CHAPTER 1

From Hiroshima to the Nazi Doctors

The Evolution of Psychoformative Approaches to Understanding Traumatic Stress Syndromes

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Introduction

When we gather as an intellectual and moral community in connection with our concern about traumatic events and posttraumatic responses, we seek to have good emerge from the bad. Although I feel this is especially true in my work, which involves so many destructive, indeed evil, events, I think it is also true for all of us. The logical aspect of that paradox for us is that, as we pursue our work, we seek the moment when our work is less necessary. We seek and work toward the cessation of destructive events on a massive scale, such as the Holocaust, the Vietnam War, or Hiroshima. As a result, we must keep a watchful eye on perpetrators, even as we pursue our work to help victims and survivors. At the same time, we have to keep a sharp moral and psychological distinction between victimizers and victims. In that regard, I refer to my own study of Vietnam veterans, Home from the War that I subtitled Vietnam Veterans: Neither Victims nor Executioners (Lifton, 1973/1992). This title reflects my understanding, as I began to work with Vietnam veterans, that they had been cast into the two roles that Albert Camus warned us never to assume. Those with whom I worked subsequently struggled courageously to extricate themselves from the roles of executioner and of victim. One does not want to be a victim any more than one wants to be a victimizer.

My purpose in this chapter is to present an overview of my work with victims from the atomic bomb at Hiroshima to the recent study of Nazi doctors who oversaw massive killing in concentration camps in World War II.

In retrospect, as I consider my earlier work involving victims of Chinese thought reform and survivors of the nuclear attack on Hiroshima (Lifton, 1976/1991), I have come to realize, especially through my more recent work with Nazi doctors, that if we want to understand what has happened to victims and cope with posttraumatic stress reactions, we must understand more about the deed of the victimizers. Moreover, that understanding must include some of the psychology of victimizers, even as we seek to understand the victims. In this sense, we not only seek to help people but also to do things that take a stand against the victimizing process.

The Evolution of Ten Principles of Psychoformative Theory and Traumatic Stress Syndromes

1. Life/death paradigm and symbolization of the self.

From my own work, as well as from that of others, I have derived 10 fundamental principles that can inform us in our research and treatment of posttraumatic stress disorder (PTSD) (Lifton, 1976b). First is the principle of
the life/death basis and the recognition that, in the most artificial and harmful way, the issue of death traditionally has been omitted from posttraumatic stress. Although people acknowledge death as an issue, conceptual resistance to death is coupled with a general cultural resistance to the idea of death. In my research on Nazi doctors, I have recognized that victimizers as well as victims experience death immersion. In the case of the Nazi doctors (especially in the death camps) some of their behavior was a means of warding off their own death anxiety. Certainly, the issue of death is central conceptually and in every other way, and our task is to confront death personally and conceptually. The more that we do this, the more effective our work will be.

2. The concept of being a survivor. The second principle, which is a direct corollary to the first, is the concept of the survivor, and, again, death is a key. The clear point is that survival is an achievement. Moreover, survival has a dialectical nature. The survivor has different alternatives. He or she can remain locked in numbing, or can use that survival as a source of insight and growth. We all seek the second choice in our work. The principle of survival keeps us on a normative level because we know that if one survives something, this is not of itself pathological.

3. The human connectedness of survivors. Third is what I refer to as the ultimate dimension (Lifton, 1976b). We know that trauma involves very immediate and painful nitty-gritty experiences and we know some of the symptoms as posttraumatic stress disorder (American Psychiatric Association, 1987, DSM-III-R; in press, DSM-IV). But there is also a dimension in posttraumatic stress disorder that involves larger human connectedness. If we review some of our experience with Vietnam War veterans and other groups who have undergone severe trauma (e.g., Holocaust survivors) we find in each case a struggle to restate a larger human connectedness or a sense of being “on the great chain of being.” This is one of the most poignant and difficult struggles that accompanies the recovery process. We symbolize immortality—our historical and biological connectedness to those who have gone before and those we assume will follow. We do this through our limited life span, whether through children, our works, our influences, or through nature, or through some spiritual principle, or even through experiences of transcendence.

When we experience radical discontinuity in an immediate way, in the intrapsychic self, the self is dislodged from its forms. In the nineteenth century, Pierre Janet (cited in van der Kolk & van der Hart, 1989) described this and Freud later addressed it within the context of depth psychology (see Chapter 5, in this volume, for a review). The vulnerability to dissociation and splitting in this acute or radical discontinuity at the immediate level renders the self susceptible to doubling.

3a. Vulnerability to stress and dissociation. Although prior characteristics of the self are of enormous importance in the outcome of any kind of posttraumatic stress reaction, the experience and our knowledge of radical discontinuity teach us that dissociation can be created in anyone. Moreover, severe stress can make contact with some prior vulnerability to dissociation, to splitting, to discontinuity, which exists to some degree in everyone. Although the degree of vulnerability to discontinuity and dissociation may vary in each of us, some such vulnerability is part of the human condition.

4. Posttraumatic stress disorder as a normal reaction to extreme stress. Fourth is the normative principle. The posttraumatic stress disorder is a normal adaptive process of reaction to an abnormal situation. Understanding this leads to a greater acceptance, on the part of the therapist and of the person who has undergone that posttraumatic stress reaction, of his or her situation and symptoms.

5. Survivor guilt and self-condemnation. Fifth is the issue of self-condemnation. Self-condemnation is the source of what we call psychological guilt, which occurs in people who experience extreme trauma and in posttraumatic stress disorders or survivor reactions. I refer to this as a paradoxical form of guilt because, sometimes, one can condemn the self more as a survivor or victim than as the victimizer because the victimizer may numb himself or herself.

5a. Failed enactment during trauma and self-image. This self-condemnation is associated with a combined extreme sense of helplessness at the time of the trauma and what I call failed enactment. At the time of the trauma, there is a quick and immediate sense that one should respond according to one’s ordinary standards, in certain constructive ways, by halting the path of the trauma or evil, or by helping other people in a constructive way. Neither of these may be possible during extreme trauma. At the very most, the response that is possible is less than the ideal expectation.

I speak of this as failed enactment because some beginning, abortive image forms toward that enactment in a more positive way that is never possible to achieve. One can then describe the idea of an image as a schema for enactment that is never completed. The response to this incomplete enactment can be perpetual self-condemnation.

When we say that a survivor or somebody who has undergone stress some time ago is “down” on himself or herself, we may be referring not to a sense of guilt but rather to self-condemnation that is related to that lingering failed enactment and to a residual, traumatized “self” that is still to some degree in that state of helplessness. In other words, the entire functional self is still in that state of helplessness and failed enactment, and the self in that state brings about self-condemnation. The recovery process involves transcending that traumatized self.

6. Emotional vitality and fragmentation in the self. The sixth principle is that of feeling versus not feeling. I suggest that the standard psychoanalytic defense mechanisms are less discrete than we claim; they overlap to a great extent and relate to feeling and not feeling. This whole issue of dissociation originally described by Pierre Janet (cited in van der Kolk & van der Hart, 1989) is central to posttraumatic stress reaction and survivor experience.

7. Psychic numbing: Discontinuity in the self. This central concern in our work now takes us to a seventh principle, namely psychic numbing. Psychic numbing stops the symbolizing or formative process. The mind needs the nourishment provided by the continuous process of creating images and forms in order to function well. In extreme forms of psychic numbing, such as dis-