THE PEN AND THE DOLLAR BILL: TWO PHILOSOPHICAL STAGE PROPS

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[WITH LARGE GESTURES I PLACE PEN AND DOLLAR BILL IN PLAIN SIGHT]

I come before you as a physician, an unlicensed philosopher, and a missionary for the veterans I serve. Primarily, I am their missionary to military forces: they don't want other young kids wrecked the way they were wrecked. The combat veterans I've worked with for eighteen years are a contentious bunch, but they are united on this one thing—protecting the service members who are serving now. This mission strongly colors my perspective in everything I say here. But it's also fair to say that I am an unreconstructed intellectual, and am deeply immersed in the perennial philosophic quest—what is this wonderful/terrible critter, this Human? I have come to see trauma as a vista-opening standpoint for inquiry and research as rich and productive in its own way as *e. coli*, *drosophila*, and *c. elegance*. It is not only a scientific crossroads from which to observe the interaction of brain, mind, social system, and culture, but a similar crossroads in philosophy for ethics, epistemology, and ontology. Now to the subject at hand, the diagnostic construct *Post-traumatic Stress Disorder* [hereafter PTSD] of the American Psychiatric Association's *Diagnostic and Statistical Manual* [hereafter DSM]

My interest in preventing psychological and moral injury in

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DISCLAIMER: These remarks are the author's personal view and do not represent any official position of the Department of Veterans Affairs, the Department of the Navy (including the Marine Corps), or the Department of the Army.

military service, and about ten years of missionary adventures with the US Armed Forces has led me to advocate the use of the word "injury" in the nosology, rather than "disorder,"[2] for the following reasons:

- The word "disorder" would be transparently ludicrous in an analogous physical injury setting: Missing Arm Disorder [MAD] for a veteran with a traumatic amputation of his arm!
- Injury in the line of duty is honorable. Illness, malady, disorder, is at best unlucky (no soldier wants an unlucky comrade in a fight!). "Injury" is more culturally acceptable, less stigmatizing, less of a barrier to seeking help.
- The relation between injury and subsequent complications is typically clearer and mindsets more *proactive* than for the relationship between illness and subsequent complications of that illness. Right from the start, Medics/corpsmen and military surgeons think about preventing complications of wounds—such as hemorrhage and infection.

I have proposed that everything would be greatly simplified and still in accordance with the facts, if we viewed the primary psychological injury as ***persistence*** **into the time *after* danger/horror/deaths of comrades has passed, of valid psychological and physiological adaptation to that traumatic situation.**[3] While the primary injury can sometimes be severe enough to wreck a veteran's life or disable an active service member, this is not always the case, just as

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[2] Canadian Forces has adopted this terminology, "Operational Stress Injury."

[3] I leave it to the reader to notice that most of the items in the PTSD diagnostic criteria fit this description. I see the intrusive symptoms the workings of very ancient forms of *learning* about danger; the avoidant symptoms as the persistent shutdown of emotions or ways of thinking that do not immediately serve (or that impair) survival of the danger, and the hyperarousal symptoms as mainly the persistent mobilization of the mind and body for danger. The mapping onto Criteria B, C, and D is not exact and the differences are beside the point. The main point is that the primary injury is *persistence* of formerly valid adaptations into a new condition of life where they now are maladaptive.

If this is the case, consider now the quandary of military leaders, policy makers, mental health professionals, and chaplains as they ask themselves, "Do I want to deprive this returnee of his adaptations, when we know, and he knows that he is going back in six months?" For this reason, a Navy/Marine Corps program called Warrior Transformation got rebranded as Warrior Transition.

with physical injuries.[4] Often a primary psychological injury will cause a *focal* disability, such as the combat infantry vet who has a non-negotiable aversion to showing up in the open in a crowd, like at his son's or daughter's Little League game.[5]

I have argued that, as with physical injuries, the *complications* can be devastating or lethal. Hemorrhage and infection are complications of ballistic and burn injuries, and control of these complications has been the root miracle of modern military medicine. In psychological injury, the complications alcohol/drug abuse, suicide, criminality, danger-seeking can be fatal or utterly wreck the lives of the veterans, their families and sometimes workplace and community. Destruction of the capacity for social trust, a major non-lethal complication of psychological injury, derails human flourishing, and deforms character, absent recovery. So everything that controls complications of psychological injury and promotes their prevention is a BIG plus. In military mental health we are nowhere close to what military medicine accomplishes against complications of physical injury.

Now to the first of my props.

I pick up the pen and announce, "On the count of three, I shall drop the pen…One, Two, Three," and I drop it on the desk before me. Less than eight seconds have elapsed.

I have just given a very compact and very accurate account of a human act. The account, the ability to give the account, the little pantomime it delivers, your capacity to hear and understand it, to observe it, to match your observation of the physical act to the speech act that preceded it are all evolved biological capacities with anatomical and physiological facilities necessary to their performance as given. Mind, society, and culture are all demonstrably present in this bit of philosophical theater, but let us leave those aside for the moment

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[4] E.g., GEN Rick Shinseki, USA, ret. has a prosthetic foot from Vietnam, and a Marine Lieutenant General I worked with in the *Commandant of the Marine Corp Trust Study* has facial scarring and jaw deformity from Vietnam.

[5] This would be analogous to impairments of Shinseki's ability to run, of the Marine general's ability to chew on the wounded side of his mouth.

I shall consider two reductionist accounts of my simple skit:

One is at the level of basic physics and chemistry. Is it within our ability to give a strict deterministic account at the level of atoms and electrons? While we are quite good at this under very special conditions with a few atoms and their outermost electrons, we have neither the technical means for mapping this from the individual atoms and their electrons in my brain, upper limb and vocal apparatus, your ears and brains, nor the data storage and computation capacity to complete the reductionist project for this modest little skit.

So which account has epistemic superiority here? The compact, efficient, and accurate one produced by human evolution or the not-yet, and maybe-never promise of future scientific and technical advances lying scores of Moore's-Law-doublings in the future?

Well, that was a straw man, especially before a group of practicing neuroscientists and their colleagues. So what about a semi-deterministic account that accepts as given, that the atoms of my body are arranged in special ways which we currently group as Pacinian corpuscles, forearm muscles, peripheral afferent and efferent nerves, central neurons and tracts? Well, here too, our claims-in-principle are far in advance of our claims-in-practice. We are decades, perhaps many decades from anything resembling a "complete" neurophysiological account of my eight second skit and of your accurate and easy grasp of what I have said and done.

If I had Parkinson's disease and could not initiate the movement of my hand toward the pen or release it if I already held it, *if* I had multiple sclerosis and wildly missed the pen with my hand when I reached for it, the merit and utility of the semi-reductionist account would be immediately obvious and beyond dispute. For almost all of a neurology patient's life-purposes, that semi-reductionist account holds superior promise, compared to other accounts.

The question before us, as I choose to see it, is whether the diagnostic entities of the present or any future *DSM* should be, or can be culture-free, social process-free, narrative-free brain dysfunctions akin to

Parkinson's disease and multiple sclerosis. The human critter is *at every moment* brain, mind, society, and culture. These four manifestations of the human co-evolved in relation to each other as each other's environments during the Upper Paleolithic. There's nothing unusual about an animal co-evolving in relation to a micro-environment of its own creation. It is generally true that whole life-cycles (of which molecular genes are a part) are perpetuated in future generations, not the genes alone. The termites build their nests; the nests shape the anatomy and physiology of the termites; nests and termites co-evolve.

I do not dispute that brain diseases, including "inborn errors of metabolism" as we quaintly used to call them, can in themselves cause distinctive mental and social dysfunction. What I dispute is the inverse: the explicit or implicit claim that presence of a distinctive mental and social dysfunction demonstrates the presence of a brain disease and/or "inborn errors of metabolism." Another way of stating what I dispute is—that bad experience causes *only* PTSD and cannot cause any *other* DSM diagnosis.

Coming back to the dropping pen…Is a veteran's compact explanation of his current depression epistemologically inferior to learned talk about neurotransmitters? On what basis are we to believe that?

This brings me to my second prop.

We have all been raised to believe—I know I have—that natural facts, like the heartbeat or the liver, have a different ontologic standing than, say, the Red Sox, which is a human cultural, social, and mental construction. Of course we can point to demonstrable physical facts about the Red Sox, such as Fenway Park, but whatever those physical artifacts are, they are entirely part of this human creation, the Red Sox. The heartbeat or the liver or quartz crystals are somehow "given," not made, at least by us—not humanly constructed, except to the extent that when we talk about them to each other we inevitably add some interpretation, at minimum the subtle flavors imparted by different languages. But natural entities have an irreducible ontologic standing that remains when social and cultural construction has been subtracted,

while *nothing* remains of the Red Sox when social and cultural constructions are removed. We hold the liver to be "really real" in senses that the Red Sox are not.

What is the ontologic standing of the DSM diagnoses? Liver or Red Sox? Are the diagnostic entities of the DSM facts of nature like the liver, unrelated to cultural construction, social interaction, or personal history? Are they manifestations of "underlying" biology, even if we are currently incapable of detailing that biology? Promissory notes about future biology are thick on the ground everywhere in medicine. However, in psychiatry we have a formal epistemological resource, which comes to us from our colleagues in the discipline of Psychology: psychometric properties—construct validity, inter-observer reliability, and good-enough scaling.

While never explicit in the DSM, we have been encouraged to believe that the good "psychometric properties" of the DSM diagnoses point to as yet undefined acquired or inherited defects in neurophysiology or anatomy, which are as free of human agency as the heartbeat.

Which brings me to my second prop, this $1 bill. It is my pitch to be ruthlessly honest with ourselves and others about what we learn about a construct when we can demonstrate that it has "psychometric properties." Strong legitimation of the DSM diagnoses by good psychometric properties has been borrowed by governments, universities, health care organizations, health cost reimbursement sources, courts, disability insurers, etc. The DSM has become institutionalized to a degree undreamed of 30 years ago. As temporary guides to perception and communication these constructs have great utility, but do they warrant the ever-increasing institutionalization that has crystallized around them? They do not.

I reject the culturally legitimizing claim demonstration of good psychometric properties for a DSM diagnosis somehow substantiates for it an experience-free biological origin—an as-yet unidentified inborn or acquired error of metabolism. Solid psychometric properties are widely seen as the visible projection of "underlying" biological reality—an ontologic plane that is more real than the plane of anything directly or

indirectly made by human activity. The best practitioners neither of psychometrics nor of biological psychiatry actively make or even believe this claim. If challenged, most will deny that psychometric properties are probative of pristine, unmade human essence. However, these same experts are strikingly silent when it comes to disabusing those who treat the implied biology/psychometric properties link as a source of the political, social, and cultural legitimation of the institutional, economic, legal, and political uses of the diagnoses.

By now some of you will have already surmised how I plan to use this dollar bill as a stage prop. *Nothing* in psychology or psychiatry has stronger construct validity that this piece of paper; *nothing* has better inter-observer reliability. It even scales as a *real number*—Can you beat that?!—and yet not a soul will claim that the dollar, or money more generally, is anything but a very recent human creation, taking appearance of *Homo Sapiens* as the time frame. To be sure, money requires "underlying" biological capacities, such as language, and the cognitive/emotional capacities to value things at all. But then the Red Sox also depend upon "underlying" sensorimotor capacities to engage in the human practice of baseball. Despite money's greater antiquity and near universality, compared to the Red Sox, I submit that its ontologic standing is way closer to the Red Sox than to the heartbeat.

I turn now to a related issue in the DSM nosology:

At the risk that you think I contradict myself and try to "have it both ways," I want you to understand that I am not trying to make trauma the cause of *all* mental distress and dysfunction. I don't believe that, having myself had personal experience with a fierce propranolol-induced depression after a brain infarction at age 40 from hemiplegic migraine. I have no doubt whatever that as-yet to be discovered inborn errors of metabolism and brain diseases *can* cause some phenomenologies outlined in the DSM. The question I want to raise with you is whether it is credible that bad enough experience can cause *no other* DSM disorders, such as Major Depression, Bipolar Affective Disorder, Panic Disorder, etc. The DSM is famously agnostic about the causes of most disorders within its covers, again excepting PTSD. In many quarters, there is a wink-and-a-nod understanding that that

agnosticism will soon be swept away by progress in biological psychiatry revealing the genetic or acquired brain diseases "underlying" the DSM diagnoses.

It is contrary to fact that bad experience can *only* cause PTSD, and as corollary, cannot cause *other* DSM diagnoses, unless they are "associated…mental disorders"—"associated" with PTSD, that is. A trauma survivor who does not "make" the diagnosis of PTSD at the moment he or she is being evaluated may still suffer post-traumatic—

- Affective phenomena that add up to DSM affective disorders—both mania and depression
- … DSM psychotic disorders
- … Other non-PTSD DSM anxiety disorders
- Deformities of character and personality that add up to DSM personality disorders
- DSM alcohol/substance abuse and dependence disorders

Acquired or inborn "errors of metabolism" or other disordered brain physiology *can* certainly cause or contribute to the above. But trauma alone can *also* cause them. To deny this is contrary to fact.[6]

To assert, for example, that trauma can *never* cause, a stand-alone depression in the absence of a hidden pre-existing "diathesis" (demonstrable only with some always-in-the-future, not-yet-existing technology) is to make a claim that cannot, in principle, be refuted by empirical evidence. Thus is not a scientific claim. Such unscientific claims are made especially about personality disorders, about which more later.

I hope that it is clear that I do not reject pre-trauma robustness or

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[6] Dr. Mark W. Miller, a fine young researcher in Dr. Keane's section of the National Center for PTSD, wrote to me in response to a prior draft of this the following: "The data show that PTSD may be the most common psychiatric syndrome to develop following trauma (Green, Lindy, Grace, Leonard, 1992; Kulka et al., 1990) but other conditions frequently co-occur with the disorder, or develop independently of it, including other anxiety disorders and the unipolar depressive, substance-related, and personality disorders (Breslau, Davis, Andreski, & Peterson, 1991; Breslau, Davis, Peterson, Schultz, 2000; Davidson, Hughes, Blazer, & George, 1991; Helzer, Robins, & McEvoy, 1987; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Kulka et al., 1990; Orsillo et al., 1996; Golier et al., 2003)." In general, I am not a good source for the current psychological literature, but Dr. Keane and others at the NCPTSD are. (With Dr. Miller's permission.)

vulnerability (= "diathesis"?) as part of an overall analysis of *every* injury, including bones broken on the ski slopes. It would be completely contrary to fact to say that prior robustness/vulnerability make no difference, and when speaking of this make the following analogy: A stone the size of a golf ball is dropped from a height of one meter onto the shin, respectively of a frail elderly person with osteoporosis, and of the circus strong man. In the former instance the bone breaks; in the latter, the stone bounces off without leaving a bruise. I then continue the analogy: But is the outcome different if a two-ton boulder is dropped on the leg of each? No. Both turn to mush. It is hard to evade the conclusion that the experiences of some combat veterans are the psychological equivalent of the two-ton boulder.

To demonstrate through twin studies that there is a genetic component to psychological injury proves…what? There are such genetic components to bone fractures and to the healing of those fractures. So what else is new? My writing and your reading at this moment are physiological, psychological, social, and cultural, all at the same instant. None of these has ontologic priority—this one "really real" and the others merely epiphenomenal. The genetic research is very valuable, but it does not trump experience arising from the environment created by other human beings. Genes exist to respond to their environments; neither genes nor environments have ontologic priority. This is the thrust of the current explosion of productive research at the intersection of molecular genetics and embryology, and of both with research in evolutionary biology.

I now want to briefly point out a smaller contrary-to-fact issue in DSM PTSD—although it is no small matter to a veteran denied health or disability pension benefits because of it. Please keep this in mind as you work through your deliberations. Veterans denied VA benefits on the technicality of a poorly drafted diagnostic criterion often take the denial as an adverse judgment of the honorableness of their combat service. Combat veterans' reactions to being dishonored can be very violent and dangerous to themselves and others. We need to get these things *right.*

Criterion A-2 ["the person's response involved intense fear, helplessness, or horror"] is contrary to fact. Here are some of the things wrong with it:

- "I didn't feel a fucking thing!" is a frequent veteran response to the question "What did you feel when…" Or "Hate. I just felt hate and wanted payback" [7]
- There is substantial evidence that if a person dissociates at the time of the traumatic event[s], that person is more likely to be psychologically injured and that the injuries are likely to be worse than if he or she felt fear, helplessness, or horror at the time.

Veterans I work with who follow the news fear that this IOM study is simply an attempt to kill off the PTSD diagnosis and to deny both treatment and disability benefits based on that diagnosis.

It should be clear from my 18 years of work with combat veterans, my two books and other writings on combat trauma, that I am criticizing the diagnosis PTSD neither in order to discredit the idea that war can maim the mind and spirit as well as the body, nor to save the VA money.[8] I would be aghast if anyone twisted my words to mean that the VA should push combat trauma out of its field of vision, and deny treatment and disability pension benefits. If anything, I want to see virtually *every* diagnosis in the DSM permit a post-traumatic coding, if the data made this compelling. As it stands it is possible for a Vietnam veteran to receive a diagnosis today of combat PTSD, having previously never been so diagnosed. Further, it is possible, at this late date, for that veteran to get a disability pension for this PTSD. The very same veteran coming for the first time to the VA with disabling, refractory depression since the Vietnam War, but with no VA diagnosis of depression within a year of discharge, no prior VA PTSD diagnosis to hang it on as an

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[7] Dr. Miller, the same researcher mentioned above wrote: "Fear, helplessness, and horror comprise only a fraction of the affects experienced by trauma victims at the time of the event and they are not uniquely predictive of the development of PTSD Anger shame, and others are also strong predictors."

[8] It pays to know history: After the First World War *The American Legion* led the fight to count psychological injuries—then "shell shock"—as compensable injuries.

"associated …mental disorder," probably could not get VA treatment for that as a service-connected condition—and definitely could not get a service-connected disability pension for depression. So I am not criticizing the DSM in an effort to save the VA money.

Those of you familiar with my books are aware of my interest in traumatic damage to good character. As a matter of scientific accuracy, I believe that it is essential that the DSM be corrected on this score. Life-blighting personality changes such as—

- Embitterment and extreme cynicism
- Hair-trigger expectancy of harm, exploitation, or humiliation
- "Strike first!"
- Fulminant xenophobia and prejudice
- Intimidation as one-size-fits-all social coping
- Demands for constant deference and tokens of honor

—are all elements of a malignant transformation of character that can destroy the life of not only the veteran, but of his family, co-workers, and neighbors. I have observed that veterans with unhealed combat traumatic personality changes are utterly disabled for democratic participation, and are especially available for recruitment by criminal gangs, terrorist groups and other violent extremist movements and cults.

Our colleagues in the World Health Organization do recognize in the ICD the possibility of "Persistent Personality Change after Catastrophic Experience." I believe it is time for Americans to acknowledge it also.

If I express myself here on some policy dimensions of the DSM—knowing full well that they are not part of your charge—it is because I want to bring them to mindful, conscious awareness, or they can exert an invisible magnetic attraction or repulsion to thinking about the diagnostic constructs. I am not attempting to recruit you to support or oppose a policy regarding the eligibility of character-damaged veterans for VA health and disability benefits, so much as to seek to prevent the

lightning-fast self-censorship that takes place when an agile mind leaps ahead to an unacceptable policy outcome of a scientific result. The "don't go there" reaction can happen in a millisecond and pass unnoticed, derailing a scientific inquiry before it starts. The scientific question here is whether bad experience can deteriorate adult good character, change adult personality.[9] Here are the policy issues I think are in play:

1. Can post-traumatic character deformity be exculpatory in a criminal process?[10]
2. Should VA health coverage be extended to these deformities as service-connected injuries?[11]
3. Should service-connected disability pension benefits be available to veterans with post-traumatic deformities of character? [12]

I am told that a number of you are familiar with my books *Achilles in Vietnam: Combat Trauma and the Undoing of Character* and *Odysseus in America: Combat Trauma and the Trials of Homecoming.* In the former, I formulated the causative side of "moral injury" as "betrayal of 'what's right' in a high stakes situation." The stakes don't get higher than in war, and sometimes in training for war. People can and do die in both. It's not hard to grasp that, when a beloved comrade dies, or a brush with death came because of betrayal of "what's right" by someone who holds power, the psychological wound is worse and more prone to subsequent complications of character damage than that from

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[9] Philosopher/anthropologist Pierre Bourdieu referred to these invisible attractions/repulsions as the workings of occupational "habitus." While working on this I found myself humming Leonard Bernstein's satirical chorus of juvenile gang members, "Well, Officer Krumke, we're really upset…." from *Candide.*

[10] I oppose this, and have refused all requests to serve as an expert witness for either side in a criminal trial.

[11] Post-traumatic character deformities *can be successfully treated!*

[12] Cost/benefit analysis here, must be nation-focused, rather than federal government-focused, and take into account the economic costs, not only direct incarceration costs, but criminal victim losses, veteran family costs, etc. Health and disability pensions are superior to the all-too-common incarceration of veterans with unhealed character deformities. Incarceration (mostly at state, rather than federal) expense will remain the fate of the minority who do not recover despite good treatment and community support. I find the unavailability of VA physical and mental health benefits to incarcerated veterans to be utterly shameful. If you find that in contradiction to my avowal in footnote #11, so be it.

terror or the traumatic bereavement alone. By rejecting the idea that bad experience can deform previously good adult character, American psychiatrist are in good company. They express an old and prestigious philosophic position, tracing its roots to Plato and the Roman Stoics and through them to Kant and Freud. It is both unscientific—*and wrong*. Bad enough experience can deform previously good adult character.[13]

Most psychiatrists, aspiring to be culture-free and objectively universalistic in their abstract constructs, "don't go there" when sitting on committees and drafting diagnostic manuals. The same psychiatrists, when sitting across from any of these patients, will probably be sympathetic, helpful, and willing to bend the diagnostic criteria a bit, just to help these suffering souls. That's not a healthy situation.

It has been a pleasure speaking with you and I appreciate the opportunity to speak my mind. May only good come from your efforts.

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[13] Philosopher Martha Nussbaum has shown how contemporaries of Plato, the father of this philosophic assertion, rejected it. See her Epilogue, "Tragedy" to *The Fragility of Goodness.*

But what if nobody dies, no one is maimed? Should the nosology acknowledge moral injury when what is at stake is "merely" social honor? Sociologist Orlando Patterson has described the social processes of enslavement as "social death." Lamentably the phenomenon of enslavement is all-too-prevalent, despite the world-wide end to public, legal, chattel slavery. Virtually everywhere we find prostitution and human trafficking, there is enslavement. In American prisons, the more brutal prisoners literally enslave the weaker ones, often with the connivance of the overstretched prison authorities. In a 1997 symposium on enslavement I compared Patterson's social process analysis and showed them to be virtually identical to Herman's description of conditions of "coercive control" that produce the multiple personality changes that she termed "complex PTSD." (The symposium handout making this comparison is attached.)

Mention of prostituted women and prison tier denizens may allow those familiar with these settings to say, "But in both there is a threat of death, a threat of violence, or repeated witnessing of same against others that brings it squarely under DSM PTSD." But what if the "social death" consists of a non-violent, but comprehensive loss of social position, relationships, and resources, such as the National Guardsman who is sole support of his family, and during a much-longer-than-promised deployment loses his respectable job, house, car, and marriage? Or the academic who loses his funding and laboratory after being slandered by a senior colleague?

Handout for ENSLAVEMENT: CULTURALLY/HISTORICALLY WIDESPREAD SOCIAL PROCESS WITH BROAD TRAUMA RELEVANCE

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CHARACTERISTICS OF SYSTEMS OF COERCIVE CONTROL[14]

Summarized from Judith Lewis Herman, *TRAUMA AND RECOVERY.* New York, Basic Books, 1992. Chapter 4.

Level I — Resocialization

Barriers to escape
Control of body and bodily functions
What and when to eat
When, where, how much to sleep
Manipulation of body form (what to wear, body weight, haircut)
When and where to urinate and defecate
No privacy of bodily functions
Prolonged daily contact with power-holder in the group
Combination of enticement, force, intimidation
Power-holder as source of small rewards, comfort, and approval
Inconsistent, unpredictable, capricious, enforcement of rules
Monopolization of communication, resources, control
Secrecy regarding some activities and events
No alternative to seeing world through power-holder's eyes
Required repetition of buzzwords, songs, slogans, clichés, even if inwardly disbelieved, rejected

Level II — Breaking

Terror and helplessness
Loss of communication with all others outside
Conviction that others have forgotten or betrayed you
Renunciation, destruction of symbolic tokens of connection to others
Inconsistent, unpredictable, capricious, and violent enforcement of rules
Threats to close comrades
Debilitation by sleep-deprivation, starvation, exposure, drugs, alcohol
Paradoxical attachment to power holder as savior
Violation of own moral principles
Participation in sacrifice, victimization of others
Participation in immoral, disgusting, illegal practices
Betrayal of own basic human attachments
[Branding, tattooing, scarification]
[Serial rape]
[Other injuries and body invasion]

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[14] From *Achilles in Vietnam: Combat Trauma and the Undoing of Character*, pp150-152 By Jonathan Shay, M.D., Ph.D.

ENSLAVEMENT UNIVERSALS

Summarized from Orlando Patterson, *SLAVERY AND SOCIAL DEATH: A COMPARATIVE STUDY*. Cambridge: Harvard University Press, 1982. Page references in [].

- Slavery represented as **substitute for death** in war, execution, and destitution [5]
- Natal alienation defined: no claims on parents, no rights in children, no sanctity of matrimony [6]
- Dishonored in a global, pervasive, generalized way [10]
- In slave systems, slaveholding **always** accrues honor to the master [11] and usually accrues honor to non-slaveholding freemen [cf. "bystanders" in trauma literature]
- "Slavery is the permanent, violent domination of natally alienated and generally dishonored persons." [13]
- Two types of slavery—conceived as external enemies who have been subdued [intrusive 39ff], or internal people who have "fallen" through criminality or destitution [extrusive 41ff]. "We may summarize the two modes of representing the social death that was slavery by saying that in the intrusive mode the slave was conceived as someone who did not belong because he was an outsider, while in the extrusive mode the slave became an outsider because he did not or no longer belonged….One fell because he was the enemy, the other became the enemy because he had fallen." [44]
- Rituals of enslavement [52ff]: forced symbolic rejection by the slave of his past and his former kinsmen [53f]; a change of name [54ff]; imposition of some visible mark of servitude [58ff]; shave head face or pubic hair [60f]; assumption of a new status in the household or economic organization of the master [62ff] Cf. Judith Herman, "Systems of Coercive Control"
- Honor and degradation [77ff]; Generalization: Slaveholding increases emphasis on honor throughout the slaveholding society, even among non-slaveholders [85ff]; Sambo degraded man-child ideologies in many cultures and eras [96f]
- Hegel and the dialectic of slavery [97ff] O.P. disputes the "existential dilemma" of the slave master relationship because the retinue of slaves increases the master's honor in the eyes of the **non-slaveholding** segment of the free population. Historically and cross-culturally this is sometimes the only function for the slave who may have no economically productive role. Societies where there are only masters and slaves are *extremely rare* and apparently unstable.
- Original sources of slaves [105ff]: Capture in warfare; Kidnapping; Tribute and tax payment; Debt; Punishment for crimes; Abandonment and sale of children; Self-enslavement (usually to avoid starvation or being killed by third party); Birth
- Slave trade [149ff] may have been the earliest long-distance trade, long distance being barrier to running away as well as increasing sexual exoticism
- Condition of slavery [172ff]: Totality of master's power in private is supported by public processes, customs, laws, attitudes; Absolute sexual access; Injure with impunity; Kill with impunity; Slaves punished more severely than free for comparable infractions