

Episode 269—Dr. Judith Herman: Issues and Perspectives on Trauma and Trauma-Informed Care in the Age of the #MeToo Movement

[00:00:08] Welcome to inSocialWork, the podcast series of the University at Buffalo School of Social Work at www.inSocialWork.org. We're glad you could join us today. The purpose of inSocialWork is to engage practitioners and researchers in lifelong learning and to promote research to practice and practice to research. We educate. We connect. We care. We're inSocialWork.

[00:00:37] Hello and welcome to inSocialWork. I'm Louanne Bakk, your host for this episode. We're heading towards the end of summer here in Buffalo and the beginning of a new academic year. As we begin this transition, I would like to take this opportunity to thank you, our listeners, for your continued loyalty and support. The worldwide MeToo movement has raised awareness about sexual abuse, including issues of sexual harassment in the workplace and has heightened attention to the long term implications that can result from the trauma of past abuse. Moreover there has been considerable progress made in relation to recognizing the various forms of PTSD and the importance of maintaining a strong therapeutic alliance when working with trauma survivors. In this podcast, Dr. Judith Herman engages in informative conversation on current issues and perspectives concerning trauma and Trauma Informed Care. She discusses research on justice from the perspective of trauma survivors, how this is related to the MeToo movement and why individuals who are victims of abuse choose to speak out. The relevance of the therapeutic alliance was stressed, particularly when working with individuals who have been traumatized by interpersonal violence. Dr. Herman considers the progress and relevance of changes within the DSM-5 PTSD diagnostic criteria how chronic shame is related to dissociation and PTSD and the consequences of forming an insecure attachment. The episode concludes by providing examples on how resilience can be built through community based interventions and lead to more secure attachments. Judith Herman M.D. is professor of psychiatry at Harvard Medical School. For 30 years she was director of training at the victims of violence program at the Cambridge Hospital in Cambridge Massachusetts. Dr. Herman has lectured widely on the subject of sexual and domestic violence. She is the recipient of numerous awards and in 2007 was named a distinguished life fellow of the American Psychiatric Association. She was interviewed in May 2019 by Dr. Mickey Sperlich, assistant professor here at the UB School of Social Work. We would like to mention that this episode contains some background distortions that are due to technical problems we experienced while recording. Thank you and we hope you enjoy the podcast.

[00:03:16] Dr. Herman, thank you so much for being with us today and sharing your expertise and your experience. I really appreciate you.

[00:03:23] Oh I'm delighted to be here. Thank you.

[00:03:25] I know you've been doing research on justice and what that looks like from the perspective of trauma survivors and I'm interested in how you see this perspective playing out or its current age of the MeToo movement.

[00:03:38] I did a study with in-depth interviews of survivors of sexual and/or domestic violence over 10 years ago now and I asked them what justice would look like if they were ever consulted. What would make things right for them or as right as things could be. And what they said did not really fit with our common notions of criminal justice or even civil law. The thing that they most wanted, there was almost them to be on this point was

acknowledgment of both the facts of the abuse and also the harm that was done and they wanted acknowledgment, not just from the perpetrator or not even primarily from the perpetrator, but mainly from the bystanders, from the community. If for example there was sexual abuse or incest within the family, the adult survivor wanted the family to acknowledge what has happened and if it required a confession from the perpetrator to get the family to believe the survivor then they wanted that. But it was bystanders the community said people really wanted to know and to acknowledge, not to be part of the cover up, not to turn a blind eye to what has happened. And second to acknowledgment of the fact, they wanted denunciation of the crime. They wanted the bystanders to say "this happened, it hurt you and it was wrong." They wanted the bystanders to denounce the crime and to denounce the perpetrator. And in some ways to take the burden of shame off the victim and move it on to the shoulders of the perpetrator. And so beyond that they were not terribly invested in punishment of the offender and they were also not terribly invested in forgiveness for reconciliation. In fact, as one survivor put it, they've said "I've had enough trouble just dealing with my own recovery. I don't need to deal with his recovery. He needs to make his peace with God. And I don't want to have to be part of his recovery. I want to deal with him anymore." That was kind of the general consensus. In a certain way, I think the MeToo movement, in a rough way really, because there are no standard procedures here, it's all improvised. But they are mainly talking about acknowledgement. Acknowledgement that very powerful men at the head of various media organizations who have used their power to exploit women sexually need to be exposed and need to be shamed. And beyond that what punishment faces suffer, with the exception I guess of Harvey Weinstein, no one's facing criminal charges and none of the survivors seem to be terribly invested in criminal punishments, imprisonment or even fines. There are some civil actions but the remedy is that the justice system offers, whether it fines in civil law or whether it's imprisonment in criminal law, these were not the remedies that survivors were most interested in. In fact certainly imprisonment for offenders, most survivors were not invested in that. They wanted some sort of prevention so that the offenders would not continue to harm others. But unless imprisonment was the only method of keeping the community safe, survivors by and large didn't want punishment for punishment sake. It was not as though the laws have been broken and so standard punishments have to be applied. That was not the mentality of all. So with MeToo, what we're seeing is public exposure, public shaming and this seems very much in keeping with what survivors want and need.

[00:08:08] In that sense it seems like it's more about incapacitating the perpetrator from continuing to do what they're doing.

[00:08:15] Exactly.

[00:08:16] I was watching the documentary on the Larry Nassar situation with a gymnast and it seemed that that was at the end of the day a prime motivating factor for why many women came forward. What, if I don't speak out then this person is going to keep doing that to other people. How can we incapacitate the person from having the chance or the ability to do that with access to the victim.

[00:08:39] Right. And usually if there is public exposure and if he's removed from his position of power then he doesn't have the opportunity. People will be warned about him and they will not be seduced. By the way, I have a theory about MeToo, which I've never seen written about anywhere. And that is that it has to do with what happens when women enter patriarchal male dominated organizations. And when we're below, say 15 to 20 percent of the membership of the organization, then we're token women then we have to

basically be one of the boys. Nothing much happens in the way of change. But my theory is that when women reach between 15 and 20 percent of the organization then change begins to happen, women begin to get together at one of the first things that women have to do is clean house, is clean up the messes that the boys club has made. We saw this in psychiatry in the 1980s. I was a member of the Committee on Women of the American Psychiatric Association and we had a feminist committee and what we did was conduct a nationwide study on sexual contact, we put it in very neutral terms, between psychiatrists and patients because it was the same sort of situation there where there were certain psychiatrists who were exploiting patients. And everybody knew you don't send young women to that guy but nobody did anything about it until we reached this critical mass. And we did the study, and what do you know, about six percent of psychiatrists acknowledged. It was an anonymous survey and in fact some of the perpetrators were very keen to tell us all about what they did because it was so highly rationalized. And they had so many excuses for why what they did was really okay. And so once we brought this to public attention we published some results for the American Journal of Psychiatry. The editor sent the paper out to seven reviewers, usually they send it to two, and the reviewers all came back and said "Gee, you know, the methodology is pretty good. We don't see anything wrong with this study. And maybe you should publish it," So they did. So I got to do something about the bad actors in our own organization. Well women in the media, women in film certainly, had just reached in the recent decade that crucial 20 percent. Now I know it seems odd, but turns out that women in leading roles in top 100 grossing movies are like 20 percent because so many of them are sort of male action figures and so on. And women behind the camera, women producers, directors, camera women and so on are about that 20 percent. And I think it's not a coincidence that it's at that moment that again that denunciation of the bad actors that everybody knows about and has known about for years, and that's when the Harvey Weinsteins of the organization start be publicly exposed.

[00:12:00] It's when they're not the only game in town anymore. I know that for a couple of actresses that spoke out, they listed among the reasons why they didn't come out earlier was basically it would ruin their career.

[00:12:10] Absolutely. He had the power to make or break people's careers and everyone knew it. And this was the price that women had to pay.

[00:12:19] And it's been going on for a long time.

[00:12:20] And similarly at Fox News and CBS and so on, the same sort of story that the alpha males if you will, saw this is one of the perks of their position was to have women on demand.

[00:12:36] Thank you. That's an interesting perspective and that resonates true for me.

[00:12:40] Yeah, I don't know how you would conduct a study to find out if that 20 percent figure really is the tipping point but we have now women a little over 20 percent of the U.S. Senate and all of a sudden it seems possible that women could run for president. not because of their relationship to a powerful man but because they got there on their own feet. The other place I found the 20 percent figure was in the U.S. military. Of course we have the house cleaning going on about military sexual trauma.

[00:13:14] Well I'm gonna segway to another question for you. You have long suggested that the best way of looking at the many adaptations that people make to adjusting to the

experience of having prolonged and repeated trauma thought of as complex PTSD. And I know that you really encourage those were on the working group for the Diagnostic and Statistical Manual for Mental Disorders or DSM Fifth Edition.

[00:13:41] I was a consultant. I wasn't actually on the PTSD Working Group. I was for DSM-4. And you know, we tried to get complex PTSD first in DSM-4 and we got it into the associated features only. And then for DSM 5...

[00:14:00] Well I know that the upshot was that even though you encouraged it the complex PTSD diagnosis was not adopted. And instead we have some changes to the PTSD, or Post-Traumatic Stress designation. We have a dissociative subtype now, we have child PTSD and dissociative subtype, but we don't have that complex PTSD diagnosis that I know so many clinicians are really utilizing and rushing in to and I'm just wondering if you could share your perspective on that process.

[00:14:28] Well the good news is that I see the 11, the International Classification of Diseases, which other countries besides the U.S. all use, has recognized Complex PTSD as of 2018. So I guess the rest of the world is ahead of us on that. Now they're thinking, I think, was very sort of clear and from my point of view parsimonious in a way. They had a basic PTSD category that more fits a single impact trauma like an auto accident or a single assault or a natural disaster, and that kind of experience that is horrible and terrifying, but once it's over it's over. And they have kind of a simple set of categories or descriptors for classic PTSD and then they had the more complex formulation of complex PTSD which has a much wider range of symptoms for the effects of prolonged and repeated trauma where you have a relationship of coercive control between the victim and the perpetrator and the relationship starts to deform the personality of the victim or to form the personality of the victim, of the child. So that's the good news. And the other good news is that with the DSM-5 they moved PTSD out of the category of anxiety disorders and into its own category. And I think what that symbolized is an understanding that PTSD is not just about fear and anxiety and terror. It has a much wider impact. And it also set the stage for understanding a spectrum, if you will, of traumatic disorders. You have sort of basic PTSD and then you have a dissociative subtype, which makes sense, and then you might think of the dissociative disorders as sort of further out on the spectrum of traumatic disorders. And they are, of course. The dissociative disorders are very highly correlated prolonged and repeated trauma, particularly in childhood. So there was progress, and the other thing that's happened was that many of the symptom categories that I described in formulated complex PTSD were imported into the definition of basic PTSD. So in some ways the categories have been sort of blurred. And what you find in the DSM-5 PTSD description, if you will, is complex PTSD without the name. So that's the progress of sorts, it's a compromise. It's interesting the arguments of the people who didn't want complex PTSD recognized in the DSM was that the research hadn't been done to define precisely what did and did not fit in that category. And I argued that that was something that had to happen after you had the basic recognition of the concept and then you could put in a proposal for funding for research. That's what happened with PTSD when that was recognized in the Diagnostic Manual DSM-3 in 1980 for the first time. And that was recognized not because a lot of research had been done but because basically of the advocacy of returning Vietnam veterans who want recognition of what has happened to them. They said "we're home, but we still have Vietnam in our minds and we can't get rid of it and we want recognition that this is a real condition. It's as real as shrapnel wounds and bullet wounds." It's because of their advocacy that PTSD was recognized.

[00:18:29] Right. And once that diagnosis was codified, like you say, then we see the rise of applying this diagnosis and research measures and studies to show the extent to which this is true for women.

[00:18:42] Right. And we begin to get good epidemiological studies to see how widespread it is, how common it is. We discover that 5 percent of men and 10 percent of women have this diagnosis, or have had at one time in the U.S. We could never have done that if we didn't have a name for what this condition was.

[00:19:04] As a person sort of related to this, all of this, I'm very influenced by the field of attachment and the infant mental health movement in the country and I'm very interested in your views on how the development of shame in the context of early attachment relationships, how chronic shame states are related to dissociation or post-traumatic stress that we've been talking about and I'm just hoping you'd share more about that with me.

[00:19:29] We talked a little bit earlier about moving the burden of shame from the victim to the perpetrator by having a community witness and denounce what has been done. But I think there is a way in which relationships of dominance and subordination, which relationships of coercive control, relationships in which abuse is chronic, are inherently shaming and humiliating. There is something in us that rebels against the dominated being humiliated. And so, for example there was a study done in the U.K. with crime victims that looked at shame in the aftermath of the crime and found that shame in the immediate aftermath of a crime was the most powerful predictor of developing PTSD in the aftermath. And there was another study done by researchers in upstate New York in a hospital looking at the relationship between shame and dissociation and they found two interesting things. Patients with high shame had much higher dissociation scores than patients with low shame. But patients who did not have a childhood abuse history, their association scores were still within the normal range of high shame, the high shame group and the low shame group. But patients who had a childhood abuse history, the low shame group was still in the normal range in terms of dissociation scores, the high shame had very high association scores up in the range where you would begin to suspect a dissociative disorder. So those were two interesting studies I think that gave us good data on the relationship and then at my victim surveillance program at Cambridge Hospital, which is an outpatient trauma program, we asked patients to fill out a bunch of self report questionnaires when they first came into treatment and then we repeated reports at intervals, because we were hoping to document that our patients actually did get better and happily we were able to document that. Whether you were measuring shame, whether you're measuring dissociation whether you're measuring PTSD or any other measure, most of the patients improved significantly. But what we found was that looking at measures when people filled out that questionnaire for the first time, that set of questionnaires. Shame was a predictor of PTSD of dissociation, highly highly correlated with dissociation, and it was also highly correlated with suicidal ideation, having a suicide plan or a belief that one might eventually commit suicide and actually having made a suicide attempt. So we're talking about something that is pretty toxic. And when you think about how shame develops, you can really think about it as a measure of attachment or measure of a safe connection. Shame appears in the toddler years. Eric Erickson describes the essential conflict of the toddler years as autonomy versus shame and doubt. And high autonomy of course doesn't mean that a toddler is an autonomous person, because a toddler is still very much in need of care and protection. But what toddlers are trying to do is to learn to regulate their own wishes and desires in connection with others so that the toddler who wants to hold the spoon and feed herself is reaching for autonomy, if you will, but needs to learn how to do it properly so the food goes into the

mouth rather than on the floor and everywhere else. And similarly with toilet training, when the toilet train a toddler it's not that his poop is disgusting and horrible and he's dirty filthy, it's that it would be so much nicer if he did it in the toilet instead of in the diaper. So he's learning to regulate his body and his wishes in connection with the social world. Alan Shore describes the interactions of shame as a returning toddler running up to, excited, running up to the caretaker, "Hey look at me, look at me." And encountering a caregiver who is busy or tired or just can't pay attention right then. And what happens with securely attached children is that the toddler makes abashed face, the face of shame, the loss of eye contact, the bowed head, the bowed shoulders, the slumped sort of wanting to sink through the floor position, and with securely attached toddlers, the caretaker, seeing that abashed look, will say "Oh come come now, it's not that bad," give a hug and the breach in attachment is repaired. That doesn't happen with insecurely attached children. And so what you see with insecure attachment and seen development of chronic shame state and a sense of inner badness.

[00:24:56] And then especially in cases of abuse, it's almost a logical world view to take forward that "there must be something deeply flawed with me that this is happening to me." Right?

[00:25:07] Well first of all, of course perpetrators make sure to either prey on children who are insecurely attached and they can pick that up very quickly, or they make sure to interfere in the relationship between the child and the primary caretaker. And so to prevent, if you will, a secure attachment from developing. Because if there were secure attachment a child could go to the caretaker and ask for protection and talk about what the perpetrator was doing and presumably the caretaker could intercede. So basically for chronic abuse to keep happening in childhood, the perpetrator really has to actively prevent secure attachment from developing.

[00:25:50] Right, or engage in the type of grooming behaviour to draw the child into an attachment relationship in that way.

[00:25:58] Right. Well to draw the child into disorganized attachment where the price of care and affection is exploitation and cruelty.

[00:26:08] While we're on the subject for childhood abuse, twenty years ago when I started looking at the effects of trauma during childbearing, there was very little awareness of the Adverse Childhood Experiences Study or Trauma Informed Care. Now they used to give talks and ask people who had heard of these things or maybe one hand would go up in the audience. And now a lot of people have heard of these things and they've become almost buzzwords in some circles. And I wonder if you might speak to where you see the rise of the ACES study in perspective and Trauma Informed Care and the sort of long trajectory of addressing trauma and in particular wondering if there is any caution or pitfalls you see us falling into with increased awareness and whether we can be more hopeful now that there is more awareness.

[00:26:57] I can speak to what I've seen with the residents I supervise and the psychology trainees and certainly they all know about the ACES Studies now. I mean that is a real service that Dr. Felitti and his colleagues have done for the country and the world. I think what really got public attention was documenting the connection between adverse childhood experiences and the 10 leading causes of death in terms of heart disease, lung disease, liver disease, and of course the needing any variables, if you will, are cigarette addiction, alcohol, substance abuse, I.V. drug use and suicidality. So you really see how

incredibly powerful the impact of childhood adversity can be. So people have heard about that, but judging from the residents I supervise, they don't know what comes next. I mean they may have heard the buzzword Trauma Informed Care, but they don't know what that means. And I've supervised the third year and fourth year residents at Cambridge Hospital every year. The questions I get at the beginning of the year are usually "If I get a trauma history what I do with it?" And a lot of fear of making patients worse by paying too much attention to the trauma. Will that be destabilizing, will that exacerbate their post-traumatic stress symptoms? So people may get a history now but they don't really know what to do with it. And a lot of what I teach at the beginning is really the patient will tell you, you can tell by how the patient reacts whether you're treading too abruptly into a sensitive area, but what you do need to communicate to the patient is that you are ready and prepared to hear about it because otherwise it leaves the patient still in a shamed and isolated place he or she doesn't dare speak about what happened. So you have to be curious, be interested, be compassionate, just as you are with any other issue. And if you form a good alliance with patients you're doing Trauma Informed Care. I guess the other thing I have to say is that for me a good alliance is something that may take some work because people who have been traumatized by interpersonal violence have reason to be very distrustful of others, especially others in positions of power and authority. And so you may need to be open about the fact that you don't expect trust right away and you know that that has to be earned and built. And that's something you're prepared to do, to be transparent, share your thinking and build a relationship. And that will be an antidote to the exploitive relationship that the patient has suffered.

[00:29:50] That is something I really, to me seems athread throughout your work and something I really appreciated to see when it comes to relationships.

[00:29:58] Oh I don't see any other way really. And by the way, if you're looking for an evidence base, the data now from numerous studies shows that the therapeutic alliance is the single most powerful predictor of positive outcome in psychotherapy. And beyond that the particular technique or therapeutic school that the therapist adheres to accounts at most for maybe 10 percent of the variance. And so some of the researchers that have done this work promote what they call now the Dodo Bird Theory, from Alice in Wonderland where the Dodo Bird says that "All have won and all shall have prizes." So it doesn't really matter what your therapeutic technique is. If you build a good alliance you get a prize.

[00:30:48] People need to know that you care about them at the end of the day. I think we're starting to see that same phenomenon in other areas of medicine as well. It perhaps matters a lot more than we thought just that your doctor's listening to you, even regarding variety illments.

[00:31:03] Absolutely.

[00:31:04] And what particular medicine that he or she might prescribe. That kind positive regard.

[00:31:08] Unfortunately the way we've figured that out is because now with electronic medical records having been introduced in most places and with the speed up of the production line for doctors now that doctors are not for the most part self-employed but are non-unionized employees of an exploited system. You have 15 minute doctor's appointments in which doctors are looking at the computer screen instead of looking at the patient. And what do you know, that doesn't work out so well either for the doctor or the

patient. Patients hate it and doctors hate it. And burnout among physicians is at the highest level it's ever been.

[00:31:49] Related to that, when I look at ACES and the Trauma Informed perspective, it's sort of a bridging concept here that we're going moving toward this with resilience and I'm of course very hopeful that we gain a better understanding of all the ways in which we think that resilience can be built. But I worry that in some cases we're putting resilience out there as a sort of bar to jump over without providing the necessary tools and resources that it's really going to take to get at the root cause of distress in people's lives.

[00:32:17] Oh yeah, I do think resilience has become a buzzword. We do have some good studies about what makes for resilience too that I'd like to talk about. One was done in the island of Kauai in Hawaii where a researcher named Emmy Werner and there and her colleagues followed an entire birth cohort for one year from birth to adulthood with frequent interviews and they found a particularly resilient group and have had childhood hardships but did well as they developed and there were quite a few predictors and some of them were things like having at least two years before the next child was born, which means that the mother needed to have some control over her reproductive life. And then the kinds of things that you would expect having, if not the primary caretaker at least caretaker in the child's life that was available and nurturing. And then having appeared being good at something. Intelligence helped, being good at something in school. Having some group to belong to, whether it was a church group or sports team or any other place where the person felt a sense of belonging. So you're looking at really relational predictors of resilience. The other study was done by a psychologist named Colin Lyons at Cambridge Hospital. She did also a prospective longitudinal study where she followed families that had been referred because there was some concern about parenting. Often young depressed teen single mothers, for example. But in this study there was intervention and there were two intervention groups. One was a group that got weekly home visits by social workers who worked with the moms and did of practical things to help out, getting food stamps, helping with housing, whatever the mom needed but also sat with the mom and the baby and kind of modeled what good care looks like and gave a lot of information about normal development when the child cries. It's not cause the child hates you, it's because the diaper's wet. And this went on only till the babies were 18 months old. There was a second group that had the same kind of home visiting but with community women who didn't have any kind of formal credentials but were selected because they were thought of as good mothers. And they did the same kind of weekly home visits. Also social workers and the community women got weekly supervision themselves in a group. So there was a holding environment for the caregivers. And then there was a holding environment for the mom and the moms in turn provided holding environment for the infants. And there was a control group that only got pediatric care as usual, randomly assigned. The two intervention groups were followed as they developed and what they found was that in the intervention groups the majority of kids were securely attached, whereas in the group that didn't get the intervention about two thirds of the kids were insecurely attached. And once you had secure attachment you had a virtuous cycle so that the kids did better in school, they made friends, and got on track developmentally. So the source in resilience was early home visiting for isolated moms and there been many studies now that look at the powerful effect of home visiting for first time mothers who are dealing with poverty or isolation or need help becoming good parents. And once you've got that you've got resilience.

[00:35:59] I agree. The earlier the better. And the combination of not only providing that sort of modeling of what attuned care looks like but also connecting to resources and

helping to address some of the structural inequalities that are present in people's lives are really intractable.

[00:36:18] Well at least things pay for themselves many many times over. And of course they don't pay for themselves immediately. They pay for themselves 20 years down the road, because just when you think about now the impact of any ACE you're talking about the cost in medical care and psychiatric care costs in terms of the educational deficits that abused and insecurely attached children suffer. And the percentage that end up themselves being victimized or having early pregnancies or getting involved in the legal system, and, you know, preventing a host of medical, psychological and social problems. And yet if your frame of reference is the two year electoral cycle of Congress you're not going to vote in these things you're not going to be able to show the outcome immediately.

[00:37:13] Well we have covered a lot of ground here and I also just wanted to give you a chance to kind of sum up or add to or pose a question or challenge for all of us or just anything else that you want to contribute to the conversation.

[00:37:29] Oh, I'm not sure I have any other words of wisdom. We have covered a lot. And I do want to thank you because, you know, you've talked about some of my pet issues and things I really care a lot about. So thank you.

[00:37:43] Well, thank you so much. You have and are a real role model for me and I want to thank you for that.

[00:37:49] You've been listening to Dr. Judith Herman's discussion on trauma and Trauma Informed Care in the age of the MeToo movement. I'm Louanne Bakk. Please join us again at inSocialWork.

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