In K. Davis, R. Bergner, F. Lubuguin, & W. Schwartz (Eds.) Advances in Descriptive Psychology, (Vol. 10, pp. 155-180). (2013). Descriptive Psychology Press: Ann Arbor, Michigan.

Trauma Concepts: A Descriptive Psychological Formulation of the Nature of Trauma and its Consequences

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Abstract

In this chapter, I seek to answer four questions about psychological trauma that have not been properly conceptualized. They are: (a) What is psychological trauma? (b) Why do some people get traumatized and others do not? (c) Why do the symptoms of PTSD take the specific forms that they do? And finally, (d) What is the role of physiology in creating or perpetuating the condition? In addressing these questions, I shall be drawing upon the conceptual resources of Descriptive Psychology, among which are the conceptual device of Paradigm Case Formulations, the formulation of pathology as disability, and the concept of a person's World and how it is related to his/her self-concept. The resulting clarifications will lay the foundation for a later elucidation and integration of approaches to therapy with PTSD victims.

Key words: Paradigm Case Formulation, trauma, Post-Traumatic Stress Disorder, personal worlds, Face in the Wall

We are all vulnerable to life's evils and misfortunes; how we adapt to them determines what our world will subsequently be and whom we will experience ourselves as. Thus, the study of psychological trauma deals with some of the most fundamental questions about the nature of one's world and its relationship to oneself. Despite its salience in many of our clients' lives and often in our own, making the concept of psychological trauma accessible proves to be challenging. In reviewing the literature on psychological trauma, four central questions emerge: (1) *What*

is psychological trauma? (2) Why do some people get traumatized and others do not, even when exposed to essentially identical circumstances? (3) Why do the symptoms take the particular forms that they do? (4) What is the role of physiology in creating or perpetuating the condition? As I have become more and more involved with survivors of trauma, I have become less and less satisfied with the answers usually given to these four questions. In fact, existing accounts of trauma are problematic in a number of respects. What has been apparent is that the bulk of the writing on trauma has been from an empirical perspective. These writings have chiefly described the clinical syndrome of psychological trauma (i.e., signs and symptoms) or its epidemiology (i.e., its course, prevalence, and outcome). The conceptual perspective has been relatively neglected. With this in mind, the intention of this paper is to elaborate a formulation of psychological trauma using the conceptual resources of Descriptive Psychology (Ossorio, 2013b). I initially presented some of these ideas on psychological trauma in a presidential address to the Society for Descriptive Psychology (Wechsler, 1995).

Trauma and related concepts have been addressed previously in the Descriptive Psychology literature. Ossorio first mentioned psychological trauma in *Clinical Topics* (2013a) in his elaboration of the concept of "unthinkability" and his subsequent presentation of the "Face in the Wall" heuristic. Later, Mary Roberts discussed trauma in her papers, "Worlds and world reconstruction" (1985), and "Companions of uncertain status" (1991). Subsequently, in a 1993 presentation to the Society for Descriptive Psychology entitled: "The Self and Self-Concept," Ossorio discussed the concept of psychological trauma and its potential to change the self-concept. His most elaborated discussion of psychological trauma may be found in *The Behavior of Persons* (2013b). More recently, Bergner (2005; 2009) has presented a reconceptualization of trauma in terms of the damage it does to persons' conceptions of their worlds, a discussion of how this view integrates findings on who is most vulnerable to PTSD, and a reanalysis of how exposure therapies achieve their well-documented salutary results.

The aim of the current paper is to integrate these ideas and to clarify what actually is transformed about a person and his or her world as a consequence of trauma. I will be elaborating a hypothetical example of psychological trauma introduced by Ossorio entitled "Face in the Wall" (Wechsler and Magerkorth, 2008). This example provides a useful means of formulating the essential or *paradigmatic* features of the phenomenon. The reader is encouraged to consider what follows as a *thought experiment*, which is a traditional philosophical device involving the use of imaginary situations to help understand how things actually are.

My ultimate goal, however, is to provide a model of psychological trauma that will be accessible to individuals who have been traumatized. Having an adequate conceptual model of psychological trauma will allow them to begin answering the five fundamental questions that all people with Post-Traumatic Stress Disorder (PTSD) struggle with: (1) What has happened to me? (2) Why can't I do what I used to be able to do? (3) Why can't I do what other people do, and seem to

do so easily? (4) Why do I have to do the things that I do in the ways that I do them, which are so different from the ways in which other people do them? (5) What can I do to recover and to bring back into my life those things that have been missing, such as safety, happiness, self-respect, and intimacy?

Adding to the confusion about the concept of psychological trauma, the elements of one particular type of trauma are often universalized to all traumas. This tendency to universalize typically reflects the clinical facts of the specific population that was observed by the writer. For example, the research and clinical writings are heavily weighted towards conceptualizations of trauma derived from the Vietnam veteran experience. The focus on this population has heightened the relevance of physiological arousal and community estrangement as essential elements of trauma. Other writers, however, whose clinical population has been primarily victimized women, have emphasized terror and helplessness as essential elements of trauma (Herman, 1992b). Yet, it is just these elements that may be absent when a soldier is committing atrocities. Thus, it is difficult to distill what all instances of trauma have in common.

Problems in Defining Trauma

Weathers and Keane (2007) articulately capture the difficulty in distilling the commonalities of trauma: "Achieving a consensus definition of trauma is essential for progress in the field of traumatic stress. However, creating an all-purpose general definition has proven remarkably difficult. Stressors vary along a number of dimensions, including magnitude (which itself varies on a number of dimensions, e.g., life threat, threat of harm, interpersonal loss; cf. Green, 1993), complexity, frequency, duration, predictability, and controllability. At the extremes, i.e., catastrophes versus minor hassles, different stressors may seem discrete and qualitatively distinct, but there is a continuum of stressor severity and there are no crisp boundaries demarcating ordinary stressors from traumatic stressors. Further, perception of an event as stressful depends on subjective appraisal, making it difficult to define stressors objectively, and independent of personal meaning making" (p. 108).

That said, definitions of psychological trauma have become more sophisticated over the years. A lackluster definition of "psychological trauma" can be found in the 1974 edition of Dorland's Illustrated Medical Dictionary, which defines "psychic trauma" as: "an emotional shock that makes a lasting impression on the mind, especially the subconscious mind" (p. 1633). More recently, Stedman's Medical Dictionary (1989) defined "psychic trauma" as: "an upsetting experience precipitating or aggravating an emotional or mental disorder" (p. 1626). A 2012 definition of (psychological) trauma from the Substance Abuse and Mental Health Services Administration's website (http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx) illustrates the increased sophistication about trauma definitions. The authors define trauma succinctly: "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual

well-being." They go on to posit the centrality of the individual's experience in determining whether the event or circumstances prove to be traumatic.

What should be clear by now, however, is that you cannot establish a unique set of defining features (as required by a definitional approach) by remaining at the level of the observable clinical phenomenon of trauma. You must go beyond this observational level to the conceptual level. The conceptual level describes the significance of the symptoms themselves.

What makes something traumatic per se, rather than merely painful, unpleasant, or scary is not immediately evident, yet this distinction is crucial. This point was brought home to me during discussions with Peter Ossorio (personal communication, March 1, 1994) when I shared with him what I thought was a personally traumatic experience.

I described an incident in 1988 when my (very) pregnant wife and I went into a submarine sandwich shop in a deserted strip mall for a late dinner. It was about 8:45 pm and we had been working long hours to prepare my daughter's room for her imminent arrival. As we placed our order, we chatted amicably with the young woman behind the counter, who was a few months pregnant. Suddenly, as we were eating, two men entered the store and one immediately vaulted the counter with a revolver in his hand as the other took up a position as a look-out near the front door.

I sat there dumbfounded and stared at what was taking place. I had seen similar scenes many times in movies or on television shows, but never unfolding in real life before me. Fortunately, my wife had the presence of mind to get me to stop staring and to look away. We were sitting in a booth to the side and we continued to eat, acting as if we were unaware that an armed robbery was taking place. As we sat there, we listened to the clerk's voice from the back room as she pleaded with the gunman, "I can't open the safe. Please don't hurt me or hurt my baby!" At that moment, I grasped the real possibility that I might be seriously injured or dead very shortly. After a few minutes, however, the robbers left without ever interacting with us. We went to the back of the store to help the clerk, who was scared but unharmed, and called the police.

After I described the incident, Dr. Ossorio kept asking me, "But what made it traumatic?" I would try to give an answer, such as, "I thought I might be killed." But after each answer I gave, he simply repeated the question, "Yes, but what made it traumatic?" Finally, he said to me, "That experience doesn't sound traumatic. That just sounds scary." With that comment, I began to understand a very important aspect of the concept of psychological trauma. It was not the incident itself that was crucial; it was how it had affected my world and my ability to behave as myself in it. I realized at that moment that the experience had not significantly reduced my *behavior potential* (i.e., the type and range of behaviors that I took to be possible for me) to the point that I was left in a pathological state.

I showed none of the signs that actual traumatic events engender, such as avoidance, hyperarousal when memories of the experience were triggered, or finding that the experience intruded into my thoughts unbidden. I still could go to sub

shops (although if I did so in the evening, the thought of the robbery always came to mind and I was conscious of where I sat). I realized that my world had not changed significantly, and that I had not experienced a net loss, but actually a net gain, in my behavior potential. For example, street crime became more "real" to me (rather than merely true), which allowed me to be more consciously aware of personal safety and my environment. The experience also taught me to "trust your gut" because, as we drove up to the deserted strip mall, a thought had fleetingly passed through my mind that I had chosen to ignore: "This would be a good place for an armed robbery."

Physical Trauma as Prototype for Psychological Trauma

Physical trauma is the prototype for the notion of psychological trauma so I will elaborate on their conceptual similarities and differences. The term "trauma" comes from the Greek word meaning to wound or hurt. The American Heritage Dictionary of the English Language (1969) defines "trauma" as "a wound, especially one produced by a sudden physical injury" (p. 1366). Essential to this notion of trauma is that it entails some sort of damage to the normal functioning of the individual.

The injury that occurs in physiological trauma can often be easily seen. With a gunshot wound, for example, the damage is evident. What is "wounded" or "injured" in psychological trauma, however, is much less clear. To put the question slightly differently, exactly what is damaged in the case of, for example, a Vietnam veteran who commits atrocities, a girl who has sexual relations with her grandfather from age six to age twelve, or a person who is a passenger on a plane that is hijacked for seventy-two hours? What is damaged in psychological trauma is the essential question to be addressed in the formulation to follow.

The term "trauma" in medicine refers to injuries that result in *significant* physical damage to a person's body. Not just anything qualifies as trauma. The paper cut on the back of our hand we receive from the edge of a magazine may cause us to wince and to curse, but we do not count it as significant. What makes an injury "significant"? The answer lies in the injury's likelihood of being disabling in some way—in it constituting a *disability.* In the broadest sense, a disability is *something that restricts our behavior potential,* either in our own eyes or in the eyes of others. If the restriction or deficit in our behavior potential is significant enough, we (or others) might consider our self to be in a *pathological state*; i.e., a state of affairs in which "there is a significant restriction on (a person's) ability (a) to engage in deliberate action and, equivalently, (b) to participate in the social practices of the community" (Ossorio, 1985, p. 158). As will be seen, what is central here is the notion of a pathological state; i.e., a state characterized by significant deficits in a person's ability to behave (either as an individual or within the social context within which the individual must participate with other members of his community).

Let's alter the situation somewhat and see where we end up. Instead of a paper cut across the back of your hand, imagine a mistake with a power tool that results in a large laceration across the back of your right hand. The cut is deep enough to

have severed tendons and is bleeding profusely. In this case, you or any bystander would have no trouble recognizing the injury as a significant one and treating it accordingly, such as by applying direct pressure to stop the bleeding and finding some way of getting immediate medical attention. You would also readily agree with the decision to transport you by ambulance to the trauma center at your local hospital.

In this case, the causal connection between the injury and any subsequent disability (i.e., its ability to restrict our behavior potential) is patently obvious. Unless you repair the tendons that have been cut, you will very likely be much less able (and perhaps even unable) to use your right hand to do the things that your life requires you to do with your right hand. You might, henceforth, do them awkwardly, slowly, or clumsily. You might also be able to accommodate to the situation and become accustomed to using your left hand, albeit with a net loss in your dexterity that will manifest itself in how quickly you can do some tasks. Perhaps some behaviors you simply cannot do anymore. In other words, the disability may manifest not just in how well you do certain things, but also in whether you can do others at all.

Furthermore, who you are as a person becomes a relevant consideration in judging how disabling the injury will be. For example, as a right-handed person who has become accustomed to relating to the world with your right hand, an injury such as this would result in more impairment than the same injury would if you were left-handed. The extent of impairment would also depend on a variety of other factors related to your personal characteristics (e.g., fine motor abilities, cognitive flexibility, and personal discipline) and life circumstances (e.g., available social support in the relearning process and your economic status).

I will also highlight an additional aspect of our laceration example to make clear why there is a point in calling this a case of traumatic physical injury. Not only can your cut tendons leave you with a significant restriction in your behavior potential, but other factors are relevant as well. When you are cut, you bleed. If you do not stop the bleeding, you bleed out. If you bleed out, you die. If you die, in effect, you have encountered the limiting case by having had your behavior potential reduced to zero.

Applying these perspectives to psychological trauma is not so straightforward, however. In this case, an easily seen injury with its readily recognizable implications cannot be found. If you ask people with PTSD the question, "What is it that gets damaged or injured in psychological trauma?" you get a variety of answers, such as "my relationships with people," "my brain," "my mind," "my emotions," "my feelings," or "my soul." What these answers have in common is that none of them are the sort of entity that you can look at or point to; none of these are visually present in the world in the same way as that laceration. Yet, ask anyone with PTSD if their psychological injury is just as real and perhaps significantly more disabling, most would emphatically say, "Yes!"

The Unthinkable

So the question then becomes: "What *is* it that gets damaged or injured in psychological trauma?" In coming to an answer, we start with an observation.

What all persons with psychological trauma have in common is that they have had an encounter with the *unthinkable*—an encounter with something that the person heretofore had not considered a real possibility in his or her world—something that he or she is unable to conceive as actually occurring in the first person; i.e., as actually happening to them. How traumatic this something is depends on how much of the individual's world is affected. If only a small portion of his or her world is changed, we do not call it trauma. Take, for example, the case of grief over the death of an elderly parent after a long illness. Although the loss may change your world and give you a new status in it (i.e., "orphan"), there is usually a place for such a loss in a person's world. The unthinkable(s) involved in trauma must change a substantial portion of the person's behavior potential, if not all of it. In the Face in the Wall heuristic I will describe shortly, *everything* is affected.

In other words, the traumatized person has had something become real that dramatically altered their concept of their *world* and/or their place within it (i.e., their self-concept). A person's world concept codifies the version of the world that he or she simply takes to be real, based on experience, acquired knowledge, and fundamental expectations about how the world is. It embodies the possibilities and impossibilities for how the world is—what is a given and what is an option *for me* in this world. To quote Ossorio, "What is given, in the present sense, is what is taken for granted and not subject to question, doubt, or uncertainty. And what is taken for granted does not come up for consideration one way or another... That is a virtue. It provides a limit within which the possibilities for action are conceived and saves our decision making from being swamped by an endless succession of fruitless 'possibilities.'... How does one develop Givens? Mostly through simple experience.... Where it is a Given that something is not so, we speak of the Unthinkable" (2013b, p. 264).

When something psychologically traumatic occurs, a person suddenly takes it that he or she is living in a fundamentally different world than he or she had always taken it to be. Further, since whatever world a person takes to be real always includes them as a part of that world, a psychologically traumatic experience must affect their self-concept—their place, or *status*, in this world and their corresponding behavioral eligibilities. Moreover, the new, post-trauma world is an impossible world; i.e., one within which the person finds it impossible to behave. Having your world torn apart, and thus you within it, is what qualifies as psychological trauma. It is this discontinuity in your world that is traumatic. You have lost your basic understanding of what the world is like. Your world, after this occurrence, does not function adaptively. Your world fails you, not just on this one occasion but also in its totality. This damage to your world results in a massive reduction in behavior potential. It results in an "injury" that leaves the person with a disability or an inability to function. It is this notion of damage to one's personal world that explicates the phenomenon of psychological trauma. Without it, you are merely left with vague notions such as references to the person's "inability to integrate successfully a traumatic event into his or her cognitive schema" (Jones & Barlow, 1990, p. 303). Such a description still leaves unanswered the question: "Yes, but

what is a "cognitive schema?"

Perhaps what comes closest to the model proposed in this paper is the notion of an *assumptive world* (Janoff-Bulman, 1992; Kaufman, 2002). Janoff-Bulman identifies what she considers to be the three basic assumptions that are challenged by traumatic events: (1) The world is benevolent, (2) The world is meaningful, and (3) The self is worthy. However, the present exposition, using the formal conceptual resources of Descriptive Psychology, allows us to connect explicitly the concepts of person, behavior, and reality to psychological trauma, by using Ossorio's vital distinction between an individual's *Real World* (the world that the individual takes to be real and is prepared to act on) and *Reality* (a set of constraints on how we can construe and act successfully on our real world).

The Face in the Wall Image as a Paradigm Case of Psychological Trauma

An image is a heuristic device used in Descriptive Psychology-based psychotherapy. It is a short story or analogy presented to clients as "a way of formulating what somebody does wrong, or a way of formulating what's wrong with how somebody is, or a way of drawing the contrast between those two for somebody who is confusing one with the other" (Ossorio, 2013a, p. 228). It serves as a diagnosis of sorts, although not in the traditional taxonomic sense. The following presentation of the Face in the Wall image (Ossorio, 1993) consists of two parts: a formal presentation of the image and then an additional elaboration applying it to the individual's circumstances.

Presentation:

"Imagine that you and I are alone in an office just talking and you catch a movement out of the corner of your eye and you look at the wall behind me. The wall is behind me so that only you can see what's there. What you've caught out of the corner of your eye and what you now see fully and directly is a huge Easter Island type of face. The face emerges from the wall for a few seconds, looks around, glares at you, and then fades back."

Elaboration:

"You have two options here. You can say: 'Hey, I just had the most interesting hallucination,' or you can walk out of there knowing that the world you are in is a vastly different place from what you thought it was. Because a world in which that could happen has no relation to what you thought you were living in." Which option you take, A or B, depends on a number of factors.

Option A: Retention of your world. The option of dismissing the Face as a hallucination is a twofold move to (a) retain one's view of reality, and (b) preserve the world, as it heretofore had been known. You are assimilating the experience to your existing concepts and frames of reference. You are saying, in effect: "The world is not a place where this happens, i.e., where humanlike faces come out of walls." Instead, you are saying: "The world is a place where people can imagine things and have hallucinations." This view of your world, and necessarily yourself, has some consequences, however. You may, for instance, begin to view yourself as

erratic or unpredictable in your reality contact. Seeing yourself in this way is the "lesser of the two evils," for it still preserves intact the overall integrity of your world. In doing so, you retain your world as a functional whole and can act on the behavior potential it provides.

Dismissing the experience as a hallucination, however, comes at a cost, because then you have to make further adjustments in your model of the world to accommodate your understanding of the significance of having that hallucination then and there. You might, for instance, need to conclude that you have suddenly entered a psychotic state and are mentally ill. Other explanations are possible as well. You might attribute the hallucination to delirium resulting from changes your physician made in your medications. You might even be disposed to take a psychedelic route: "Maybe I should have cut that mold off of the slice of bread I had for lunch yesterday!" If you were to call the face a hologram, you are then left to explain how it got there and might then attribute its origin to the smoke detector in the ceiling of the room. Every move to explain calls for other accommodations; everything is connected to everything else because it's one world. Ultimately, what explanation you accept for your hallucination requires its placement into the larger scheme of what you consider in your world to be real.

Option B: Encounter with the unthinkable. In the paradigm case presented, dismissing the Face as a hallucination is an option. Change the situation only slightly, however, and exercising this option would be increasingly difficult. The more reality the Face offers, the harder it is to dismiss as merely a hallucination, a hologram, a hypnotic suggestion, or anything else other than what it presents itself as. In our thought experiment, let's add some additional dimensions of reality.

What if, for example, the Face came out a little longer? What if the Face came out of the wall and stayed there? When the Face is visible for only a few seconds, you do not have much of a chance to do any reality testing on it. It becomes easier to dismiss the Face as something transitory, illusory, or merely a figment of the imagination. What if you had time to walk over to the wall and touch the Face? Instead of moving through thin air as you reach out, your hand thumps in to a definite solid *something*. In doing so, you are thereby creating multisensory inputs: sight and touch. Touch is not only the proximal sense of what we encounter in the world with our hands, however. We are also touched distally by the world. For example, perhaps as the Face came out of the wall it created a vibration that traveled across the floor that you felt up through the legs of your chair into the seat?

The real world does not just consist of sights and tactile sensations, however; reality comes in "3-D" and "Technicolor." What if the Face was accompanied by other sensory inputs as well? It seemed to have an odor, a taste, or to make a sound. Could you still dismiss your experience as a "mere" hallucination? What if both of us saw the Face at the same time? Hallucinations are personal, private experiences rather than experiences we share with others. Both of us "hallucinating" the Face at the same time would contradict your fundamental concept of a hallucination. That is not how hallucinations work—that is how real things work!

A foundation for what we take to be real in our world is what others can see or consensually affirm. Thus, both of us seeing the Face would further emphasize its reality and prompt even greater need for you to alter your existing frame of reference to accommodate these new facts about your world—the fact that there are these Faces and that they can appear out of nowhere in walls.

Option C: Other. In closing, it may be noted that there are other, more benign but unfortunately quite rare options for how one might regard the Face in the Wall. They involve having recourse to other alternative frameworks in order to retain your world. For example, if you have a technical predilection, perhaps you could just as easily have concluded, "There is an amazing hologram [of a Face] that you have projected on your office wall!" or "Your powers of hypnosis are just incredible, because you just got me to see a face coming out of the wall behind you!"

What Changes When the Face Becomes *Real*?

What follows will be an elaboration of the changes that unfold as a consequence of this fundamental revision in a person's world, using the paradigm case example of the Face.

Changes in World Concept

By drawing the most devastating conclusion about the Face (Option B), your world has been fundamentally altered. Your world is nothing like you thought it was—everything is up for grabs. Your world is now pervaded with uncertainty and has become "mysterious." The effect is like an inconsistency in a logical system. None of the rules that previously applied or organized your world remain.

To get a sense of the magnitude of the changes wrought on your world, consider the following. In your world after seeing the Face, even the laws of physics are challenged; objects do not materialize out of nowhere and then disappear. Additionally, the laws of psychology are challenged; humans do not have this form nor behave in this manner. Literally, you do not know what will happen in the next instance. Will pigs start to fly? All bets are off.

Furthermore, your place in this world is totally unknown. Not only is it unknown, but you also do not know what places you could have in this world. You do not know, at that point, what is the same and what is different in your world. Your world does not hold its usual possibilities or bases for behaving. In fact, it has all sorts of possibilities that you most likely do not know anything about. You may eventually find out what is the same and what is different—if you do not end up dead in the meantime.

The logical relation between your Self and your World is important to keep in mind. The relation is essentially one of identity. Self and World are different perspectives on the same thing. Your Self is your possibilities demarcated in terms of who you are (i.e., your eligibilities). Your World is your possibilities demarcated in terms of what the world allows you to do. Your Self is correspondingly changed by the occurrence of trauma. In this paper we will be emphasizing the notion of World. For a detailed exposition of how trauma changes the Self, see Ossorio (1993, 2013b).

The first change is fundamentally psychological and that is the change in a person's concept of the world and its possibilities and impossibilities (its "givens" and "options"). People acquire the particular version of the world they take to be real based on what they know from experience and what they believe to be the case. A person is not born with a particular world concept, but with the capacity to acquire one. The nature of a person's world concept is determined by personal experiences, including one's physical environment, social environment, and what one learns from observing the world, including people.

Changes in Physiology

Once the Face has become real to you, biological factors also come into play. The moment that Face becomes real to you (and not merely a hallucination), you are very likely to appraise yourself as being in imminently lethal danger and you will become overwhelming motivated to escape that danger. In such circumstances, your physiology will react accordingly, with a burst of adrenalin to prepare you for fight or flight. Keep in mind, however, that in this newly reconfigured world, it is impossible to know with any degree of certainty what the best recourse is for escaping the danger represented by the Face or for doing battle with it. For example, you don't know whether or not you will run into something even worse if you go charging out of the door.

What will happen, as a result of the motivational priorities engendered by your circumstances and your human physiology, is that you will become hypervigilant and scan your environment for any additional information that will help you determine the nature of the threat and how best to escape the danger you now perceive yourself to be in. Your brain will change how it processes information, with a shunting away from the higher cortical centers to facilitate a more focused "tunnel vision." This tunnel vision, which may serve you well in the short-run, may not serve you well in the long run, however. The "flashbulb" memory of the event can lock you into one particular version of the traumatic event, perhaps with a significance that later proves to be problematic.

For example, what if you conclude that you are a coward because you fled from my office? You may then disparagingly treat yourself as a coward for the rest of your life, with a consequent restriction in your eligibility to relate as an equal to others? The challenge for the therapist you eventually see for your PTSD will be to help you ascribe a different significance to your actions under the traumatic circumstances, a significance with less malignant implications. You might be dramatically helped to see that your reaction was normal, rather than abnormal, and simply what most people would have done under identical circumstances. However, you were left so suffused with shame after the event that you could not breath a word about what happened to another person. You had judged your actions to be "unspeakable," and therefore could not relieve your shame with the ameliorating social judgments of others (e.g., "I would have done exactly the same thing!")

Physiologically, your brain adapts on the spot so that you can focus on assessing the perceived threat. You no longer pay attention to the wallpaper in my office

or the flowers in the vase in the corner of the room. You do not think about how much time is left on your parking meter. You operate on a basic principle: in the face of a potentially imminent lethal threat, doing something is better than doing nothing. You have no guarantee that what you are going to do will be the right thing to do under the circumstances, but there is a higher probability that doing nothing at all is the wrong thing to do.

Psychological trauma is importantly considered a case of learning. In particular, it is a case of learning that your world comes in two versions: the one you assumed was reality before and the one that now confronts you. This new version is fundamentally different and highly problematic. In fact, traumatic circumstances provide the perfect conditions for learning, because they are: (a) important enough to pay attention to, and (b) arousing enough to stay awake. With that learning comes changes in the brain and other physiological systems, including the stress arousal response, that persist and subsequently alter brain and other functions, sometimes permanently. A number of authors (e.g., Bessel van der Kolk, 2006) have articulated in detail the changes in brain and other physiological functions that result from acute and prolonged exposure to stress and *psychological* trauma. (For an extremely accessible account, see Robert Sapolsky's 2004 book entitled, *Why Don't Zebras Get Ulcers?)*

Changes in Meanings and the Persistence of the Effects of Trauma Over Time

With the change in your world concept come other changes beyond the physiological changes briefly touched on above. Before seeing the Face come out of the wall, perhaps you had not give much thought to walls. Walls were merely structures in your environment that you had to decide what color to paint or where to hang the picture on. Whatever your previous relationship was to walls and whatever status they had in your world, after you see the Face come out of one, you are never going to think about walls the same way for the rest of your life. Their meaning will have fundamentally changed forever. You could go your whole life without ever seeing another Face come out of a wall and still not be convinced that it could not happen today. Other people might challenge your views (and often do so with people after a traumatic event). However, such efforts to convince you of the unreality of your thinking about walls are almost always unsuccessful...as well as highly unwelcome. In a related vein, others may urge you to "get over it". For example, the Vietnam veteran is told by a well-meaning person, "Why don't you just forget about the war? It was over 45 years ago?" These comments typically provoke anger from the veteran, as they only serve to make him feel even more alienated and misunderstood. The veteran may also become angry with himself, chastising himself for not being able to just "forget" about the event and not have it bother him so much. This sort of dialogue with the self leaves the veteran feeling inadequate and defective, and contributes to the low self-esteem that often accompanies posttraumatic adjustment difficulties. It may also add to his desire to stay away from "civilians" and to relate exclusively to other combat veterans, who he knows will not make comments like

this to him.

It is difficult for the ordinary person who has never experienced the consequences of trauma and world transformation to imagine how pervasive its effects are. A further example may serve to illustrate this point: imagine that five years have elapsed since you saw the Face in my office and you have not seen the Face since then. Nonetheless, emergent Faces remain real and thus real possibilities in your world, so you act accordingly. You are applying for a job you really need, so you want to make the best impression on the various department heads that will be interviewing you. Basic interviewing protocol dictates that you try to learn the name of each interviewer as they are introduced to you, as well as the department in which each of them works and its particular issues and concerns. That is all good in theory. In reality, however, what is uppermost on your mind is how close your back is to the wall behind you and where the exits are, just in case today is the day another Face comes out of the wall. Whether you want them to be or not, these concerns about your personal safety and survival remain uppermost in your mind and intrude to distract you from your intention to attend and remember. The bottom line is that no matter how much you want or need the job, your personal survival will always trump any other needs and your behavior will reflect this priority.

Changes in Relations with Others

Seeing the Face also has a profound effect on where you stand with other people. Consider your circumstances after you see the Face in the wall of my office. Are you going to rush out and implore my receptionist to assist you in dealing with the Face? Maybe, but not likely.... Why not? Because up until a few minutes ago (when you saw the Face and it became real to you), you shared the receptionist's world. In both of your Real Worlds, a face such as this coming out of a wall was not a real possibility (and probably not even an imagined one). In the world that you had before, where the Face was not a real possibility, there were only two ways to account for someone saying he or she saw such a Face. The person was either lying (deliberately distorting reality) or crazy (mistakenly distorting reality). And you know that you are not doing either of these, so you do not approach the receptionist. You know full well what he or she will think of you and how they will begin to treat you. They will eye you suspiciously or with fright, while considering pushing the panic button under the desk to summon security to help deal with this agitated, irrational person jabbering about faces and walls.

Being treated as someone you are not (i.e., as a liar or a crazy person) is degrading and is likely to provoke anger. So, over time, you begin to isolate yourself and stay away from people who are going to challenge your view of the world, as a means of both avoiding such degradation and managing your anger. You, like many traumatized individuals, find yourself easily angered and highly sensitive to what you take to be degradations. Seemingly minor snubs or annoyances can provoke angry outbursts that leave others mystified and lead them to avoid you.

Yet your isolation adds to your loss of behavior potential and, as your world contracts, you begin to experience the changes in mood that are characteristic of

lost or constricted behavior potential, i.e., depression. It is not only your anger that reinforces your isolation, however. You quickly come to find that interacting with people who have not seen the Face is also depressing. As you interact with people whose world you once shared, you are painfully reminded of how different your world is from everyone else's. You are acutely aware of what you have lost (that you once just took for granted). Each interaction makes you feel again that you are outside a glass bubble, looking in on everyone else's happy, secure, and blissfully naive lives. So you start staying away from other people on this basis, and because of your fears of the consequences of getting angry with other people. You do not want to lose control of your anger and go to jail for assault and battery (or worse).

Thus, your social world changes. You do not share a world in the same way with people anymore. You are no longer "one of us;" you are no longer a member of the community at large. (Aylesworth and Ossorio, 1983 describe how pathology can result from cultural displacement.) Other changes occur in your social world as you live your life with your version of the world and other people with their versions.

A few more examples may serve to illustrate these changes. Imagine it is now the winter after you have seen the Face and you are living in cold climate where it snows. Your family cannot find you anywhere but they finally track you down via your cell phone signal and locate you in a sleeping bag out in the woods in the middle of a blizzard. They rush up to you and ask if you are okay. You look up at them and say that you are perfectly fine and ask what the problem is. They look at you and say, "Have you lost your mind? You are lying here in a sleeping bag in the middle of a blizzard! Why aren't you even in a tent?" To this inquiry, you reply, "Have you lost your mind? A tent has walls!" What makes perfect sense for you to do is nonsensical or mystifying for someone else (who does not share your world).

The interpersonal effect of having seen the Face on your social world can be much more subtle yet far-reaching. Imagine that you are back in my office and the Face is indubitably real to you. You now have two additional facts about the world and must take them in to account in your behavior henceforth; there are these Faces and they come out of walls. You will use this information to help you act (and survive) in the strange new world that has been thrust upon you. As you walk out of my office, you will apply these new facts. As you go down the hallway, you will do what you consider to be the smart thing to do and walk as far away from either wall as possible. You walk down the exact middle of the hall.

Unfortunately, a lady is ambling along from the other direction in the center of the hall. Will you step aside and allow her to pass? Most likely not, because getting any closer to the wall than you have to could cost you your life. So you do whatever you can to get by safely. If a polite, "excuse me" does the trick, so be it. If you have to jostle her to get by, so be it. If you have to knock her over, so be it. In each case, the significance of your behavior is fear rather than aggression. No harm is intended. You are simply trying to stay safe in the face of what you take to be overwhelming danger. Perhaps if the person coming down the hall was frail and elderly or a family

member, you might behave differently under those circumstances. You might, for example, squeeze a little closer to the wall so that your child does not have to. (Recall how soldiers in combat routinely expose themselves to danger so that their fellow soldiers can be safer.) But, in the example above, you encounter a stranger with whom you have no prior relationship. In this case, you simply act on your priorities among your various motivations and knock her over so that you can stay in the center of the hallway.

Recall that I am unaware of any of these goings-on and I have not seen the Face. I might have been more than a little puzzled at why the color drained from your face before you suddenly and inexplicably ran from my office. I go to the door of my office, look down the hallway, and observe your interaction with this woman. I see you suddenly knocking her on her behind as you charged down the hallway. Because I am unaware of the circumstances (i.e., danger) prompting your behavior (i.e., escaping danger), I am liable to cast them in a different light to give them a different significance. I might, for instance, mistakenly judge your behavior to be hostile behavior. I will be totally wrong, because there is no aggression in what you are doing. You are simply trying to escape danger; it is simply a case of fear behavior. Nonetheless, after I describe your behavior as aggression, I am very likely to take the additional step of characterizing you as an aggressive person. Once I take that additional step, this characterization becomes the lens through which I appraise your subsequent behaviors. In a later interaction with you, when you raise your voice to make a point in a discussion we are having, I startle and back away, fearing that you might lose control and become violent (again).

When I see the interaction with you and the lady in the hall, I may attribute other significance as well. I might, for example, conclude (mistakenly) that you think you "own" the entire hallway and that others should move out of your way. The significance I attribute leads me to characterize you as an egocentric or narcissistic person and to treat you accordingly in our subsequent interactions. When you come to me for a favor, it is not just *anyone* making a request; it is a person who feels entitled to have each and all such favors granted without question. That "fact" alone may give me reason to deny, delay, or otherwise act to thwart what you are hoping to achieve.

In both of these instances of mistaken significance (hostility and egocentricity), the effect can be myriad and even become a self-fulfilling prophecy. In the case where I have characterized you as an aggressive person and have begun to treat you as one, my doing so can *make* you into one. You might, for example, react angrily to my (degrading) mischaracterizations of you and, over time, become the kind of angry person that I cast you as originally. Similarly, my characterization of you as feeling entitled alters how I interact with you and, in turn, affects your attitudes and behavior. My undermining interactions with you may force you to be more assertive and to stand up vociferously for your rights. Over time, I will have created a level of self-focus in you that would not otherwise have been there.

Changes in Motivational Priorities

Although I cannot tell with any great certainty what you will do after you see the Face in my office, I can tell you with great certainty what you will not do. What you will not do is whatever you would have done before you saw the Face and it became real to you. Will you go to the lunch meeting you had planned to attend after you met with me? Not very likely! Will you drop off your car for the oil change? Not very likely! What you will do instead is whatever you deem as the priority in your new version of the world.

Such priorities are very person-specific and will reflect who you are at the point when your world concept changed. You might be the kind of person whose priority is to protect your loved ones (against this new and barely known threat). So, as you run down the hallway in my office building (knocking down the lady), you reach for your cell phone to call home and warn your loved ones. You know this will be a strange and alarming phone call to them, as you order them to step away from whatever wall they are near or ask them to scan their environment for "Faces." Nonetheless, you could not live with yourself if something happened and you did not at least make an attempt to warn them.

You might also be the kind of person who feels better with some sort of weapon. At this point, you have no idea about what kind of weapon would be effective against the Face (or whatever else is about to happen in your new and mysterious world). That does not matter to you, because you are the kind of person that having *some* kind of weapon is better than not having any weapon at all. So you reach in to your pocket and grab a pen to use as a stabbing device, or you break up a chair in the hallway and grab a leg to use as a club.

You might also be the kind of person who feels better with some sort of perimeter around you, so you duck into the restroom. You are aware that the restroom also has walls, but these walls are smaller and more manageable. You can more easily scan them for Faces or anything out of the usual. Or you might be kind of person who flees into the outdoors where there are no walls; there you are left to ponder if the sides of your car are *really* like walls....

What should be evident from all of these examples is how diverse people's reactions to traumatic events can be. The reactions will depend on what kind of world the individual had before and what kind of personal characteristics the individual had at the time of the trauma.

Changes in Cognitive Processing

People with PTSD frequently report significant problems with their attention, concentration, and memory, even when they have not been exposed to events that cause traumatic head injuries. After you have seen the Face, you are very likely to have similar complaints about how your cognitive processing has been negatively affected. Traumatic events alone are sufficient to cause these effects and do so in the following ways.

Up until you saw the Face and it became real to you, you had everything everyone else had to think about in the normal course of the day and in life generally. You

had the usual concerns on your mind, such as going to the bathroom, eating lunch, remembering to pick up dog food at the store, doing laundry, or paying taxes. After you have seen the Face, however, dealing with implications of how your world has changed will be an immediate and overwhelming priority. These other life concerns do not go away, however, so not only do you have everything you had before to deal with but you also have to deal with everything created by this profound change in your world. In short, you are faced with a serious case of "multi-tasking." The problem is that all of us have a limited "bandwidth" that we will devote to whatever matters most to us at the moment.

Imagine for a moment that you are a highly experienced juggler and are quite comfortable juggling six eggs. If I toss you a seventh egg, you can probably manage to juggle seven eggs but it will take considerably more effort to do so successfully. What if I tossed you an eighth egg or perhaps a ninth? At some point, you simply cannot manage the task and you must face the consequences. The egg goes *splat* as it falls to the ground and similar "splats" are very familiar to people with PTSD when life demands exceed their bandwidth.

Returning to our familiar example of the Face, imagine that it is several years after the Face became real to you and that you have been living as best as you can in this new and very strange world. Imagine further that your spouse or significant other has asked you to go to the grocery store to pick up a half gallon of milk. He or she has learned that you are not as reliable as you once were ever since you "saw" that Face, so you are given a shopping list with the milk on it. (Depending on the person's attitude, the list can be appreciated and feel supportive, or it can be presented in a disparaging, degrading way. Let's assume that the list is given to you helpfully in this example, however.) So off you go to the grocery store with the list safely in your pocket.

You drive up to the grocery store and you see an available parking space right next to the store. Are you going to take that space and park next to a wall? No way! Not on your life! You may not have seen another Face since that one day, but it has continued to be a real possibility to you that you take in to account. So you pass on that parking space and drive through the lot looking for the perfect parking space... one that is not next to a wall and that allows you to pull in one end and directly out the other. You never know and you cannot be too careful, because today *might* be the day it happens.

Just as you are about to pull in to the perfect parking space, some "yahoo" comes along and slips in to the space before you can. How do you feel? Enraged! How does he feel? Probably very little because, to him, it is merely a parking space. To you, on the other hand, that parking space signifies so much more. It represents safety, retreat, and possibly your life, and your emotional reactions reflect this significance. The other driver, by taking your parking space, has potentially put you in grave danger and you react accordingly. You glare at the other driver, you curse, and angrily confront him as the store's security guard comes over to separate the two of you.

We have already mentioned one of the reasons that people are often angry after a traumatic event. They frequently experience others as degrading them. This degradation takes many forms and I have already mentioned a few. Recall that being seen as a liar or as crazy are implicitly degrading status assignments by others. Another source of anger derives from fear; it is a provocation to be put in danger.

A more mundane example of the same principle might be the following. Imagine you are standing on the curb waiting for a bus that is bearing down on you. Just as the bus reaches you, a person standing behind you jostles you directly in to the path of the bus. The first thing you do is to leap back on to the curb and out of the way of the bus. The next thing you do is to turn around and give the miscreant a piece of your mind (or worse). Provocation elicits hostility and being put in danger is a special case of a provocation.

Returning to the example of the trip to the grocery store, after you have had your angry confrontation with the other driver, you enter the store. However, you do not enter the store in a cool, calm collected state of mind. You are distinctly agitated, physically aroused and mentally distracted. Feeling the way you do, your greatest concern is how you are going to drive yourself home in your present state of mind. How are you going to keep your mind on the road as you review the angry exchange you just had with the other driver? Or perhaps you are now worried about how to drive home without experiencing a road rage incident. In either case, your priority becomes to calm yourself down to the point where you can safely drive home. An obvious solution comes to mind; so you walk over to the beer section where you grab a six-pack of beer, pay for it, and head out to your car. You sit in your car and down a couple of beers so that you are calmed down enough to drive home safely. You walk through the door and say, "Honey, I'm home. Want a beer?" (I will have more to say later about the role that substances play in traumatized persons' attempts to manage their emotional states and avoid thinking about the traumatic event.)

Unfortunately, the shopping list and the original purpose of the shopping trip has vaporized from your mind. You must deal with the interpersonal consequences of your omission. Your spouse or significant other may publically or privately assigns to you the status of "Unreliable Person," and begin to treat you in accordance with your now diminished status. You may become less eligible to be trusted in other more central ways that have important implications for the eventual success of that relationship. You may even assign yourself such a degraded status and henceforth restrict your own eligibility to participate in the world.

The Idiosyncrasies of Trauma

Vulnerability to Trauma

Much attention has been paid to who becomes traumatized and who does not. The question is particularly evident in studies of individuals exposed to similar traumatic circumstances. Those who become traumatized are seen as more "vulnerable" whereas those who are not traumatized seen as less "vulnerable." When the concept of vulnerability to trauma is examined more closely, the following points can be made. Vulnerability depends on the background notion of quantity. It views

trauma as a matter of degree. Some people can "stand" more; some people can "stand" less; some people can "stand" less of certain kinds of things. Eventually you get to the point where what you can and cannot stand is unique to you. At this point, the explanatory power of the notion of "vulnerability" disappears. Thus, the notion of vulnerability *per se* is not truly explanatory, resting as it does on after the fact labeling. It is reconstruction, rather than actual explanation.

One way to view what is being gotten at in a notion like "vulnerability" is a probabilistic continuum of sorts. It is probabilistic in the sense that there can be no absolute certainty about who gets traumatized and who does not. According to the research, two factors seem to make a difference, however. They are: (a) the degree of control the person experienced over the event, and (b) the amount of social support available to the person at the time of the event and subsequently.

In examining the question of who gets traumatized and who does not, you get much more mileage from looking at how bad the trauma was than at what were individuals' pre-morbid personality characteristics. In particular, notions of psychological "robustness" have been evoked to deal with this question of who gets traumatized. Much of the variance is simply how bad it was, rather than how normal you are. Clearly there are some traumatic situations with which virtually nobody is prepared to cope. For example, despite the lengths gone to in military training, nothing truly can prepare an individual for the realities of combat and war. What you face exceeds what you have available.

The Uniqueness of Unthinkability

Each individual's experience is unique. This unique experience reflects an interaction between the individual's real world and reality. No two people's worlds are exactly alike. Therefore, for no two people is what is unthinkable exactly alike. The most appropriate question is the following: "What is and is not unthinkable for this particular person at this place and time?" This is an empirical question. In examining this issue, a distinction between what is True and what is Real can be made (Ossorio, 2013b). Something is *true* if one simply believes it to be the case. Something is *real* if it has a place in one's world such that one is prepared to act on it. What is traumatic is what has become real and can, to use Piaget's terms, neither be assimilated nor accommodated.

Trauma and the Individual

As suggested in the previous discussion, you need to operate at the individual level when dealing with notions of trauma. You can point to certain personal characteristics, however, which might make a certain state of affairs more unthinkable or less unthinkable. For example, take the issue of "U.F.O. abduction." A place exists for this occurrence in popular culture and, for some groups of people, close encounters of the third kind are a very real possibility. Some U.F.O. believers participate in formal organizations and activities centered on these beliefs. If U.F.O. abduction actually happened to one of these individuals, it is less likely to be traumatizing to him or her. There is already a place in that person's world to accommodate such an experience. If it happened to someone who did not hold such beliefs, then it is more

likely to be traumatizing to that person. For this person (i.e., the non-believer), there will not be a place in his or her world for such an occurrence to *really* happen. It is conceivable, however, that there might not be a *Real* place in the U.F.O. believer's world, in the True versus Real sense. Thus, if U.F.O. abduction was actually more True than Real, then the person might, in fact, become traumatized if it were to occur.

Commonalities and Trauma

You would not expect to see similarities between what causes trauma concretely and how trauma is expressed symptomatically. Their commonalities will emerge at the conceptual level, however, when their significance is examined. At the conceptual level, two individuals will be alike in terms of drastic changes in their worlds resulting in disabilities. The disabilities will be related to the specifics of what trauma it is. These disabilities will be evident as various disabilities in thinking, remembering, interacting with the world, relating to others, et cetera.

Emotions and trauma: fear. Some accounts of trauma emphasize emotions as fundamental to trauma. People will often try to reduce all situations that are considered traumatic to fundamentally instances of fear of death or annihilation. Empirically, fear very often accompanies situations which are experienced as traumatic. Fear is not an essential part of trauma, however. With the Face in the Wall, you might be scared but fear is not an essential part of what makes the Face traumatic. The experience of seeing the Face is confusion or mystery. It is not fear *per se* which makes the Face traumatic. It is what seeing the Face does to your world that is traumatic. (See Ossorio, 1997.)

Arousal and Trauma

Physiological arousal has been considered an essential element of trauma. It is based largely on the "classical conditioning" frequently evident in posttraumatic conditions. For example, Vietnam veterans often react to the distinctive sound of an approaching or departing helicopter with elevated heart rate and respiration. From their experiences, a helicopter has been a powerful symbol for safety and support. As a result, they are extremely attuned to this sound even almost a half-century later.

It is not the arousal, in and of itself, which creates the trauma. Two different examples may help illustrate this point. First, imagine taking a ride on the Twister roller coaster at the local amusement park. This experience entails high levels of physiological arousal while the person has a psychological sense of control. Second, consider a soldier who commits an atrocity. The person may have low arousal but it may be traumatic, nonetheless. It may be traumatic only at a later point in time. The person may be cool, calm, and collected while perpetrating the acts. It is only after the fact that the person says: "My God! *I* did that?"

Physiology of Trauma: Risks of Reification

Physiological descriptions of trauma are helpful in explaining the perpetuation of trauma over time and its increased effects. Learning, even learning that the world is vastly different from what you thought it was, will have physiological consequences. Clearly there are also conditioned responses to certain trauma-related

stimuli and evidence is also accruing that the limbic system and particularly the amygdala play important roles in mediating posttraumatic syndromes. The amygdala is crucial in regulating emotional responsiveness and can itself can process emotionally relevant information without input from higher cortical centers. This processing may make the emotional responsiveness more automatic and less inhibited. Physiology may potentiate reactions and lead to hyperarousal, particularly in situations of "type II trauma" (Terr, 1991) or "complex PTSD" (Herman, 1992a), which involve traumatic situations that are experienced repeatedly over time. The trend in the trauma field is to say that PTSD is primarily a physiological condition. This view, in turn, strongly affects what sorts of treatments are considered.

Perpetuation of Trauma over Time

Physiological descriptions of trauma are helpful in explaining the perpetuation of trauma over time or its increased effects. Physiology offers a good mechanism for this inertial element. You do not need such a mechanism, however, as the nature of personal worlds and related status dynamic principles (Ossorio, 2012) also embody inertial notions: "A person takes the world to be as he has found it to be" (p. 30), and "If a person has a given person characteristic he continues to have it until and unless it changes" (p. 70). You do not need explanations for the persistence of knowledge beyond these. You continue to have it until something changes. Worlds are not here today and gone tomorrow. There is a temporal stability and continuity to worlds. If the Face comes out of the wall now, that it did so will make a difference ten years or even twenty years later. Changes in your world that result from trauma can be permanent and unshakeable. They remain extant unless and until something happens in the meantime to lessen the implications of the Face for your world. (Descriptions of posttraumatic stress disorders as chronic conditions make some sense viewed in this light.) If everything remains the same for the next ten years, other than that I once saw a Face come out of the wall and go back in, then evidence is accumulating over time. If nothing happens in that period of time, I am much more likely to dismiss the experience as a hallucination. But I still might not....

Symptoms of Trauma.

Much could be said about the clinical phenomenon of trauma from the vantage point offered by the formulation. One current perspective on the symptoms of trauma is that offered by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV-TR) (2000). The DSM-IV-TR represents a variety of symptom clusters, which may or may not be present in any individual. The emphasis on the empirical specification rather than the conceptualization is evident in how they describe the traumatic events precipitating Post-Traumatic Stress Disorder. Criterion A states: "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" and "the person's response involved intense fear, helplessness or horror" (A.P.A., 2000, p. 467). What ties these diverse elements together is not clear, however.

"Persistent re-experiencing of the traumatic event": intrusive thoughts, flashbacks, and nightmares. This cluster of symptoms results from the person's continuing attempts at world reconstruction. The person is trying to accommodate a place for the event in his or her world. He or she is faced with a problem of immense proportions, so that it occupies the person's thoughts (or "preoccupies" them, as the case may be). It also occupies the person's thoughts while asleep in the form of trauma related dreams, a very common feature of the clinical phenomenon. The attempts at world reconstruction continue in the form of trauma related dreams (Roberts, 1985).

Returning to our Face example, consider the following points. Are you going to be able to get the Face out of your mind and not think about it? Even while you are asleep, you will be thinking about what concerns you and dreaming can be considered as thinking while you are asleep. If what you are "thinking" about is highly problematic, preoccupying, or traumatic, that thinking is likely to manifest as nightmares. That first night after you see the Face, are you going to be able to sleep? Perhaps, but it is more likely that you will fearfully lie in bed watching the walls and be reviewing the utterly strange events of the day. You will go over again and again in your mind those exact moments in my office. You will recall glancing up, the first moment you saw the Face, your vain attempts at trying to dismiss it as a mere hallucination, and so forth. You will review your entire past and everything that has occurred in it up to this point, to see if there was anything that foreshadowed today's occurrence. You will review the details of the day since that point, noting everything that seemed the same and anything that seemed aberrant. But will you fall asleep in your highly mentally and physically aroused state? Not likely. How about the next night? Perhaps, but despite your increasing physical exhaustion, your mind is still racing and you are unable to fall asleep.

Finally, on the third night, your exhaustion overtakes you and you fall asleep. Yet, while asleep, you are still considering the problems in your life. And one problem looms above all others—making sense of the world as you have now found it to be. Dreams are attempts at world reconstruction and seek to find solutions to the problems we find in our lives. In this case, your problem is immediate and overwhelming. Traumatic nightmares are often literal recreations of the traumatic event, as the person struggles mightily to assimilate and/or accommodate what he or she has experienced about how the world seems to be. So your nightmare involves being back in my office and sitting back in the chair that you were sitting in when you first saw the Face. It is a literal recreation, except for a few subtle twists. In your nightmare, after you realize that the Face is real and you are about to rise out of the chair to escape the danger you now recognize yourself to be in, you look down and realize that you have been duct-taped to the chair and are immobilized. The dream is a literal recreation of the traumatic event, except for this one element of elaboration in the dream, which serves to unnervingly highlight the overwhelming sense of helplessness and vulnerability that you only experienced emotionally in real life. Thus, nightmares often can bring a focus on just those elements of a

trauma that are most emotionally intense and that the individual least wishes to re-experience again in his or her life. In fact, traumatic nightmares are frequently one of the reasons that individuals with PTSD drink alcohol. By drinking to excess, they can "pass out" without dreaming while they sleep. (Alcohol, in fact, suppresses the REM stage of sleep when dreaming occurs).

"Persistent avoidance of stimuli associated with trauma and numbing of general responsiveness." The person, while preoccupied with the trauma, does not want to think about the trauma or its implications. For to think about the trauma is to make it more real; avoiding thinking about the trauma is an effort to maintain the world as it was. In this manner, some of the concomitants of the trauma are avoided, such as an experience of oneself as helpless or confusion about the nature of the world. Avoidance is also an effort to avoid the dysphoric emotional states that are triggered by trauma-associated stimuli, since remembrance of them can reactivate intense states of fear, rage, or sadness. People with PTSD are diverse in their strategies for avoidance, ranging from the aforementioned use of substances to becoming a workaholic.

"Persistent symptoms of increased arousal." One frequent aspect of trauma is the lingering of arousal and/or a lowered threshold for its reappearance. This arousal can result from the person acting on the behavior potential they have retained, such as anger as a means of dispelling helplessness. The arousal may also reflect the person's ongoing appraisal of the dangerousness and unpredictability of his or her world. In this sense, the arousal is primarily initiated by a cognitive process, rather than merely perpetuated by a physiological one.

Summary

I proposed to answer four questions about psychological trauma that I believe have not heretofore been properly conceptualized. These were: (1) What is psychological trauma? My proposal has been that psychological trauma is a change in one's world that renders some aspects of the new world as unthinkable which, in turn, reduces one's behavior potential in ways that qualify as pathological. (2) Why do some people get traumatized while others in very similar situations do not? For any individual, the answer to this will ultimately come back to: "How unthinkable was what has happened *for this person*?" The answer will hinge in turn on the nature of the person's world in the first place, and in particular on (a) how much of a place was there in this world for this particular unthinkable, and (b) how much was their world damaged by its occurrence? (3) Why do the symptoms take the specific forms that they do? The formulation presented above suggests that the variety of symptoms may be seen as efforts to control one's damaged world and to reconstruct a more viable one that can accommodate what has happened. Avoidance of reminders as a way to hold onto one's former world; flashbacks and dreams as attempts to reconstruct one's damaged world; and hyper-arousal as normal vigilance to prevent further damage to one's world all fall under these rubrics. Finally, (4) what is the role of physiology in creating and perpetuating the

condition? I have argued, briefly, that arousal may also reflect the person's ongoing appraisal of the dangerousness and unpredictability of his or her world. In this sense, the arousal is primarily initiated by a cognitive process, rather than perpetuated by a physiological one. This does not dismiss the importance of physiological arousal but casts it in a different light than traditional formulations.

The reformulations presented in this chapter draw upon the conceptual resources of Descriptive Psychology, among which are the conceptual device of Paradigm Case Formulations (a device for articulating concepts that do not permit formal definitions), the classical formulation of pathology as deficit or disability (Ossorio, 1985), and the concept of a person's world and how that is related to his/her self-concept. The resulting clarifications will lay the foundation for a forthcoming elucidation and integration of approaches to psychotherapy with PTSD victims and others who are faced with an impossible world after having encountered the unthinkable (Wechsler and Breshears, 2012). For now, I have found the Face in the Wall formulation to be a very accessible means of presenting the complex concept of psychological trauma to people with PTSD and their families. A combat veteran with PTSD recently illustrated how powerful sharing these ideas can be. He had heard my presentation about the Face in the Wall and told me that he had purchased several "Tiki" masks and put them around his house and in his back yard to remind him of the formulation and thus aid in his recovery from the impact of his trauma on his world and self-concepts.

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