Traumatophobia: Paradoxical Amplification of Posttraumatic Symptoms, and the Role of Third Parties

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Abstract:

"Traumatophobia" is fear of fear itself, sensitizing people to the psychological effects of stressors such as crime, terror, and hurtful communications. Paradoxically, increasing knowledge of trauma has not empowered, but sensitized us to it -- thereby amplifying its effects. The Institute of Medicine challenged society to examine this process, and redirect our knowledge toward building resilience. Data for this are well-established, but under-attended. Neutral third parties play a pivotal role, by modulating trauma's effects through mutual suggestion. Sensitizing interactions foster traumatic re-enactment, and polarize people against one another. Appeasing and counter-traumatizing lead to escalation of traumatic coercion. Validating victimhood and rescuing its targets can regressively destabilize them by unintendedly undermining their agency. Social trends further amplify through enabling, media, selective non-responsibility, and coercive information control. Mitigating interactions shift emphasis from victimhood toward active agency without denying the former, and promote abstaining from re-enactment. Also pivotal are standing firm at one's locus of control, seeking alternate narratives, and optimizing all parties' accountability. Promoting constructive discourse over trauma-driven suppression is a fundamental precondition for building resilience.

"Traumatophobia" is *fear of fear itself* (1), famously qualified in president Franklin D. Roosevelt's 1933 inaugural address as a "nameless, unreasoning, unjustified terror which paralyzes needed efforts to convert retreat into advance" (2). We've learned much about trauma since then. Normally, knowledge is power -- new technology, more control. But trauma strangely differs. Here, knowledge appears to have *sensitized* us to trauma, so that today, a given stressor might be many times as traumatizing as a hundred years ago -- when people simply knew that life's hard, bad things happen, and people play the hands they're dealt. That is, we have become a traumatophobic society. Its organizing principle is *"Try to avoid trauma, at any cost!"* We try, at terrible cost.

Terrorists sense our vulnerability and knowingly exploit it to the hilt (3). After 9.11, the Institute of Medicine (IOM) labeled our psychological vulnerability as a top societal concern, and challenged us to shift toward resilience – knowing that some bad events will happen, and life must go on (4). To respond, means asking three questions. *How did this sensitization arise? What processes amplify it? How can we mitigate it?*

First, an introductory summary. Trauma conscripts personhood into its own service at all levels, and may contribute to nearly half the symptoms of major mental illness (5). Traumatic affect takes on a life of its own that dominates peoples' rational intellect and best intentions (1). Its effects extend to all neurochemical systems and elude unique formulation (6,7). From such complexity, one can identify core themes.

Pathways that both compete with and paradoxically reinforce one another become activated (6): *e.g.*, avoidance and approach (8), sensitization and addiction (9,10), defending against lethal threat and securing affiliative nurturance (11). Whenever opposing systems balance, they can self-stabilize. But *if one process acts unencumbered while its counter is either absent or undermined, destabilization is more likely to occur*. Such imbalances are hypothesized to underlie paradoxical amplification.

One particular dichotomy appears to dominate. This is *victimhood*, whose natural antithesis is *active agency* and one' associated natural responsibilities (12). To the extent that this applies, *traumatophobia arises from selective reinforcement of victimhood at the expense of agency and natural responsibilities*. If so, mitigation requires a shift toward emphasizing all parties' active agency and natural accountability.

A victim dilemma follows. Victimhood is real, egregious, and appalling. Decent persons and a just society are called upon to label it for what it really is, "validating" it in

order to combat and correct it. But there's an underside. Ratifying victimhood can tacitly undermine the natural responsibilities on which a free society rests (13), and inflame allies against enemies – as malignant aggressors have long done (14).

Social causation is paramount, and strangely under-emphasized. Peoples' story lines influence what one experiences as traumatic, and the form and course of subsequent symptoms (15). Some narratives sensitize and can lead to amplifying trauma's effects, while others are equally true but potentially mitigate – serving the traditional function of knowledge as power. Memories often conflict. Because the whole truth is rarely known, *third parties' rulings* determine which narrative prevails (16). *Reframing* heavily shapes these rulings, and is pivotal to both psychotherapy (17,18) and conflict resolution (19).

"Third parties" are neither active agents nor targets of trauma, but *interact* with others in ways that affect how we *interpret* an event, thus how we *experience* it, and how it *affects* everybody involved. They include all citizens, and psychiatrists may be particularly potent in this role. Now look at the first question. How did traumatophobia arise? How might new knowledge have paradoxically *sensitized* us to trauma?

EMERGENCE OF TRAUMATOPHOBIA

Out of World War II and early Cold War traumas, a counter-culture emerged to individuate against the greatest generation's sometimes-traumatizing moral rectitude. After Kempe *et al's* "battered child" paper (20), all fifty states enacted mandatory child abuse reporting. Civil rights and feminist movements led to instituting protective prerogatives in favor of formerly abused minorities. A particularly prominent moral

legacy was *coercive speech codes,* to not offend traumatic sensitivities (21). A victim focus was consolidating, with the victim dilemma taking on a newfound prominence.

The 1980s were pivotal for traumatology. Knowledge exploded, with most key issues being defined. Lenore Terr's followup study of Chowchilla kidnapping victims suggested that *utter helplessness* is pathogenic for posttraumatic symptoms such as cognitive distortions and dangerous re-enactment behaviors, and these symptoms resisted her best therapeutic efforts (22). Neurobiology showed that in addition to adrenergic sensitization (23), one becomes addicted to endogenous opioids that are also secreted heavily during traumatic experience (9). Adrenergic arousal shares much neurochemistry with infantile helplessness, and endogenous opioids with affiliative nurturance (11).

This new knowledge was misinterpreted to favor regressive perspectives (24). Dissociative disorders were diagnosed in near-epidemic proportions, taken to signal catastrophic victimization and require therapeutic rescue. The logic of re-enactment was inverted to deduce that traumatic memories could be deemed true by their form alone, and evidence that trauma is burned in was extended to the content of these memories.

A "recovered memory controversy" (RMC) soon erupted (25,26). People reported horrific abuse memories newly "recovered" even decades after an alleged event. Some experts certified these as necessarily true, with alleged "perpetrators" therefore presumed guilty without physical evidence. At a 1993 APA forum, attendees were loudly cheering these views, and appeared to demonize skeptical memory researchers as enablers of perpetration (27). A temporary consensus had congealed: victim narratives are presumed true and must be "validated", alleged abusers are presumed guilty, trauma

survivors require therapists for both safety and recovery, and contrary research data are seditious products of evil intent. Traumatic symptoms paradoxically amplified *en masse*.

False convictions and broken families occurred (28). Many patients deteriorated with increasing distress, pleas for rescue, and dangerous acting out -- some losing all ability to function (29,30). Those who practiced through that era recall the scale of iatrogenic regression as massive. Trauma to all parties was the interim victor.

Remarkably, the tide turned only a half-decade later. Strong advocacy for family integrity and the presumption of innocence forced the courts to weigh new memory research (31). The content of traumatic memories proved to be about as malleable as all memory – no more, no less (26). After Y2K, post-traumatic debriefing and re-living also turned out to be problematic, and treatment shifted toward building on patients' intrinsic strengths (32). Psychiatry is now re-positioned to better meet the IOM's challenge.

But the RMC's transient consensus had highlighted key trauma-amplifying factors that persist in everyday clinical practice and many prominent social trends. Victimhood's unchecked dominance over natural accountability continues to escalate, with aversion to "micro-aggressions" nearly overturning free speech on many campuses (33,34). Although traumatophobia still escalates, the new data emerging since the 1980's also allow for its mitigation. With this in mind, we now turn to our second two questions. What processes amplify posttraumatic symptoms? And what might provide mitigation?

BASIC CONCEPTS

Key concepts are summarized. One, is the *trauma response*, and its biology. Two, is *traumatic re-enactment* -- its fuel, and a focal point for intervention. Three,

trauma alters *self-identity* and perceived *locus of control* -- both in self-contradicting ways. Four, trauma is *socially coercive* – compelling affiliative nurturance for some, aggressive defense against others, thereby *polarizing* people into allies and enemies. Five, most important, people are always influencing one another via *mutual suggestion*, as in hypnosis -- at both overt and covert levels, which often act in opposition.

The "trauma response" conscripts human personhood and sociality into its own service, as if it had separate interests of its own. Its neurobiology has been increasingly clarified since the 1980's. Trauma *sensitizes* to fear avoidance &/or the "rush" of combat, mediated largely by catecholamines (23). At the same time, one gets *addicted* to "re-enacting" the trauma, partly through secretion of the endogenous opioids (9) that also mediate nurturant affiliation (11). These processes both oppose and reinforce one another (10). Sensitizing increases the "need" for opioid relief, and withdrawing from re-enactment further sensitizes. Trauma thereby gains a life of its own, in which emotional drive corrupts rational intellect and overpowers good intentions (6).

Re-enactment is the fuel that feeds trauma's flames. It's been known since Freud struggled to grasp his patients' "repetition compulsion" (8). Terr saw it in her kidnapping subjects (22). It takes over peoples' lives, like chemical dependency (35). Paradoxical amplifiers all fuel this fire – often quite subtly. Also like chemical addictions, it is modifiable -- by voluntary choice, selective attention and/or social framing.

Voluntarily abstaining from re-enactment robs the trauma response of its fuel, and the fire slowly dies out – "extinction", through learned suppression by our frontal cortices (36) and related processes (37). Like substance abuse, this is difficult -- but possible, and underlies all mitigation. Selective re-enforcement can also shift. To selectively reinforce

trauma-maintaining strivings covertly re-enacts them, and amplifies -- while to shift toward one's intrinsic strivings is more like abstaining, and can mitigate (17,18).

"***Personal identity"*** is one's experience as being uniquely distinct from others. Trauma *marks* identity disproportionately. My father was an "Iwo Jima veteran" more than an insurance retiree, for example, though the battle took up far less of his life span. Trauma need not make one worse, only *different* – marking its content's "salience" (26).

A trauma-maintaining "false self" often gets "split off" from intrinsic strivings, linked with the survival instinct and so defended (38). Which "self" dominates, varies to quite some extent with whatever significant third parties selectively reinforce.

"Locus of control" is whatever is subject to one's voluntary muscles, for which one is naturally accountable (12) – related to but not identical with personal identity. Trauma also affects it in conflicting ways. *Perceived* controllability is often undermined by symptoms, which resemble infantile helplessness -- while *actual locus of control remains intact*, unlike real infants. Intact strengths may go into hiding, defended by traumatic affect, but people need to access and employ them if they are to recover (30).

Social coercion is wielded by traumatic affect in two seemingly opposite but self-reinforcing ways. One, like the infantile helplessness whose neurobiology it shares (11), such coercion pulls others toward nurturant affiliation, support, or rescue. Two, it pushes others to defend against "perpetrators", as a matter of survival. Consequences follow.

"*Symptoms as power tactics"* has been long noted by social psychologists (39), confirmed by evolutionary biology (40), but under-attended. Again, posttraumatic symptoms may act much like the coercive effect of infants' cries – calling for nurturance.

Polarizing into allies and enemies is more serious, e.g., the global destabilization that threatens our species' stay on this planet. Victimization implies perpetration and conflict, and presents that yet-unsolved victim dilemma. Trauma even polarizes people with shared interests. Prior to the RMC, for example, most antagonists-to-be shared common interest in both child welfare and family integrity. But trauma marks its content's relative salience (26). If one's witnessed child abuse, even third hand, child protection becomes more salient than family integrity. But if one's seen families broken by spurious accusations, this polarity is reversed. Conflict ensues (41).

Selective affiliation accentuates such polarizing (42). When one affiliates only with like-minded others, biases reinforce one another and traumatic affect pushes them ever further from perceived enemies. Needed instead, is to seek and consider other sides.

Mutual suggestion leads to people co-creating one another's "mental states", as in hypnosis (43,44) -- differently at conscious and unconscious levels (45). "Hypnosis**"** refers to simple social interactions that profoundly change people's experience and its underlying neurobiology. It is the most heavily researched topic in all psychology, a basic science of social causation (46) -- but is strangely under-appreciated today.

Trauma's association with hypnosis was established by the late 19th century, with still-accumulating data also poorly appreciated (47). Lenore Terr long ago emphasized traumatic affect's exceptional social *contagiousness* (1).

Third parties act through suggestive influence, as in hypnosis (16,44,48). Humans' natural tendency is to reciprocate others' narratives (49). When these are traumatic, this can amplify trauma directly. Countervening this natural tendency can feel awkward, and often needs to be done differently at overt and hidden levels (18,48,50,51).

PARADOXICAL AMPLIFIERS OF TRAUMA

Social interactions can amplify traumatic sensitivity in several ways, all of great import to psychiatric practice. To illustrate how hard it is to avoid these pitfalls, reflect on some core psychiatrist obligations. Duty to protect puts us at risk of symptomatic coercion by patients who are at risk of doing harm. Seeking a treatment alliance may pull us to "validate" victim narratives. Our charge to be helpful might tip us to attempt rescue. All of these obligations confuse the parties loci of control, in ways that are not adequately understood. Amplifying can follow from their unintended misapplication.

Appeasing difficult patients' coercive demands often leads to escalating demands, just like appeasing a military aggressor, and is surprisingly under-attended. In extreme cases, yielding to symptomatic coercion can reduce a naïve therapist to utter subservience (52). This dynamic also applies to "sensitivity politics" (21) whenever offense-taking is being used coercively… as with today's campus "micro-aggressions" (33,34). Without natural check or balance, a coercive process is likely to escalate unimpeded. Needed instead, are respectful limit-setting and defending one's right to think for oneself.

Counter-traumatizing is seemingly opposite – but like "fighting fire with gasoline", fuels the flames. "Symmetrical escalation" is seen in disturbed marriages, where accusations and counter-accusations fly without useful information exchange (51). Needed instead, are collaborative negotiation with meaningful exchange of information.

Uncritically validating victimhood is common in everyday clinical practice, as well as some prevalent social trends. Many patients present victim narratives with intense traumatic affect, or imply victimhood through avoidance and re-enactment

symptoms. Many therapists believe that we must "validate" victimhood in order to gain rapport, deal with "real issues", and not re-traumatize patients through either denial or blaming the victim. But doing so can amplify trauma by direct suggestion, polarize against perpetrators, and even provide rationale for retaliatory violence (14).

Only its target retains the locus of control for one's subsequent life, even where victimhood is real and egregious. Usually, there is room for therapeutic reframing that is more health-promoting (17,18), with the target becoming more of an active agent (12).

"Rescuing", in its negative sense, is trying to do for another person what only one can do for oneself -- associated closely with validating victimhood. It can usurp patients' already-fragile loci of control, undermining it under guise of being therapeutic. Some patients sense this as a threat, with increasing anxiety, regressive destabilization, and acting out (29,30). To understand this dynamic, it helps to distinguish patients' *perceived* locus of control from the *actual* locus of control that remains intact but hidden. All therapists straddle the victim dilemma -- acknowledging real victimization, while holding patients accountable for whatever lies within their sole control.

Societal trauma-amplifying occurs at many levels with huge consequences, and is remarkably under-studied. *"Enabling"* is collusion in the very pathologies that one either complains about or is charged with correcting. Buying liquor and "protecting" a substance abuser from consequences is legendary. Social enabling occurs in many forms, and in general, *violations are collusively allowed and covered up*.

Enabling of trauma occurs widely, but is discussed rarely. In their 1999 book *Stolen Valor*, Burkett and Whitley cite voluminous well-documented cases where false PTSD disabilities diverted scarce resources from deserving veterans -- perhaps on a large

enough scale to create false Vietnam-veteran stereotypes and their "blame America first" mores (53). We do not know why such process is so under-studied.

Mass media further fuel the fires. Sensationalism sells. Terrorist atrocities are publicized disproportionately to their physical impact, amplifying their social impact.

Selective non-responsibility manifests in two of the most sensitive arenas of domestic politics – race and policing, and the campus rape crisis. Basic prudence warrants natural responsibility for at-risk populations to lessen their risk – *e.g.*, not to scare officers, and to preserve one's capacity to deny sexual consent. We seldom hear these asked for or expected. The result is more victimizing, polarizing, and sensitizing.

Coercive information control compounds all of these dynamics by actively suppressing consideration of correctives (21). Whenever offense-taking is being used to coerce others, then non-offending is no longer basic respect but appeasement -- amplifying the sensitivities. Traumatophobia escalates unchecked. *In principle, a society that cannot discuss sensitive social issues cannot solve sensitive social problems.*

MITIGATION STRATEGIES

Now turn to the third question – how to respond to the Institute of Medicine's challenge (4), and tamp down our newfound vulnerability. Reflect again on the victim dilemma. Ratifying victimhood polarizes, inflames and sensitizes – all paradoxically amplifying sensitization and posttraumatic symptoms. But again, victimizing is real and often egregious. What else is one to do, if not to "ratify" it for what it really is?

Active agency and associated responsibilities are the antithesis of victimhood, and the ultimate goal of mitigation strategies. Powerful internal and social forces stand in

the way. Many traumatized people conceal their still-intact personal strengths, and defend this process with intense traumatic affect that will be wielded against any who challenge it (30). And our "victim culture" is so deeply entrenched (13), that calling for more responsibility will be vilified as "denial" (54) or "blaming the victim" (55).

Reframing "victimhood" as "helplessness" may help as an intermediate. Both terms are accurate. But victimhood implies and fuels conflict, and extends into the social surround. Helplessness is *internal* – still validating the trauma (22), but interrupting that amplifying social component. We can now bring our full therapeutic armamentarium to bear: establish alliance and safety parameters, mentalize, redirect attention, reframe, contract and set limits. That is, all that we're trained to do (6,32).

From this forward base, we now work toward trauma's antithesis – active agency. We increasingly challenge patients' intrinsic assets and hold them responsible over their sole loci of control. Success begets success (6), hopefully promoting a beneficent cycle.

Interdicting traumatic re-enactment underlies all mitigation strategies, and is analogous to abstaining from addictive drugs (9,35). One asks whether a specific re-enactment pattern is involved, whether it's under voluntary control, then how one can be helped to recognize it and accept responsibility for voluntary interdiction (56).

Alternate narratives can often replace victimhood and remain equally accurate. One can *invite third parties* – not to do systems therapy, but to better understand the problem (32,44). This non-judgmentally conveys wanting more information. Many patients welcome this, and the significant other often becomes a valued treatment adjunct.

Challenging patients' responsibilities is more difficult when they feel helpless and defend this with traumatic affect (6,30). Accepted practice comes in again -- helping

patients to build mastery (12,32). Informed consent is particularly helpful (57), with contracting for roles and responsibilities (58,59). Reframing is pivotal (17,18,44,48,56).

Redefining personal identity can paradoxically change who one is. Patients can be challenged to answer three questions: "*Who are you? What do you stand for? Where are you headed?* Try answering these for yourself. It's almost impossible not to change in the process! But because no change is asked, there's no threat from which to defend. Contracting for and testing patients' behavioral safety are most challenging. Once this is secured, data show this model to be comparatively effective, efficient and safe (56).

Standing firm at one's locus of control is particularly helpful whenever one is being coerced by some traumatizing agent. In lieu of either appeasing or counter-traumatizing, one identifies whatever lies within one's sole control, then acts at this level, and finally *stands firm* against the offending agent's efforts to push one off course. This concept is hard to grasp and to implement, but essential. Here are three illustrations.

Eric Berne's antithesis to the "why don't you, yes but" game is paradigmatic: "That *is* an interesting problem. What *are* you going to do about it?" (50). He thereby acknowledged the problem, refused to usurp responsibility, and respectfully put it back where it belonged. Rescuing was thereby redirected to becoming respectful challenge.

Vicious-circle interactions are exemplified by the nagging spouse of a problem drinker (51). Nagging fails partly by trying to act where one has utterly no control. Spouse can reclaim control by taking a firm moral stand, and seeking social support through Al Anon. This changes the rules, and is totally outside the drinker's control.

Standing up to coercive offense-taking is paramount. Anti-therapeutic patient demands routinely complicate clinical practice. To yield, risks amplifying (52). Instead, we respectfully decline even when punished with traumatizing accusations or threats.

Mitigating social trauma-amplifiers is a society-wide challenge (4). Even so, third parties sometimes have a disproportionate positive impact. For example, just one principled dissenter can reverse an entire jury's problem-maintaining groupthink toward a more just verdict (60) -- again, by defining and standing firm at one's locus of control. Large-scale societal enabling is almost unstudied. One can launch new research here.

Re-opening constructive discourse is most essential. Free speech is a pre-condition for problem-solving in a democratic society (21), and probably for building resilience. How, isn't clear -- perhaps for interested parties to simply push back against the coercive taboos and stand up to the traumatizing accusations almost sure to follow.

De-catastrophizing is more elusive -- to accept the inevitable facts that we'll all die, endure major setbacks, and become more resilient to trauma once we're resolved that life will still go on (4). To minimize risk, but not "try to avoid trauma, at any cost."

Some questions may be unanswerable. How can psychiatrists change patients' brains without usurping their sole loci of control? Fulfill a duty to protect while holding patients to their own natural accountabilities? How can open discourse be restored, without re-inviting prejudice? How can one motivate prudent self-protection, without the phobic mind set of "try to avoid trauma at any cost"? *Who is responsible for what, to whom, and at what levels?* As we all know, there are no easy answers.

REFERENCES

1. Terr L: Too Scared to Cry: Psychic Trauma in Childhood. NY: Basic Books, 1991
2. Roosevelt FD: Inaugural address, March 4, 1933
3. MSNBC: Inside the mind of Osama Bin Laden. May 20, 2015
4. Butler AS, Panzer AM, Goldfrank LR (Eds.): Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy. The Institute of Medicine, National Academy of Sciences. National Academies Press, http://www.nap.edu/catalog/10707.html, 2003
5. Bryer JB, Nelson BA, Miller JB, Krol PA: Childhood sexual and physical abuse as a factor in adult psychiatric illness. Am J Psychiatry 1987; 144:1426-1430
6. Bateman AW, Fonagy P (Eds): Handbook of Mentalizing in Mental Health Practice. Washington, DC: American Psychiatric Press, 2012
7. Yehuda R, LeDoux T: Response variation following trauma: a translational neuroscience approach to understanding PTSD. Neuron 2007; 56:19-32
8. Freud S: Beyond the Pleasure Principle. Ed & Trans J Strachey. New York: Norton, 1979 (originally published in 1920)
9. van der Kolk BA (Ed.): Psychological Trauma. Washington, DC: American Psychiatric Press, 1987
10. Abraham AD, Neve KA, Lattal KM: Dopamine and extinction: a convergence of theory with fear and reward circuitry. Neurobiol Learn mem 2014; 108:65-77
11. Reite M a& Fields T (Eds.): The Psychobiology of Attachment and Separation. Orlando, FL: Academic Press, 1985
12. Bandura A: Self-Efficacy: The Exercise of Control. New York: Freeman, 1997
13. Sykes CJ: A Nation of Victims: The Decay of the American Character. New York: St. Martin's Press, 1992
14. Volkan V: The Need to have Enemies and Allies, from Clinical Practice to International Relationships. New York: Jason Aronson, 1994
15. Loftus EF, Frenda SJ: Bad theories can harm victims. Science 2010; 1329-1330
16. Beahrs JO: Memory as power: who is to decide? Journal Am Acad Psychiatry Law 1999; 27:462-470

17. Watzlawick P, Weakland J, Fisch R: Change: Principles of Problem Formation and Problem Resolution. New York: Norton, 1974
18. Beahrs JO: Limits of Scientific Psychiatry: The Role of Uncertainty in Mental Health. New York Brunner/Mazel, 1986
19. Atran S, Axelrod R & Davis R: Sacred barriers to conflict resolution. Science 2007; 317:1039-1040
20. Kempe CH *et al*: The battered child syndrome. JAMA 1962; 181(1):17-24
21. Glendon MA: Rights Talk: The Impoverishment of Political Discourse. New York: Free Press, 1994
22. Terr L: Chowchilla revisited: the effects of psychic trauma four years after a school-bus kidnapping. Am J Psychiatry 1983; 140:1543-1550
23. Solursh L: Trauma combat addiction post-traumatic stress disorder re-explored. Psychiatric Journal of the University of Ottawa 1988; 13:17-20
24. Beahrs JO: The cultural impact of psychiatry: the question of regressive effects, in American Psychiatry After World War II. Edited by Menninger RW, Nemiah JC. pp. 321-342. Washington, DC: American Psychiatric Press, 2000
25. Beahrs JO, Cannell JC & Gutheil TG: Delayed traumatic recall in adults: a synthesis with legal, clinical, and forensic recommendations. Bull Am Acad Psychiatry Law 1996; 24:45-55
26. Schacter DL: Searching for Memories: the Brain, the Mind, and the Past. New York: Basic Books, 1996
27. Terr LC, Herman JC, Briere J, Loftus E & Guze SB: Adult memories of childhood trauma: current controversies. Forum presented at the 146th annual meeting, American Psychiatric Association, San Francisco, CA, May 26, 1993.
28. Wright L: Remembering Satan, Parts I and II. *The New Yorker*, 69(13), 60-81; 69(14), 54-76, May 17 and May 24, 1993
29. Stewart H: Technique at the basic fault/regression. International Journal of Psycho-Analysis 1989; 70:221-230
30. Beahrs JO: Dissociative identity disorder: adaptive deception of self and others. Bull Am Acad Psychiatry Law 1994; 22:223-237

31. Lipton A: Recovered memories in the courts: report of the FMSF legal survey, in S Taub (Ed.): Recovered Memories of Child Sexual Abuse: Psychological, Social and Legal Perspectives on a Contemporary Mental Health Controversy. New York: Charles C. Thomas, 1999

32. American Psychiatric Association: Practice guidelines for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Supp to Am J Psychiatry 2004; 161:1-57

33. Lukianoff G, Haidt J: The coddling of the American Mind. The Atlantic Monthly, September, 2015

34. Campbell G, Manning J: Microaggression and moral cultures. Comparative Sociology 2014; 13:692-726

35. Kaag AM, Levar N, Woutersen K et al: Hypperresponsiveness of the neural fear network during fear conditioning and extinction learning in male cocaine users. Am J Psychiatry 2016; 173:1033-1042

36. LeDoux JE: The Emotional Brain. New York: Simon & Schuster, 1996

37. Monfils M, Cowensage KK, Klann E, LeDoux JE: Extinction-reconsolidation boundaries: key to persistent attenuation of fear memories. Science 324:951-955, 2009

38. Lowen A: Narcissism: Denial of the True Self. New York: Macmillan, 1983

39. Haley J: Strategies of Psychotherapy. New York: Grune and Stratton, 1963

40. Cantor C: Evolution and Posttraumatic Stress: Disorders of Vigilance and Defense. New York: Routledge, 2005

41. Beahrs JO: Posttraumatic polarization in psychiatry and law. Journal Am Acad Psychiatry Law 1999; 27:335-343

42. Sunstein CR: Going to Extremes: How Like Minds Unite and Divide. Oxford: Oxford University Press, 2009

43. Beahrs JO: Hypnotic transactions, and the evolution of psychological structure. Psychiatric Medicine 1992; 10(1):25-39

44. Beahrs JO: A social brain interpretation of psychotherapy. Psychiatric Annals 2005; 35(10):816-822

45. Hilgard ER: The Experience of Hypnosis: A Shorter Version of Hypnotic Susceptibility. New York: Harcourt, Brace and World, 1968
46. Nash MR, Barnier A (Eds): The Oxford Handbook of Hypnosis: Theory, Research and Practice. Oxford, UK: Oxford University Press, 2008
47. Spiegel H, Spiegel D: Trance and Treatment: Clinical Uses of Hypnosis, 2d. Ed. Washington, DC: American Psychiatric Press, 2004
48. Erickson MH, Rossi EL: The Collected Papers of Milton H. Erickson, M.D. New York: Irvington, 1980
49. Alexander RD: The Biology of Moral Systems. Hawthorne NY: De Gruyter, 1987
50. Berne E: Games People Play. New York: Grove Press, 1964
51. Watzlawick P, Beavin JH, Jackson DD: Pragmatics of Human Communication: A Study of Interactional Patterns, Pathologies, and Paradoxes. NY: Norton, 1967
52. Eckstaedt A: Ego-syntonic object manipulation: the formation of a submissive relationship. Int J Psychoanalysis 1989; 70:499-512
53. Burkett GB, Whitley G: Stolen Valor: How the Vietnam Generation Was Robbed of its Heroes and its History. Dallas, TX: Verity Press, 1998
54. Milburn MA: The Politics of Denial. Cambridge, MA: MIT Press, 1998
55. Ryan W: Blaming the Victim. New York: Random House, 1971
56. Beahrs JO: Assessing attributive causation in psychiatry: psychotherapeutic results correlate with self-therapeutic activity. Clinical Neuropsychiatry 2006; 3(2):154-161
57. Beahrs JO, Gutheil TG: Informed consent in psychotherapy. Am J Psychiatry 2001; 158:4-10
58. Beahrs JO: Legal duties of psychiatric patients. Bull Am Acad Psychiatry Law 1990; 18:189-202
59. Beahrs JO and Rogers JL: Appropriate short-term risk in psychiatry and the law. Bull Am Acad Psychiatry Law 1993; 21:53-67
60. Zimbardo PG. & Leippe MR: The Psychology of Attitude Change and Social Influence. Boston, MA: McGraw-Hill, 1991