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Abstract

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Trauma is a social justice issue by which many of its sufferers historically have remained mystified in a web of misdiagnosis, the most notorious being *hysteria*. Today, individuals suffering from attachment disorders, anxiety, and depression and the victims of violence, addiction, emotional abuse, and physical abuse often have overlapping symptoms roughly mirroring trauma response symptomatology. These individuals comprise the bulk of those seeking relief from the healing professions, yet the *DSM-V* has but one diagnosis for trauma: posttraumatic stress syndrome. Recent advances in neuroscience have converged with observations from the field of psychology to confirm the need for a more complex trauma diagnosis. It is time to bring trauma out of the lab and into the streets. Using artistic-creative methodologies, this production thesis channels the expanding body of trauma research into comic strips designed to stimulate social dialogue about the existence of trauma response symptoms in our communities.

Dedication

To all the people whose attentions have thrilled me. Being seen by you and sharing your warmth is the only life I've ever lived: S.G., U.S., A.S., and so many more.

Thank You

I have struggled with these two ends of rope
trying to tie them together to be at peace

One comes from a dark place, and one from some light
and together they don't quite reach

I pulled on one and the other got smaller
I tugged on the two together and nearly broke my back

One became frayed,
and the other stiffened in the sun and rain
and I became used to their lying around.

Then in you walked and tied them together,
almost as I slept.

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Chapter I
Introduction

Area of Interest

This production thesis combines two primary areas of interest: social justice and comic books. The two are a natural fit because comics exist in a gray area between language and image and have a rich history as a tool of choice for social change and social justice exists in the gray area between what a culture can understand about itself and what it can change.

When I became a parent I was rocketed into a part of society that had been hidden from my conscious awareness. I realized parenting was something I had not actually thought about beyond the pregnancy. So I took a parenting class called "non-violent parenting" taught by educator Ruth Beaglehole (2004) at the Echo Parenting and Education Center in Los Angeles, California, the basic tenet of which was simple: treat all children with empathy and respect for their autonomy. I was fascinated and engrossed, and also radicalized in a sense—radicalized because the child in me had been reawakened in the process of parenting and I felt my consciousness shifting and rebelling, but in ways I could not understand. As a parent I felt the presence of a much larger social system engulfing me, and at the same time I saw how the same system had swallowed me as a child. I was a spirit in the belly of the whale of American parenting culture. Becoming a parent awakened hidden dimensions in my soul and somehow this parenting class allowed me to contextualize the experience; in a flash I saw my own upbringing

differently, as well the culture I was parented in. My eyes were opened to the language and customs of cultural transmission vis-à-vis parenting.

I saw clearly how my adult self had been built on top of my younger, emotionally disempowered self. I began to see parenting in the context of social justice. Through this new pair of glasses, I saw many children as disempowered in their struggle to have their emotional needs met—children like me. I hypothesize that there are many parents like me: wounded adults with unmet childhood needs being activated by disempowered children, with their only skills to defend against these feelings being the very ones that disempowered them as children. I saw these finely honed social instruments practiced at the playground, in the park, and in the classroom.

With this new frame of reference, I was open to like-minded citizens, educators, and scholars who see many of our current American parenting and educational paradigms as possibly contributing to *developmental trauma* (Anda et al., 2006, p. 174). As I became interested in the field of trauma as it relates to psychology, I felt that the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) (American Psychiatric Association [APA], 2013) was impoverished in its concept of trauma. There simply had to be more to the trauma narrative than what the clinical world had on hand in the *DSM*.

At the same time, I was a therapy trainee at a homeless shelter in downtown Los Angeles and seeing many individuals with trauma symptoms who might not meet the criteria-A stressor requirement for a Posttraumatic Stress Disorder diagnosis (APA, 2013, p. 274); that is, they had trauma symptoms with no clear single or multiple stressor events such as combat or natural disaster. Seeing and experiencing such an array of human suffering, the questions came fast and furious in my mind: drug addiction, homelessness,

poverty, domestic violence, personality disorders, depression, anxiety, alcoholism—was there a connection? I felt sameness, an affect regulation that does not exist, something primal, something elemental, something deeply planted that cannot hold—and then I heard the word *parent* again. Parenting became central in my questioning. Parents have the ability to build optimal systems of affect regulation in their children (Perry, 2004, p. 2); or more to the point, parents are the entities that have the obligation and the motivation to do so. Unfortunately, however, there continue to be millions of adults suffering from personality disorders, depression, anxiety, and addiction, and much of the focus is on the adult patient walking into the mental health center and so little on the epicenter of personality development, which is childhood (Fisher, 2003, p. 3). Developmental trauma in children and adolescents contributes hugely to social ills such as poverty, addiction, poor performance in school, domestic violence, and crime (McDonald, Brontrager, & Rostad, 2014, p. 188), and yet we continue to be complicit in its perpetuation through our parenting paradigms, educational systems, and other institutional factors and interpersonal matrices.

As I looked around my community in Southern California, I felt as though much of the parenting was done for economy, a kind of management system that was in place to guarantee maximum number of working hours available for parents to exchange for as much money as possible. I observed that when children forced a parent away from this economic exchange ("bad" behavior, sick days, need for attention), parents reacted in predictable ways: the child was unreasonable, or bad, or misbehaving, or difficult, or manipulative, or at the very least a stressful inconvenience. In addition, I noticed that those other actors (i.e., bystanders, relatives, friends) in the parental system supported

this view and also saw the child as unreasonable and manipulative and somehow "bad" by such common sentiments as *she's got him wrapped around her finger*, or *she's a spoiled brat*, or *who's in charge?* In all this is being lost the voice of the child, because to attend to the child's need to be seen and heard and empathized with is a threat to personal economy. In what ways is developmental trauma related to the way Americans conceptualize their economy?

I certainly have understood economic pressures and am able to identify in my own life that the tension between my need to work and my heart's desire to be with my child is a main thread of friction and stress in my current existence. Naturally, I wondered if a world where parents placed children's emotional well-being above economic considerations was possible, or would it run counter to our free market system, and if this were the case, wouldn't there be a forceful unconscious resistance to change? Put another way, my question is: Would a comprehensive trauma diagnosis, accounting for all traumatic wounding that impaired normative functioning, run counter to America's free-market system?

There are a number of emergent terms used to give voice to symptoms of traumatic experience that may exist outside the *DSM* diagnosis of PTSD—*complex trauma* (Courtois, 2004), *developmental trauma disorder* (DTD) (van der Kolk, 2005), and simply *non-PTSD criterion A childhood trauma*. I am interested in focusing on children and adolescents because this population is at a crossroads of brain development and cultural inculcation. This thesis looks at the traumatic aspects of early childhood experience that remain hidden in American cultural paradigms such as parenting,

education, family structure, capitalism, and gender and hopes to stimulate a conversation about how to better support children's developing minds and souls.

Trauma as a concept is complex because it has many potential sources that snowball into a matrix of interconnected developmental deficits that cause "enduring brain dysfunction that, in turn, affect health and quality of life throughout the lifespan" (Anda et al., 2006 p. 175). By the time symptoms surface and begin to affect normative functioning, it is often difficult or impossible to understand that long before the current stressors, developmental trauma might make certain individuals more susceptible to personality disorders, psychotic disorders, or addictions (p. 175). Physician Gabor Maté (2010) illustrated this well in his book, *In the Realm of the Hungry Ghosts*, in which he pointed out that many veterans returning from war likely have preexisting developmental trauma that made them more susceptible to addiction:

> The Vietnam veterans study pointed to a similar conclusion: under certain conditions of stress many people can be made susceptible to addiction. . . . About half of all American soldiers in Vietnam who began to use heroin developed addiction to the drug. Once the stress of military service in the brutal and dangerous war ended, so, in the vast majority of cases, did the addiction. The ones who persisted in heroin addiction back home were, for the most part, those with histories of unstable childhoods and previous drug use problems. (p. 146)

This is further complicated by the fact that many of the cultural patterns fueling complex trauma are by their very nature hidden from the conscious awareness of the perpetrators, enablers, and victims. To acknowledge the trauma challenges many tightly held practices and belief systems, which makes open dialogue very explosive. I call this the "smoking is good for you" syndrome, because the solution to lung cancer caused by smoking is not in successfully treating the cancer pathogens but from breaking the grip of the paradigm that sees smoking as benign. Non-PTSD trauma faces the "smoking is good

for you" syndrome because many of its contributing factors are cherished cultural norms, such as spanking a child. Because of these layers of complexity, a different approach must be taken to open the dialogue. In the case of this thesis, I attempt this challenging dialogue with comic strips.

Guiding Purpose

The purpose of this production thesis is to communicate concepts of developmental trauma to as many people as possible. The use of comic books is an attempt to remove the barriers inherent to academia, medicine, and language in general. Although scholarly standards compel me to present this formal written component to be acknowledged by the establishment (the American Psychological Association), the true measure of success will be if the comics produced transmit my message when placed in the hands of any reader. I have compassion for those suffering as a result of trauma and my hope is that the comics will give refuge to those who did not know that they had been seeking shelter from a storm they could not even name. In awareness is healing, and my wish is that as adults access their own unmet childhood needs, they will be better suited to meet the needs of today's children.

Rationale

This topic merits further study because in American society people continue to suffer from addiction, ADHD, anxiety, depression, and personality disorders and no professional can truly say why. The suffering drains educational systems, medical systems, and legal systems at a tremendous cost to society. Neuroscientists are discovering that perhaps many of these disorders have their roots in childhood brain development (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012, p. 187), in

which case non-PTSD trauma is an issue of child welfare. Protecting the welfare of children is an issue of social justice, which is in and of itself a reason for further study.

The comic strips produced are psychoeducational in nature and easily understood by any reader. The language is simple and the concepts pared down for readers of all ages. Each comic is stand-alone and designed to be given away and passed around. This is an attempt to get the information about trauma out of academia and into the hands of teachers, parents, children, addicts, and those suffering from mental illness.

Methodology

This thesis is a production thesis, the production being comic strips that illuminate specific aspects of the thesis topic, which uses a mixed-method research approach. Naturally the artistic-creative method is present, as are hermeneutics due to a reliance on the multitude of research texts as well as personal experience, which form the bedrock of my understanding of the topic; as psychological researchers Joseph Coppin and Elizabeth Nelson (2005) stated,

> This reunion of hermeneutics and psychological inquiry is quite fortunate. It points the way toward inquiry that will not be limited by measures of observable behaviors or linear causal laws. It points toward research that can illuminate the lived experience of psyche in a fuller sense. (p. 37)

An artistic-creative methodology is inherently heuristic, yet there is a third element that must be present due to the very nature of comics, and that is participatory epistemology. “Nature’s reality is not merely phenomenal, nor is it independent and objective; rather it is something that comes into being through the very act of human cognition” (Tarnas, 1991, p. 424). In this way, comic images aim to foster a dialogue of emotion rather than intellect, phenomena tailored to the unconscious. Jung (1961/1963) himself relied on images to bypass language and speak to the raw emotions of the psyche

when he was in the depth of his own crisis: “I learned how helpful it can be, from the therapeutic point of view, to find the particular images which lie behind emotions” (p. 177). Psyche exists outside the realm of any one culture. Participatory epistemology is particularly relevant because it mirrors the comic experience. The experience of looking at a comic is in essence that the image has multiple purpose and meaning beyond the text that accompanies it. It carries the meaning of what it represents, and it carries the projections and associations of the viewer. In this way much of the meaning is created through the interaction of the image with the viewer’s psyche, an experience different from reading language; the observer is participating in the meaning making with her own psychological material, creating something beyond what I could convey.

I am working with an illustrator (J. A.), who is himself a victim of childhood physical and emotional abuse at the hand of a parent. We work like this: I write a script and I send it to J. with no instruction. He reads the script and works first with whatever passages stimulate his drawing imagination. He then sends me the drawings and we dialogue about them. I also send J. scholarly articles on the topic of non-PTSD developmental trauma, paying particular attention to what they stimulate in J.’s consciousness. In this way I receive feedback that I fold back into a participatory epistemological framework, noting the way that our interaction alters the way I view the thesis material. I gain valuable insight from J.’s subjective interaction with the information I feed him, and in turn a third element is born between us.

Ethical Considerations

This thesis has two parts, an analytical component and an artistic component, and in this marriage of opposites there is an ethical concern that the comics will be taken

literally. A comic viewed as a scientific document would miss the mark altogether. Comics are stereotypes, necessary shorthands that draw from the matrix of our shared cultural heritage. The comic strips synthesize a number of concepts introduced to me via lectures, texts, conversations, and personal experiences. These concepts are generalized and purposefully simplified, and naturally some of my own opinions, agendas, and aesthetics will skew the information. From an ethical standpoint, it is important to me that I get the science right so to speak, yet these are not scholarly documents, they are comic books. I will not use citations in the comic strips unless of course I use someone else's words. On the comic's back page, I include the books and materials that cover the concepts introduced in the comic strips. I hope to remain true to the facts, at least as far as the scientific community understands them at this point in the scientific timeline.

Further is the issue of my own transference. I am a person and not a piece of data, and as such I have to factor in my personal equation. There are no doubt subjective opinions and agendas that I am wedded to. There is the very real possibility that in my search for solutions to my own questions I have built a ladder of which the rungs consist solely of information moving me to the answers I hope to find. I am reminded of the picture painted by psychiatrist and Jungian analyst Anthony Stevens (2013) of Dr. Sigmund Freud in *The Talking Cure.* Addressing this very issue, Stevens said of Freud,

> He stands exposed as an unscrupulous clinician, capable of bullying his patients into providing the data he needed to "prove" his etiological fantasies, and of generating an extensive literature which used and re-used a tiny number of "classic" cases with such consummate cunning as to create the illusion of an enormous clinical database. (p. 62)

No doubt Freud was convinced beyond a doubt that he was correct in the theoretical assumptions he held so dearly. Yet it was his inability to question his own

motives that ultimately brought such a scathing rebuff to his practices of proving these theories. Because of my own convictions and strong attraction to the subject matter, I must allow for a certain degree of blindness to opposing data and viewpoints.

Overview of Thesis

Chapter II reviews the literature as it relates to the evolving nature of trauma as conceptualized throughout modern time. A history of trauma research (Figley, 1985) provides the evolution for the only APA-sanctioned trauma diagnosis, PTSD, which is followed by feminist trauma research centered around systematic violence against women (Herman, 1997), to developmental trauma in children (Perry, 2004; Siegel, 2010), and finally to complex trauma (D'Andrea et al., 2012).

In Chapter III, this production thesis discusses the findings and then explores the artistic-creative aspect of the topic. Comic scripts that synthesize portions of the literature review are passed to an artist who then translates them into image. The phenomenological aspects of our collaboration are discussed as they relate to the topic.

Chapter IV synthesizes the artistic-creative aspect of the work with the literature review and explores the usefulness of the comic books to the field of psychology as well as draws any relevant conclusions from Chapters II and III.

Chapter II
Literature Review

Introduction: Definition and Etiology of Trauma

Merriam-Webster defined *trauma* as "a very difficult or unpleasant experience that causes someone to have mental or emotional problems usually for a very long time" ("Trauma," 2014, def. 1). Would a comprehensive trauma diagnosis, accounting for all traumatic wounding that impaired normative functioning, run counter to America's free-market system? As an exploration of this question, this chapter reviews a diverse spread of literature touching on warfare, workplace injuries, violence against women and children, parenting, and the neurobiological response by the human brain to these stressors.

Throughout the millennia that humans have endured traumatic events, the etiology of the word *trauma* has shifted to match the times. With the changing conceptual frameworks have come different names ascribed to the symptomatology: "hysteria" (Herman, 1997, p. 9) and "war neurosis" (p. 9), to name just a couple. Currently, trauma response symptoms that impair normative functioning are known by the professional and layperson alike as *posttraumatic stress disorder*, or PTSD.

Those licensed by the American Psychiatric Association to treat psychological illnesses use a manual called the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) (APA, 2013) as a reference guide for accurate diagnosis. It is of great significance to note that although the healing of broken bones was no doubt understood

well before written language, there was no trauma diagnosis available prior to PTSD's inclusion in the *DSM-III* in 1980 (Figley, 1985). In *Trauma and Its Wake* (Figley, 1985), neurologist Michael Trimble (1985) commented on the appearance of an official trauma diagnosis in the *DSM*: "Although the DSM-III has neatly sanctioned post-traumatic stress disorder in its umbrella of diagnoses, this relatively common human problem has been known for many hundreds of years, although under different names" (p. 5). The names have changed but the human organism has not, and likely the same trauma response triggered at our earliest stage of biological development is similar to the trauma response in Homo sapiens today. "Attacks by saber tooth tigers or twenty-first century terrorists have probably produced similar psychological sequelae in the survivors of such violence" (Friedman, 2014, para. 1).

One of the earliest and often cited references to trauma symptomatology is taken from Shakespeare's (1980) *Henry the IV*, in which Lady Percy recounts the dreams of Hotspur, the eponymous Henry the IV, a war veteran:

> Why dost though bend thine eyes upon the earth,
> And start so often when thou sit'ist alone?
> Why hast thou lost the fresh blood in thy cheeks,
> And given my treasures and my rights of thee
> To thick-eyed musing and cursed melancholy? (p. 805)

Unlike an open bleeding wound, Hotspur suffers the internal bleeding of the soul. As is often the case with trauma sufferers, his wife, Lady Percy, cannot fully comprehend his internal state. His injuries are beyond her sight, and she is vexed because she cannot know that perhaps what she is witnessing are the symptoms of his traumatic wounding. In this way trauma has often existed just beyond the pale: "The concept that following an accident a person may develop symptoms, mainly subjective and usually not associated

with any clearly defined somatic pathology, is an old one" (Trimble, 1985, p. 6). It has appeared as madness, fainting spells, the vapors, hysteria, post-traumatic neurosis, combat neurosis, shell shock, and for our modern age, posttraumatic stress disorder.

The current *DSM-V* description of PTSD is: "The essential feature of posttraumatic stress disorder (PTSD) is the development of characteristic symptoms following exposure to one or more traumatic events. . . . The clinical presentation of PTSD varies" (APA, 2013 p. 274). This is problematic because beyond the collectively agreed-upon tragedies such as death of a loved one, natural disasters, or combat, what constitutes a traumatic event? Further, is any given event stable as social contexts change? Trauma is a concept with its foundation built in a subjective realm, usually retroactively: "The diagnosis for PTSD is unique because it requires a causal link between an external factor and a psychopathology. The external factor has historically been considered a discrete event, and what qualifies as traumatic has been problematic" (McDonald et al., 2014, p. 185). An x-ray determines if a bone is broken. There is no x-ray for PTSD. The determination of a "traumatic event" is subjective, based on cultural beliefs and other ever-changing factors.

PTSD: Warfare, Capitalism, and Violence

Another possible reason for this may be that the history of the PTSD diagnosis is tied to warfare, capitalism, and violence against women and children.

> Two important human activities . . . led to an explosion of literature and interest in the concept of post traumatic disorders. First, there were the wartime experiences, mainly the American Civil War, and later the First World War. Second, there was the development of workmen's compensation acts in many countries which, for the first time, provided some financial compensation for those injured during the course of work. (Trimble, 1985, p. 7)

Business (capitalism) and the business of war are essential to modern organized societies.

With the industrial revolution sprung an entire class of workers, many performing hazardous jobs resulting in loss of life and limb. For an employer to compensate a worker is a very old concept, perhaps as old as labor for hire. Compensation for loss of limb or body functionality was first documented as early as 1750 BCE:

> Ancient Greek, Roman, Arab, and Chinese law provided sets of compensation schedules, with precise payments for the loss of a body part. For example, under ancient Arab law, loss of a joint of the thumb was worth one-half the value of a finger. The loss of a penis was compensated by the amount of length lost, and the value of an ear was based on its surface area. (Guyton, 1999, p. 106)

Loss of a body part could not be refuted, and the *disability* to perform specific tasks is measured by one's physical ability. Yet often with traumatic wounding there is no clear reason as to why an individual is unable to perform a task or set of tasks. With no clear physical impairment, there is no clear path to determining who is wounded and who is not:

> All the early compensation schemes consisted of "schedules" such as this; specific injuries determined specific rewards. The concept of an "impairment" (the loss of function of a body part) separate from a "disability" (the loss of the ability to perform specific tasks or jobs) had not yet arisen. (Guyton, 1999, p. 106)

It seems fitting that it was the railway system, the paragon of the industrial age, that gave rise to the earliest literature on trauma first conceptualized as a lingering impairment of the psyche. At the time it was called "compensation neurosis" because it arose from those traumatized by the frequent railway accidents and seeking compensation from the railroad companies (Trimble, 1985, p. 8).

> As the traffic began to grow, so did the number of accidents, and railway companies, clearly identifiable industrial megaliths, were seen as an easy target for compensation. Physicians, or course, were called upon to examine potential litigants, and an influential book appeared in 1882 entitled *On Concussion of the Spine: Nervous Shock and Other Obscure Injuries of the Nervous System in their Clinical and Medico-legal Aspects* by John Eric Erichsen. (p. 8)

This naturally opened the door for litigation by both those who were justifiably injured by the railroad companies and those who sought to perpetrate fraud for monetary gain. Competing studies fueled by competing interests laid out convincing arguments that the etiology of the litigant's complaints were either malingering or of a psychological nature: "Indeed, this subject is the bitter kernel found at the center of the whole issue of post-traumatic disorders in general" (p. 10). These bitter fights crowd the courtrooms in the present era with both industry and individuals making strong cases supporting their particular views. Yet the burden remains on the worker to convince juries and judges that their subjective experience of traumatic wounding is legitimate.

As for the business of warfare, there arose during World War I a caste of psychologically traumatized combat veterans who puzzled the physicians of the day because their bodies were sound, but their minds were not. In 1919, noted physician Frederick Mott "coined the term 'shell shock' and suggested that the condition was due to a physical lesion of the brain, brought about by some manner of carbon monoxide or changes in atmospheric pressure" (Trimble, 1985, p. 8). Yet it was Mott himself who attempted to abort the label *shell shock* shortly after coining it, saying,

> I have, however, from a far greater experience come to recognize the fact that the psychogenic factor is the predominant causal agent in "War Psychoneuroses," and that a large portion of cases which were regarded as shell shock did not owe their condition to any pathological changes which would have been recognizable in the central nervous system by any known methods of microscopic investigation. (As cited in Trimble, 1985, p. 5)

Mott's writing was prophetic in that what is currently known about the organic etiology of trauma has been discovered thanks largely to modern imaging systems more comprehensive than the microscope (more on that below). However, before these advances, it took the combined research from the civil war, the first and second world

wars, and the Vietnam War to produce a trauma diagnosis, and still its legitimization is not without a sense of reluctance. The U.S. Department of Veterans Affairs noted,

> PTSD is unique among psychiatric diagnoses because of the great importance placed upon the etiological agent, the traumatic stressor. In fact, one cannot make a PTSD diagnosis unless the patient has actually met the "stressor criterion," which means that he or she has been exposed to an event that is considered traumatic. (Friedman, 2014, para. 4)

This means that if a patient is presenting symptoms of trauma, a PTSD diagnosis cannot be applied unless said patient meets one of the stressor criterion. Put another way, the patient is suffering only in theory until a professional legitimizes his or her suffering. In many cases, there may exist a disparity between the actual experience of the patient and society's construction of reality.

This is the same high hurdle as noted in the labor force. It is not enough that a worker is injured by her work, she has to be injured in a way that is agreed upon by the society. Writing on the present-day worker's compensation structure in the United States, physician Gregory Guyton (1999) stated in the *Iowa Orthopaedic Journal*,

> A distinction is made between "impairment," a medical definition of the degree of loss of anatomy or function of a body part or system, and "disability," a legal definition of the degree to which an employee's impairment limits his ability to perform work. Some states continue to have "schedules" for certain injuries, however, which directly correlate the loss of certain anatomical parts to amounts of compensation. For instance, the loss of a thumb in South Dakota entitles the worker to fifty weeks of compensation regardless of his disability. (p. 109)

This is reminiscent of the compensation schedule set at the dawn of organized societies; the idea that a physical reality must be present to accept the existence of trauma has in essence gone unchanged since the time of Babylon.

In the ensuing years, many have seen the refining of the PTSD diagnosis in subsequent editions of the DSM as a victory, yet it could also be viewed as a move away

from embracing the client's somatic experience and a move toward the collective's acceptance of what constitutes a traumatic event. Note the following from The U.S. Department of Veterans Affairs website:

> From an historical perspective, the significant change ushered in by the PTSD concept was the stipulation that the etiological agent was outside the individual (i.e., a traumatic event) rather than an inherent individual weakness (i.e., a traumatic neurosis). The key to understanding the scientific basis and clinical expression of PTSD is the concept of "trauma." (Friedman, 2014, para. 2)

Now it is up to the professionals to decide whose concept of a "trauma" is legitimate and whose trauma is just "individual weakness." As with the litigants versus the railroad example, there is an inherent conflict of interest: Who should decide what is trauma, the railroad company's physician or the patient?

Unfortunately, cultural beliefs are notoriously difficult to observe because they are hidden in the culture just as a person's unconscious hides belief systems within the human organism's psyche. In his book, *The Silent Language*, anthropologist Edward T. Hall (1973) paraphrased Harry Stack Sullivan: "The unconscious is not hidden to anyone except the individual who hides from himself those parts which persons significant to him in his early life have disapproved" (p. 61). Likewise many cultural beliefs are wired beneath the surface and are hidden from society even as its members imagine that they are acting of their own free will. In this way, very simple implicit cultural assumptions in America such as *hard work is rewarded* take on much more explicit meaning for the individual.

In the introduction to her paper, "Authenticity Anyone?," psychologist Felicitas Kraemer (2010) summed up philosopher Charles Taylor's view as he described the same ideal explicitly:

> Each person should strive for self-perfection, should make the best out of life, and should actualize hidden potential. In a capitalist or neo-liberalist society, those who fail to meet this standard of ongoing self-actualization and self-optimization are regarded as losers who lead unhappy and unfulfilled lives. (As cited in Kraemer, 2010, p. 1)

Or as author and educator Alfie Kohn (2005) wrote,

> In our society, we are taught that good things must always be earned, never given away. Indeed, many people become infuriated at the possibility that this precept has been violated. Notice, for example, the hostility many people feel toward welfare and those who rely on it. (p. 17)

If one takes this as a truth of the American belief system, then it is not a stretch to understand why patients with no physical disabilities and no socially sanctioned traumatic experience would find themselves shunned, denied, and accused and why as a collective there has been such a reluctance to accept a comprehensive trauma diagnosis.

A Feminist Systems Approach to Trauma

Stepping outside of this paradigm took a systems approach, which was embodied by feminist thinkers such as psychiatrist Judith Herman (1997). These thinkers contended a great bulk of traumatic wounding was occurring in the homes of average people in the form of violence toward women and children—violence such as rape, neglect, physical abuse, fiscal abuse, emotional abuse, and incest. Herman wrote,

> In the 1970s, the speakouts of the women's liberation movement brought to public awareness the widespread crimes of violence against women. Victims who had been silenced began to reveal their secrets. As a psychiatric resident, I heard numerous stories of sexual and domestic violence from my patients. (p. 2)

These thinkers joined the voices of others who felt that as far as the *DSM* definition of trauma went,

> the criteria for PTSD had been derived directly from the study of adult male combatants exposed to war trauma. As a result the reactions of those involved in combat were likely significantly different than those of immature individuals

> whose exposure to traumatic stress was ongoing and related to family life. (Courtois, 2004, p. 413)

Herman (1997) became aware of what in systems theory would be called a *taciturn system* (Keeney, 1983) of socially sanctioned violence against this population perpetrated yet denied by the dominant culture: “All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil” (Herman, 1997, p. 7). These socially constructed desires to separate ourselves from trauma are hidden deep within our social system. Describing the mechanism of these systems, psychologist Bradford Keeney (1983) wrote, “Taciturn systems allow an observer to act as though he is distinct from the system of interest. . . . For the most part we overlook any ongoing interaction between operator and machine” (p. 75).

Herman’s (1997) epiphany came when she recognized that the concept of rape was being defined and validated by a male-dominated society and not by those being raped: “In practice the standard for what constitutes a rape is not at the level of women’s experience of violation but just above the level of coercion acceptable to men” (p. 72). In the very simplest of ways, this illustrates the nature of Keeney’s (1983) insight by highlighting that the lawmakers who contributed to the statutes defining rape thusly are not themselves necessarily sex offenders but contribute to the denial of rape through their actions on behalf of the culture. In being just so far removed are able to “overlook any ongoing interaction between operator and machine” (p. 75).

For the purpose of this thesis, Herman’s (1997) epiphany is important not for the acts of rape themselves but becasue these crimes pointed toward the hidden nature of cultural bias as they effect the diagnosis of trauma.

> The systematic study of psychological trauma therefore depends on the support of a political movement. . . . The study of war trauma becomes legitimate only in a context that challenges the sacrifice of young men in war. The study of trauma in sexual and domestic life becomes legitimate only in a context that challenges the subordination of women and children. (p. 9)

That these acts of violence are taking place did not make them more relevant than the violence of war and workplace and nature, but they were, in the view of many feminist thinkers, *sanctioned* forms of violence in the same way war was a sanctioned form of violence and therefore they remained essentially protected from being exposed for what they were. Herman (1997) wrote,

> Combat and rape, the public and private forms of organized social violence, are primarily experiences of adolescence and early adult life. . . . The period of greatest psychological vulnerability is also in reality the period of greatest traumatic exposure, for both young men and young women. Rape and combat might thus be considered complementary social rites of initiation into the coercive violence at the foundation of adult society. (p. 61)

If rape violence is viewed as socially sanctioned, it follows that it would be even more difficult for a sufferer of PTSD to meet the diagnostic criteria if the complaint one had were in fact not actually viewed as a legitimate stressor by the dominant culture, as so eloquently stated in Herman's book *Trauma and Recovery*:

> Conventional social attitudes not only fail to recognize most rapes as violations but also construe them as consensual sexual relations for which the victim is responsible. Thus women discover an appalling disjunction between their actual experience and the social construction of reality. (p. 67)

It was not that these traumatized patients were not meeting the criteria of a stressor, but that the dominant culture purposefully omitted the relevant stressors to further the dominant paradigm of sanctioned violence. "In spite of a vast literature documenting the phenomena of psychological trauma, debate still centers on the basic question of whether these phenomena are credible or real" (p. 8).

A similar seismic shift is taking place in the way parenting is being conceptualized. Many of our current parenting techniques might be contributing to trauma. Understandably, there is great resistance to this notion in that it exposes the cracks in another taciturn system within our society the acknowledgement of which would mean our participation in the traumatizing of children; as Herman (1997) noted above, perpetrators prefer silence (p. 7). Physical abuse and severe neglect can result in PTSD-like symptoms in a child. But perhaps the socially sanctioned violence against children is hiding in plain sight: forced isolation *e.g. time-outs*, spanking, shame, control, coercion, bullying, threats, and verbal abuse can create trauma response symptoms in children. As noted by one study,

> The role of multiple stressors not included in PTSD Criterion A, such as experiencing multiple moves, chronic sibling discord, witnessing frequent nonphysical parental discord, and bullying, is just beginning to be recognized in the literature and is thought to result at times in complex trauma reactions. (McDonald et al., 2014, p. 189)

Another study concluded,

> Consequently, understanding of complex PTSD has been influenced by developmental research, which has demonstrated that childhood abuse as well as other childhood adversities (neglect, emotional abuse, absent or psychiatrically disturbed parents) result in the impairment in developmental processes related to the growth of emotion regulation and associated skills in effective interpersonal behaviors. (Cloitre et al., 2009, p. 400)

Yet because these larger patterns of subtle abuse do not meet the criteria for major stressor, there is no available framework to account for the symptomatology.

> The current definition of a traumatic event may not be broad enough, particularly for children and adolescents. Research demonstrates that many stressful childhood experiences are not included in PTSD Criteria A, such as living with a caregiver with mental illness, frequent separation with a caregiver, repeated verbal abuse and so on. (McDonald et al., 2014, p. 186)

Therapy sessions overflow with material from damaging yet "normal" childhood experiences. The suffering of clients is real and immense, as many working in the healing professions will attest to. "Childhood exposure to interpersonal traumatic stressors is extremely common and has been described as a silent epidemic" (D'Andrea et al., 2012, p. 187). The examples above – exposure to mental illness, separation from caregiver, or verbal abuse – encompass a vast swath of so-called "normal" childhood experience: *Mental illness* could mean substance abuse, personality disorders, or depression – diagnosed and undiagnosed. *Repeated separations* could be multiple nannies – as is the case in many wealthy families – or constantly absent parents who out of necessity choose work over spending time with their children – as is the case with many economically disadvantaged families. Verbal abuse is devastating and is obvious when overt, but much more prevalent in its covert form as when a parent says "you're just tired" in response to a child insisting on her needs being heard. Perhaps this last example is extreme to some readers, yet a child is deserving of free expression of feeling states just as all adult human beings are, but often this inconveniences others and rather than address honestly the feeling state of the child, a parent might simply deny the child's experience with the statement, "you're just tired." This is also another solid example of Keeney's (1983) system analysis wherein an individual is able to "overlook any ongoing interaction between operator and machine" (p. 75); the parent uses his authority to sidestep the child's primitive request for attention and the net result is a very subtle form of neglect for the convenience of the parent.

Parenting for Survival

In response to the forces of economics, much of our parenting is done for efficiency and control, not for the quality of the connection between parent and child. In reaction to this is a splitting off of parental responsibility by pointing the finger at the child as the cause, not at the tacit system that stimulates the parenting choices. The result is coercive parenting standards designed for control and domination of the naturally erratic and chaotic developmental fits and starts of a healthy organism. Parenting on behalf of the free-market system paints a picture of insatiably manipulative children always on the cusp of being spoiled or having a tantrum. Children need to be heard, seen, and included as an equal partner within the family system, as many thinkers at the forefront of education and parenting research, including Kohn (2005), are in agreement about:

> Such a perspective is not romantic or unrealistic, a denial of the fact that kids (and adults) sometimes do rotten things. Kids need to be guided and helped, yes, but they're not little monsters who must be tamed or brought to heel. (p. 17)

Still, those who take the time to dialogue with children about their needs and perspectives are often seen as being dimwitted rubes hell-bent on destroying their children with permissiveness. The challenges of parenting with respect and empathy are not framed as a cultural attitude handicapped for the free market, but a weakness in the character of the parent, or to reflect back the PTSD criteria stressor cited earlier, "an inherent individual weakness" as opposed to an "external trauma" (Friedman, 2014, para. 2).

This type of misdirect appears very much akin to the dominant culture's approach to the oppression of women, as in the time of Freud when the somatic response to oppression was given the diagnosis of hysteria. As his patients began to reveal the hidden

nature of their trauma, which was nearly all sexual abuse, Freud noted, "I therefore put forward the thesis that at the bottom of every case of hysteria there are *one or more occurrences of premature sexual experience*" (as cited in Herman, 1997, p. 13). Freud backed off from his own theoretical stance because "his correspondence makes clear that he was increasingly troubled by the radical social implications of his hypothesis" (Herman, 1997, p. 14). Nearly 100 years later, Herman and others have the data that show that the sexual abuse that Freud hypothesized was unfortunately a reality:

> The data on this point are beyond contention. On careful questioning, 50-60 percent of psychiatric inpatients and 40-60 percent of outpatients report childhood histories of physical or sexual abuse or both. In one study of psychiatric emergency room patients, 70 percent had abuse histories. (p. 122)

Likewise, today those who see childhood trauma as the source of so much adult pathology might back away from their own realization. After all, our abilities as a culture have been crafted over several centuries and there is much good in it as well. Psychiatrist Jean Baker Miller (1976) stated, "Whatever their origin, these abilities became highly valued and were elaborated by the dominant culture. They had to be painstakingly cultivated; tendencies that interfered with them had to be put aside and tamed or 'mastered'" (p. 23). Perhaps in this spirit of mastering that which may undermine it, there has grown a tacit system in America that undermines those who choose the well-being of children over the free market. The symptoms of this are evident in a steady smear campaign in popular culture that attempts to shame and deride anyone who puts raising children above the free market. This is explored at length in Kohn's (2014) book, *The Myth of the Spoiled Child*, in which he listed some of the articles that carry these messages:

> "Spoiled Rotten: Why Do Kids Rule the Roost?" (The New Yorker), "How to Land Your Kid in Therapy" (The Atlantic), "Just Say No: Why Parents Must Set Limits for Kids Who Want it All" (Newsweek), "Parents and Children: Who's in Charge Here?" (Time), "The Child Trap: The Rise of Overparenting" (The New Yorker again), "The Abuse of Overparenting" (Psychology Today), "The Trouble with Self Esteem" (New York Time Magazine) . . . to name just a few. (p. 4)

Kohn reported that these articles do not cite any real data, relying "primarily on snarky anecdotes, belaboring them to give the impression that these carefully chosen examples are representative of the general population" (p. 5). Luckily Kohn's work is scholarly and provides ample evidence of a cultural bias against the well-being of children in so-called "normal" households. "In short, if we want to raise psychologically healthy and spirited children, we'll need to start by questioning the media-stoked fears of spoiling them" (p. 8).

The Financial Cost of Trauma

The dilemma is that raising children with care, empathy, and respect for their autonomy interferes with valued abilities of the dominant culture in that parenting this way takes a lot of emotional investment and clock hours. These are resources that are even scarcer than the money most families need to stay solvent. The average family income in California in 2013 was $57,688 (United States Census Bureau, 2014), which is among the highest in a country of 50 states (as a comparison, the lowest is Arkansas at $42,001). If two parents are working, if those parents are also divorced, and if a lion's share of the paycheck goes to childcare and the rest to food, gas, and lodging, what is left emotionally and otherwise for the parents to transmit to their offspring? What ground has been gained by Herman (1997) and the other feminist thinkers with regard to a more comprehensive trauma diagnosis? The cultural paradigm of the day cares little of who is masculine and who is feminine; it is a systems conflict, not a gender one.

Ever-insightful Jean Baker Miller (1976) wrote, “As women change, they will create severe challenges. . . . Whom will society then use as objects?” (p. 45). She then went on with great beauty and optimism to state: “If there is no one to use, what kinds of revolutionary personal transformations will the dominant group have to make for itself?” (p. 45). Unfortunately the bright tomorrow envisioned by Miller may have simply resulted in another priceless resource being fed into the machine of our cultural paradigm. Now both men and women treat children as one more object to be managed and mastered and the methods needed for this are traumatizing to both the parents and the child. It is not a matter of providing more proof or of building a better mousetrap, but of changing the paradigm. The current standards of care for children are not sufficient to protect children from trauma.

> In the last 10 years, our society has spent billions of dollars studying and treating adult trauma victims, primarily male combat veterans—this despite the fact that many more females are traumatized by rape in our society than males in combat. In comparison, few resources have been dedicated to research or treatment focusing on childhood trauma. (Perry, Pollard, Blakley, Baker, & Vigilante, 1995, p. 275)

The fiscal truth is that this traumatic wounding is very costly to our society. The cost is so great that it further perpetuates the downward pressures on family resources (emotional, clock-hour, and financial), furthering the very trauma that is so costly.

> Some estimates place the fiscal cost of childhood abuse and neglect in 2007 at $103.8 billion. . . . The financial cost of childhood victimization represents an urgent public health need that has been identified as the most significant public health issue in the country. (D’Andrea et al., 2012, p. 187)

This is a clear example of what is termed “positive feedback” (Keeney, 1983, p. 70) in the systems theory sense; the system responds with more of the same to cure the problem created by responding to more of the same, essentially a feedback loop (p. 68). “Negative

feedback" (p. 67) would be the system responding to counter the financial bleeding that traumatic wounding costs society with corrective measures. One such response might be a comprehensive trauma diagnosis that would recognize all traumatic wounding, not just socially sanctioned stressors such as combat violence or natural disasters. As stated, the cost of trauma to children alone, not to mention soldiers and women is estimated at $103.8 billion; what is the total cost of traumatic wounding? It would likely boggle the mind. However, much of traumatic wounding during childhood and adolescence predisposes individuals to later trauma in life (more on that later), which may make childhood PTSD and complex developmental trauma an even more pressing dilemma (read: costly to society). Yet still the medical establishment's insistence that "seeing is believing" keeps the PTSD diagnosis hinged on a socially sanctioned single event stressor or series thereof.

Neuroscience to the Rescue

Enter neurobiology; the reader will remember that Mott (as cited in Trimble, 1985, p. 8), the man who coined "shell shock," was frustrated by his inability to discover the biological etiology of wartime trauma. Neuroscience has indeed been able to tap some of trauma's secrets. What it has found is that trauma response has the same reaction in the brain regardless of the trauma, be it a single stressor or a pattern of seemingly small stressors. The stress response system, when activated, has a pattern of reciprocal reactivity that has been consistent since our species first mistook a stick for a snake.

> The human body and human mind have a set of very primitive, deeply ingrained physical and mental responses to threat. . . . The most familiar set of responses to threat has been labeled "fight or flight" response—a pattern commonly seen in adult, male mammals. (Perry et al., 1995, p. 277)

The consistent activation of this bodily response can lead to changes in the brain over time:

> An expanding body of evidence from rodent, primate, and human research suggests that early stressors cause long-term changes in multiple brain circuits and systems. The amygdala mediates fear responses, and the prefrontal cortex is involved in mood as well as emotional and cognitive responses. The hypothalamic-pituitary adrenal (HPA) axis plays a crucial role in stress response. (Anda et al., 2006, p. 175)

In America alone, there are dozens of well-known doctors, clinicians, and researchers all drawing the same conclusions: Bruce Perry (2004), Daniel Siegel (2010), Bessel van der Kolk (2009), and Joseph Spinazzola (D'Andrea et al., 2012), just to name a very few. The stress response is the same for a soldier in combat or a child being threatened by a parent. One of the factors that neuroscience agrees upon is the concept that, as Perry coined, *states* can become *traits*: "Developmental experiences determine the organization and functional status of the mature brain" (Perry et al., 1995, p. 271).

This process of wiring the brain begins at the very earliest stages of development: "In utero and during the first four years of life, a child's rapidly developing brain organizes to reflect the child's environment. This is because neurons, neural systems, and the brain change in a 'use dependant' way" (Perry, 2004, p. 1). "If the environment is chronically traumatizing . . . the survival response system will become chronically activated, resulting in long-term effects on the developing brain and body" (Fisher, 2003, p. 1). Perry (2004) described some of these environmental factors:

> Inappropriate or abusive caregiving, a lack of nurturing, chaotic and cognitively or relationally impoverished environments, unpredictable stress, persistent fear, and persistent physical threat. The adverse effects could be associated with stressed, inexperienced, ill-informed, pre-occupied or isolated caregivers, parental substance abuse and/or alcoholism, social isolation, or family violence. Chronic exposure is more problematic than episodic exposure. (p. 2)

When consistent physical or psychological abuse is extreme, diagnosis is clear-cut, but

> given the prevalence of chronic and multiple stressors in children's lives, as well as concerns that the current PTSD diagnostic criteria may accurately describe a majority of trauma-exposed youth, van der Kolk expanded upon Herman's work by suggesting a new diagnosis for young victims of complex trauma. (McDonald et al., 2014, p. 188)

In these children,

> dysregulation can occur in any of the following areas: affective somatic, behavioral, cognitive, relational, and self-attribution areas. Examples of dysregulation in these areas include somatic complaints, reenactment of the traumatic experience, confusion, clinging behavior, and self-hate. Examples of persistently altered attributions and expectancies include "negative self-attribution, distrust of protective caretaker, loss of expectancy of protection by others, loss of trust in social agencies to protect, lack of recourse to social justice, and inevitability of future victimization (Criterion D; Van der Kolk, 2005, p. 404)." (p. 188)

Perry (2004) added,

> A child with a brain adapted for an environment of chaos and unpredictability, threat, and distress is ill suited for the modern classroom or playground. . . . When a child experiences repetitive activation of the stress response systems, their baseline stare of arousal is altered. The result is that even when there is no external threat or demand, they are psychologically in a state of alarm. (p. 2)

This perspective is supported by neuroscience, but not so by the culture at large. The question, as it is in war and workers comp and the oppression of women, remains: Who should decide what is traumatic?

As explored, a child can suffer PTSD symptoms without a major stressor and in this way "the current definition of a traumatic event in the Diagnostic and Statistical manual of Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013) may be too narrow to describe the myriad of difficult childhood experiences" (McDonald et al., 2014, p. 184). Perhaps more importantly, a child will have a developmentally

different view of what constitutes a traumatic event than an adult. “Evidence-based trauma exposure measures are keyed to the DSM and may under identify events that youth may consider traumatic” (p. 185). Just as society tacitly accepts the traumas of war and workplace and violence against women, it too accepts violence against children.

> The influence of childhood experience, including often-unrecognized traumatic events, is as powerful as Freud and his colleauges originally described it to be. These influences are long-lasting, and neuroscientists are now describing the intermediary mechanisms that develp as a result of these stressors. Unfortunately, and in spite of these findings, the biopsychosocial model and the bio-medical model of psychiatry remain at odds rather than taking advantage of the new discoveries to reinforce each other. (Felitti & Anda, 2010, p. 86)

Many households treat children as property to be controlled at the whim of the adults. For children, expressions of anger, strong emotion, longing, and free expression are discouraged, monitored, punished, and mystified.

Spanking and other forms of discipline – read: control and domination –are widely accepted as the correct way to treat children: “Spare the rod, spoil the child” is a common enough phrase to describe the adult attitude toward a child. But are these forms of discipline effective in changing a child’s behavior? And, is “good behavior” even a truly valued goal in a society where outlaws, rule breakers, and iconoclasts are financially rewarded at a much higher rate than those who follow the rules? “When we make children feel powerless, forcing them to submit to our will, this often generates anger, and just because that anger can’t be expressed at the moment doesn’t mean that it disappears” (Kohn, 2005, p. 55). What spanking, threats of abuse, time outs, and harsh treatment are effective at is not producing acceptable behavior for adults but stimulating the trauma response system.

> There is a continuum of adaptive responses to threat and different adaptive styles. Some use hyperarousal response (e.g., fight or flight), and some a dissociative

> response (essentially "tuning out" the impending threat). . . . A child adopting a hyperarousal response may display defiance, easily misinterpreted as willful opposition. . . . They are locked in a persistent "fight or flight" state. (Perry, 2004, p. 2)

It is possible then that many children in "normal" households are being affected in ways that are below the definition of traumatic stressor, yet society's demands ask us not to accept it as such. Perhaps in the same way that society is complicit in the domination of women, so is it with children. In upholding our commitment to our current form of capitalism, do we guarantee an overload of stress factors on the family system, robbing Peter to pay Paul by selling our labor hours for survival and taking parenting hours away from our children? What is certain is that a victim of sexual assault, a combat veteran, or simply an overstressed child will undergo changes in their neurobiology that will produce symptoms that more or less can be called "trauma response" symptoms. In speaking of the need for a more comprehensive trauma diagnosis for developmental trauma in children, psychologists Wendy D'Andrea et al. (2012) wrote in the conclusion of "Understanding Interpersonal Trauma in Children: Why We Need a Developmentally Appropriate Trauma Diagnosis":

> With respect to biological data, childhood interpersonal trauma has documented associations with structural and functional abnormalities in the CNS areas and neurohormonal systems representing key pathways for the regulation of consciousness, affect, impulse, sense of self, and physical awareness—that is, precisely the aspects of functioning that are consistently found to be impaired in the victimized children and adults who were victimized in childhood. (p. 194)

That is to say that a single stressor victim of trauma that meets the current criteria for a PTSD diagnosis as outlined in the *DSM-5* has the same traumatic wounding as an individual suffering a pattern of less acute interpersonal traumatic stressors.

Neurobiology provides a unifying x-ray that comprehensively describes the physical properties of trauma response in the human brain.

> The detrimental effects of traumatic stress on developing neural networks and on the neuroendocrine system that regulate them have until recently remained hidden even to the eyes of most neuroscientists. However, the information and data present herein suggest that this veiled cascade of events represents a common pathway to a variety of important long-term behavioral, health and social problems. (Anda et al., 2006, p. 180)

More importantly for the purposes of this thesis is the idea that repeated activation of this system, even in the absence of a socially accepted traumatic stressor, can alter the development of a child's brain and result in trauma response symptoms as are present in PTSD. This is of importance because a child who is in a traumatized *state* grows into an adult with traumatized *traits*. Again, if the victimization of children costs society over 100 billion dollars, imagine what the cost would be if the full spectrum of traumatic wounding were explored. Consider this: As explored above, the treatment of children that creates a consistent pattern of stress response can result in trauma symptoms, some of which are:

> alterations in the regulation of affective impulses, including difficulty with modulation of anger and self-destructiveness . . . alterations in attention and consciousness leading to amnesia and dissociative episodes and depersonalization . . . alterations of self perception, such as a chronic sense of guilt and responsibility, and ongoing feelings of intense shame . . . alterations in relationship to others, such as not being able to trust and not being able to feel intimate with others . . . somatization and/or medical problems. (Courtois, 2004, p. 414)

Given this diverse set of challenges, it is not difficult to imagine how such traits might snowball in the classroom and on the playground. A child falls behind in school due to an inability to concentrate, or gets the reputation of being a bully, or is scorned for other socially inappropriate behaviors and a chain reaction is set into play that guarantees

perpetuation of the very thing that has stimulated the stress response to begin with. "Numerous studies have established that childhood stressors such as abuse or witnessing domestic violence can lead to a variety of negative health outcomes and behaviors, such as substance abuse, suicide attempts, and depressive disorders" (Anda et al., 2006, p. 175).

Summary

This chapter explores the way the current trauma diagnosis (APA, 2013) evolved and asks if it is purposefully inadequate to serve the needs of the dominant culture (Herman, 1997). The history of PTSD was reviewed (Trimble, 1985) and relevant parallels were drawn between it and the history of worker's compensation (Guyton, 1999) to demonstrate a longstanding cultural bias against those suffering from traumatic wounding (D'Andrea et al., 2012), a bias that was perhaps fueled by powerful companies within a free-market system that used science as a weapon against loss of capital (Trimble, 1985).

This was magnified in the work of feminist thinkers such as Herman (1997), who saw that violence against women and children created the same symptoms as those seen in combat veterans. The dominant culture sanctions war violence (Herman, 1997) and hides society's complacency within a taciturn system (Keeney, 1985) that accepts violence toward women and children simply by not acting (Herman, 1997).

Given that culture is hidden from itself (Hall, 1973), there is the likelihood that this taciturn system will remain intact except for the great cost (in dollars) to society, which is vast (D'Andrea et al., 2012). Perhaps this will incentivize the cultural attitudes

of lawmakers and citizens to act against a cultural bias that sees trauma sufferers as malingerers despite evidence supporting the opposite (Herman, 1997).

As this debate carries on, neuroscience has definitively shown that the trauma response system reacts the same to all stressors, regardless of source, duration, or severity (McDonald et al., 2014). Most importantly, there need not be a single stressor or acute multiple stressors as necessary for a PTSD diagnosis; so-called "normal parenting" could over time change the brain to be primed for stress response, changing "states" to "traits" (Perry et al., 1995).

Developmental trauma is occurring due to potentially harmful parenting techniques such as spanking, threats, mild neglect, shame, and this kind of low spectrum abuse snowballs into patterns of poor functioning with lifelong impacts (Courtois, 2004, p. 414). A comparison is made between this and the cultural bias against acknowledging violence against women in order to highlight the ways that society may be complicit in abdicating sound parenting practices for the purpose of satisfying the needs of the free-market system (Kohn, 2014). The literature reviewed provides a foundation for the following chapter's discussion of the author's personal engagement with trauma as a social justice issue.

Chapter III
Where There's Smoke, There's Fire

The research question stated in the first chapter is: Would a comprehensive trauma diagnosis, accounting for all traumatic wounding that impaired normative functioning, run counter to America's free-market system? In this chapter, I analyze the findings from the reviewed literature and explore the possibility that a comprehensive trauma diagnosis has been purposefully delayed and obscured to protect taciturn systems of sanctioned violence. In the last part of this chapter, I describe the creative-artistic component of this production thesis, namely the comic texts and the accompanying drawings, and demonstrate how they are applied clinically to the field of trauma and the subject of this thesis.

Part One: See no Evil, Hear no Evil, Speak no Evil

In the second chapter, I reviewed a selection of literature that touched on themes of control and domination in warfare, work, rape, and parenting to demonstrate the tendency within American culture to deny the validity of trauma in order to protect the cultural hierarchy. I presented literature that showed injured and maimed workers had been compensated since at least 1750 BCE for that which could be seen, namely loss of limb or other bodily function, but that when the impairment was of an unseen psychological nature, request for compensation was resisted (Guyton, 1999, p. 109). Next I reviewed combat trauma and the resulting PTSD diagnosis, focusing specifically on the

key ingredient of a single (or multiple) universally accepted traumatic stressor (Friedman, 2014).

In contrast to combat trauma, I explored systemic violence against women and children, with particular interest in two aspects: the hidden nature of the stressors and the fact that despite the greater number of traumatized women and children than soldiers, the APA trauma diagnosis (PTSD) is tailored to soldiers (Courtois, 2004, p. 413). Finally, I considered parenting and its relationship to developmental trauma (Kohn, 2014, p. 8). As a unifying element to this vast field of subjects, I turned to neuroscience to illustrate that all traumatic wounding, although having a remarkably varied etiology, produced the same core cluster of symptoms (McDonald et al., 2014, p. 189). I cited studies that demonstrated these symptoms are the result of an overactivated stress response system, a system that is hardwired in the oldest part of all mammals (Anda et al., 2006, p. 174). I then questioned whether the way Americans currently live (with regard to a social hierarchy geared towards the nurturance of a free-market system) is at the expense of many millions of people (National Center for PTSD, 2014), most of them innocent and vulnerable. Do we, as a culture, accept widespread trauma in warfare, the workplace, and in our attitudes toward rape and parenting? And if so, why?

This thesis acknowledges the possibility that the current paradigm may be the most effective way to sustain the broadest number of people at the highest standard of living and does not offer a solution to those who perceive themselves to be the victims of societally sanctioned violence. However, without being too deterministic, I suggest that in a game of chicken, culture will yield to the truth of human biology. This is an optimistic outlook that relies on the fact that cultural evolution is more fluid than

biological evolution. Yet in a culture so dependent on empirical truth, the question remains: Why does the establishment as represented in the *DSM*, not reflect the scientific data that legitimizes the existence of widespread trauma beyond the sanctioned violence of war, natural disaster, and other single stressor traumas? I am reminded of the 1980s, when cigarette companies were in court to defend the now widespread understanding that cigarettes can cause lung cancer. It was not until 1950 that the first paper was published showing a definitive connection between smoking and lung cancer (Levin, Goldstein, & Gerhardt, 1950), followed that same year by an even more comprehensive longitudinal study in Great Britain confirming the same connection (Doll, Petro, Boreham, & Sutherland, 2004). The lengthy court battles hinged on whether cigarettes were addictive or not and whether the cigarette companies knew or aided in these addictions and if so were they culpable. In 1994, representatives of the U.S. tobacco firms testified in federal court that nicotine was "not addictive" (Eriksen, Mackay, & Ross, 2012, p. 91). There was overwhelming scientific evidence proving their statement to be false, but the truth was denied and obscured until the very end, and the motive was capital in the form of profit.

The difference between my argument and the above example is that there is no such clear-cut perpetrator defending an indefensible position for the sake of profit. If it should become known at a later date that insurance company interests, for example, exerted energy to prevent the acceptance of diagnoses that better defined the full numbers of those suffering from trauma, then it would be a more rounded comparison. Nonetheless, I find it a useful comparison to illustrate that even with a mountain of scientific evidence and a longstanding public awareness of the dangers of smoking, it

took an army of lawyers, millions of dollars, and consistent political will for justice to be served and sanctioned violence in the form of cigarette sales to be curtailed. Similarly, there have been multiple voices calling for a comprehensive trauma diagnosis to be included in the *DSM*, both for the *DSM-4* and the more recent *DSM-5*, and those voices have gone mostly unanswered. According to psychologist Christine Courtois (2004),

> Despite the obvious advances that were made at the time in understanding posttraumatic reaction, a number of researchers and clinicians argue that the diagnosis of PTSD was not a perfect fit for the reactions experienced by victims of child abuse and domestic trauma and other populations where traumatization occurred repeatedly and extensively. They note that the criteria for PTSD had been derived directly from the study of adult male combatants exposed to war trauma. As a result, the reactions of those involved in combat were likely significantly different from those of immature individuals whose exposure to traumatic stress was ongoing and related to family life. (p. 412)

Rather than confront the difficult task of publicly addressing this morass of suffering, there is the sense that the new *DSM-5* "punted" on this issue; or is it simply as renowned PTSD researcher Terence M. Keane said, "Studies still need to be done, but who will do them?" (Keane & Najavits, 2013, p. 513). Perhaps the establishment is just proceeding with necessary scientific caution, yet the irony is not lost with the APA's inclusion of a diagnosis for premenstrual syndrome (premenstrual dysphoric disorder) in the *DSM-5* (APA, 2013). One view of this could be that a magical and essential aspect of the embodied feminine has been pathologized whereas the very real, nuanced trauma (the hidden violence in the family, workplace, and bedroom as explored in Chapter II) that might make up the bulk of traumatic wounding remains protected simply by not being legitimized in the professional manuals of our time. That is to say that the establishment (as represented by the *DSM*) does not need to disprove the presence of non-PTSD trauma but only needs to do nothing. As a clearer picture emerges on the traumatic effects of the

tactics employed for control and domination of women and children, the *DSM* pathologizes menstrual periods and expands the definition of ADHD. It is not my belief that there is an entity that is purposefully denying a more comprehensive diagnosis; instead, I return to the notion that as a collective the choices Americans make in voting, research, spending, parenting, and diagnosing reveal the hidden nature of a core belief that the sustenance of a free-market system is key to survival and therefore must be defended regardless of damage to self, community, or planet.

When I write of "warfare, work, rape, and parenting," I recognize this is a vast sample of societal systems, and it should be noted that the relevant point is not to define these systems or to correct them, only to demonstrate that within these systems exists a *taciturn system of sanctioned violence*. I could just as well turn to television, marriage, firearms sales, education, or welfare, for in each system within the American societal system, these patterns of violence will reveal themselves. "Violence," used in this thesis as a concept, is present in all of these systems and for that reason does warrant specificity with regard to its usage herein. Violence is taken by most to mean the physical force of one body acting on another. Yet violence is a concept in which physical force is just one of the most prominent possibilities. Violence as a concept has been adopted by the World Health Organization and its member state organizations as a treatable public health issue. As defined in the WHO's *World Report on Violence and Health* (*WRVH*), violence is

> the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation. (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 5)

Given this definition, violence as a concept is woven deeply into the American social fabric. According to the *WRVH*,

> The human cost in grief and pain, of course, cannot be calculated. In fact, much of it is almost invisible. While satellite technology has made certain types of violence—terrorism, wars, riots and civil unrest—visible to television audiences on a daily basis, much more violence occurs out of sight in homes, workplaces and even in the medical and social institutions set up to care for people. Many of the victims are too young, weak or ill to protect themselves. Others are forced by social conventions or pressures to keep silent about their experiences. (Krug et al., 2002, p. 3)

As for example in the previous mention of the tobacco interests, the knowing refusal to acknowledge the danger of their product was an act of violence against a huge population, "resulting in injury, death, psychological harm, maldevelopment," and deprivation. One could extrapolate and assert that the cultivation of tobacco itself accelerated and helped sustain the slave trade in North America for nearly 150 years, contributing again to a vast array of violent acts spanning many generations:

> As with its impacts, some causes of violence are easy to see. Others are deeply rooted in the social, cultural and economic fabric of human life. Recent research suggests that while biological and other individual factors explain some of the predisposition to aggression, more often these factors interact with family, community, cultural and other external factors to create a situation where violence is likely to occur. (Krug et al., 2002, p. 3)

In addition, tobacco companies such as R. J. Reynolds and Phillip Morris, in advance of the legal ruling against their tobacco products, moved their profits into other companies; Phillip Morris now owns General Foods and Nabisco (Boreo, 2003), hugely profitable companies generating enormous wealth for a very few, all built on the back of tobacco violence. Again, this thesis acknowledges that the profits generated by these companies may have benefited many thousands of others in the form of wage labor, tax revenue, and other trickle down benefits and in this way may be part of an overall free-

market structure that is the most efficient way to provide the best quality of life for the largest number of people. This thesis does not present a cost-benefit analysis for capitalism; it only wishes to explore, challenge, and question the presence of the pervasive taciturn systems of sanctioned violence needed to sustain the social hierarchy. This system has allowed profits to be reaped from the public in exchange for cigarette-related illness. In 2010 alone, world tobacco profits of the top six companies were put at half a trillion dollars (World Lung Foundation, 2012). Then consider what smoking-related illness cost American society, from the American Lung Association (2014) fact sheet: "Smoking cost the United States over $193 billion in 2010, including $97 billion in lost productivity and $96 billion in direct health care expenditures, or an average of $4,260 per adult smoker" (para. 1). That is an astonishing 732.2 billion dollars the tobacco industry extracted from society in 2010 alone.

This is violence, yet it is a kind of violent action that is difficult to see because it is hidden inside the context of the free market, Kenney's (1983) example of a toaster is again appropriate: by accepting this type of violence as a "normal" part of the free-market system, our society has "overlooked any ongoing interaction between operator and machine" (p. 75). The idea is that the machine of the free-market system does what it will do and we are just standing in it without any connection to it. Yet the notion that overt violence such as war or covert violence such as rape is inevitable is a fallacy, one that is much easier to accept as truth when the violence is hidden.

> Despite the fact that violence has always been present, the world does not have to accept it as an inevitable part of the human condition. . . . Violence can be prevented and its impact reduced, in the same way that public health efforts have prevented and reduced pregnancy-related complications, workplace injuries, infectious diseases, and illness resulting from contaminated food and water in many parts of the world. The factors that contribute to violent responses—

> whether they are factors of attitude and behavior or related to larger social, economic, political and cultural conditions—can be changed. (Krug et al., 2002, p. 3)

Violence as a concept will exist wherever there is exploitation. Like slavery, "rape" and "warfare" are words easily linked to physical and emotional violence in American culture. Common words like "cigarette," "parenting," or "work" are not. I have reviewed literature that focuses on the shadow side of the workplace and of parenting. In both parenting and work environments, there exist systems of domination and control that have required carefully constructed legal boundaries to protect the dependent minors and employees subject to the abuses of these systems. Legislation to protect the rights of workers and of children have been hard fought over many decades, which alone is evidence of a taciturn system of sanctioned violence. There are continuous pressures on unions and individuals within the workplace to reduce the rate at which labor hours are sold and eliminate "benefits," which include such essential components of basic humane treatment as pensions, medical insurance, vacation pay, sick days, child care, and paternity leave, while the Dow Jones continues to swell with profits.

In the last 10 years as productivity has risen in the U.S., overall civilian earnings have decreased (Bureau of Labor Statistics, 2014). And there is no shortage of carefully constructed urban fantasies about the welfare cheats and the insurance fraud, such as Ronald Reagan's infamous welfare queen, who was actually a criminal outlier whose scam was the welfare system yet who was held up as emblematic of a system rife with lazy citizens living off the fat of a permissive government. That there are those who cheat the welfare system and the insurance companies is not evidence of malingering by the traumatized but evidence of a system that values monetary gain over honesty on both

ends of the continuum of the law. On one end there are thieves posing as those in need, and on the other end there are thieves whose need is built on the back of those in need; surely it is self-evident that without the poor and the worker, Wall Street would not exist (though interestingly this is likely not true in the reverse). Defense contracting fraud equaled the combined Medicare and Medical fraud alone (Bennett, 2011); this is to highlight the curious part of our American belief system that is angered by the idea of poor people getting free access to benefits more than it is angered by wealthy defense contractors stealing from the government. Kohn (2014) summed up this strange irony with the quip: "After all, people shouldn't get something for nothing. Not even happiness. Or love" (p. 18).

The above thoughts are not new or striking, but they are presented here because the value is in the dialogue. There is no company or group of companies to blame for a system that denies its own violence. One group of individuals may assert that an externalized factor such as "China" is contributing to a sense of American economic and social imbalance whereas another population may assert that an externalized factor such as "multinational corporations" are contributing to a sense of American economic and social imbalance. I assert the burden of any social imbalance in the form of violence rests with the moment-to-moment choices of each individual within a societal system and not in an external factor, even though a belief in the importance of an external factor may be a consideration in behavior outcomes. Even the government (federal and state branches of the legislative body) lives within the free-market system; it does not create it. The government cannot move without political will; it is a tool, inert in that it reflects those with a controlling share, ideally the electorate. Biology sees that each ecological system

is interconnected. The worm cannot disown the earth any more than the earth can disown the worm. Yet there is the tendency to externalize the societal forces within a culture, forces that are actually coming from within as represented by each individual's small (or large) action of purchase, word, career choice, clothing, vacation destination, favorite foods, and many thousands of other actions that make up a complete picture—like a photograph when magnified reveals the crystal clear image is actually a multitude of unfocused tiny points of varying hues. The culture is made from the raw material of these actions.

If the collective truly is the locus of culture (regardless of how one perceives this truth), why is trauma so omnipresent yet undiscovered? The research question is asking if a taciturn system is in place to make the free-market system possible and whether that is why American culture is so resistant to adopting a trauma diagnosis that acknowledges the extent of traumatic wounding within these systems. Do empathy and compassion cost too much? What would a systemic paradigm shift in the way we viewed trauma mean to insurance companies, HMOs, schools, corporate workplaces, factories, and the Veterans Administration, or the president's ability to wage war for that matter (that would be a very interesting project: to weigh the total cost of war against the total cost benefit of the interests protected or fought for)? In workers' compensation cases, who should decide who is suffering traumatic injuries—the corporation or the individual? In the matter of warfare, who should decide who is traumatized—the soldier or the society that soldier fought to uphold? In matters of healing, who should validate the reality of the trauma sufferer—the giver of a diagnosis or the patient? As is, I hope, self-evident in the above questions, the answer is dependent on one's acculturation; the acceptance of the patient's

reality is dependent on the cultural paradigm of any given era. Trauma as a concept is a social justice issue and must not be defined solely by academia or medicine or other branches of the dominant paradigm, which will attempt to obscure and deny it.

Part Two: Seeing Is Believing

"Seeing is believing," "a picture is worth a thousand words," "it couldn't have been that bad," and "that's how it was when I was a kid and I turned out alright" are common expressions that embody a cultural reluctance to accept the report of a subjective experience as legitimately traumatic enough to have produced impairment. Perhaps due simply to the lack of clear visual proof of the persisting and internal nature of these hidden traumatic wounds, there has always been skepticism from society and accusations of malingering. But now a clearer picture is emerging from the field of neuroscience showing that sustained traumatic experiences in childhood actually change the developing brain by continually activating the trauma response of hyperarousal or dissociation (fight or flight): "Childhood maltreatment has been linked to a variety of changes in brain structure and function and stress-responsive neurobiological systems" (Anda et al., 2006, p. 174). This response system, when chronically activated, will change the pattern of the brain's functioning and produce trauma response symptoms. "Because the developing brain organizes and internalizes new information in a use-dependant fashion, the more a child is in a state of hyperarousal or dissociation, the more likely they are to have neuropsychiatric symptoms" (Perry et al., 1995, p. 271). Much of this trauma is non-PTSD trauma in that it does not meet the criteria of single or multiple stressors as defined in the *DSM-5*. "Individuals exposed to trauma over a variety of time spans and develomental periods suffered from a variety of psychological problems not included in

the diagnosis of PTSD" (Courtois, 2004, p. 413). This is not because trauma is not real, but because there is no appropriate diagnosis for it—"Moreover, these problems were catagorized as comorbid conditions rather than being recognized as essential elements of complicated posttraumatic adaptations" (p. 413).

That children and adolescents are particularly vulnerable should come as no surprise, because their brains are still under construction so to speak, and "evidence-based trauma exposure measures are keyed to the DSM and may underidentify events that youth may consider traumatic" (McDonald et al., 2014, p. 185). As the brain is growing, it wisely incorporates materials from the environment it is immersed in. If the feedback it is receiving from the parasympathetic nervous system is a constant flow of threats from without, it wisely keeps its defenses on alert. It matters not if that feedback comes in the form of a pattern of incestuous rape, or from consistent verbal abuse from a parent, sister, or "bully," or from inconsistent care in the home of an affluent family, or (in the case of PTSD) intrusive memories stemming from a single stressor event during combat, rape, industrial accident, natural disaster, or assault; the same switch is flipped in the trauma response system and over time in those traumatized, "the acute adaptive states, when they persist, can become maladaptive traits" (Perry et al., 1995, p. 271).

Evidence proves the existence of non-PTSD trauma and that the bulk of trauma sufferers are likely non-PTSD trauma sufferers, mostly women and children; yet resistance remains—why? What is that hard part of current collective consciousness that wishes to deny? What does denial get in return? What is being protected by obscuring the harm done to traumatized individuals? No doubt there are those in our mental health system and emergency rooms who are suffering; why does it remain unnamed in a culture

obsessed with naming? What are we, as human beings, as citizens of the United States, willing to sacrifice to wear the mask of our current cultural expectations? What are the choices we are making and how are they affecting our daughters and sons or those of our fellow citizens? Does one become an apologist for the free market, like Michael Corleone in *The Godfather*, who says to Sonny when justifying murder: "It's not personal, it's strictly business" (Ruddy & Coppola, 1972)? The socially agreed-upon notion that money is the ultimate motivating factor in a rational man's world has cost us more than any store of gold. In our collusion with these forces, it allows for collateral damage in the form of battle casualties (not just civilian and enlisted persons, but of cultural heritage sites, artifacts, and entire landscapes), crippled, maimed, or poisoned workers, and mass pollution of the earth's water, air, and soil. The voice of the wounded is the voice of social justice.

In fact, it is the very cost of capitalism that may ultimately force culture's hand into accepting that human capital is more valuable than monetary capital. Trauma may be the most costly crisis in society today due to the broad range of maladaptive functioning it potentially produces. Here are the populations at potential risk of trauma symptoms due to chronically activated stress response: victims of childhood neglect, abuse, and attachment disorders (poor/absent parenting); victims of rape, threat, and psychological abuse; political prisoners, combat veterans, and non-combat veterans in war zones; police officers, fire fighters, and mental health workers; workers injured on the job; homeless individuals; sex workers; incarcerated individuals (juvenile and adult); the poor; and the chronically sick. This is potentially a vast swath of society. So vast in fact that one begins to have empathy for Freud's choice to bury his head in the sand.

Parenting (nurturing of our young) is an aspect of the human species that has a great affect on culture. Parents and caregivers have the special burden of bearing responsibility for transmitting the cultural norms to the next generation, a task that no doubt causes many parents and caregivers to stick their own heads in the sand. According to the 2012 U.S. Census Report on households, 28.6% of married households had children under the age of 18, 12.1% of single female households had children under 18, 2.3% of single male households had children under 18, 1.5% of grandparent households had children under 18, and an additional 2.8% of the children under 18 were cared for by additional "householders" (Vespa, Lewis, & Kreider, 2013, p. 4, Table 1). Nearly half of the households in America are engaged in parenting children. It is in these environments that developmental trauma can be addressed. Parental caregivers have the choice to make decisions that can create resilient children who are able to self-regulate and build muscles to deal with potentially overwhelming stress that is inevitable in the life of a human being regardless of social structure.

The internalized values of a system that may value productivity and financial capital over mental health will attempt to obscure and mystify the power each caregiver has in parenting choices. The main tool of these internalized messages is the threat of downward mobility: You value your child, but work productivity demands you give the lion's share of your life energy to earning a paycheck, and then you show your love and care for your child with your paycheck in your absence. But it's okay to make choices that are less than optimal for your child's psychological well-being because "it's not personal, it's strictly business."

In our free-market system, many parents may be parenting for survival, not for their highest aspiration of parenting; after all, a paycheck has many other uses beyond playing pinch hitter for a parent. The working population may stretch their values to conform with the time available, as they perceive it. This means they must maintain a tight control on the needs of their children for purposes of work life. They might want to take the time a child needs for empathic communication and understanding, but they make a choice not to because of exterior stressors, such as making more money to keep the utilities on in the home. On the other end of the spectrum, others may choose work over time with their child because they find emotional security in the current parenting paradigm in that a demanding workload allows them to obliterate the inherently difficult feelings of parenthood. The parent who wishes to spend more time with her child but can't because of economics mourns the selling of her labor hours at the expense of time with her child. The parent who wishes to avoid her parenting may use the same exchange as a cover to avoid the emotionally and physically challenging aspects of parenting, relying instead on nannies, daycare, X-box, Internet, television, or relatives. Both attitudes are functionally equivalent in that the child spends less time with his or her parent.

Parenting is the writing of the operating system code that will run the social computer of the individual—what one will do and how one will do it based on one's acculturation (the *computer program* in this metaphor). But the hardware, the physical wiring of the brain as it relates to trauma response, is the same in all mammals, and certain well-defined emotional and physical stressors create a consistent response that over time produces a cascading trail of trauma symptoms.

> If society ignores the laws of biology, there will inevitably be neurodevelopmental consequences. If on the other hand, we choose to continue researching, educating and creating problem-solving models, we can shape optimal developmental experiences of our children. The result will be no less than a realization of our full potential as a humane society. (Perry, 2004, p. 4)

If a developmentally traumatized individual is predisposed to maladaptive behavioral functioning *and* has not developed the skills to soothe her or his own uncomfortable emotional states (Perry et al., 1995), does focusing on developmental trauma hold the key to preventing the formation of drug, sex, gambling, work, and shopping addictions, so-called personality disorders, anxiety, and depression (Anda et al., 2006)? Where does developmental trauma fit in the poverty narrative? Where does developmental trauma fit in the education narrative? Where does developmental trauma fit in the free-market narrative? Perhaps the current parenting paradigm is where developmental trauma can best be addressed (Kohn, 2005).

Regardless, "there are a variety of events considered traumatic in childhood that are not typically considered traumatic according to the DSM-5 PTSD Criterion A definition" (McDonald et al., 2014, p. 197). A pattern of stress response can lead to trauma symptoms in the same way a single stressor can, and the only difference is how society views it. For the myriad of complex reasons discussed in this thesis, our American culture feels comfortable affording compensation (monetary and emotional) to those who can prove they are suffering as the result of certain sanctioned stressors, but not to those who are suffering because of causes outside the socially accepted norms. With science substantiating the existence of trauma response symptoms developing from a wide range of behavioral patterns both sanctioned and un-sanctioned by society, this

thesis will not attempt to further explore the existence of trauma or the treatment of trauma.

Instead, it is the aim of this thesis to move out beyond the question of who is suffering and put the information about trauma into the hands of those affected by trauma, which is all of us; if the reader of this thesis doesn't know or love someone who is suffering or has suffered from trauma, she need only turn to the society around her and witness school shootings, persistent incurable poverty, perpetual warfare, dangerous products in food, air, and water—the list goes on ad infinitum.

> The constellation of effects from childhood stressors calls to mind the wisdom of Occam's razor, a celebrated dictum in medicine, which holds that if a single unifying explanation can be found for multiple symptoms and problems, then it is likely that the correct explanation lies in the simplest account. (Anda et al., 2006, p. 180)

Perhaps the simplest account is that trauma is pervasive and a fixed part of life. To continue to deny it or disown it as something else simply compounds it. Accepting that it is present and real as demonstrated by those who suffer and providing those individuals with safety, empathy, and care may be the simplest answer. To that end, a comprehensive trauma diagnosis that addresses the vast array of traumatic experience would better reflect the reality of American society.

Into the Image

I have a natural antiestablishment streak. Perhaps as a result, I conceived this thesis as a production thesis because I felt that so much of our culture's intellectual body and soul was funneled into reams of written word and then put on the shelves for god knows who and god knows why. I wished to create something that could be taken out in the field and passed around and discussed—something that had three dimensions and a

personality, maybe even a little flawed, like a person; a thesis that would challenge as well as be challenged. I chose comics for this reason.

The other reason I chose comics is because, as stated in Chapter I, an image has the ability to speak beyond words and penetrate to the emotional core, much in the same way that music does. Using this power that image embodies, I hope to slip past the linguistic sparring that can obscure the presence of traumatic experience. In Chapter II of this thesis, I made the point that perhaps part of the difficulty in the acceptance of psychological trauma in years past is that there often are no obvious physical impairments visible to the eye—no missing limbs, crutches, or scars. The *image*, as such, is of a functional organism, yet the truth is that the organism is not fully functional and in fact may have severe maladaptive behavioral patterns that make her life much more challenging than those of her peers. Image can convict or exonerate. My mind jumps to the absurdity of O. J. Simpson's theatrical confusion as he demonstrated that his hand was not able to fit into the bloody glove recovered near the murder scene. The brilliance of his legal team was that they knew the jury would have that image forever in their minds—that of a hand which did not "fit" the crime.

In all things, the image speaks louder than intellect. Intellect is more often used to deflect, deconstruct, and convince, whereas the image transmits. In 1980 photographer Mike Wells took an iconic photograph during a severe famine in Karamoja Uganda, a photograph that likely any American born before 1970 is familiar with: the strong, healthy white hand of the photographer is holding up the tiny, shriveled, dark-skinned hand of a child. This image does not need to convince anyone; it sends a bolt to the soul that reveals the suffering of famine. I would wager that most Americans could not tell the

Ugandan famine apart from the famine in Sudan or the famine in Ethiopia, yet through that one photograph was transmitted the concept of *famine in Africa*. The intellectual story of famine in Uganda, or any other famine, is no doubt complex. The image of the child starving to death is archetypal and it transmits something to the human heart that needs no "facts."

In the case of the comics I am creating for this thesis, I attempt to pair facts and image to transmit some of what is currently know about trauma. I create short scripts that describe or discuss an aspect of the research I have done, and I e-mail these scripts to an illustrator, J.. This part of the process is a collaboration and J. is free to draw whatever it is that ricochets off J.'s psyche. In addition to the scripts, I send articles and additional reading suggestions. J. sends me drawings in the order that they come. Some are responses to particular lines in the scripts, some are overall reflections. In time we have pared them down and focused on specific passages to sculpt more of a narrative. The concepts illustrated are psychoeducationally written with a narrator's voice and J.'s illustrations building on the text.

In what I hope has been an entertaining and informative read, this thesis has spoken on many subjects: smoking, parenting, neuroscience, workers' comp, social justice, feminism, the industrial revolution, comics, O. J. Simpson, and famine. The comics that could be produced are endless but fortunately for J.'s sake, I have chosen just a sliver of topics for illustration: "Window of tolerance," "Why do I want drugs?," and "All you need to know to be a parent." These scripts can be found in full in the appendix but I will break them down here briefly.

"Window of tolerance" takes its title from psychiatrist Daniel Siegel (2010), who conceptualized successful affect regulation as a space of safety, which is wider or narrower based on each individual's personality and social matrix (p. 137). An important element of an individual's window of tolerance is that because of neuroplasticity, one's window of tolerance can be widened and affect regulation improved by practice, much like a muscle's ability to grow stronger. I like this construct because it empowers individuals to explore their own potential and limits outside of what society or any given system expects or accepts as "normal," at the same time that it offers the hope of growth and adaptability.

This piece of artwork will have clinical applicability to anyone who can read, young or old, who has difficulty regulating their emotions. This is a very wide population; it could be useful for so-called "anger management" with children as they learn to tune their emotional responses on the playground, in the classroom, and at home, with couples as they navigate the murky world of their colliding needs, and as a training tool for managers and employees.

"Why do I want drugs?" attempts to normalize the measures many suffering individuals take to ease their pain. It is spoken in plain language to address the deep wounds of the addict and alcoholic. In the script, drugs, alcohol, sex, shopping, gambling, and food are treated as medications that one uses to treat pain. In this way, substance use disorders and their cousin compulsions—shopping, eating, and gambling—are viewed as affect regulation tools with unwanted side effects. As with the above script, the attempt is to take the power away from any given social system or any particular substance and put the responsibility back in the individuals hand's. This way individuals are empowered to

address their emotional pain however they choose. The clinical framework drawn upon for this script is a melding of attachment theory, acceptance and commitment therapy (ACT), and neuroscience. Naturally the clinical application is addicts and alcoholics, yet this piece of artwork may also be very useful for families and friends of addicts and alcoholics who cannot conceptualize addiction as a very normal adaptive response to the complications of life.

"All you need to know to be a parent" focuses on one thing: the attachment between child caregiver(s). The title is somewhat humorous because the script presents only one thing as "all you need to know," and that thing is *empathy*. In this way, the script transmits one simple idea: as much is possible, promote a warm bond between a baby and her caregiver(s). The script draws on the science behind attachment theory as conceptualized by Perry (2004), Beaglehole (2004), van der Kolk (2005), and many others in the field of developmental psychology, public health, and neuroscience.

This piece of art has clinical application to parents, educators, physicians, anyone really, as we are all part of the matrix that affects the ways in which our children adapt to the environment. As with the two others, the goal is to return power and control to the reader and away from any given system or social matrix. In this script, it means supporting him or her in the awareness that one's best chance at raising a happy child is likely possible even with the least amount of money, power, or prestige. And, conversely, no amount of money or prestige can replace the essential ingredient, which is empathy.

Chapter IV
Conclusion

Summary

I would like to return to the original question I posed in Chapter I: Would a comprehensive trauma diagnosis, accounting for all traumatic wounding that impaired normative functioning, run counter to America's free-market system? This is an ambitious question, one that defies a definitive answer. In this thesis, I have only attempted to scratch the surface by examining historical concepts of trauma as pathology (Figley, 1985; Herman, 1997; Trimble, 1985), the current diagnostic framework for PTSD (APA, 2013), and where trauma diagnosis may be headed in the near future (McDonald et al., 2014; Perry, 2004; van der Kolk, 2005) to demonstrate that developmental trauma (specifically non-PTSD trauma) is every bit as prevalent and costly to society as criteria A single stressor PTSD but is treated as a second-class citizen.

I choose the colloquialism "second class-citizen" purposefully to fortify the theory that developmental trauma is possibly denied its place at the table of pathological etiology so that business as usual can continue, well, as business as usual. In this thesis, I hypothesize that children's emotional needs conflict with economic pressures felt by parents and that many aspects of American childrearing paradigms may be in place to dominate and control children in order to ease this conflict. The domination and control of children as a solution to the conflict between the emotional needs of a child and the demands of the society is tantamount to sanctioned violence against children (as I have

defined violence), and this system of sanctioned violence is obscured to protect the free-market system. One of the tools used to delegitimize those suffering from this violence is not acknowledging the symptoms of the violence of developmental trauma in the form of a diagnosis.

I am not advocating the abandonment of the free-market system, nor do I condemn it; in fact, as I stated earlier, the current free-market system may be the best possible way to support the largest number of people at the highest quality of life and with an adequate sense of autonomy and self-determination. I feel strongly that this viewpoint must be considered so as not to be blinded by personal bias both conscious and unconscious.

In addition, there is the very real possibility that suffering and trauma are parts of the human experience that not only are intractable, but also carry unknowable and necessary balancing for the human emotional landscape. Homelessness, poverty, crime, misery, war, famine, and disease all have an element of the archetypical. Archetypes need no cure any more than the color blue needs a cure. I accept that suffering exists and that it is a powerful force that can stimulate both illness and cures. On this point, it is interesting to note that one of the ways our bodies stay symptom-free from certain dangerous germ-born illnesses is exposure to these germs.

Yet, beyond these philosophical considerations, depression, anxiety, substance abuse disorders, and personality disorders are a very real quantity and as much as is known about our bodies and minds, not very much is known or agreed upon bout the cause of these disorders or how to ease their pain. It is my opinion that the best way to stem the suffering from these disorders lies in a paradigm shift by those who care for

children—a shift away from behavior that serves the free-market system and toward a paradigm of empathic attunement that honors the autonomy of children.

Further Study

Part of my argument in this thesis is that changing our caregiving paradigm (parenting) is a social justice issue, and that our current parenting paradigms are designed to normalize the control and dominance of children at the benefit of the free-market system. It is my opinion that "further study" is one of the methods used by a dominant culture to delay an outcome. The *DSM* is a tool of the dominant culture by proxy because it is the official manual on which diagnoses are legitimized both in the legal sense and in our concepts of sick-healthy.

> The legal system is designed to protect men from the superior power of the state but not to protect women and children from the superior power of men. It therefore provides strong guarantees for the rights of the accused but essentially no guarantees for the rights of the victims. (Herman, 1997, p. 72)

As noted earlier, it was 40 years after the first substantial longitudinal studies proving causality between lung cancer and smoking that social justice was served. No doubt there were numerous calls for further study, and I wonder what part of the medical establishment's reluctance on behalf of developmental trauma is related to the element of sanctioned violence and what is simply caution for the benefit of public safety. Or perhaps the old guard simply is comfortable with their own theories surrounding anxiety, depression, and personality disorders and not prepared for the new.

In my research, the attraction has been toward research showing that children benefit from a consistent, warm caregiving system in the first years of life, and that this benefit extends for the duration of their lives. This in turn gives them a better chance at successful adaptive behavior and more satisfaction in romantic relationships, work

relationships, and better overall physical health. When the caregiving system does not provide sufficient empathy and warmth, there are cognitive and emotional deficits that have the potential to worsen over time, possibly appearing as pathology in adulthood. So I wonder what motivates a system to delay a prescription of empathy and consistent care-hours between parent and child? What possibly could be the negative outcome of such a prescription? Should either subject overdose from too much love and caring, every home could be equipped with a defibrillator. Does such a prescription really need more research? I think not. It is my opinion that children as the least empowered group simply not have a formidable enough voice to demand an equal share of adult clock hours.

There is of course another side to my argument and that is simply one of scientific method. The scientific method is a recipe, and in the scientific community it must be followed to the letter or the research is not valid. I respect this recipe and I am indebted to it for yielding so many wonderful things, from vaccines to effective prenatal care, to environmental law, to the promise of an erect penis in my old age. So much of what we enjoy in our modern time has been proven effective and relatively safe. In this way, I am sure that the scientific community has a very valid reason for delaying a more comprehensive trauma diagnosis in the *DSM*, and I am sure that part of that argument has to do with the body of acceptable research not equaling the volume behind the other diagnoses.

Such was the case for psychologist Terence Keane, whose research team was instrumental in the inclusion of PTSD in the *DSM*. Keane was also part of the Harvard Study Group on Trauma, an informal think tank that included Judith Herman, which I note to highlight that Keane would be considered an ally to those wishing for more action

on a comprehensive trauma diagnosis. Yet his struggles to legitimize PTSD have shown him that only rigorously tested hard data could sway the fixed beliefs of the scientific community:

> I was compelled to do so not because I had a burning interest in learning psychometrics or classification science, but because I was grilled on the topic. Sometimes the grilling was very hostile and sometimes I was invited to lecture just so that people could pick me apart. (Keane & Najavits, 2013, p. 511)

One cannot help but reflect upon Herman's (1997) thoughts regarding rape victims who also must provide an inordinate amount of hard data to legitimize their experience: "Indeed, an adversarial legal system is of necessity a hostile environment; it is organized as a battlefield in which strategies of aggressive argument and psychological attack replace those of physical force" (p. 72). I am perhaps unfairly comparing the scientific community and the legal system, but as foundational institutions in the support of the dominant culture, they share many functions and characteristics.

The evidence is mounting in favor of a more comprehensive trauma diagnosis and there is likely nothing those wishing to obstruct it can do. Developmental trauma, whatever the official diagnosis later becomes known as, will be heard, not just because it is in the best interest of a minority of our society, but because of its benefit to our entire society.

> Now we know that if somebody lives in a really stressful environment, then there will be an effect at the genetic level, which then leads to an effect at the protein, enzyme, cellular, tissue, or organ level, and then at the holistic level, and then on the family level, and then at the community level, and finally at the societal level. (Keane & Najavits, 2013, p. 515)

How we care for our children radiates from the epicenter of the parental bond outward into our culture and beyond, transforming our human consciousness. I envision a trauma diagnosis for which the strongest solution is prophylaxis that requires no medication, no

special equipment, no hospital, no co-pay, can ease the suffering of millions, and free up billions of dollars for other social programs. Keane said, “There is no question in my mind that’s coming. It may be sooner than I think” (Keane & Najavits, 2013, p. 515).

Appendix A
Comic Scripts

PARENTING

A child needs a warm connection with a caregiver above all else.

It's more important than the crib or the color of the paint or getting the car washed. It's more important than teaching her manners, getting along with brother. It's more important than getting good grades, going to prom or college.

That is because in the first two years of a baby's life the brain is doing the majority of its growth. It will continue to grow at a slower rate for the next 20 years or so, but the major construction happens early on.

In this first incredible burst of brain growth Baby is learning the key to relationship with another, and that is why the caregiver is so important. This key is called connection and it can come from anyone, even from a team of people.

What does a warm and connected caregiver do? Holds baby, talks to baby, smiles at baby, looks into baby's eyes and reacts with and to baby. These are the things that we all do naturally to babies across all cultures. When Baby is held and seen and reacted to there are quite literally new neuronal pathways being constructed. Baby is learning the complex and amazing array of facial cues we take for granted as adults.

These actions tell Baby that she is seen and cared for, and Baby sends the signal back to the caregiver; the caregiver is seen and cared for too. This is called empathic attunement, or just "empathy."

With this simple action of empathy Baby's genetic code reacts to express genes within that will build Baby's own capacity to care and nurture another. This means the ability to have meaningful relationships with family, friends, lovers and co-workers. For a social species this quite literally means a very high chance of survival.

In a *good enough* environment Baby learns that she is safe and taken care of. The environment only needs to be "good enough," there are no perfect caregivers. When Baby learns that she is safe and cared for she learns to regulate her own emotions. She is less worried and anxious. There is a higher likelihood that she will be able to meet the challenges of school and job and love. There is less of a chance that she will abuse substances, or be incarcerated.

The *not good enough* environment: Baby is not held, or Baby left alone for long periods of time, or Baby is abused with eyes, words, tone of voice, or by physical means.

In the not good enough environment baby does not learn to be safe. Baby is anxious and worried. Baby does not learn to regulate her emotions. She either learns to cut herself off from her emotions and "sucks it up" in silence or makes even more of a fuss, which might guarantee more frustration from the already overwhelmed caregiving system she was born to.

A baby in this environment is more likely to abuse substances, or have difficulty in school, or be incarcerated or have a psychiatric illness.

Unfortunately if there is no caregiver able to focus on Baby in the first two years of her life, then this structure will follow her into childhood. Without empathy as teacher the child has not learned to regulate her emotions and is frequently overwhelmed by them and acts in ways that scare adults (so-called tantrums or acting out). Or she may have maladapted behavior to get needs met that is unacceptable to the rest of society—aggression (hitting, biting, bullying) lack of accepted boundaries (not sharing, over-sharing, inappropriate touching, aversion to touch).

There are no broken children. Children are a product of their parenting matrix. A child's body, like all humans, aspire to the highest health and make astounding adaptations at all developmental stages in an attempt to survive to their highest potential.

All behaviors that may appear as "bad" are adaptations to get fundamental human rights met. A child who did not receive the loving care needed for so-called normal behavior has more challenges ahead than one who did. Yet empathy and connection heal and grow the brain towards "normal" functioning at ANY AGE.

Although poverty, lack of education, and many other social challenges play a factor, it is the conscious awareness that a Baby must have a consistent, warm caregiving system in the first two years of life that is key, and it is possible at all levels of society. The good enough environment can be in a mansion or in a shack.

This information may create anxiety among adults because it forces reflection on our own parenting and our own parents. Yet there is still in all of us the joy we feel when we see a little baby smiling at us. Or maybe it is a puppy or a kitten or something in nature. Regardless, what we are really seeing is our social heritage as embodied by a connection with another. We can return to this human truth at any point and know that it is a mirror looking back at us.

WHY DO I WANT DRUGS?

All humans feel uncomfortable when faced with life's everyday stresses. Some people choose so-called healthy ways to deal: exercise, meditation, reaching out to another human and relating.

But most do it the other way: a few beers, cigs, TV, computer, video games, ice cream, salt and vinegar chips and porn.

This is not a moral question. Our bodies are designed to regulate stress, and they will use whatever is at their disposal to do so. Our organism is a thing of beauty and operates automatically and strives continually to the highest possible health. Our life forms are truly magic in the material.

For a variety of reasons some of us feel more uncomfortable than others. Some have very real traumatic pain carried forward from the past—death, loss, accident, misfortune, neglect, abuse. Some are just more sensitive to the stress of life for no reason at all. Again, this has nothing to do with morality or strength of character. These individuals feel the feelings in a more painful way.

There are many theories and complex ideas to explain why some people are built like this. A simple idea that is based on scientific research is this: we have a power plant in our brains that produces a feeling of well-being; some of us do not have a large enough power plant to supply a normal level of good feeling.

Some of these individuals get sweet relief from drugs, booze and sex. They are not weak people, they are people in pain who need strong relief. Imagine a person in the emergency room with incredible pain from cancer; the doctor does not tell them they are weak, they give them the mercy of pain relief.

Drugs, booze and sex act on these bodies and make up for the missing feel-good power. They give us that missing thing that makes us feel normal. Sure, the high is great, but the goal is to just be out of pain.

Although the drugs, sex and booze work at first there is a twofold problem to this kind of solution. The body, in its wisdom, only builds what it needs. When the power plant sees that there is all this extra help from the outside (drugs, sex and booze) it stops producing its own feel-good product. Now you need more booze, drugs and sex. We know how that ends.

The other problem is one that affects all the other bodies around us. This kind of problem solving (booze, sex and drugs) hurts everyone else around you, drawing power from the feel-good power plants of your loved ones, roommates and communities.

There is a solution and it is called emotional regulation. This just means taking care of your own emotions. It is hard at first because if you feel a lot of emotional pain it can feel

like the worst pain on earth. But quickly you will learn to manage it and all you need is your body and the wish to feel good—which is why we shoot, smoke, drink and fuck in the first place.

If you're just coming off a 20-year run this will feel like rocket science. But remember, your body knows stuff your mind doesn't, so just follow its cues. Emotional regulation is easy. First step is knowing when you are having an emotion; some people have never been able to recognize them.

An emotion is happy, sad, mad and many shades in between. Your body knows them before you do…increased heart rate, change in breathing, change in bodily temperature, agitation, tightness of the chest, narrowing of vision…these are just a few common signs. Just pay attention to your body, the only thing that ALWAYS knows right where you are at. Is your heart beating fast? Are you feeling hot? Is your breathing getting shallow and quick? Is your vision narrowing? Your body can always be trusted and is faster than your thinking, so look to it.

Once you learn to listen to your body, regulation is easy to do. Step away from the people, place or thing that has you in its grips and take 15 seconds to listen to your body. Walking is good. Listening to your breathing is good. Snapping your fingers one then the other is good. Blink one eye then the other. Pinch your left ear, then your right, that works too. Experiment. Talk to your self. Talk to a bird. You will laugh when you realize how many ways there are to help your body regulate the stress.

If you've been talking out of the side of your neck in motel rooms for ten years this might try your nerve, but stick with it if you want peace of mind in your life. If you are currently strung out or shake when you don't drink you will most likely need medical attention before you can "regulate your emotions." After you are clean it takes a leap of faith to believe that these simple things are the difference between being at peace and being miserable. Try it and see if it works for you. It's your body, and it's your life.

There will always be life stress, and some individuals will always feel it more than others. Yet with practice there is the very real chance that where once the solution was shooting drugs, drinking liquor and smoking cocaine, the solution is now exercise, meditation and reaching out and connecting with another human being. At the core is a very powerful thing called emotions, and they CAN be regulated. GOOD LUCK!

P.S. you can teach this to your children too and they can maybe avoid some of the pain you have endured!

THE WINDOW OF TOLERANCE

There is a space in us where we feel comfortable. Our body is relaxed so our breathing is easy. We are at peace, and we feel good just being alive. We are in the window of tolerance.

Sometimes we feel the opposite, our emotions are out of control…like when a baby is crying and thrashing around and can't catch it's breath…or we don't feel anything, we are shut down like a clam and nothing can touch us…we are outside the window of tolerance.

Things happen in the day, and we can get our moods blown around by the stuff we do and see or the stuff that gets done to us. We get startled when our friend jumps from behind a door and surprises us…or we get angry when we fight…or feel warm excitement when we hug someone who loves us. Our emotions are like magic wands, when they wave over us, everything changes in the blink of an eye.

The stuff that changes our mood can be called "arousal." Arousal moves us up and down in the window of tolerance. Some arousal makes us feel good, and some makes us feel bad. Another word for arousal is "stress." Our body is perfectly designed to handle stress.

Stress has a bad reputation, but the right amount of stress is actually a very important thing. Stress challenges us to build emotional muscles that let us feel more love, feel more sadness, feel more excitement—without leaving the window of tolerance and turning into the overwhelmed infant or the closed up clam that shuts everything out.

Our bodies are very smart, and they automatically change to regulate stress. "Regulating" just means your body is doing something to help you. Like when you breathe faster to catch your breath. That is your body regulating.

The more stress we can handle, the wider our window of tolerance will be. The wider the window, the more chance we have to feel comfortable and safe. When we feel comfortable and safe we feel better and can focus on the things we like: friends, games, books, school, lovers, music, dreams, jobs, plants, outer space, cooking, etc.

Everybody has a different size window. A person with a wide window of tolerance can quickly regulate a lot of different kinds of stress. A person with a narrow window will take a longer time to regulate a smaller amount of stress. Window size is not about being a good or bad person or a smart or dumb person or a rich or poor person or a right and wrong person. Window size is about what kind of person you want to be, because window size can be increased if you want.

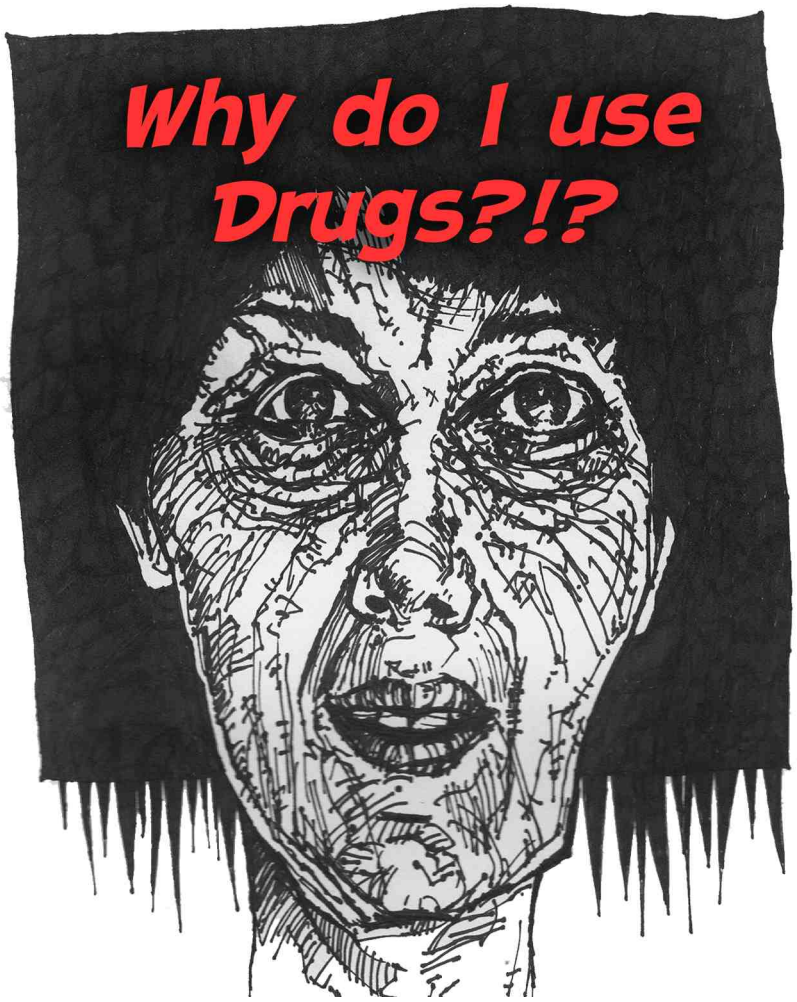
How do you increase your window? Practice. First step is knowing when you leave your window. Just pay attention to your body, the only person who ALWAYS knows right where you are at. Is your heart beating fast? Are you feeling hot? Is your breathing

getting shallow and quick? Is your vision narrowing? Your body can always be trusted and is faster than your thinking, so look to it.

Once you learn to listen to your body, moving back into the window is easy. Step away from the people, place or thing that has you in its grips and take 30 seconds to listen to your body. Walking is good. Listening to your breathing is good. Snapping your fingers one then the other is good. Blink one eye then the other. Pinch your left ear, then your right, that works too. Experiment. Talk to yourself. Talk to a bird. You will laugh when you realize how many ways there are to help your body regulate the stress.

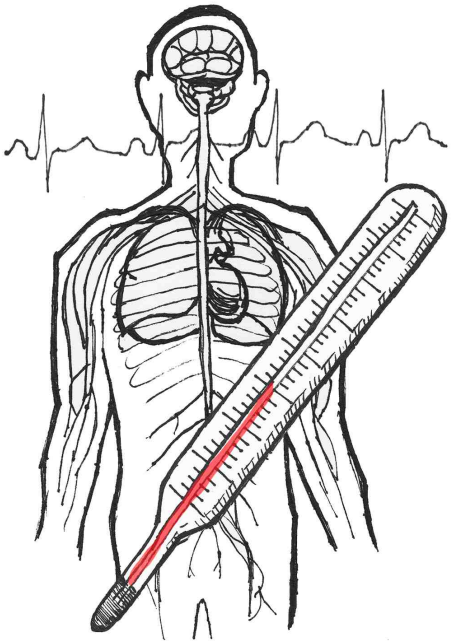
It takes a leap of faith to believe that these simple things are the difference between being at peace and being miserable. Try it and see if it works for you. It's your life, so open the window wide!

Appendix B
Comic Pages



All humans feel uncomfortable when faced with life's everyday stresses. Some people choose so-called healthy ways to deal: exercise, meditation, reaching out to another human and relating. But most do it the other way: a few beers, cigs, TV, computer, video games, ice cream, salt and vinegar chips and porn.

This is not a moral issue, it is biology. Our bodies are designed to regulate stress, and they will use whatever is at their disposal to do so. Our organism is a thing of beauty and operates automatically and strives continually to the highest possible health. Our life forms are truly magic in the material.



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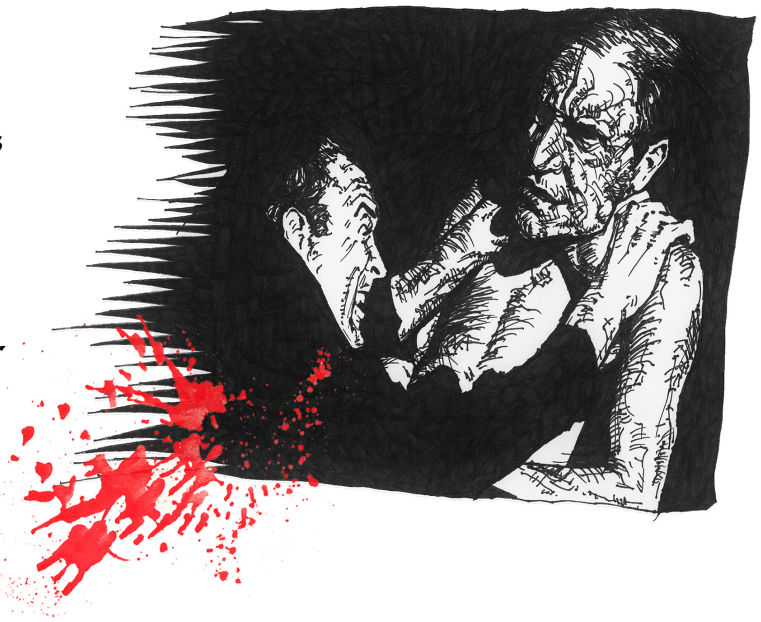

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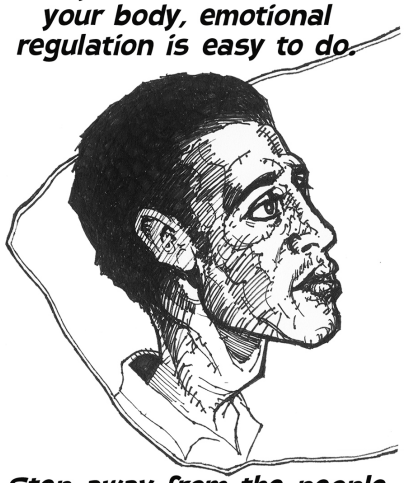

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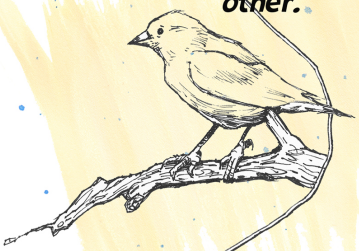

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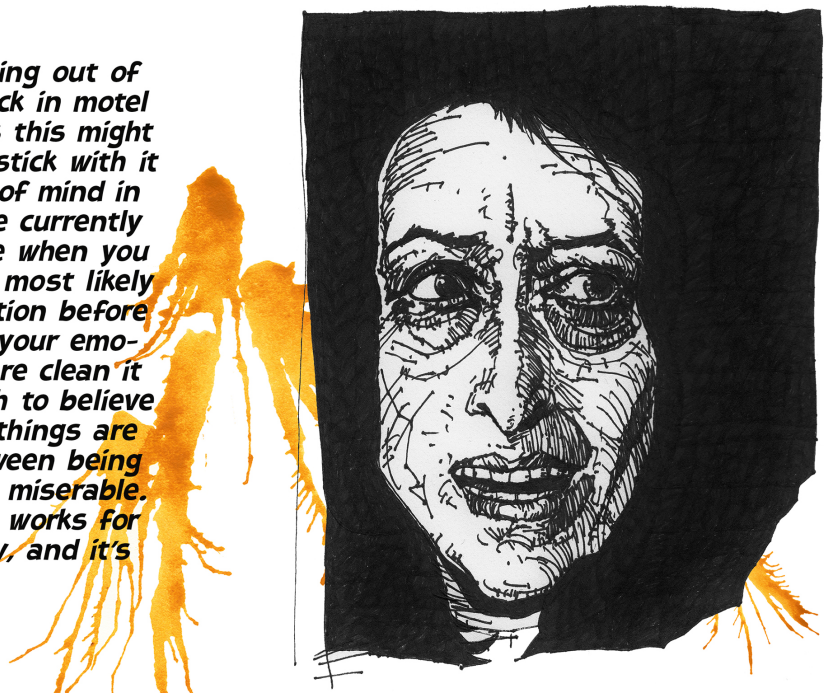

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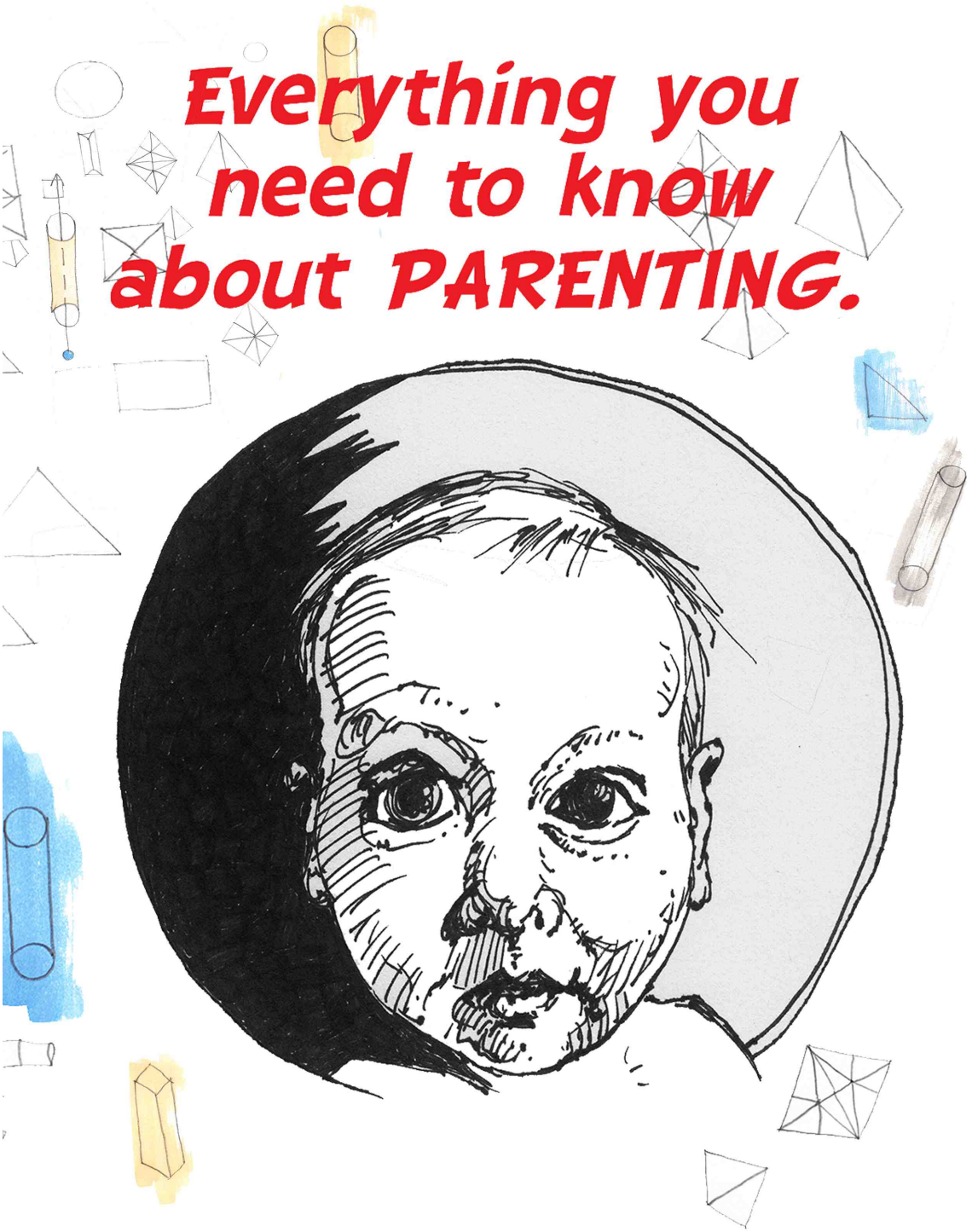
Everything you need to know about PARENTING.

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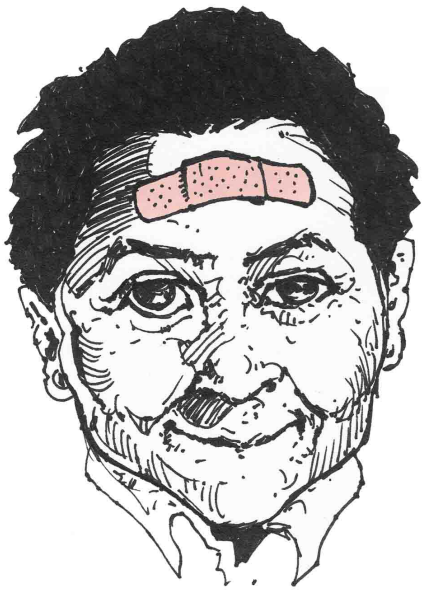

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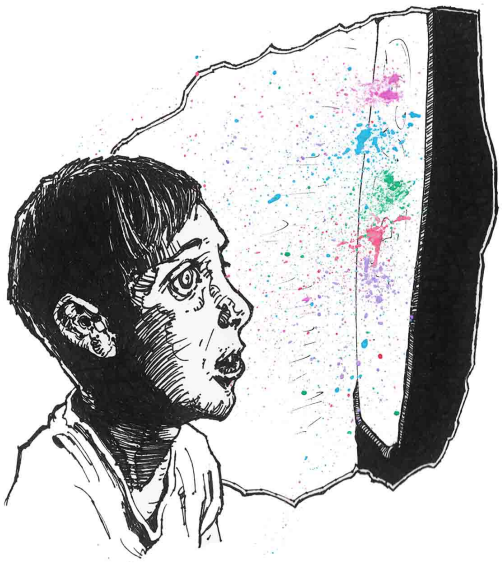

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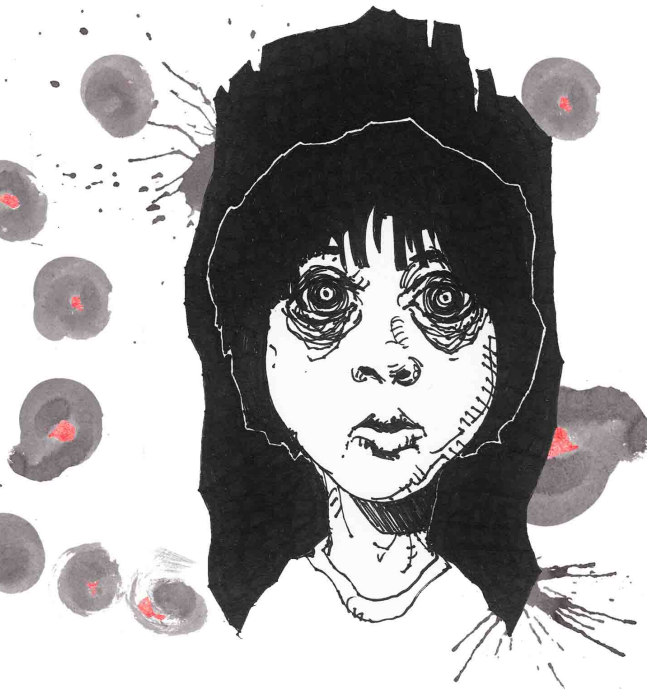

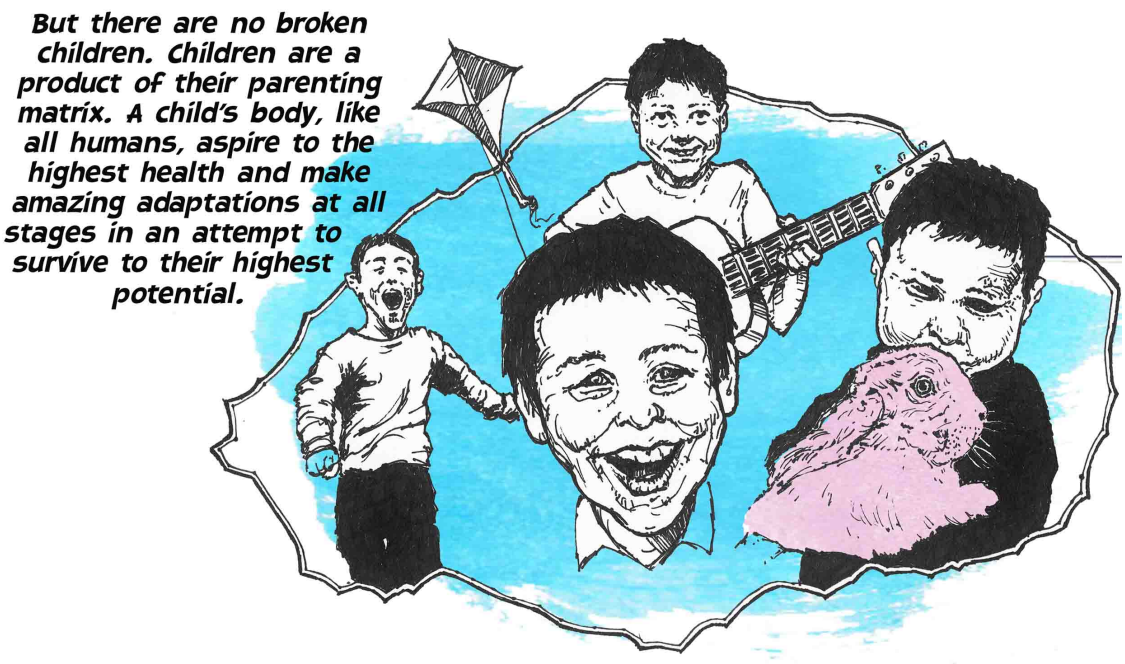
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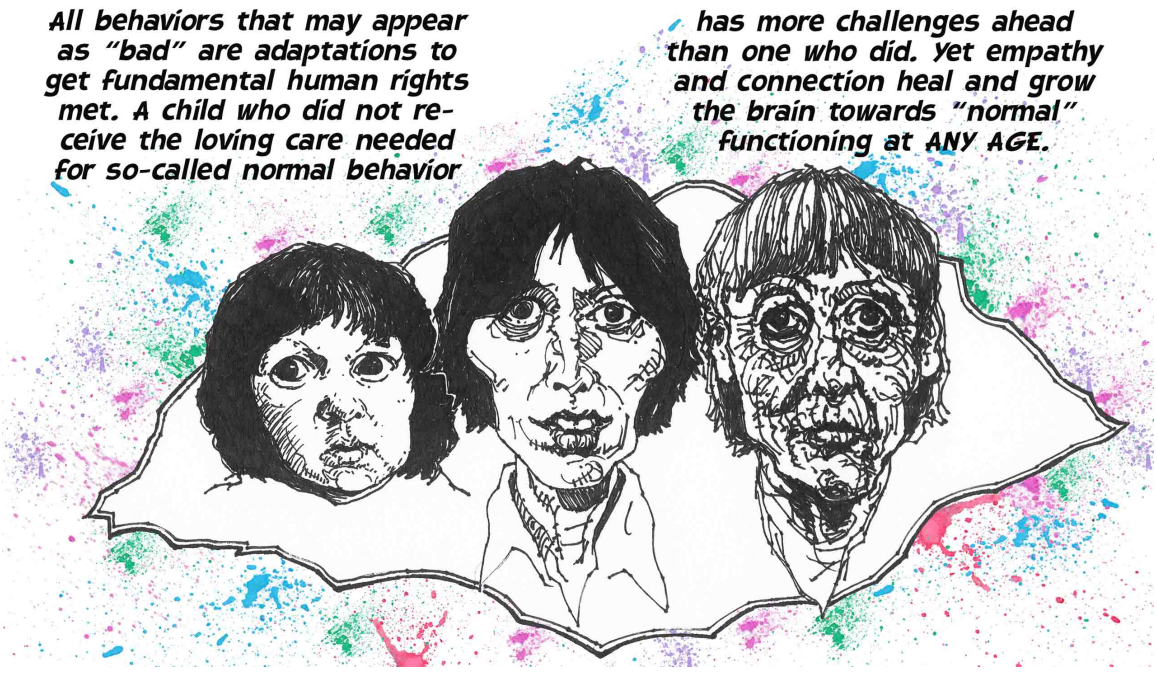
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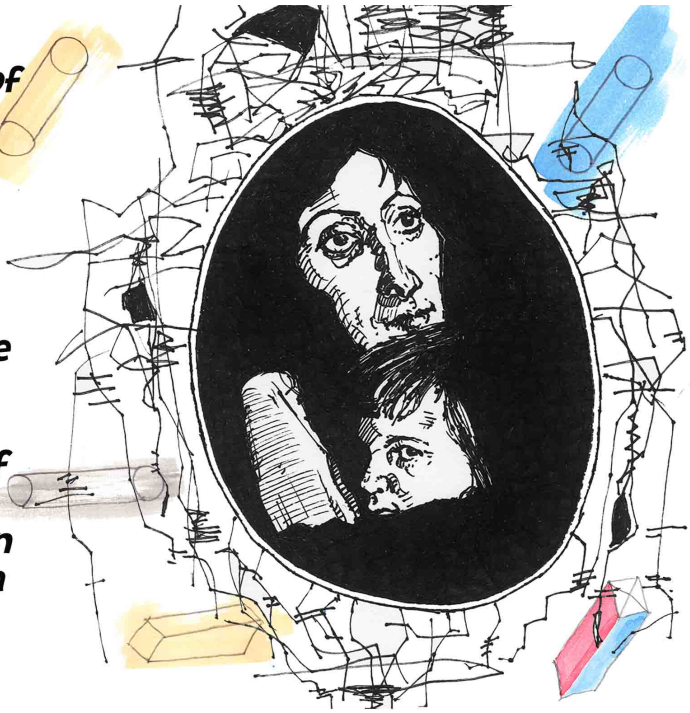

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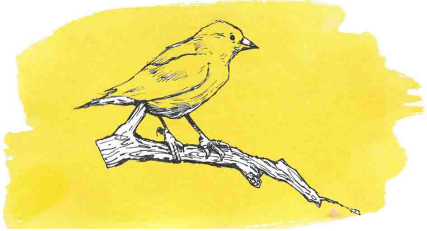
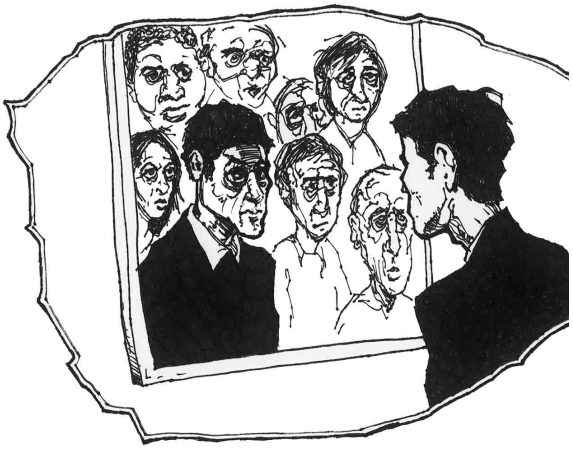
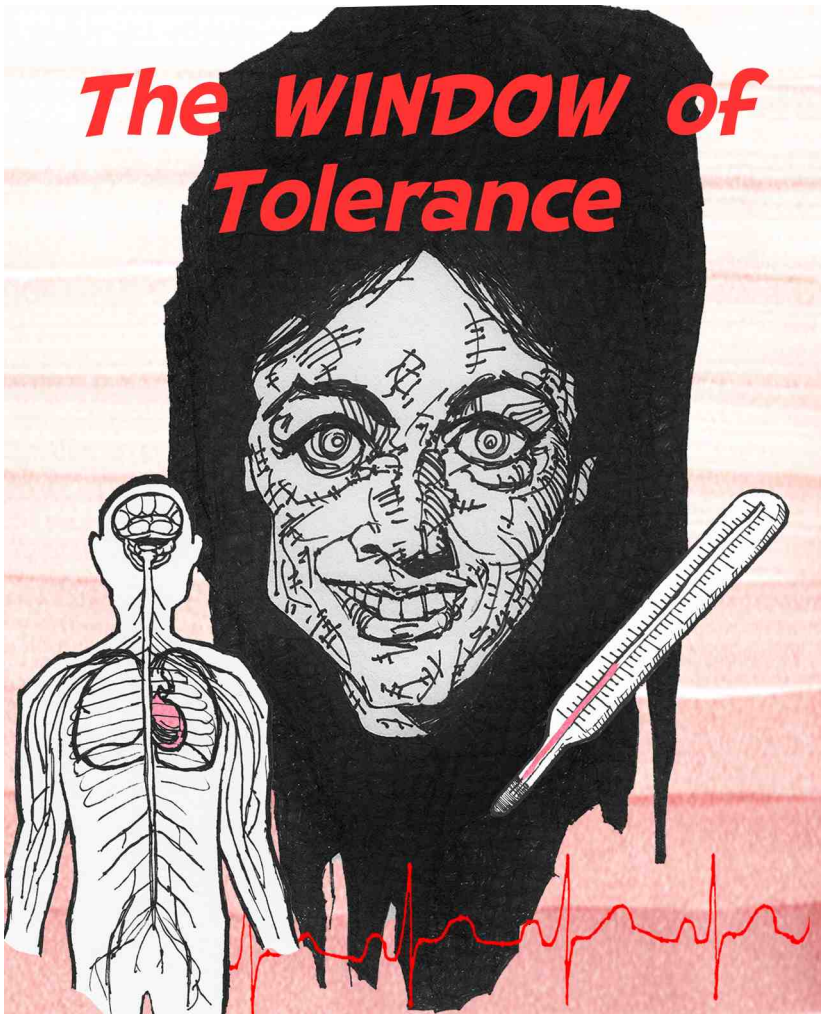




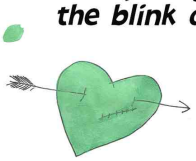
We can return to this human truth at any point and know that it is a mirror looking back at us.


The WINDOW of Tolerance

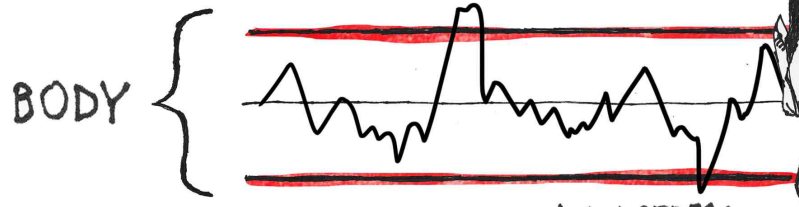
There is a space in us where we feel comfortable. Our body is relaxed so our breathing is easy. We are at peace, and we feel good just being alive. We are in the window of tolerance.

Sometimes we feel the opposite, our emotions are out of control...like when a baby is crying and thrashing around and can't catch it's breath...or we don't feel anything, we are shut down like a clam and nothing can touch us...we are outside the window of tolerance.

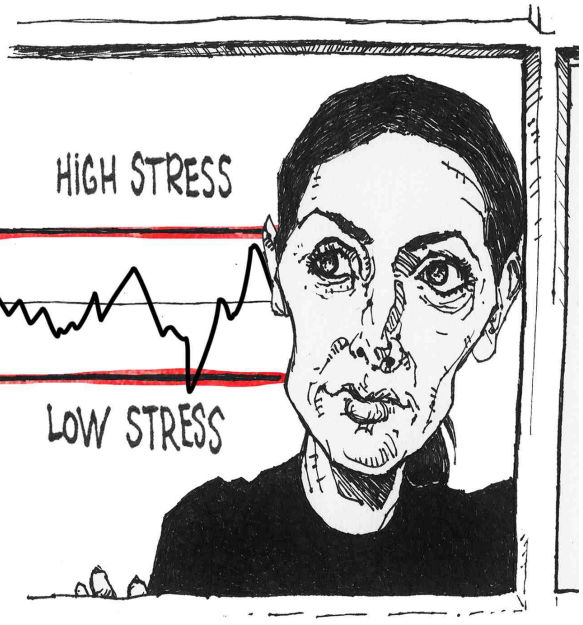
Things happen in the day, and we can get our moods blown around by the stuff we do and see or the stuff that gets done to us. We get startled when our friend jumps from behind a door and surprises us...or we get angry when we fight...or feel warm excitement when we hug someone who loves us. Our emotions are like magic wands, when they wave over us, everything changes in the blink of an eye.



The stuff that changes our mood can be called "arousal." Arousal moves us up and down in the window of tolerance.

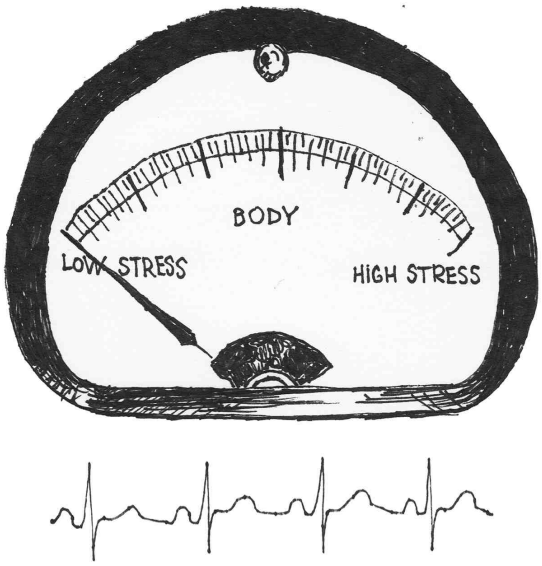


Some arousal makes us feel good, and some makes us feel bad. Another word for arousal is "stress." Our body is perfectly designed to handle stress.



Stress has a bad reputation, but the right amount of stress is actually a very important thing. Stress challenges us to build emotional muscles that let us feel more love, feel more sadness, feel more excitement – without leaving the window of tolerance and turning into the overwhelmed infant or the closed up clam that shuts everything out.

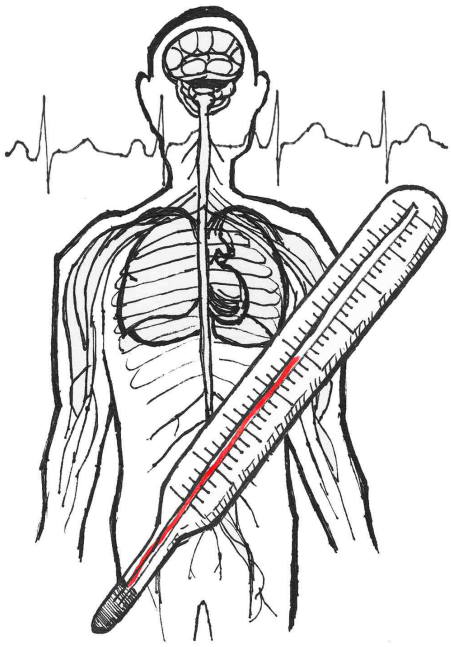
Our bodies are very smart, and they automatically change to regulate stress. "Regulating" just means your body is doing something to help you. Like when you breathe faster to catch your breath. That is your body regulating.



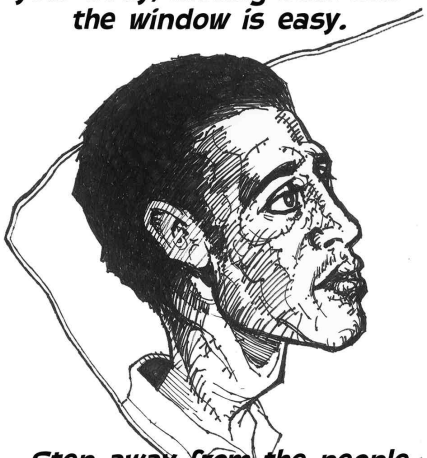
The more stress we can handle, the wider our window of tolerance will be. The wider the window, the more chance we have to feel comfortable and safe. When we feel comfortable and safe we feel better and can focus on the things we like: friends, games, books, school, lovers, music, dreams, jobs, plants, outer space, cooking, etc.

Everybody has a different size window. A person with a wide window of tolerance can quickly regulate a lot of different kinds of stress. A person with a narrow window will take a longer time to regulate a smaller amount of stress. Window size is not about being a good or bad person or a smart or dumb person or a rich or poor person or a right and wrong person. Window size is about what kind of person you want to be, because window size can be increased if you want.

How do you increase your window? Practice. First step is knowing when you leave your window. Just pay attention to your body, the only person who ALWAYS knows right where you are at. Is your heart beating fast? Are you feeling hot? Is your breathing getting shallow and quick? Is your vision narrowing? Your body can always be trusted and is faster than your thinking, so look to it.



Once you learn to listen to your body, moving back into the window is easy.



Step away from the people, place or thing that has you in its grips and take 30 seconds to listen to your body.

Walking is good. Listening to your breathing is good. Snapping your fingers one then the other is good. Blink one eye then the other.

Pinch your left ear, then your right, that works too. Experiment. Talk to yourself. Talk to a bird. You will laugh when you realize how many ways there are to help your body regulate the stress.

It takes a leap of faith to believe that these simple things are the difference between being at peace and being miserable. Try it and see if it works for you. It's your life, so open the window wide!

Appendix C
Forms

Informed Consent Form
for an Experimental Study in a Production Thesis

Project Title:

1. I understand that this study is of a research nature. It may offer no direct benefit to me.
2. Participation in this study is voluntary. I may refuse to enter it or may withdraw from it at any time without creating any harmful consequences to myself. I understand also that the investigator may drop me at any time from the study.
3. The purpose of doing this study is:
4. As a participant in this study I will be asked to take part in the following procedures:
5. Participation in the study will take_____of my time and will take place in _____.
6. The risks, discomforts and inconvenience of the above procedure might be: _____
7. The possible benefits of the procedure might be
   a. Direct benefits to me:
   b. Benefits to others:
8. The information about this study was discussed with me by_____.
   If I have further questions, I can call her/him at: _____
9. ____ I am (not) receiving any compensation for participating in this study.
10. My compensation for being in this study is $_____. If I do not finish the _____ procedures, I will receive a minimum of $_____.

Signature: _____ Date: _____

Parent or Legal Guardian (if participant is a minor):

Signature: _____ Date: _____

Ethics Application for Approval for the Use of Human Participants in a Production Thesis

Researcher:_____ Today's Date: _____

Full Address: _____

Phone (Day): _____ Phone (Eve):_____

Title of Activity: _____

Sponsoring Organization: _____ Contact Person: _____

Signature of sponsoring organization:_____

Phone number: _____

Affix appropriate signatures

I will conduct the study identified in the attached application. If I decide to make any changes in the procedures, or if a participant is injured, or if any problems arise which involve risk or the possibility of risk to the participants or others, including any adverse reaction to the study, I will immediately report such occurrences or contemplated changes to the Institutional Review Board.

Investigator/Student:_____ Today's Date: _____

I have read and approve this protocol, and I believe that the investigator is competent to conduct the activity as described in this application.

Research Associate:_____ Today's Date: _____

Notice of Approval

The signature of the representative of the Institutional Review Board above indicates that the activity identified above and described in the attached pages has been approved with the conditions and restrictions noted here.

Restrictions and Conditions:_____

_____

_____

Ethics Application (Continued)

Brief Description: Describe the study in two or three brief sentences.

1. Participants: Describe the participant population and how it will be obtained. Who will participate and how will you find/select them? Current clients may not be used as participants in research for the thesis.

2. Procedures: From the participants' point of view, describe how you will involve them in your study. How will you conduct your study?

3. Consent: Describe procedures for how and when you will receive informed consent from your participants. Enclose in this application a copy of the informed consent form you will use. (Consult the guideline sheet for developing a consent form.)

4. Risks: Describe and assess any potential risks and the likelihood and seriousness of such risks. How might participants be harmed during or after their participation in the study?

5. Safeguards: Describe procedures for protecting and/or minimizing the potential risks (including breaches in confidentiality) and assess their likely effectiveness. Given the risks, how will you prevent them from occurring?

Ethics Application (Continued)

6. Benefits: Describe the benefits to be gained by the individual participants and/or society as a result of the study you have planned. What good will come of this research?

7. Post Experiment Interview: Describe the contents of your conversation with people in the study after their participation is completed. How will you inform them of the study's purpose?

8. Attachments: Include in this application all of the following supplemental information:
   1. Informed Consent Form from participants.
   2. Verbatim instructions to the participants regarding their participation.
   3. All research instruments to be used in carrying out this study.
   4. Other documentation pertaining to the study that will be shown to participants.

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