The Germ Theory of Trauma: The Impossibility of Ethical Neutrality

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This final chapter is likely to be the most provocative. Sandra L. Bloom argues from a feminist-theoretical perspective that we have collectively created violence and that this violence is like an infection that is destroying our humanity. While some will not be able or willing to take on Bloom’s perspective, others will likely cry out in relief to read it. It is not a chapter that can be responded to lightly. It challenges our thinking and invites quantitative questions. I invite you to read this chapter and see for yourself how you will be affected by the material.

To study psychological trauma means bearing witness to horrible events....When the traumatic events are of human design, those who bear witness are caught in the conflict between victim and perpetrator. It is morally impossible to remain neutral in this conflict. The bystander is forced to take sides.

Judith Lewis Herman
from Trauma and Recovery

Before Pasteur’s discovery that it was microbes that were causing infections, people generally thought that the source of disease came from within, a manifest form of inner corruption, an expression of the punitive wrath of God,
or demon possession. The germ theory showed that the infectious agent came from outside the person and if the person was vulnerable an infection would ensue (Schwartz, 1995). As the science of microbiology grew, it became apparent that some bacterial agents were so virulent that they could overwhelm the defenses of virtually everyone and that some social conditions like poor nutrition and improper sanitation were known to increase the likelihood of infection universally. The public health profession grew upon the premise that infectious agents killed and maimed the innocent and the guilty and could only be kept at bay by the enforcement of public policy that applied to all. Protecting the health of the nation's most valuable resource—human labor—was considered a social, moral, and economic responsibility.

In some meaningful ways, trauma theory is the psychological version of the germ theory. We now have an understanding of the connection between pathogenic forces in the external world and the internal pathology of the person. We know a great deal about how the body, mind, and soul of the victim interact with the body, mind and soul of the perpetrator (Davidson & Foa, 1993; Janoff-Bulman, 1992; van der Kolk, 1988, 1989, 1993; van der Kolk, Greenberg, Boyd & Krystal, 1985; Wilson & Raphael, 1993; Wolf & Mosnaim, 1990). But what impact does this profound shift in perspective have on us? In this chapter I want to extend the infection metaphor to our entire socio-cultural milieu and present an argument to the reader that the current epidemic of violence is a major public health problem. As clinicians who deal with the immediate and long-term effects of violence, we are part of the extended public health system. In this capacity we have a critical, but challenging role to play that may be vitally important to our attempts to care for ourselves as well as our patients. To understand where we are going, let us dwell for a minute, on where we have been.

The greatest significance of Pasteur's observations was that he was able to establish a cause-and-effect relationship between pathogens and disease. Once a causal connection could be established, efforts could be undertaken to combat the causal agent and to increase the resistance of the host to disease. In contrast, until now the etiological basis for mental disorders has been insubstantial to nonexistent. This is reflected in the DSM categorization schemes, which are descriptive accounts of symptom complexes. As a consequence, psychiatry has never been able to achieve the same level of respectability as the other medical professions which are based on a the cause-and-effect relationship between disease, external pathogenic factors, and the state of the targeted organism.

Unfortunately, the focus of attention for psychiatric dysfunction has, for the most part, remained firmly fixed within the individual, a century after the focus expanded outwards for physical disorders. In earlier times, the individual psychiatric defect revolved around original and internal corruption, punishment by God, or possession by demons (Ellenberger, 1970; Porter, 1987; Zilboorg, 1941). Over time the demon theory as well as the punishment-by-God theories lost momentum, but the locus of the problem still remained within the individual whether it was due to Freudian theories of arrested psychosexual development or faulty brain neurotransmitters. As a consequence, the individual model of treatment has prevailed and mental health has never really caught on as a major public health concern or social responsibility.

Among some biological psychiatrists, the individual model has been reduced even further to a total preoccupation with brain function, divorced from any outside pathogenic agent. In the last several decades, this approach has been so influential, that in some circles psychotherapy is considered an unnecessary luxury, if not a waste of time, while we wait for medications to be discovered that will wipe-out mental illness (Mender, 1994). Some psychiatric programs have become so reductionistic that little meaningful emphasis is placed on the skills involved in developing relationships, working through transference, and
managing countertransference reactions. Since, in this model, mental health problems are largely a result of individual neurotic, psychotic, or character problems, the political and moral values of the patient's contextual frame are largely irrelevant, and the therapist, physician, or psychiatrist therefore has no real moral responsibility to do anything except follow a standard set of long-standing professional ethics. In political and moral terms, "the actions dictated by those who focus on individual pathology are carefully claimed to derive from no moral or political base; ordered to no social goal beyond that of patching the wounded" (Armstrong, 1994).

The individualistic approach is analogous to the practice of pre-Pasteur medicine. Since physicians could not see microbes and could not, therefore, see the relational aspects of disease, the measures they took could not be grounded in an understanding of microbial function. If they were compassionate and intuitive, they would recommend kindness, concern, and compassion on the part of others, but this was not a requirement for healing, rather a sign of benevolence on the part of the healers. If they washed their hands or took any sanitary measures, it was because they preferred it that way, not because it was known to be necessary. And because their practices were based on unsound theory, some of the things they did were downright harmful, like continuous bleeding and the administration of herbs and potions that were sometimes poisonous.

When the great microbiology discoveries began to occur the enthusiasm for antibiotic treatment grew. In the early heydays of antibiotic treatment many thought that the elimination of infectious disease was just around the corner. Enormous strides were made in conquering disease that had plagued humans since the beginning of time. But nothing is ever that "easy" and nature has a way of fighting back. Now we know that infectious agents tend to mutate readily, are difficult to eradicate, and that our "scorched earth" policy in regards to infectious agents may be dangerous in the long-term, as microbes rapidly develop resistance to our usual antibiotic regimens. Consequently, more attention is being paid to increasing the resistance of the host to infection, promoting other factors that lead to healing, and decreasing the external factors that foster disease (Goldberg Group, 1994).

Public health officials have sometimes been forced, often against their wishes, to enter the realms of politics, social values, and ethics as it has become increasingly clear that social factors play a large role in the spread or containment of various diseases, most recently, for example, AIDS. In trying to liberate us from these scourges, some people have lost a great deal in the struggle, as the culture refuses to break through its own denial about the relationship between disease processes and social disorder. Trauma theory provides the theoretical framework to bring psychiatry into a much better alignment with medicine, as the health care field gears up for the new century and a new paradigm. Trauma theory proposes that the origin of a significant proportion of physical, psychiatric, and social disorder lies in the direct and indirect exposure to external traumatogenic agents. Trauma causes chronic, infectious, multigenerational, and often lethal disease. Although some traumatic events are highly likely to create post-traumatic effects in anyone, the more usual interaction is between the strength and persistence of the stressor and the vulnerability of the stressed. Van der Kolk (1989) points out that traumatization occurs when ones' combined internal and external resources are insufficient to cope with the impending external threat. Certain environments are clearly more likely to provide a fertile breeding ground for traumatogenic events than others.

Just as bacteria and viruses are the usual infectious agents, the perpetrators of violence are the carriers of the trauma infection. The more destructive the perpetrators are, the less the chances of survival for their victims. The more intense the level of contact, the greater the likelihood that the victims will suffer from the long-term consequences of the perpetrators' dis-
ease. The poorer the health of the victim—physical, psychological, and social—the greater the likelihood of exposure. The infection even takes on a pseudo-genetic form of transmission as the effects and patterns of violence are passed from parents through children, both through what is done that is negative and what is not done that is positive. But bacteria have relatively few friends among people. The carriers of the infection of violence traditionally have been men, the men that women and their children love, need, respect, and obey.

For hundreds of generations, fathers and mothers have carefully and dutifully prepared our boy children to become the carriers of violence so that they would fight and defend the survival of the species. Violence administered in childhood was used almost as an inoculation to prepare boys for the inevitable violence of manhood. That boy children may be more hormonally predisposed to violence and therefore more trainable may be true. But ascribing violence largely to biology is a cop-out. Our cultural training of boys is far too methodical, pervasive, and insistent to ascribe anything but a relatively small role to biological predisposition. As long as people were strung out in small numbers around the globe, and as long as our weapons were limited to stones, clubs, and even knives, the most violent of our species—our infectious agents—could live in relative harmony with the rest of us. Similarly, under normal circumstances, thousands of microbial varieties live within our bodies in such a state of relative harmony with each other because of a balance of power between them and our immune system. Many microbes serve a beneficial purpose in furthering our existence. Violent males used to have alternatives less available now. There was always a frontier to be settled, an indigenous people to be conquered. Likewise, there were women and children to be protected from the danger of others. But under changing conditions, when the balance is lost, a microbe that has been previously harmless or even beneficial, can become a killer. AIDS victims do not die from the AIDS virus, they die from what the AIDS virus does to the internal microbial balance.

Our human balance of power with our “violence microbes” has been lost as well. It is as if the infectious agent carrying violence has mutated and the infection has become so virulent that it no longer serves any master except the Grim Reaper. The causes for this increased virulence are complex—increasing world population, diminishing resources, loss of frontiers, urbanization, increased destructive power of weapons—some of the same circumstances that lead to the increase in other forms of disease as well. Whatever the cause, we do not appear able to contain the infection. People are coming down with the disease faster than we can treat them, and for many the damage is so profound that our best efforts to save them are stymied. Our entire society has been infected by an AIDS-like virus that has destroyed our capacity to resist violence. In fact, we long for it, seek it, profit from it, enjoy it, get sexually aroused by it, and deliberately expose our children to it. The social forces that previously held violence to sustainable limits have been shattered in this century. Our capacity for violence has outstripped our ability to limit it. The infection is out of control and we now have an epidemic. It is not enough to look for increasingly potent antibiotics—we cannot afford to imprison or kill the large percentage of the population that it would be necessary to isolate from others if we were to focus on perpetrator behavior alone. While we try to contain the most virulent strains and take steps to decrease the virulence of the rest, we must provide the conditions that improve our ability to resist the infection of violence. This is a public health emergency.

Few of us who stumbled upon trauma theory ever intended to become public health clinicians and therein lies one of the chief difficulties in achieving adequate self-care. One of the many consequences of the shift in perspective towards a trauma-based approach for the mental health professions is to place us in the
uncomfortable position of recognizing the validity of the long-standing feminist aphorism that the personal is political. The problems of our patients are not entirely their own. Even if they are now "sick," their sicknesses spring from their injuries. They have been unable to protect themselves from the infection of violence, and no one else was effective at providing the necessary protection. Now they appear to need our protection—in reality or in symbols. The results of this recognition can be professionally and personally confusing, disorganizing, even disastrous. "Victims invite us to violate the basic tenets of psychotherapy—to suspend value judgments, moralizing, and therapeutic activism. The desire to take a moral stance, to actively side with positive action, interpersonal connections, and empowerment, puts a great strain on our capacity to take a passive, listening stance from which we can help our patients figure out how the trauma has affected their inner world and outer expressions" (van der Kolk, 1994).

So what happens to us? We listen to stories of pain, loss, and despair every day. We watch our injured patients, children and adults, struggle to overcome the devastating legacies of their past. Our minds and our bodies are affected by their pain, as we use our natural human empathic skills to provide the bridge back to safe human contact. We are therapists who are supposed to bring healing to the sick. But we are also bystanders to the events they reveal, to the infection to which they have succumbed and which they now carry in their souls. We often help promote the circumstances in which healing can occur and provide the empathy, support, guidance, and education that each survivor needs in order to transform pain and destruction into meaning and creation. As a result of hard work, they are often able to free themselves from the infection of violence and turn to helping others to free themselves as well.

But we make a living off this pain and infection. We are all part of the matrix of abuse, oppression, and violence that characterizes our culture. It is an intrinsic and usually undiscussed paradox of the entire psychiatric profession. Without suffering, we could not survive. When the problem could be laid at the door of the individual patient's vulnerability, perversity, obstinacy, or stupidity, we could pride ourselves on our patience, perseverance, wisdom, and compassion. Now it is hard to avoid feeling vaguely guilty, not just survivor guilt, but guilt by association, guilt by complicity. When we focus exclusively on our patients, we fail to fulfill our public health function of at least notifying someone about the source of the infection, the violent perpetrators. They frighten us, they overwhelm us, we do not know what to do about them. If we get near them, they are very likely to infect us as well. As a result, we have an endless stream of infected people to treat, while the "typhoid Marys" of the infection of violence are left to wander where they will. Louise Armstrong has addressed this in her powerful book about the politics of sexual abuse:

Psychiatry and psychology on either side, believing or disbelieving women and children, defuses the issue by medicalizing it. That, in removing it from the political sphere to that of individual pathology, it is an excellent vehicle for problem management rather than for social change....The therapeutic ideology readily leads to not change but imaginary change. Not to an assault on the root cause of rape but to the building of endless treatment centers for a predictably endless supply of the wounded who, in their public display of anguished neediness, are taken to suffer from diminished capacity - to be humored....Their illness is what is to be studied, debated, named, and renamed; their defects are focal (Armstrong, 1994).

One of the reasons that the trauma model is so disturbing is that it forces us to confront our own hypocrisy, denial, and rationalization if we are to be effective in helping our patients to face the truth of their own lives. They were the victims and cannot
change the past. They have been infected by the disease of violent perpetration. It is not necessarily a lethal infection. But, if they do not die from the effects of violence, either as a direct result of injuries inflicted by the perpetrator or injuries inflicted as they turn the violence inward, then they are quite likely to spread the infection to others, either by acting violently themselves, or by failing to protect those in their care. In the face of this horror, we have weekly, daily, sometimes hourly choices to make. We can, if we wish, choose to become a part of the ancient “conspiracy of silence,” the term used initially to describe the typical interaction of Holocaust survivors and their children with psychotherapists when Holocaust experiences were mentioned, and more generally used to describe the pervasive social denial of the effects of human violence (Danielli, 1994). This dark conspiracy of silence has permitted the infection of violence to reach epidemic proportions, exposing us all to ever-increasing risks. If we wish to stop colluding with this silence, then we must determine how we can bear witness to what we see and what we know without damaging the therapeutic relationship. What is our responsibility in actively advocating for changes in the social forces that contribute so largely to creating environments that are traumatogenic—poverty, illiteracy, patriarchal domination, inadequate health care, poor childcare, unemployment, corporal punishment, racial and gender discrimination, abuse of power, corruption in government, and criminal capitalism?

It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement, and remembering....In order to escape accountability for his crime, the perpetrator does everything in his power to promote forgetting. If secrecy fails, the perpetrator attacks the credibil-

ity of his victim. If he cannot silence her absolutely, he tries to make sure that no one listens....The more powerful the perpetrator, the greater is his prerogative to name and define reality, and the more completely his arguments prevail (Herman, 1992).

The trauma model goes a long way towards resolving the mind/body dichotomy that has divided psychiatry from the rest of medicine. Biological and clinical researchers are providing us with a way of understanding and visualizing many points of contact between the threat of harm, the responses of the body to that threat, and the long-term emotional, cognitive, and physical effects of those responses. But in doing so, they are also providing the justification for a greatly enlarged public health system. Traumatic experience, particularly early trauma, places human beings at greatly expanded risk of premature death, disease, social maladjustment, and psychological distress. For every adult patient that we take the time, energy, and money to treat, there are simultaneously hundreds of children who are being placed at risk for the very same problems as they become adults (Garbarino, Dubrow, Kostelnky & Pardo, 1992; National Victim Center, 1992; Sherman, 1994). This is no longer speculation or hypothesis. We who deal with the devastating effects of trauma know this to be true.

And therein lies the dilemma for many of us. We can take time off, be good to ourselves, get our own therapy when we need it, obtain routine consultation to help work through countertransference issues, and follow all the other excellent guidelines for self-care. But what are we going to do about the moral burden of knowing what we now know? In our individual work with our patients, we can be very clear about the political nature of their oppression, remain neutral enough to be that sounding board that they need, while conveying a therapeutic stance of “ethical nonneutrality” (Agger & Jenson, 1994). But therapists now are being roundly criticized for trying to do too much, for
interfering in family matters, for crossing over the boundaries between therapy and politics in their practice. Many of these critics are supporting the development of a "Mental Health Consumer Protection Act" which claims as its mission the protection of the public from the adverse consequences of mental health practitioners. Part of the development of this legislation is to be a "legal analysis comparing fraudulent and politicized psychotherapists to drunk drivers" (Barden, 1994). Some therapists have become overinvolved, much to their ultimate detriment, in trying too hard to bring about change in individual patients for whom the only solution is self-empowerment. But in many cases, this is the result of misplaced moral concern. We cannot bring about social change via individual therapy without doing damage to the necessary bonds of trust, confidentiality, and safety that the individual requires for healing. But we also cannot turn away from our moral obligation to provide testimony to our culture about what we have witnessed.

This crossover point of connection between the individual patient, the therapist, and the society has perhaps been best discussed by those who have treated victims of trauma under conditions of state terrorism, torture, and political repression, as in the case of therapists working in Chile during the right-wing, military dictatorship.

The development of the concept of the 'committed bond' between therapist and patients seems very significant to us. In this way subjectivity was integrated into political discourse, and countertransference could become a medium for social change, for example, through therapists' prosocial commitment to denouncing human rights violations....This bond implied a therapeutic stance of 'ethical nonneutrality' toward the patient. This attitude followed naturally from the organizational setting of therapy, which was offered in institutions that were in opposition to the government and its human rights violations. Without this commitment, basic trust and empathy could never have been established....The experiences from Chile seem, then, to demonstrate that the problem of the wounded healer cannot be discussed only from the perspective of the intrapsychic dynamics of the therapist. In a context of human rights violations, this problem must also be related to the political context. To be on a survivor's mission in Chile was not only a question of one's own survival but also of the survival of democracy and human dignity" (Agger & Jensen, 1994).

In the treatment of victims of violence, particularly as a result of childhood violence, we know now that we are not dealing with the safe ground of individual pathology. We are confronting the results of years of civil rights violations for whom no one is held accountable, violations that go largely unchecked. There is insufficient public will to truly act to protect the rights of children from abuse and neglect. From the 1990 Board Report of the U.S. Advisory Board on Child Abuse and Neglect:

Child abuse and neglect in the United States now represents a national emergency...in spite of the nation's avowed aim of protecting its children, each year hundreds of thousands of them are still being starved and abandoned, burned and severely beaten, raped and sodomized, berated and belittled....The system the nation has devised to respond to child abuse and neglect is failing....It is not a question of acute failure of a single element of the system but instead, the child protection system is plagued by chronic and critical multiple organ failure (U.S. Advisory Board, 1990).

What are we supposed to do in the face of this disaster? Why do so few people notice that we are feeding on our own young? If we do not blow the whistle, who will?

When we serve in our professional role of therapist, we are duty bound to protect boundaries for the sake of our patients
and ourselves. But as citizens, there is no justification for our participation in the conspiracy of silence about child abuse. Neither scientist nor psychotherapist can remain morally “neutral” (Weaver, 1961). There is no such reality. If we do not become more socially and politically engaged and organized, then we are simply bystanders. Who is a bystander? If you are not a victim or a perpetrator, you are a bystander. Bystanders are the audience. They are all those present at the scene of an incident who provide or deny support for a behavior. The victim and perpetrator form a linked figure and the bystanders form the ground against which perpetration is carried out or prevented. It is of vital interest to note that among many acts of perpetration which have been studied, it is the behavior of the bystanders that determines how far the perpetrators will go in carrying out their behavior:

Bystanders, people who witness but are not directly affected by the actions of perpetrators, help shape society by their reactions. If group norms come to tolerate violence, they can become victims. Bystanders are often unaware of, or deny, the significance of events or the consequences of their behavior. Since these events are part of their lifespaces, to remain unaware they employ defenses like rationalization and motivated misperception, or avoid information about the victims’ suffering. Bystanders can exert powerful influence. They can define the meaning of events and move others toward empathy or indifference. They can promote values and norms of caring, or by their passivity or participation in the system they can affirm the perpetrators (Staub, 1989).

In this concept lies the key to interrupting the victim-perpetrator cycle of violence that is destroying our social safety. History attests to the fact that once violence is tolerated and supported as a group norm, an increasing number of bystanders become victims and/or perpetrators until it becomes progressively more difficult to make clear differentiations among the three groups. It is time to turn our attention away from our exclusive preoccupation with the pathology of the victim and the pathology of the perpetrator and begin planning how to activate the bystanders, including the bystander in each one of us. It is time for us to augment the level of health and well-being in the population so that the infectious agent has some limits, some containment. Perpetrators can only spread their infection when they are allowed to do so, when the vulnerable remain unprotected. Violence is currently the most critical public health problem facing this nation and as clinicians who know this, we have a professional, personal, political, and moral responsibility to say so.

An important part of self-care is being able to look ourselves in the mirror in the morning without shame. It is being able to create for ourselves and our patients a climate of not just biological, psychological, and social safety, but moral safety as well (Bloom, 1994). But this is a course of action that is fraught with danger. Again, clinicians who have confronted state terrorism have the most immediate experience of the dangers involved.

It appeared that therapists were exposed to the same kinds of trauma as their patients. They were exposed to direct and indirect repression, to social and individual marginalization, and to primary, secondary, and tertiary traumatization. Their work, which helped the enemies of the regime, was fraught with danger and could bring on traumatization by direct actions from the regime. The work could per se be traumatizing without an adequate safe-holding environment. The work could, however, also be experienced as healing for therapists because of the commitment to a higher goal, the struggle for prosocial change and human rights” (Agger & Jensen, 1994).

As trauma therapists, we too are routinely working with victims of torture. Sometimes we are asked to provide guidance to
victims of political terrorism and torture, of combat, of disasters. But they come to us, here in the United States as refugees, seeking and finding sanctuary. We do not know their torturers, or may already perceive them as enemies. We do not share the values of their perpetrators. The stories of their suffering are less likely to trigger our specific childhood memories. But what about the torment that we see here that occurred not in a totalitarian dictatorship, was not inflicted by strangers, and was not endured as an adult. It occurred in a free and democratic country in which children are supposed to be protected by law, it occurred at the hands of primary caretakers who usually displayed both love and hatred for their children, and it was endured during the helplessness and dependency of childhood. It happened at the hands of people we see everyday, who work side-by-side with us, who enjoy the same movies, read the same newspapers, watch the same sports, who share many of our same values. The fact that a significant proportion of the United States population has been traumatized in childhood indicates that the problem of the abuse of power is as problematic here as in many totalitarian regimes—but the abuse of power is in the home, if not in the state. This being the case, we can expect that any meaningful therapeutic challenge to this power will be poorly received. And it has been. For an increasing number of therapists, self-care now extends to attempting to master the constant concern about lawsuits, worries about being pickedet, and fears that those whom they see may be secretly taping interviews hoping to bring legal action against a therapist (Doehr, 1994).

It is not only the patients but also the investigators of post-traumatic conditions whose credibility is repeatedly challenged. Clinicians who listen too long and too carefully to traumatized patients often become suspect among their colleagues, as though contaminated by contact. Investigators who pursue the field too far beyond the bounds of conventional belief are often subjected to a kind of professional iso-

lation. To hold traumatic reality in consciousness requires a social context that affirms and protects the victim and that joins victim and witness together in a common alliance...For the larger society, the social context is created by political movements that give voice to the disempowered. The systematic study of psychological trauma therefore depends on the support of a political movement (Herman, 1992).

We look around and the "enemy" is not across the sea. The enemy is in our schools, in our government, our police force, our churches, our homes. Many of us sleep with the enemy; some of us see the enemy every morning in the mirror or across the breakfast table. The enemy is us, our very own, and the enemy is sick. The need to control, to dominate, to avoid experiencing the full range of emotions, to be unable to put feelings into words, to experience relief in hurting other people, to watch and participate in other people’s suffering without compassion, to deny reality, to deny committing wrongful deeds—these are signs of a virulent and life-threatening, infectious disease called violence. But even those of us who are not directly inflicting the violence are infected as well. The most recognizable sign of infection in us is fear and compliance with a system we know is dealing death. We collude with the violence by allowing it to determine our behavior without steady and insistent protest against the freedom that we consequently lose. We collude with it by failing to consistently and actively and loudly protest against the situations that promote violence within the family. We collude with it whenever we maintain the pretense that the individual model of treatment can possibly address the enormous social problems that play such a role in guaranteeing that violence will increase, not decrease.

Part of our self-care must revolve around saying just this, saying what all of us are terrified to say. The long-term, multigenerational effects of trauma comprise the worst infection known to humanity. Our species can only be free when we have learned
to control this infection. The balance of health must be restored to the social body by permitting less exercise of power by those already badly infected. The 20th Century plague of violence must be contained and as witnesses to the debilitating results of this disease, we must speak out. This public health emergency requires our active and vocal participation in an organized, financed, nonviolent, grassroots, multiracial, bi-gendered social protest. Part of self-care is achieving some acceptable measure of moral integrity and this we cannot do alone.

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