

Complex Responses to Trauma: Challenges in Bearing Witness

Amaryll Perlesz*

This paper explores variability in family and individual response to trauma. The discussion draws on results from a study that investigated family adaptation to traumatic brain injury (TBI) and also refers to literature on the Holocaust. Outcomes to trauma are complex and it is argued here that hope can coexist with despair (within families and within particular individuals). The challenge for therapists in bearing witness¹ to testimony following significantly traumatic events is also explored.

INTRODUCTION

My interest in response to trauma comes from at least two different directions. Firstly, this paper draws on my clinical and research work with families where a member has suffered a traumatic brain injury (TBI). Secondly, my personal experience as a child and grandchild of Holocaust survivors leaves me with a strong curiosity about individual and family response to trauma and grief. Relevant here is Judith Kestenberg's notion of 'transmission of experiences ... (and) traits' (Kestenberg, 1972: 319-320) where the legacy of memories, emotions and the lived experience and aftermath of the Holocaust is passed on unconsciously to subsequent generations within families. More recently, de Graaf (1998: 233) has argued that transgenerational traumatisation is evident in a wide range of families where parents have been traumatised; for instance, 'as victims of child neglect and abuse, as orphaned children, or during military service.'

I write this paper somewhat tentatively because I am addressing profound questions which many others, with much more direct experience of trauma, have already explored. I begin with an example (from my own research) of a complex (and some might say 'messy') outcome following TBI. In order to make sense of this family's experience I have drawn on other trauma research and personal accounts. The intention here, I must emphasise, is not to make comparisons between different traumatic experiences such as severe accidents, sexual abuse, torture or genocide, or to pass judgement in ways that might appear to trivialise or minimise victims' experiences. Rather, I hope to raise

questions which may be useful to clinicians working in a wide range of areas post-trauma.

'CRISES OF WITNESSING'²

It is not difficult to detect the common theme in the following scenarios:

Scenario one: In several of his books on the Holocaust, Primo Levi (1987a; 1987b; 1989) revisits what he describes as an almost universal dream of Holocaust survivors, emerging from both their written and verbal accounts. In these dreams, the survivor returns home and begins to tell his/her family the story of his/her suffering. In the telling the survivor experiences a real sense of relief. However, the relief does not last long, because in different versions of this dream family members do not listen, do not believe, or even turn their backs on the survivor and silently walk away.

Scenario two: Shortly after he was released from a concentration camp early in the Second World War, Bruno Bettelheim (1952), a psychiatrist, wrote a paper based on his observations entitled 'Individual and Mass Behaviour in Extreme Situations in 1940-1942.' The paper was rejected for more than a year by journals because the psychiatric and psychoanalytic establishment doubted its veracity.

Scenario three: There are many critiques of the legal and psychiatric system's inadequate response to, and support of, women who have been sexually abused (Herman, 1992). Recent research by Heenan (cited in Jarvis and McIlwaine, 1997) indicates that 44% of detectives from the Criminal Investigation Bureau (CIB) doubt that victims of sexual abuse are telling the truth.

Scenario four: Families one of whose members has suffered a head injury frequently describe their social isolation and sense of burden in those situations where extended family members, friends and neighbours do not understand or empathise with what they have been through. Those not living with the family frequently fail to acknowledge the challenging situations families have

*Senior Lecturer, School of Public Health, La Trobe University. Address for correspondence: The Bouverie Centre, 50 Flemington Street, Flemington Victoria 3031; A.Perlesz@Latrobe.edu.au

to deal with post-trauma, because the person with the injury (despite negative changes in personality and behaviour), frequently looks just as he or she did before the accident (Lezak, 1978).

Common to these experiences is a 'crisis of witnessing' (Felman and Laub, 1992). That is, those giving testimony have not been adequately listened to or heard. It is generally believed that it is critical to the process of recovery from trauma that the victims be provided with opportunities to have their testimony witnessed, not as a catharsis, but as an opportunity to 'reconnect to', and 'reconstruct' the experience of abuse (Herman, 1992), 'repossess' the painful experience of separation and loss (Lamb, 1992b), or 'reinterpret' traumatic experiences of abuse (White, 1995).

However, even in those instances where there has been the utmost goodwill, graciousness, attempt at forgiveness and desire to bear witness (listen) in good faith, the witnessing itself can be almost unbearably painful. For instance, there is an indigenous concept key to the South African Truth and Reconciliation Commission called *kbulumani*, meaning 'to speak out—not individually but communally' (Cooper, Kahn and Kahn, 1997: 13). During this process of *kbulumani* village people might gather together to share stories of their brothers, husbands and sons who vanished, were brutally tortured and/or were murdered during the terror of the years of apartheid. Bearing witness to this healing process of speaking out and sharing traumatic experience is no easy task. As Archbishop Desmond Tutu, the head of the South African Truth and Reconciliation Commission says:

We thought we knew the extent of the evil that was abroad in the dark days of oppression and injustice. But we've almost been overwhelmed by the depth of depravity and the ghastliness of it all. At the same time we've been humbled and moved by the incredible nobility, generosity and spirit in the hearings (cited in Cooper and Kahn, 1997: 14).

Bearing witness (both the telling and the hearing) and its relevance to therapy is something I will return to later in this paper. However, before exploring this process in greater detail, I would like to digress for a moment and present some curious findings from my research on family adaptation following head injury. These results confirm the complexity of outcomes post-trauma.

THE TRIUMPH AND TRAGEDY OF TRAUMA

In my study I followed up 59 families over 18 months (Perlesz, 1997). The underlying theoretical basis to this project was a stress-appraisal-coping paradigm (Lazarus and Folkman, 1984). The major premise of an outcome study such as this is that the level of stress experienced after a traumatic accident depends on family members' appraisal of the accident and its sequelae, the resources they have to deal with the crisis, and the way they cope post-trauma.

The outcome measures I was interested in were family members' levels of distress (anxiety, depression, anger, fatigue and mood disturbance) and their levels of family satisfaction. The independent variables I assessed were: family members' appraisal of the impact of the accident in terms of strain and burden, the severity of the injuries, the degree to which family members felt socially supported, how well they functioned together as a family and how well they coped. By 'coping' I mean things like how they pulled together at the time of the accident and related to the acute care team, how they grieved and got on with their lives after the accident, their sense of meaning and purpose post-trauma and the positives they drew from the accident. Such positive outcomes included feeling closer as a family, discovering strengths they did not realise they had, feeling more mature, tolerant, and so on. Family members filled out questionnaires at six-monthly intervals and I interviewed 25 of these families in depth.

I would like to focus on how different families, facing injuries of similar severity and resultant disability and handicap, appraise, and respond uniquely to, their trauma. It is not a new idea that a traumatic event need not be inherently stressful (Lazarus and Folkman, 1984; Singer and Irvin, 1989; Thoits, 1983), and that many factors come into play in determining outcome, namely injury and demographic variables, appraisal of impact, perceived family and social support and coping strengths. As Shakespeare's Hamlet reminds us, 'There is nothing either good or bad but thinking makes it so' (Shakespeare, *Hamlet*, Act II, Scene II). In a superficial sense, this idea is easy to understand because it is a common concept within cognitive psychology and family systems thinking that our way of constructing an event is critical to how we respond to that event (Berger and Luckmann, 1967; Efran, Lukens and Lukens, 1988; Kelly, 1955). Data from the current study (Perlesz, 1997), as reported below, support the idea that we socially and cognitively construct our responses to traumatic events. However, these and other clinical research findings (Contos, 1996) contradict Hamlet's relativist notion that 'there is nothing either good or bad ...' and support a theoretical position (Banja, 1992; Geras, 1995) that some things (and in this case we are speaking about the experience of trauma) *can* be intrinsically bad.

Factors related to distress and family dissatisfaction

As I had expected, for this group of family members (212 people), on average 19.3 months post-trauma, I found no significant relationship between demographic factors, severity of injury and the ensuing distress of family members. That is, more severe injuries were not necessarily associated with greater distress. Also, as expected, positive outcomes were contributed to by a sense of being less burdened and viewing the TBI sequelae as being less problematic, an appraisal of the TBI as having 'neutral' impact on the family, healthy family functioning, and the capacity of families to effectively resolve their grief.

I had also expected to find that those family members

who had gleaned some personal sense of meaning following the accident and had been able to acknowledge positive personal and family growth following TBI would be correspondingly less distressed, and would report greater family satisfaction. However, I found no such straightforward relationship. For instance, some family members reported discovering personal and family strengths they had not realised they had and described 'growing' as a result of the accident—yet they continued to report clinical levels of distress and family dissatisfaction. There were also family members who reported no positive growth, or any acquired sense of meaning or purpose post-trauma, yet simultaneously reported low levels of distress and high levels of family satisfaction.

These curious findings held true for the sample as a whole, for particular families, and for individual family members interviewed in this study. Family members could appear to make good adjustments to trauma, to be coping well, to be getting on with their own lives, and yet remained 'clinically depressed'.

Unique Response to Trauma

The following description is a vignette focussing on a wife's experience of loss and grief following her husband's severe traumatic brain injury after a motor cycle accident. Tom and Anna Kelly were in their early 40s. Excerpts taken from six therapy sessions over a six month period are presented here, not with a focus on the intervention, or the spousal or family relationships, but rather to illustrate aspects of Anna's process of adjustment to the trauma and its devastating sequelae.³

Initially, Tom was described by his wife and the neuropsychologist as having a profound inertia, concrete thinking, circumlocutory speech, a poor memory with impaired new learning, and flattened affect—all of which prevented him from returning to work. Even turning lights on and off, and going to the toilet were thought to be beyond him. Anna had given up her own work in order to provide full-time care for Tom.

Grieving

In the early sessions Anna's grief and bewilderment were palpable as she struggled with her yearning to have her husband back as he was prior to his accident.

(crying) '... I've lost part of him ... hasn't part of him died? [*Yeab, it bas. And part of your relationship bas died too. And part of you bas died in the process.*]⁴ ... A couple of times I've said to him, 'I want my husband back' ... that's fucked (wiping away her tears). [*That's not fucked*]. To him, that is. Because he says, I am your husband ...'

Both the desire to have the 'old Tom' back, and Anna's understanding that he would never be the same again, contributed to her profound sadness: 'Of course I'd like him back the way he was ... [but] ... I know he is not going to be back'. Faced with such loss and the apparent lack of resolution of the grief, Anna was fearful of openly expressing her distress: 'I try to cry but can't ... too much of a mess to clean up! ... I'd be terrified

... I'm scared that I'm not going to be strong for both of us.'

Anna also repeatedly attempted to make sense of why the accident had happened, in part struggling with the idea that perhaps she, herself, was to blame:

'Just why? Why does it happen? I think, Christ, what am I being punished for now? ... If there's someone up there high, why would they hurt him to just get at me, that's not right ... Just a whole lot of shit goes through your head ... Why would you hurt someone just to punish someone else? But I've never done anything *that* bad. I'm not that bad. I'm not so bad, whatever ...'

Anna's grief and resignation was such that she had even come to believe that Tom had lost his personal sense of agency, because he could no longer do the things he was once able to do, and he was no longer his own man: 'No, no, he's not his own person, he's not!'

So tenacious was this belief that, despite strong evidence to the contrary, Anna had not permitted herself to acknowledge that Tom *was* able to do a wide range of tasks without any prompting. That new information emerged when she went away for a weekend respite holiday with friends. While Anna was away, Tom managed to feed the dog, go to the toilet and to bed, turn the TV on and off at different times, cook a steak for dinner, make breakfast, wash up after each meal and put away the dishes, cut up trees and put the logs in the car, walk down to the shops and buy a lotto ticket and other shopping items, and more!

Although Anna knew that Tom had done these things, she did not acknowledge that Tom had personal agency, because it evoked for her the possibility of the 'old Tom' re-emerging, something she longed for, yet something she had been told by the neuropsychologist was impossible.

Resolution of grief

Anna's exceptional way of resolving her grieving and identity crisis was to give up the comparison of her 'old husband' with her 'new husband'. She did this by relinquishing her attachment to Red Lion, the motorcycle-identified, tough part of her husband, while retaining her attachment to Tom, the gentle husband:

'I've put Red Lion to rest! Work that one out! (loudly laughing) ... I didn't wear my 'I'm property of Red Lion' (on my back) to the Christmas party ... I felt that Red Lion was no longer there. He's *not two* people, but Red Lion was always the tough one on the bike. You should see him with his helmet on, with his bloody red beard flying and leathers and everything. I was too scared to back chat him (laughing). He would have won out of it (long pause). And then he kept saying, no, I'm still alive. I said to him, it's all right, I always loved Tom, not Red Lion. Red Lion always worried me!' (loudly laughing).

In addition to resolving the identity crisis, Anna also decreased her preoccupation with Tom's accident, spontaneously ceasing to compare life pre-accident with life post-accident: 'I'm sick of the bloody accident ... I

just said it one day. I said, I'm always bloody saying "Before your accident" ... As if we've got nothing now and we had everything then.'

Creating a meaning and purpose for enduring the TBI

Both Anna and Tom agreed that the knowledge that Tom was saved on the night of the accident was a message for them to get on with their life. The moment of understanding that crystallised both Tom's and Anna's sense of purpose and meaning in their lives was Tom's recollection, between the third and fourth sessions, of a near death experience (NDE)⁵ in which he had had a conversation with his friend 'Ballbearing' in heaven. Ballbearing had died a year earlier in a motorcycle accident. Tom recounted that Ballbearing was now in charge of the motorcycle club in heaven, and he told Tom it was time to go back, because he was the boss and not Tom. They had a short argument about who should be in charge of the club in heaven, and Ballbearing eventually forcefully told Tom to 'Piss off' and get back to do what needed to be done on earth. This strange but moving experience contributed to both Tom's and Anna's desire to continue to live and to live as productively as possible.

Achieving a sense of positive growth

Despite the trauma and the enormity of their losses, Tom and Anna were able to acknowledge their personal and relationship strengths, as well as achieving a sense of positive growth. They viewed themselves as lucky to have survived, and compared themselves favourably to others who were worse off.

Both Anna and Tom agreed that they had never considered separating after the accident. Anna said, 'I wouldn't leave him ... I do love him still. I'm not doing it just because I feel obligated to look after him ... we'll always be together, no matter what.' Tom, too, was adamant about the security of their commitment to each other: 'We've got each other ... the relationship's stronger'. Anna viewed thinking positively as a coping mechanism:

'It's positive ... As bad as it is, it could always be worse ... Like he's not in a wheelchair. He's not flat on his back ... He *is* still capable of doing things, whether it be just putting the rubbish bin out ... He knows today is the dog's heart worm tablet. Things like that. Six months, twelve months ago, he couldn't remember those. They're only *tiny* little things. At the moment our life's only tiny, it's gradually growing, but they're added pressures that are off my shoulders that he's taking responsibility for.'

As a result of the accident (and during the course of the therapy over six months) the couple had attained a deeper understanding and appreciation of life. As Anna said:

'... things can be taken from you very quickly, so don't take things for granted any more ... Life's too precious for that. I almost lost Tom. I haven't lost him, I've got him. That's good. That's very fortunate. And we're living well. We're doing well together. So let's get on with that ... I want to get on with our life. I mean it's good to know now that

that is a possibility down the track ... that would never have entered my mind.'

Anna described valuing life more and being less self-destructive since Tom's accident:

'What happened to him could happen to anybody. It could have happened to me ten thousand times! ... I value life more now ... You've got to put full meaning into your life and try and do as best you can. I can't just sit here and say woe is us any more ... I've grown from this experience!'

Continuing depression and family dissatisfaction

Although Anna had struggled to come to terms with her perceived losses, to value her suffering (Bettelheim, 1952) and to change as a result of it, she continued, throughout the study to report a clinical level of depression on the Beck Depression Inventory (BDI) (Beck and Steer, 1987) as well as reporting feeling dissatisfied with her family.

I was deeply moved by Anna's ability to embrace with 'tragic optimism' (Frankl, 1984) her fury, rage and depression following the accident and its aftermath, while simultaneously reevaluating her life and finding significant personal value in her suffering. Working with this couple helped me realise that Anna's depression and family dissatisfaction were legitimate legacies of trauma. Although her grief was clearly lessening, and she had resumed many activities put aside at the time of the accident, her low-grade, perhaps chronic, depression was an integral part of her whole self. Or, as Thomas Moore (1994: 148) puts it: 'Depression is one of the faces of the soul, acknowledging it and bringing it into our relationships fosters intimacy'.

Anna's reported high level of dissatisfaction with her family life throughout the study perhaps reflects her still unresolved yearning for what had been lost in her spousal relationship with Tom. This finding is consistent with recent work in the bereavement literature that indicates that even up to seven years following the sudden death of a spouse in a motor vehicle accident, more than 70% of widowed partners were still unable to make any sense of the loss or attach meaning to the event (Wortman, Silver and Kessler, 1993).

Coexistence of hope and despair

Recovery from trauma is a complex process. It is quite possible, if not probable, that finding meaning, acknowledging one's strengths and luck in comparison to others less fortunate, and relief at survival, can all coexist with the experience of persisting pain, sorrow, anxiety about the future and discomfort with one's family. For instance, persisting depression in family members may be evidence of increased sensitivity to tragedy, an outcome that may strengthen one's self-awareness and maturity.

It appears that recovery following TBI involves the experience of despair at the magnitude of the tragedy along with hope for the positives that can emerge through suffering. Neil Adams points out that Frankl's idea of a tragic optimism applies to these extremes of

experience: 'While there may be nothing good *in* the experience of ABI (acquired brain injury), family members may be able to extract something good *out* of it' (Adams, 1996: 81).

However, in addition to this 'both/and' perspective, there is an equally valid 'either/or' position. John Banja argues that *tragedy* is an authentic outcome to TBI, and for this reason it cannot be overcome but only accommodated to:

The truly tragic situation is categorically bad. Nothing mitigates its horror ... Those who experience tragedy are never the same. Their lives are indelibly altered ... They will smile and laugh again, but their lives take on a complexion and weightiness that will never disappear (Banja, 1992: 113, 114).

Banja's position is supported by recent empirical findings from a qualitative study of four couples post-TBI (Contos, 1996). Anastasia Contos concluded that none of the people she interviewed, whether or not their marriages had survived, had interpreted the experience of TBI as positive or beneficial:

The experience of loss the participants in this study underwent was enormous and profound and none of them really got over it, though they had to learn to live with it. All the participants showed great courage and felt deep sorrow following TBI. The outcomes for them were not positive, yet they put up with them with forbearance and optimism (176).

Consistent with this position are the clinically based, theoretical explorations of Tom Paterson (1996: 26) who argues that survivors of trauma (and here he includes 'family members who are exploited in their caring for permanently injured or disabled relatives') must not be expected to relinquish the signs of their suffering too easily:

It is belittling and insulting to suggest that such people 'work through' their problems or 'come to terms with' their losses or hurts so that they can relinquish the problematic behaviours that signal what has happened to them. If they ever relinquish the sign, they will do so when they are ready (Paterson, 1996: 26).

This theoretical move towards greater complexity suggests that future models of family adaptation to TBI should consider that levels of distress and family satisfaction by themselves may not accurately reflect family members' experience of recovery from trauma.

Narrative Approaches to Trauma

Narrative approaches have traditionally assisted survivors of abuse to 'derive alternative meanings of their experiences ... [thus making] it possible for them to reinterpret the abuse' (White, 1995: 84). This process is described by Michael White as assisting people to shift from negative personal narratives to more positive accounts. In essence the person moves from a more negative sense of their own identity to 'interpreting their experiences of abuse as exploitation, as tyranny, as torture, as violence and so on' (84). When techniques

such as this are effective, White proposes that '*hope, an antidote to despair, resurfaces*' (101; my emphasis). Implicit in the idea of an 'antidote' is a medicine counteracting a poison or a disease. Here, 'hope' is our medicine and 'despair' is our poison; the former nullifying, destroying the other. However, it is unlikely that White actually means to use 'antidote' in this sense, because also implicit here is the idea that hope lies 'under the surface' of despair, and in the process of reinterpreting the abuse hope is able to emerge, just as despair also lies under the surface of hope and at times emerges.

My data support this latter interpretation of the juxtaposition of hope with despair, indicating that responses to trauma are complex, being both positive *and* negative. Indeed, hope can, and frequently does, *coexist* with despair.

It is important, too, for the narrative therapist not to view the traumatic testimony as a mere story. Geras (1995) argues that although the description of any (e.g. traumatic) situation can yield '... a plurality of possible representations of whatever is the subject at hand' (111), there is a 'reality' in the event for the describer. As Harari (1995) points out, the survivor's testimony is much more than a story:

... He/she is also a witness, someone who is providing testimony. For the survivor there is not a plurality of readings or multiple perspectives of *equivalent validity* from which the story may be told (13; my emphasis).

Thus not only is response to trauma complex, but there are likely to be individual differences in testimony to trauma, all of which need to be accepted (in some sense, depending on timing and context, without challenge or need to reframe) by those bearing witness (hearing the testimony).

DIFFERENCE IN TESTIMONY: FRANKL AND LEVI

There are many similarities between Primo Levi and Viktor Frankl. Both were European, Jewish, professional (the former a chemist and the latter a psychiatrist) men born in the second decade of the 20th century. Both were also captured by the Nazis and interned in concentration camps during the Second World War.⁶ Although they both survived the Holocaust, there the similarity ends because they both had very different responses to it. Although the historical truth of their concentration camp experience at a superficial level would be deemed to have been similar, having been authenticated by numerous other witnesses, their personal testimonies are quite different. And by 'testimonies' I refer here to their written accounts and synthesis of their personal experience.

In *Man's Search for Meaning*, Frankl cites the same aphorism from Nietzsche several times: 'He who has a *why* to live for can bear with almost any *how*' (1984: 97, his emphasis). Moreover, Frankl continually refers to this sentiment throughout the text, leaving the reader with a clear message that the attaining of a meaning and

purpose in life can assist one to survive almost *any depth* of suffering. For Frankl, suffering is not something to be sought after, but if one is unfortunate enough to *be* suffering one must make the most of it. And the way to grow through this suffering is to find meaning and purpose, however degrading and debased one's circumstances. What is interesting about Frankl's testimony is that this is not a *post hoc* idea. That is, he has not rationalised or attempted to explain his survival after the event. He simply thought like that at the time. This cannot be better demonstrated than in an extraordinary speech he gave his fellow inmates at the nadir of their imprisonment:

... I began by mentioning the most trivial of comforts first. I said that even in this Europe in the sixth winter of the Second World War, our situation was not the most terrible that we could think of. I said that each of us had to ask himself what irreplaceable losses he had suffered up to then. I speculated that for most of them these losses had really been few. Whoever was still alive had reason to hope. Health, family, happiness, professional abilities, fortune, position in society—all these were things that could be achieved again or restored. After all, we still had all our bones intact. Whatever we had gone through could still be an asset to us in the future. And I quoted from Nietzsche ... That which does not kill me makes me stronger. Then I spoke about the future. I said that to the impartial the future must seem hopeless ... but ... that ... I had no intention of losing hope and giving up ... I also mentioned the past; all its joys, and how its light shone even in the present darkness ... I told my comrades ... they must not lose hope but should keep their courage in the certainty that the hopelessness of our struggle did not detract from its dignity and its meaning ... And finally I spoke of our sacrifice, which had meaning in every case ... (103–104; my emphasis).

I cite the core of Frankl's speech to his comrades at some length because of its remarkable courage and ability to focus on hope in such a bleak context: a bunk house in a death camp.

In contrast to Frankl, who wrote only one main text on the Holocaust and spent the major part of his academic and clinical career developing his ideas around the therapeutic technique of logotherapy, Primo Levi's *raison d'être* and the core of his life's writing⁷ was to give testimony to the Holocaust. However, this testimony is vastly different to that of Frankl. For Levi, the circumstances were such that he proposed that the victims or survivors of the Holocaust were likely to continue to suffer, '... even at a distance of decades' (1989: 12).

It appears that Levi (who himself suicided 42 years after the War) essentially identified with the position of Jean Amery whom he quotes here (Amery, an Austrian philosopher tortured by the Gestapo, suicided in 1978):

Anyone who has been tortured remains tortured ... Anyone who has suffered torture never again will be able to be at ease in the world, the abomination of the annihilation is never extinguished. Faith in humanity, already cracked by the first slap in the face, then demolished by torture, is never acquired again (Levi; 1989: 12).

Herein lies the difference between Frankl's and Levi's testimonies. The former's is optimistic and the latter's pessimistic. It is not the purpose of this paper to investigate the reasons for this difference (e.g. spiritual beliefs, psychological defences). What is of most importance to us here is that there *can* be such different testimonies to trauma (and as with Anna Kelly in the previous case study, the pessimism and optimism can coexist). In the hearing of testimonies we need to acknowledge the possibility of such difference being laid bare before us. Just as some choose silence as their testimony (Lang, 1995), others demand attention to their testimony. As therapists, all of us will have our own tendencies in either (or both) these directions and it is to the interaction between the victim and the witness that I now turn.

THE PROCESS OF BEARING WITNESS

The 'Demidenko Affair'

An interesting example of confusion over the status and meaning of testimony may have occurred in 'The Demidenko Affair'. Between 1993 and 1995, Helen Demidenko's book, *The Hand that Signed the Paper* was awarded the *Australian/Vogel* award for first fiction (unpublished author under 35 years of age), the Miles Franklin award for Australia's best novel, and the Australian Literature Society's Gold Medal. This first novel by Helen Darville (1994) was initially published under the pseudonym of Demidenko, and most readers believed that a young Australian girl, daughter of a Ukrainian father and an Irish mother, had written a thinly fictionalised, historically accurate and sympathetic account of her father's and uncle's brutal involvement as Ukrainian death camp guards at Treblinka and in the Babi Yar massacre. Darville's underlying argument throughout the novel appeared to be that the Jews had got what they deserved in the Second World War because they had been responsible for the Ukrainian famines of the Thirties, most Jews being communists and vice versa. Thus, the brutality was legitimate and understandable behaviour by her Ukrainian relatives. However, it soon emerged that Helen Demidenko was indeed Helen Darville, the daughter of English migrants with no Ukrainian heritage.⁸ Of interest to us here is the question of *why* the novel received such overwhelming approval from a segment of the literary establishment.

This is a good example of the complexity of the relationship between giving testimony and responding to this testimony. It is possible that the literary judges read the manuscript of *The Hand ...* and interpreted it as a Ukrainian author's testimony to the atrocities committed by her Ukrainian relatives towards the Jews during the Second World War. As witnesses, the literary judges responded empathically and uncritically to this 'testimony' and it may have been for this reason that Jill Kitson described the work as '... a searingly truthful account of terrible wartime deeds that is also an imaginative work of extraordinary redemptive power' (Manne, 1996: 49).

In contrast, however, Robert Manne, and other critics

interpreted the text as a poorly written, shallowly disguised piece of anti-Semitism; indeed, not a testimony but an apology for war crimes. In that sense they were not accepting witnesses but critics of the testimony.

Constraints for Therapists in Bearing Witness

Differences in testimony demand flexibility in witnessing. Much has been written on the 'vicarious traumatization' of those invited to witness testimony to traumatic experiences; historians, therapists, judges and so on (Baker, 1997; Felman and Laub, 1992; Herman, 1992; Salter, 1995). In this final section of the paper I briefly refer to my own experience as a therapist, then I draw on the work of Dori Laub (1992a) who has explored therapists' defences against this traumatization. Laub is a psychoanalyst; a child survivor of the Holocaust, as well as an interviewer of survivors who give testimony to the Fortunoff Video Archive for Holocaust Testimonies at Yale.

When bearing witness to sexual abuse, road trauma, war experiences, and so on, we are faced with many existential questions which Laub suggests we generally tend to avoid in everyday living by engaging in trivial activities.

The listener can no longer ignore the question of facing death; of facing time and its passage; of the meaning and purpose of living; of the limits of one's omnipotence; of losing the ones that are close to us; the great question of our ultimate aloneness; our otherness of any other; our responsibility to and for our destiny; the question of loving and its limits; of parents and children; and so on (Laub, 1992a: 72).

However, as therapists it is less easy to engage in trivial interventions as a way of bypassing the depth of our clients' trauma. Despite our best intentions, our finely tuned empathy, and our most accomplished skills, we may continue to feel overwhelmed and act clumsily. Which of my own vulnerabilities, for instance, can shed some light on the process for the therapist as witness?

Living in an assimilated, Hungarian Jewish family, as an Australian child growing up in Melbourne in the 1950s, I knew virtually nothing of my Holocaust background. The story of the murder of my family and relatives only gradually emerged over the years. Even now, my 81 year old mother continues to express surprise when I show any interest in my family's European past or her own war-time experiences. My parents' strong message to me has always been that the *future* is what counts, not the past. It comes as no surprise that my 'corrective script' (Byng-Hall, 1995) has contributed to my long-standing interest in transgenerational issues. Again, in defiance of my parents' discomfort with their traumatic pasts, I use grief, loss and trauma as a lens for my family work. At times I have found myself embracing pessimism and despair with greater confidence than I am able to embrace hope, leaving me with a disabling suspicion of single-session work and simplistic views of the narrative therapies.

This can have an obvious impact on my capacity to bear witness in my traumatic brain injury work. At times I find myself identifying with my clients' pain, helplessness and frustration at their losses and the senseless injustice of their accidents. I must admit that at such times my accompanying feelings of rage and anger (often directed towards the Transport Accident Commission and the Government for not providing and paying for adequate services) may be more suited to advocacy work than therapy! Therapists, then, have complex reactions to their trauma work and the following list is by no means exhaustive.

Laub (1992a) postulates that as listeners, testimony to trauma can induce in therapists a wide range of defensive reactions:

- i. *Paralysis*: We actually may feel paralysed in response to the fear of merging with the atrocities being recounted.
- ii. *Outrage and anger*: Although this anger is frequently directed at perpetrators in sexual abuse, political regimes in instances of genocide, or drunken, culpable drivers in road trauma, at times we might find ourselves unwittingly angry with the helpless victim whom we are attempting to assist. Our anger at our own inadequacy to respond helpfully is coupled with our inadvertent wish for the victim to take responsibility for his/her own suffering.
- iii. *Withdrawal and numbness*: Sometimes it is easier to withdraw or allow a numbness to protect us from the pain and the overwhelming ghastliness of what we are hearing.
- iv. *Awe and fear*: At times we sanctify the survivor, both paying tribute to their skills and courage in surviving abuse *and* keeping a distance to avoid the intimacy of knowing what they have truly suffered.
- v. *Foreclosure through facts*: This manifests itself through excessive fact finding and gathering of detail, which protects us from the depths of human experience. Or we indicate in various ways that we know it all, and have heard it all from others, thus leaving little room for each individual's unique testimony.
- vi. *Hyperemotionality*: This can superficially look like caring, but with displays of extreme emotions by the listener, the testifier can become 'drowned and lost in the listener's defensive affectivity' (Laub, 1992a: 73).

Whatever our defences, our challenge as therapists is to listen to complex testimonies: accepting the reframes, the denial, the questions, the silence, the overwhelming ghastliness and the loud angst with an unobtrusive and accommodating presence (Lang, 1995; Laub, 1992a, 1992b). Nor, as witnesses, can we ignore the sense of elation, admiration and inspiration that accompanies listening to courageous testimony and stories of survival.

CONCLUSION

In this paper I have connected the idea of 'crises of witnessing' to a range of traumatic events. This paper leaves untouched the interesting question of what distinguishes a *therapist* as witness, which deserves a paper to itself. In presenting clinical research data, I have demonstrated the possibility of complex outcomes to trauma. Getting on with life, valuing life more and achieving a sense of positive growth following severe trauma and suffering through adversity does not preclude the possibility of a coexisting sense of depression and family dissatisfaction. Openness to complex outcomes following even the deepest and most degrading human suffering offers a unique challenge to therapists who bear witness to it.

Notes

¹Throughout this paper 'bearing witness' is used both in the sense of 'giving and listening to testimony' following significantly traumatic events. Although the more usual sense of 'bearing witness' is 'to give one's testimony', the process of giving testimony necessarily includes a listener, and the listener, too, bears a traumatic load in the witnessing of the testimony. The listener is '... at the same time a witness to the trauma witness and a witness to himself' (Laub, 1992a: 58).

²Fiona McLlwaive and Tom Paterson brought my attention to this phrase in a book by Shoshana Felman and Dori Laub (1992): *Testimony: Crises of Witnessing in Literature, Psychoanalysis, and History*, NY, Routledge.

³This account focuses on the wife's adjustment rather than that of the husband with the head injury. Readers interested in the full case discussion can refer to Perlesz (1997).

⁴Interviewer's comments are in italics, enclosed in parentheses.

⁵Several authors have directly raised the role of a NDE in both enhancing meaning and contributing to one's sense of purpose or *raison d'être* following traumatic experiences (Adams, 1996; Noyes, 1984).

⁶There are no clear dates in Frankl's writing but it is likely that Frankl and Levi were in Auschwitz at the same time.

⁷Mirna Cicioni has recently published an interesting literary biography covering Levi's life work, indicating a breadth of literary contribution beyond the Holocaust: M. Cicioni (1995): *Primo Levi—Bridges of Knowledge*, Oxford, Berg.

⁸Not only was there evidence of significant plagiarism within the text of *The Hand ...*, but Robert Manne has written a compelling critique of the book's historical inaccuracies and blatant anti-Semitism (Manne, 1996). The book was withdrawn from publication in 1995.

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Conference News, 1999 and 2001

Women In Family Therapy 1999 Conference: Expressions of Interest

The WIFT Conference will be held from Sunday September 26 1999 to Tuesday September 28 1999 at Jamberoo Valley Lodge in the beautiful Jamberoo Valley south of Sydney. The WIFT Conference has three main aims: (1) To offer a venue for 'new' women presenters to try out their papers or workshops in a safe and supportive environment. (2) To encourage women to network and to build professional contacts with other women. (3) To have fun!

Fees (approx. \$200) include conference registration, all accommodation, meals and coach transport from Sydney and return. Coach will pick up from Central Railway and the domestic airline terminals. Return coach will drop people at both places as well as transporting those attending the NSW FT Conference to the conference venue at Manly. Of course, childcare will be available. What a bargain! If you want more information or are interested in helping to organise the conference, phone Ruth Orchison or Carol Boland on +61 2 9876 8243

Meet your Foreign Correspondents!

The XIIIth International Family Therapy Association Congress will be held in Melbourne, 2-8th September, 2001. Who is coming? Your Foreign Correspondents, Jürgen Hargens, Rosalía Bikel, John Hills! Will you be there?