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There Is Reason in Action

FRANK OCHBERG



1968

Bobby Kennedy was shot and killed that year and I was shattered. It was only a few months after the assassination of Martin Luther King and not that long after President Kennedy was gunned down in Dallas. These were vital young leaders, reaching the prime of life, moving many of my generation to political awareness and public service. I was 28, married to Lynn, living in Palo Alto, and halfway through a psychiatry residency at Stanford. I had no idea how young I was—how uninformed and undirected. Surely it was the triple slaying of those particular men, JFK, MLK, and RFK, at that particular time of my life, mid-20s, that focused my emotions and my attention on human cruelty and tragic loss. The whole decade was tumultuous, and 1968 was the darkest year, with race riots at home, battlefield deaths in Vietnam, and drug use turning from playful experimentation to hard-core abuse and dependence.

The day after Robert Kennedy died, Dave Daniels called and said, “Frank, we have to do something.” Dave was an untenured assistant professor, somewhat of a maverick on the faculty who partnered with the more activist residents and med students, steering us into extracurricular, self-defined assignments. Some of us worked at a drop-in center in East Palo Alto, the other side of the tracks. Some organized study groups on community mental health and deinstitutionalization. We met at Dave’s house for mentoring and mutual support. Although considered an activist, I was unprepared for action when Dave called. He was ready

to organize committees and write articles, and he wanted me to cochair an effort within the Stanford Department of Psychiatry to address the issue of human violence. I recall saying something like, "Dave, I'm still in a state of shock. I need to think about this. Let me call you back."

This was long ago and I cannot remember exactly how I felt, but I know I talked to Lynn, describing how Dave was off and running when I was stunned and still digesting what had happened. I wanted to let things sink in, to absorb the blow, because I certainly felt like I had been hit and all the air was out of me. And I knew that cochairing a committee would be a full-time job on top of everything else that a resident does.

Lynn had no hesitation. "You should call him back and get going," she said. It helps to have a spouse who wants you to tackle tough assignments. She didn't push, but spoke her mind and encouraged. She still does.

Within the hour I was on the phone with Dave and we agreed to call a meeting that week, open to any residents or faculty who cared to attend. We'd offer a few ideas about symposia and articles and events, and we'd listen and take stock afterward. We didn't envision a final product, but we knew we could mobilize a dozen or more colleagues to create something of value.

And we did.

We met that week and blocked out a group of topics and procedures and a management plan. The department chairman, David A. Hamburg, was on sabbatical, away for the year. The acting chair, Herb Lederman, was genial and supportive but occupied with his own research and disengaged from the residents and junior faculty. Erich Lindemann, professor emeritus and former chair at Harvard—my clinical supervisor—said, "You are all denying your grief." I remember that clearly, a distinguished psychoanalyst who interpreted action as denial.¹ No one in authority led us. No one stopped us.

More than half the residents in my year signed on, along with a slightly smaller number from the following year and several faculty members. Together we wrote a book published by Little, Brown, titled *Violence and the Struggle for Existence* (Daniels, Gilula, & Ochberg, 1970). We also conducted seminars, symposia, and classes under the banner The Stanford Committee on Violence and Aggression. Lloyd Cutler, Executive Director of the National Commission on the Causes and Prevention of Violence, flew out to interview us as he organized his group, larger and far more prestigious than ours, but informed by our approach nevertheless.²

As a group of volunteers, we learned that our motivation was high but our abilities mixed. Some had trouble meeting deadlines. Some felt every word was precious and resented editing. Some wanted to write chapters that were already assigned to others. Nobody wanted to write about gun control, so I took on that topic with my pal Chris Gillin, who was equally

uninformed and uninterested. Our wives, Lynn and Fran, helped with the research, and after a month we were dangerous experts, ready for combat with the National Rifle Association.

Others wrote about media and violence, drugs and violence, presidential assassination, the biology of aggression, the sociology of aggression, the connection (and the lack of connection) between major mental illness and acts of violence. We learned together and we shared ideas among ourselves. A general theory emerged: Aggression is a fundamental part of our species-specific behavior, innate and adaptive. Our capacity for aggression allows us to organize ourselves and attain needed resources in ways that are historically and biologically human. But violence, by our definition, is needlessly destructive aggression. Violence has never been adequately prevented and it threatens our existence. While we are not evolving into a more neurologically aggressive animal, we certainly are not overcoming our brutish heritage. And overcome it we must, because our impulse to hurt and harm affects so many more victims and potential victims as our weaponry grows more deadly and our deadly knowledge spreads.

I learned a lot at Stanford: how to be a psychiatrist, how to work with peers, how to manage a productive committee, how to edit a book, and how to think about our violent species. David Hamburg, our chairman, helped with his presence and his absence. He is a remarkable scientist, humanist, and leader who went on to become president of the Institute of Medicine, runner-up in the search for president of Harvard, then president of the Carnegie Foundation of New York. He and his wife, Betty, also a professor of psychiatry at Stanford, took a personal and professional interest in many residents' careers, including mine. Both stressed scientific method, critical thinking, and fact-based argument. Both were eclectic in applying several disciplines at once to the understanding of complex human issues. And both were outspoken advocates of progressive politics. Although they were diplomatic and discreet, you knew where they stood on the issues of the time.

Dave Hamburg was pleasantly surprised to return from abroad to find a significant fraction of his department at work on a book and advising a presidential commission. He joked that it might not have happened had he been there.

That could be true. Dave Daniels was the faculty member who got down in the trenches with me and sorted out personality disputes, who worked overtime to polish bad prose, who pushed to get a decent publisher, and faced down the nay sayers who thought we were overreaching. Dave Daniels had his difficulties with Dave Hamburg. I do not know all the details; I think the young professor went too far for the older professor's sense of decorum in arranging '60s-style seminars and scolding the faculty for lack of engagement in social issues. Several years later, after being passed over for advancement, Dr. Daniels left the department.

I deal with this sort of issue all the time now and I find it worth mentioning in a chapter on coming of age as a trauma expert. I paid a lot of attention back then to the behavior of alpha males. My role models were not physically aggressive. But they used science to advance humanity by organizing, motivating, and leading others. It is a rare group of primates that tolerates more than one alpha male.

A decade later I discovered the alpha female.

GOVERNMENT SERVICE

During the Vietnam era, young doctors were drafted one way or another. We could be deferred until we completed our residencies and serve as specialists, or we could be conscripted right after internship and end up near the front lines. My internship was in the U.S. Public Health Service, in uniform, in San Francisco. That made me ineligible for deferment. Very fortunately for me, I was accepted into an elite group, the Mental Health Career Development Program (MHCDP), which took a half-dozen members a year, gave us commissions in the Public Health Service, paid our way through any approved psychiatric residency, assigned mentors from the National Institute of Mental Health (NIMH), brought us to national meetings throughout our residency years, and groomed us for national leadership positions in the federal government. We were not sent to Vietnam.

By 1973 I had moved up the ranks to become director of the Services Division of the NIMH and was responsible for the federal components of community mental health in America. The position was a blend of politics, policy, personnel, budget, and law. President Nixon had nothing against community mental health; he just didn't want the feds to fund it. My job was to get Congress to fund it fully without getting my boss or me fired by the president. I had a maestro as a mentor. Bert Brown is 9 years older than I, a psychiatrist, a concert pianist, a raconteur, and a drafter of President Kennedy's first Community Mental Health Act. He was my boss when I first moved from Stanford to NIMH in 1969. As his assistant, I learned the machinations of mental health administration. When he moved up from deputy director to director of the NIMH, I moved up, too. He appointed me director of the Services Division in 1973.

Although my purview included just about everything that crossed the director's desk, my special assignments were combinations of his interests, my interests, and the jobs that had to be done. I assisted with the first Surgeon General's Report on Television and Violence. (Back then there was no reliable evidence that television caused criminal behavior; now the data tell a different story.) I designed, with others, the NIMH Minority Center and assisted in a book on racism and mental health,

explaining how that minority center was conceived and organized (Willie, Kramer, & Brown, 1973). When Stan Yolles was fired as NIMH director and replaced by Bert Brown and the two felt that they would rather not meet face to face, I ferried messages between them. This reminded me of shuttle diplomacy as a kid in Manhattan and the Bronx, dealing with estranged Jewish relatives.

For the life of me, I cannot remember how I met Jerry V. Wilson, the Washington D.C. Chief of Police, but we were well acquainted during this period in the 1970s. So it didn't surprise me when he called and said in his Arkansas drawl, "Frank, will you be my token shrink on the National Terrorism Task Force?" The attorney general had asked Jerry to head up a national panel to set standards and goals for law enforcement agencies—federal, state and local—as they faced the emerging threat of terrorism. Although I was the principal federal official in charge of community mental health, I became also—thanks to the enthusiastic support of my boss, Bert Brown—the only mental health voice on the National Task Force on Terrorism and Disorder.

COPS AND SHRINKS

I couldn't believe it. The FBI representative on our task force, Con Hassel, read the book we wrote at Stanford. Nobody read that book other than relatives of the authors and Conrad V. Hassel. We became best friends.

Con took me down to his office in the basement of the FBI Academy, where he had a picture of J. Edgar Hoover on one wall and a picture of Emily Dickinson on the other. "Hope is a thing with feathers," he quoted, and appeared to have a tear in his eye.

We spent a weekend with Frank Bolz and Harvey Schlossberg of the NYPD. Both were detectives, but Harvey had a Ph.D. in psychology and a Park Avenue practice as a moonlighting job. Some genius put Frank and Harvey together and they invented the modern era of hostage negotiation. To hear them tell it, with Brooklyn accents and salty expletives enlivening the science of calming homicidal desperados, is to learn advanced psychiatry from a vaudeville team. Harvey gives a briefing on the biochemistry of stress, noting how the urge to urinate increases with time and with the fluids supplied to the siege room by the crafty NYPD. Frank confides, "So we give them a pot to piss in and they give us a hostage. We are in business."

Harvey reminds Frank of the time he asked a uniform officer on surveillance, "Is the hostage ambulatory?" and the beat cop replied, "No. He's walking around."

That was my overtime job in the mid-1970s. I traveled the country with Con and the task force. I learned all I could about hostage scenarios. I interviewed people who had been held hostage. And when I had a



chance to extend this study to Scotland Yard, Con told me, “Study the victim, Frank. We know enough about perpetrators. Nobody studies the victim of terrorism.”

My day job—getting Congress to renew the Community Mental Health Centers Act—was done. The president couldn’t have cared less. Watergate had exploded, the tapes were revealed, the liars were exposed, and those who menaced the Kennedy mental health legacy were facing prison time.

I landed a plum assignment in 1976. It was called the Work-Study Program Abroad and was available, by competition, to one or two USPHS officers a year. I had to write a detailed essay, line up institutional support, and have letters of reference. Con Hassel and Bert Brown helped. I would study hostage negotiation, victims of sieges, and the way psychiatry and law enforcement could combat terrorism. I’d have a faculty slot and a desk at the *Maudesley*, London’s premier psychiatric teaching hospital. This would be a year’s assignment at full pay, with a generous allotment for travel and full shipping charges for the family—now five of us. The kids were 12, 9, and 6 years old.

Maudsley,
not Maudes-
ley, right? no

ROOTS

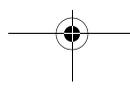
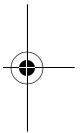
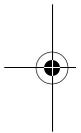
I’ll back up a bit now because the story is rolling along, and it sounds as though everything fell into place easily. That isn’t entirely true.

None of us come to the clinical practice of victim care without intimate personal experience.

When I was 16, my mom died. She had been ill most of her life with Crohn’s disease—regional enteritis—a painful inflammation of the small intestine that required surgery and periods of bed rest, dietary restriction, and a lifestyle limited by constant physical discomfort. Crohn’s disease is not supposed to become cancerous, but in her case it did. She wasted into a skeleton before my eyes. Mirrors were removed. Relatives spoke in whispers. She asked me to find out what was being said because no one would tell her. I was a high school kid. My brother was 6. My Dad, a shopkeeper, was at his wit’s end. He didn’t want me to know that this was cancer, not Crohn’s, but he blurted it out one day when I had made too much noise doing something adolescent and exuberant: “Quiet! Don’t you know your mother has cancer?” He regretted it as soon as he said it. Both of us were stone silent. I cried.

A decade later, recovered, married, serving that USPHS internship, I was on a surgical rotation, assisting in a knee repair. A nurse tapped me on the shoulder and said, “You have to scrub out. There’s been a family emergency.”

I don’t like writing about this. I don’t like remembering.



It had to be bad. You don't pull a surgical assistant off a case for anything trivial.

When I pushed through the OR doors, still in my greens, the hospital chief of psychiatry Dan Beittel was there. He said, "Your baby boy was killed in an accident," and he drove me home. Little Alex, 9 months old, had been in a crib. The side came down while Lynn was asleep and he crawled out and was strangled between the bed and a dresser.

Our daughter, Billie, was 2. She had no idea what had happened. Before I heard the news, between the operating table and the hospital hallway, I had a fantasy that everyone was dead—wife and both children. The fact that only one died was a relief.

Some relief.

There were awful calls to relatives, a coroner's inquest, a week of leave and then back to finish the internship. I did not have PTSD. But I did have a fear of further loss and grief. And I'm sure something hardened in me. I didn't want to be too close to any one person. The idea of grief counseling or any form of therapy appalled me. I wanted to share feelings with whom I chose, when I chose.

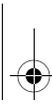
Back in college I studied English history and literature and read all of Shakespeare and most of the Romantic poets. There were lines and images and cadences that came back to me in my personal posttraumatic state, stoic and poetic at once. This was not a mature or healthy path and the marriage was chaotic until we talked, with help, several years later. Even then, I had a lot of growing up to do.

I don't believe the tragic death of my mother and the traumatic death of my son made me a PTSD pioneer. But I wouldn't be who I am and I wouldn't resonate with those who survive had I not experienced my own losses and my own clumsy steps afterwards.

The combination of science and literature was part of my formative years. I grew up in New York City and attended the Bronx High School of Science. I loved science and completed several college courses before getting to college. But at Harvard I discovered the liberal arts and would have become a Shakespeare scholar had I not flunked something called "the junior generals." This 2-hour essay exam was a hurdle in the honors program of my department. Pass it and you are almost guaranteed a summa or a magna. Fail and you graduate cum laude in general studies. I wrote a miserable exam and knew it. I figured that without highest honors in history and lit, I'd never get a scholarship to the right grad school. Professor Rueben Brower, my adviser, consoled me. "So you don't go to graduate school in English literature. You go to medical school. William Carlos Williams went to medical school."

Johns Hopkins gave me a full scholarship, although I lacked organic chemistry (I took that at summer school at Fordham). Hopkins had been censured for taking too many science majors and turning out doctors

The ages don't seem to come out right. Earlier you say "our kids were 12, 9, and 6 [presumably months for the last]. Where does the 2-year-old come in? Remember, Ochberg is "backing up" (in time). Alex died



who were “not well rounded.” They couldn’t have found an applicant with fewer college science courses.

ENGLAND

By the time I landed at Heathrow, age 36, I had experienced heights and depths, yins and yangs, but nothing beyond the borders of America (Tijuana doesn’t count). It took a while to settle in, make friends, learn to drive on the other side of the road, and handle pounds and pence, but that all fell into place soon enough.

I had a scare when the assistant commissioner told me I couldn’t take their hostage negotiators course because it was limited to a carefully selected group of officers. “But you can help us teach it,” he said. That made me gasp and smile at once. I had a spot in the room; I’d have to teach Sherlock Holmes.

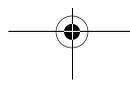
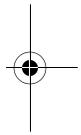
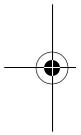
It all worked out—principally because they got me roaring drunk one day and told me the most outrageous jokes with Scots and Irish and Welsh accents and I laughed until my sides split; after that I was either “the Yank” or “the shrink,” but I was OK. And I learned far more than I taught. In fact, between my time with them and a few weeks in Holland—when a group of Moluccans held hostages on a train and in an elementary school and I ended up in the command center assisting the chief negotiator—I figured out something now known as the Stockholm syndrome.

STOCKHOLM SYNDROME

Today it is common knowledge, but back then we were all surprised and intrigued by the strange case of Kristin, the bank teller who was held hostage in a vault at the Kreditbank in Stockholm for several days in August 1973. Kristin became enamored with Olsson, the armed assailant, broke off an engagement with her fiancé, and lambasted Olaf Palme, the Swedish prime minister, during and after her captivity. According to the police investigator who discussed the case with me, she had sex with her captor in the vault (although conflicting accounts make that assertion unreliable).

OK this way?

Kidnap and hostage experts knew that in certain cases an unexpected bond forms between captor and captive. Anna Freud called a similar situation, observed in concentration camps, “identification with the aggressor.” But what I saw at least a dozen times after Stockholm, and what I learned from a year of interviewing persons held hostage, was not identification—and not aggressive behavior emulating a sadistic guard. First, there was a sudden, terrifying capture. The hostage was stunned, shocked, and often certain that he or she would die. Then the hostage



became like an infant. He couldn't talk, eat, move, or use a toilet without permission. But then, little by little, small acts of kindness by one of the captors evoked feelings that were deeper than relief. "We knew they were killers, but they gave us blankets, cigarettes," one Dutch ex-hostage told me, and then went on to explain his sense of warmth and compassion towards the Moluccans who chose not to kill him (Ochberg, 1978). I realized this must be akin to the infant's feeling that accompanies the relief of thirst, hunger, wetness, and fear of neglect—a primitive gratitude for the gift of life, an emotion that eventually develops and differentiates into varieties of affection and love.

The captor often develops reciprocal feelings of attachment, and when he does, we on the outside, concerned with rescue, have an advantage. The hostage holder wants to protect the hostage. But both captor and hostage have little trust in us and may actually come to hate us. We are the common enemy.

So I defined the Stockholm syndrome for the FBI and Scotland Yard negotiators in memos at that time as involving three conditions:

1. Positive feelings from hostage to captor
2. Reciprocated positive feelings from captor to hostage
3. Negative feelings by both to authorities managing the crisis

That definition stuck. I never named the Stockholm syndrome; I defined it. A few years later I wrote about it in several articles with FBI agent Tom Strentz and in a book with David Soskis (Ochberg & Soskis, 1978). In 2003, 30 years after the incident in Sweden, some reporters tracked me down to reprise the events and to evaluate the significance of siege room bonding. The significance of Stockholm Syndrome goes beyond rare instances of kidnapping and hostage taking. It explains aspects of attachment to battering husbands and incestuous fathers. It explains confessing to accomplished interrogators. It is not just conscious, willful behavior to avoid punishment. It is regression and recovery of a powerful, primitive feeling toward a giver of life.

LATE 1970S

When I returned from the year in Europe, things were not the same at NIMH. Bert Brown, a Kennedy Democrat who held the fort during the Nixon years, was under siege. The Secretary of Health, Education and Welfare (HEW) was Joe Califano. The Assistant Secretary for Health was Julie Richmond. And Gerald Klerman, a Harvard psychiatrist, was brought in to run the new conglomerate called ADAMHA—the echelon below Dr. Richmond and above Dr. Brown. One too many alpha males.

Betty Hamburg now worked at NIMH and David Hamburg advised both Califano and Richmond. Bert Brown pushed the boundaries with Klerman far past the protocol for loyal subordinates. Richmond backed Klerman, not Brown. David Hamburg was unhappy with the way his wife was treated at NIMH, and in a short while Bert Brown was fired. He tried to muster support from Senator Kennedy and other old allies, but there were new Democrats in town and it was their turn to rule.

I was in trouble, too. Bert's successor, Herb Pardes, didn't want me as his associate director. By then I was the number two psychiatrist at NIMH, responsible for congressional and constituency relations. That was a sensitive political position, one that the director fills with his own handpicked loyalist. So I arranged to be designated Associate Director for Crisis Management and went to work for the Secret Service. I also became the male member of the Committee on Women of the American Psychiatric Association (APA).

WORKING WITH WOMEN

We were a heck of a committee, us gals.³ We kept Hysterical Personality Disorder out of the Diagnostic and Statistical Manual (DSM). We picketed meetings until the APA trustees agreed to boycott states that refused to ratify the Equal Rights Amendment. We brought Gloria Steinem to rally support. And we paid close attention to the concerns of victimized women.

The grass roots movement to provide shelters for battered women began to pick up steam and could have received grants from the NIMH. Some psychiatrists wanted to link shelter services with community mental health centers. But my women colleagues saw how mental health management would imply mental illness on the part of the battered spouse. "The kiss of death," we all agreed, and we kept the systems separate. I still had a policy position at the NIMH and some leverage, which made a difference.

Judith Herman had not quite finished her landmark book *Father-Daughter Incest* (1982), but we knew and respected her (she eventually replaced me on the committee). Ann Burgess and Linda Holstrom had defined the rape trauma syndrome by then (Burgess & Holstrom, 1974), but there was little support or sympathy in mainstream psychiatry for the victim of sexual assault. We raised the consciousness of colleagues as best we could, using the traditional methods of workshops, seminars, articles, and effective personal advocacy within the various APA committees and councils.

We invited Marty and Allie Symonds to meetings and digested the meaning of "the second wound." Both Marty and Allie were psychiatrists,

but it was Marty, a former beat cop who put himself through med school, residency, and analytic training, who coined the term. It referred to the wound inflicted by the callous detective, the crass physician, the angry husband—after the rapist or the mugger did his damage. This second wound, inflicted with insensitive words, often cut deeper than the first.

Sue Salasin played a major constructive role, beginning in the late '70s and well into the '80s. She worked in applied research at NIMH, had survived a near fatal physical assault, and yearned to help victims of violence everywhere. We chaired many meetings together, introducing clinicians, researchers, and policy leaders who shared an interest in victims. We linked the APA Committee on Women to the NIMH and established ties to the National Organization for Victim Assistance. Sue introduced me to Yael Danieli and Bessel van der Kolk before they became prominent leaders in our field.

Our overlapping networks of APA and NIMH participants, while not explicitly feminist, had a feminist agenda. Men occupied most of the positions of influence in government and academia, defining victimized women as flawed, feckless or contributing to their own victimization. It took scientific evidence and political muscle to turn the tide. These "alpha females," connected to one another by strong bonds of respect, spoke a different language than their male counterparts, who were far more concerned with turf and pecking orders.

SEEDS OF THE INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES

This was the period in which the seeds of the International Society for Traumatic Stress Studies (ISTSS) were sown. The Vietnam War was over, but Vietnam vets had little clout within the VA. They were outnumbered, stigmatized and neglected. Slowly, the attitudes changed and the Vietnam generation found its voice. Prominent psychiatrists like Jack Ewalt⁴ spoke about "not blaming the warrior for the war." I had opposed the war in the '60s but saw the veterans as victims in the '70s—and I did not consider *victim* a dishonorable term.

We didn't have the diagnosis of PTSD back then. But we did have the observations of military psychiatrists, veterans themselves, and writers, reporters, and poets who documented shell shock and battle fatigue. I had the experiences of a different type of combat vet—the survivor of hostage ordeals and persons imprisoned by terrorist groups.

My colleagues in the Committee on Women knew about the aftermath of battering, rape, and incest. Common clinical insights eventually became a common language with a unifying diagnosis.

It took Charles Figley to pull it all together.

CHARLES

Charles Figley needs no introduction to anyone reading this chapter. We met in the '70s, when he was organizing the special interest group that preceded the ISTSS.

Charles might have been the first person I met who was younger than I but could have been my father figure. He organized, encouraged, facilitated, and collaborated. He did the dirty work, like taking notes, filing reports, raising money, and traveling out of his way to meet you. He had a vision—a global network of trauma specialists, well trained and well educated. He invented a field.

I was more than willing to help. Charles asked me to serve on his board; I served. Charles asked me to write a position paper; I wrote. Charles asked me to edit a book on treating victims, I took a deep breath, consulted my wife (knowing she would say, "Do it"), and I did. That book, *Post-traumatic Therapy and Victims of Violence* (Ochberg, 1988), was very difficult for me. I tried to make it an APA task force product with Marty and Allie Symonds as partners, but both had writer's block and took years to make progress. We began in the early '80s, and only when they said, "Go on without us" could I take over the project and finish the job. We published in 1988. My chapter authors were the stars of the field, many of whom became renowned trauma experts.⁵ I didn't consider myself a trauma treatment expert (back then there were no experts), but I felt I had a job to do, deputized by Charles Figley.⁶

Something happens in your forties if you've been a young leader. You learn to enjoy working for younger leaders or you become an ornery old coot. My experience with the Committee on Women certainly helped me. There was no way I'd ever lead that group, and simply being a member was a high privilege. When we were all walking down a hotel room corridor, gabbing away intently, and suddenly the group entered a ladies' room, I knew there were limits to my membership. But I figured that was an important lesson and I let it sink in.

RECENT INFLUENCES AND OUTCOMES

Later on, in the '80s and '90s and this decade, I met people who became very significant to me personally and professionally.

Governor William G. Milliken appointed me director of the Michigan Department of Mental Health, a cabinet position with 17,000 employees and a budget close to \$1 billion. He was the last of a generation of moderate Republicans who conducted the business of government with decency, dignity, and warmth. He respected and attracted advocates who sought power to provide resources for the underserved. That job didn't

last long. An economic collapse forced me to lay off 5,000 state workers. I lost my budget, my political support, and my freedom to innovate. I left my office shortly before the governor left his.

Mary Janice Belen of the Sisters of Mercy hired me to build and staff a new hospital. That job included the authority and resources to create the first residential treatment facility for victims in America. We called it the Dimondale Stress Reduction Center (Ochberg & Fojtik 1984).

William A. Dart and Kenneth B. Dart entrusted me with half the assets of the Dart Foundation and later with its semiautonomous division, Dart Innovations. This foundation allowed me to create or cocreate the Michigan Victim Alliance, the Dart Center for Journalism and Trauma, the Critical Incident Analysis Group, the National Center for Critical Incident Analysis, and Gift From Within.

All of these entities have websites with their histories, functions, and goals detailed.⁷ All collect remarkable assemblages of overworked volunteers and underpaid staff.

My most significant achievements in the trauma field may be the seeding and nourishing of these networks. For example, if the Dart Center continues to improve the profession of journalism, we may have a day when the general public understands trauma the way trauma experts understand it. And we will have less rewounding of victims and more judgment and reason in our responses to violence.

If the Critical Incident Analysis Group (and its successor, the National Center for Critical Incident Analysis) progresses as a forum for scientists, journalists, humanists, and crisis managers, we may understand and avoid debacles like Waco and 9/11. I doubt we can avoid certain acts of terrorism and mayhem, but we can avoid a rush to judgment and miscalculation based on passion and prejudice.

If Gift From Within grows and evolves to reach millions rather than thousands, the trauma field will be less a society of experts and more of a consumers movement, helping its own victimized members become survivors, demanding and receiving their due.

I'd like trauma scholars to build upon these opportunities, and to recognize the worlds beyond the walls of one's university or discipline or current stream of funding.

We have a science based on ancient principles—keen perception, rigorous analysis, and modest claims of new truth as new truth slowly becomes evident.

We have a species—our human species—that is capable of advanced intelligence and primitive cruelty.

What could be more exciting or productive than harnessing our intelligence to overcome our cruelty?



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ENDNOTES

1. Erich Lindemann, M.D., is best known for his seminal article on pathologic grief, published after the Coconut Grove fire (Lindemann, 1944). Although he was a wise and compassionate man—a wonderful clinical mentor—he completely missed the fact that his sample of bereaved survivors were exposed to horrifying imagery and must have had symptoms we now recognize as PTSD.
2. Thirteen staff reports to the National Commission on the Causes and Prevention of Violence are available from the U.S. Government Printing Office, beginning with an excellent historic overview (Graham & Gurr, 1969).
3. Our members were Elaine Hilberman Carmen, Elissa Benedek, Brenda Solomon, Nanette Gartrell, Dorothea Simmons, Janet Ordway, Katherine Falk, and Theresa Bernadez. Jean Shinoda Bolen was an active collaborator.
4. Jack Ewalt, M.D., ran the VA Mental Health Division after retiring as distinguished professor and chairman of the Harvard Medical School Department of Psychiatry. He was once one of the most powerful figures in academic psychiatry, loved, feared and respected, depending upon one's ability to stay in his good graces.
5. Contributors were Ann Burgess, Yael Danieli, Charles Figley, Anne Flitcraft, Carol Hartman, Judith Herman, Mary Merwin, Richard Mollica, Carol Mowbray, Frank Ochberg, Walton Roth, Edward Rynearson, Bonnie Smith-Kurtz, Evan Stark, Bessel van der Kolk, John Wilson, and Marlene Young. Dave Hamburg wrote the foreword.
6. My technique for treating flashbacks and haunting memories, invented in the late '80s and reported in the mid-'90s, never achieved the popularity of EMDR and other methods, although it is simple and effective (Ochberg, 1996). A general philosophy of treatment did have impact (Ochberg, 1991, 1993).
7. www.mivictims.org/mva; www.giftfromwithin.org; www.dartcenter.org; www.health-system.virginia.edu/internet/ciag; www.criticalincident.org

