

A Band Around the Heart: Trauma and Biology

For the covertly depressed man, what lies at the center of the defense or addiction is the disowned overt depression he has run from. And in the center of the overt depression lies trauma. For some men the underlying injuries are blatant and extreme. For others, they are seemingly mild, even ordinary. And yet, for both, the damage in their capacity to sustain connection to themselves and others may be severe. No matter if the injuries have been quiet or loud, depressed men carry inside a hurt, bewildered boy whom they scarcely know how to care for. The moment of contact with that disavowed pain is the first step toward restoration.

"A lot has happened this week," Michael lets us know, before I even have time to close the door behind him and sit down in my chair. He has come a few minutes late to Wednesday night men's group, a gathering of eight men that I have facilitated for close to three years. Old members sometimes leave this group. New members arrive. A core of four have remained. I invited Michael to join us about four weeks ago and his entry has been edgy.

"I need to talk," Michael repeats. About forty-five, he is small and wiry, with an anxious, pointed face and dark, curly hair. His large, cornflower blue eyes bear down on me, searching, hungry. When I resist the impulse to turn away, the eyes meeting mine are opaque. There is no doorway into them. Even without other clues, those greedy, unreceptive eyes would give Michael away. The

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other men in the group instinctively draw back from him, perhaps without knowing it or wondering why. But I know why. Michael is intrusive and walled off at the same time. He pushes past other people's boundaries but then doesn't accept what they offer. His need to control, this combination of urgency and rejection, is difficult to live with, and his wife, Virginia, decided a few weeks earlier that she no longer wished to try.

I had seen them as a couple only twice before Ginny broke the news to him in my office one morning. When he heard it, Michael just doubled over in his chair and sat motionless with his head in his hands.

"Michael?" I asked. "Mike?"

He didn't cry. He didn't yell. Even when Virginia told him that she had been sleeping with another man for over a year, and that she was leaving to move in with him, Mike remained calm. They had a quiet discussion about what to say to the kids and agreed to fine. No surprise, really. He'd sort of known all along. Yes, he would call me if he needed to talk.

Michael did telephone early the following morning. He called to tell me about the handgun he'd purchased just after our last session. He spoke in whispers because the kids were still sleeping upstairs and he didn't want to disturb them. Mike and I, two avowed Massachusetts liberals, shared our sense of dismay that one could obtain a pistol so quickly even in staid old Boston. He told me the details of obtaining the gun. I asked whom he intended to use it on. At that, Michael grew cagey, ironic. "If I had any balls," he told me. "I'd use it on that homewrecker."

"Homewrecker," I thought. Such an out-of-step, Hollywood word. A word from another generation.

"But then again," Michael continued, "if I had any balls, I wouldn't be in this mess to begin with, would I?" I didn't respond. "Being the schmuck that I am, I'll no doubt take it out on myself if I use it on anyone."

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"Are you thinking about doing that?" I asked him.

"I'm thinking about it, sure. Thinking about it."

"Where's the gun now?"

"I'm holding it," he told me. "Looking right at it. You know," he confided, "I really like the feel of it in my hand. Heft. It has heft."

"Michael, you're gonna scare the shit out of your kids if they walk downstairs and see you like this."

"I know," he sighed, petulant. "To tell you the truth, that's why I called. To tell you the truth, I think it may be the *only* reason I called."

"How about you put the gun away in a drawer?" I said.

"Fine," he replied, without a hint of struggle, as if he'd been waiting for me to tell him to. I could hear the drawer open and close. "You know, I never even bought bullets for it," he said.

"Probably wise," I answered.

We arranged for Michael to go with his brother to a local emergency room. His sister-in-law took the kids and his brother took away the gun. The emergency room psychiatrist evaluated Michael and decided to hospitalize him for a few days in order to start him on medication and check for suicide potential. Michael cooperated and was quickly released. The immediate storm had passed. As thoughts of suicide receded, overt depression settled in on Michael like a tough case of walking pneumonia. He couldn't sleep. He couldn't eat. He couldn't concentrate enough to work or even to drive without getting into an accident.

Like a lot of men, Michael, while appearing independent, had staved off his covert depression with his relationship. Along with the trauma of his wife's news and his grief for his marriage, Michael was in the acute phase of withdrawal from love addiction. His defense against underlying depression had just walked out with another man.

Antidepressant medication helped Michael once it "kicked in." I also allowed him to transfer some of his dependency from Ginny to me, meeting with him two or three times a week to help see him through the crisis. While I wanted him to survive it, I was in no hurry to take the crisis away. Working with covertly depressed

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men has taught me to respect crisis as a potential ally. It had taken Michael forty-five years to come unglued. While I wanted to help put him back together, I didn't want simply to return to the old status quo. If he was going to suffer the pain of this tumult, then at least he could make good use of it. In six weeks' time, Michael had "stabilized" enough for our real work to begin. I suspected that the combined support, wisdom, and confrontation of other men might help him along, and so I invited him to join us.

"I have a *lot* to tell you," Michael repeats, ignoring the other group members, impatient that I have taken so long to sit down. The other men shift in their chairs. Most are veterans of this process. They have some recovery on board. They know how to wait. Michael leans forward on the very edge of his seat, his clasped hands dangling between his spread legs, as if he were leaning over the side of a boat. He has pulled his chair to only a few inches away from mine and shifts his weight to get even closer.

"Michael," I say after backing my chair into the wall. "One of us is going to have to move or I'm going to suffer from short air supply." "Huh?"

"Move your chair back," I request.

Annoyed, Michael pulls his chair back a full half inch and begins launching into his story.

"Further," I tell him.

Two inches.

"Here." I get up from my chair, ask him to rise, and place his chair at a distance I feel more comfortable with. "Sit down and lean back," I tell him. "If you got any closer, you'd spill off the seat."

"Okay," he says, breathlessly. "Now, where was I—"

"How do you feel, right now?" I interrupt.

I watch his jaw clamp and the tips of his ears turn red with anger. "Fine," he tells me. "Fine. I'm fine. I just want to get started."

"We already have."

"I don't really see—"

"Why your needs shouldn't take precedence over mine?" I ask.

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Cornered, he wails. "I want *help!*"

I sit down again. Take a breath. "I'm giving it to you," I answer. "This is it."

"Michael, what is all this about, do you figure? This getting right up into my face business? All this urgency about getting things started? What do you think's going on for you in a moment like that?"

"I don't know," he says.

"Well, this is therapy, think about it," I tell him.

He shakes his head.

"What did you feel?"

"When?"

"Now."

"Frustrated," he moans.

"Frustrated," I think. One of those favorite male words for feeling, like "interesting." "Doc, I was frustrated when the plane went down and it was interesting when my leg got crushed."

"Can I help?" I ask.

"Sure."

"Okay, here's what you're feeling. I imagine that you feel pissed. Obstructed. Unlistened to. Uncared about. Like I was going to do what I wanted no matter what your needs were. . . ."

Hearing me, Michael almost begins to smile. "I can see this one coming from down the block," he says.

"Imagine," I conclude, "that you felt controlled."

"How did I know?" he says. He smiles, and so do some of the others.

"Well?" I ask. "A little control struggle here, do you think?"

"You mean, 'control,' as in that force by which I managed to push away my wife and ruin my family? The force I wake up to and lie down with each day? *That* force?"

"Michael."

"Yes?"

"You are what we call, in the technical language of modern psychiatry, 'a quick study.' "

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"Thank you," he sighs.

"Yes," I say, softly. "That force. The one that's trying to destroy you."

Michael looks up at me with his blue, dead eyes and begins to cry—or, as he later put it, liquid leaked from his eye sockets. "I'm sick of this," he laments. "I'm really so fucking sick of this."

I hand Michael a box of tissues. He shakes his head and wipes his face with his sleeve.

Even though Michael was hard to comfort, even though it was difficult for me to feel touched by him, the grief he experienced at that moment was real. It was pain about the pattern he was caught in and its cost. Underneath that, however, I suspected there were deeper and earlier wounds. Michael was raised by upper-class German Jewish parents whom he would have described, before this crisis, as "Fine. Just fine." But as Michael learned to probe a bit deeper, his parents emerged as more than just fine. They were perfect. They lived in a perfect little house that was perfectly decorated. They enjoyed perfect health, perfect friends, and a perfect marriage. But nothing was more perfect than Michael himself—a "straight A" student, a Harvard undergraduate, a young entrepreneur with his own business, a lovely wife, two beautiful kids. And a year's worth of cuckoldry that he didn't even notice. It wasn't that Virginia was such an accomplished liar. She had all but left her journal open for his bedtime reading. Michael never bothered to wonder where his wife had gone for whole evenings at a time, because he was so busy leading his perfect life that nothing as messy as marital dissatisfaction ever dared cross his mind, even when his wife began flying into occasional violent rages. In such altered states, Ginny hurled dishes against walls, terrifying the children. A few times, Michael succeeded in calming her down only after he called her mother to drive over and help him contain her. My wife, family "Beware of 'nice' men with 'bitchy' women." In Mike's marriage, as in his childhood, underneath the dust-free tables, the flower

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arrangements, and tasteful collections, lay wellsprings of emotional violence. In many ways, Virginia's eruptions served the marriage like a blessed storm, releasing tensions too suffocating to endure.

Michael was blissfully unaware of the impact he had on others. He moved Virginia around, nicely, politely, as if she were another art piece he had to sweep under. He moved her with that same implacable urgency he had leveled at me when I hadn't jumped quickly enough for him. Being on the receiving end of Michael's impatience, I knew something about the quality of the force he projected, which escaped him. I knew how mean it was. In small, nuanced ways, Michael was an effective tormentor. Sooner or later, any woman in her right mind would find herself unwilling to stay with him.

With the group's permission, Michael comes to sit next to me as he has seen others do. He closes his eyes and breathes deeply, allowing me to guide him into light trance.

"What are you feeling, now, as you sit there?" I ask.

"Nervous," he says.

"Nervous? Okay, and where is that in your body? What is the physical sensation connected to that?"

"It's here"—he points to his stomach—"like, all tied up in knots."

"It's tight? Constricted?"

"It's like a band," he says. "A band around my chest, my heart," and he begins to weep.

"You're feeling some pain?" I ask.

He nods again. He is having trouble catching his breath. "And fear," he says. "A lot of fear."

"In that band?" I ask.

"And here," Michael points to his throat. "I can't breathe," he says, starting to gasp. The other men lean forward, a little alarmed.

"Keep breathing," I tell him. "Deep breaths, nice and slow." He is still in trouble. It looks as though he may be at the beginning of an anxiety attack. "Okay," I say. "So, you start to feel some pain, keep breathing, Mike. Some pain comes up and some tears and then your throat constricts and there's fear?"

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He nods, unable to speak.

"Right, so, a part of you starts to feel some of the pain and then another part starts to fight it?"

He nods again.

"Okay. That's fine, keep breathing. Listen, you don't have to perform for anyone here. If you cry, that's okay. If you don't cry. Whatever. . . . Can you hear me?"

He nods, settles down. His breathing returns to normal.

I begin to question Michael about his family. I ask him to look up at each parent in his mind's eye and describe them as they looked to him as a child. Initially, his recollections are vague. Then he begins to talk about his mother's rage. As the images coming to him take on more weight, more detail, Michael finds it increasingly difficult to talk.

"How old are you now?" I inquire.

"Seven," he answers. "Eight."

"What do you look like?"

"I can't breathe," he says.

"Take your time," I say. "When you're ready, say what you look like."

Michael begins to remember the yelling—dishes thrown, epithets hurled. As the memories crowd in, anxiety crackles around him like an electric field. Finally, Michael begins to remember it all.

"What do you see?" I ask him.

"I'm running," he answers slowly, concentrating. "She's chasing me."

"What does she look like?"

He shakes his head.

"Look at her."

"I don't want to."

"You're afraid?"

He nods.

"Try," I urge. "What do you see?"

"She's drooling," he says. "Jesus." His eyes squeeze hard and he turns away.

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"Drooling?" I ask. "She's, like, foaming at the mouth?"

He nods.

"What's that like?"

"It's ugly," he says. "Frightening."

"Go on."

"There's a knife. . . . My God."

"Go on, Mike."

"She used to do this!" he cries out abruptly. "She used to do this to all of us."

"Say it."

Eyes still closed, he shakes his head. "She's saying that she's going to kill me. If she catches me, she'll . . ." Michael begins to cry, strangled gasps.

"Breathe," I tell him, bending him forward. "Put some noise into it. Go 'Boo-hoo.' Don't choke it off."

A flood of sobbing breaks over him. "Good," I say. "Good, Mike. Let it release."

The sobbing stops abruptly and Michael begins hyperventilating.

"Breathe," I tell him. "Can you talk?"

He shakes his head, gasping, trembling. To the other men, I know, it must look as though he's heading into convulsions. I hold him tightly, one hand on his shoulder, the other pressing up against his knee. I begin talking him through it. "This is called a body memory," I tell him. "It looks frightening. It sometimes happens when you reexperience an old trauma. You're in it. A dissociated memory is breaking into consciousness. Keep breathing. Keep focused on my voice, Mike, like a beacon. Can you hear me?"

He nods.

"Good. This will wash over you. Concentrate on your breathing. Send breath to that little eight-year-old inside you. Breathe, Michael. Good." It takes a long, frightening ten minutes. I talk, he listens. "You're remembering something?"

He nods.

"Good, we'll get to it. Just focus now on your breath." Finally, the racking begins to subside. Like a storm passing, slower, gentler, the gasping and the trembling recede. "You did it," I tell him. "You

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made it through." Michael first smiles and then begins to cry—clean, uncomplicated tears.

"What have you remembered?" I ask him.

"When I would cry," he answers in the tiny voice of a vulnerable child. "When she would be like that. When I would cry, she would put her hand over my mouth and hold my nose."

"You mean she would block the air?"

He nods.

"She would smother you?"

He nods.

"Until what?" I ask. "How would it end?"

He shrugs. "I don't know. I think I'd pass out."

"I see." I tell him. "So, when you started to reconnect with that boy inside, when you started to feel the pain, you reexperienced the smothering."

"I was choking," he says, almost apologetically.

"I know," I say. "I know you were."

A few minutes later, Michael shares with the rest of us an image that comes to him, of the little eight-year-old. He has run out of the house, into the woods. He sits on a huge rock, the same one every time, waiting for dark and his father's return and safety. He tells himself stories, he makes up little plays. Mostly, what Michael remembers is the cold, since he would often run off with no jacket.

As the men give Mike feedback, Billy expresses the thought that had been uppermost in my own mind. "I'll say this," he tells Mike. "I have a lot more respect than I did when I walked in here tonight about why you need so damn much control."

Carl leans forward to catch Michael's eye. "Welcome to the group," he tells him. "I'm glad that you're here."

"So much for the perfect family," offers Tom.

"I knew that was bullshit," Michael begins, but I cut him off.

"Just listen," I tell him. "Let these men nurture you. Just take it in."

For a brief moment, Michael closes his eyes. He sighs, and then wills himself to lean back in his chair. That moment is his first conscious act of recovery.

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"The mass of men lead lives of quiet desperation." Others, not so quiet. Michael's story is bold and dramatic; others are far more subtle. But the dynamics of depression in men remain the same. Helping a covertly depressed man like Michael requires peeling back the layers of the disorder. First, the addiction must fail, as it did in Mike's case when Virginia left him. The defense against the depression must either give out or else create so much trouble that the man is sent to me by those around him. He is sent by the wife who can no longer abide him, or by the employer who can not make him produce, or, in the most extreme cases, by the courts.

If the compensatory moves can be stopped, the underlying depression will stream up to the surface. Sometimes, this transition is so violent that the first priority is simply surviving it. If the man has been self-medicating with drugs or alcohol, as is often the case, he may also be in acute substance withdrawal. Hospitalization may be required. Twelve-step programs are often a help. With or without substance abuse, once the defenses of covert depression stop, unleashed pain often sweeps over the man with the intensity of a force long denied.

Since Freud's first formulation of depression as a kind of mourning, most psychological theories about the disorder have focused on the role of early childhood injury and loss. Psychiatrist Rene Spitz coined the term *hospitalism* when he studied the relationship between depression and early deprivation. Spitz studied infants housed in large orphanages with little emotional nurture, who showed signs of severe "failure to thrive syndrome." They were listless, made poor contact, had little interest in their environment, and were prone to illness. Many were so apathetic that they would not eat. A few came close to death. Although these infants were adequately fed and medically cared for, they were not emotionally stimulated or loved. Whereas such an extreme lack of nurture produces immediate results, less extreme forms of loss or failures in

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nurture may lay the foundations for later depressions. British child analyst John Bolby detailed case after case of childhood vulnerabilities resulting from even relatively minor disruptions in parental contact. In a classic documentary, Bolby's colleagues filmed a seventeen-month-old boy's reaction to his parents' two-week absence. The documentary follows the boy as he moves through the stages of traumatization: denial, protest, and despair. In the course of two weeks, this initially robust toddler moves from apparent calm to angry regression and then to apathy, as he curls up in a corner of the playroom. The documentary's final moment shows the parents' return. While the boy runs into his mother's arms, the camera closes in on his face, frozen in an expression of hostile mistrust. This extraordinary film exposes the kind of slight childhood fissures that later on, under sufficient stress, may crack open.

When compared to the experience of children in Sarajevo, Somalia, or even inner-city ghettos, the wound of a happy, affluent family's two-week absence seems barely the slightest of hurts. Children are enormously resilient, one hears, and life is full of difficulties one must master. Indeed, a child's capacity to survive extraordinary circumstances can seem, at times, nothing short of miraculous. But the vaunted resilience of our children should not blunt our sensitivity to the effects of childhood deprivation. Children will get by, often enough, but at what cost? By most measures, Michael had handily survived his childhood traumas. He was married, successful, the father of two children. But closer inspection reveals the wholesale maneuvers to which he resorted in order to keep his little ship afloat—the controlling, urgent behaviors, the disconnection he felt between himself and his own feelings. Childhood injury in boys creates both the wounds and the defenses against the wounds that are the foundation for adult depression.

Focusing on the importance of childhood experience does not stand in opposition to an increased understanding of the role biology plays in depression. Advances in physiological research finally seem at the point of concluding the age-old debate about "nature versus nurture." When I first trained twenty years ago, an enormous

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amount of attention was paid to distinguishing between two types of depression, one biological, the other not. This distinction had several names: major versus minor depression, biological versus neurotic, endogenous versus exogenous. The remnants of this old distinction still survive today in the DSM IV diagnoses "major depression" and "dysthymia." Traditionally, "major depression," often seen as "real depression," was thought to derive from a chemical imbalance. Considered to be a genetic disorder, it demanded medical intervention in the form of drugs or electroconvulsive therapy. The less serious disorder, "minor" or "neurotic" depression, was a reaction to life's stresses and was treated with "talking therapy."

Though the distinction between major and minor depression (now called dysthymia) still exists in the official nomenclature, in practical terms it has all but disappeared. The only real contrast between the two disorders is that major depression is more acute and severe than minor depression. It is simpler and more effective to think of them as one condition occurring along a spectrum of severity. Many patients who suffer the eruption of an acute severe depressive episode also have a chronic baseline of mild depression. Studies following patients with both disorders have shown that while "major" depression may be more severe in the short term, dysthymia may have devastating long-term effects. Patients suffering from dysthymia over the course of their lifetime prove harder to treat and have a higher recidivism rate. In addition, the overall economic and quality-of-life costs to these patients turns out to be, if anything, greater than it is for those who contend with depression in its more dramatic form. The relief afforded by Prozac and similar drugs to millions of people suffering from dysthymia further challenges the idea that "minor" depressions are not "biological." Prozac is no more effective than earlier antidepressants when treating classic "major" depression. Where it shines is in the relief of the "minor" conditions that earlier medications did not help much. The distinction between major and minor depressions, biology and character, seems to be breaking down.

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Close to a year after Michael's first inclusion in our men's group, he was ready to invite his parents to a week of family therapy. With extraordinary care and courage, Mike, aided by his two sisters, confronted his mother about her periodic bouts of irrationality. After initial protests, Anna admitted what everyone in the family had known for years—that for a decade she had been addicted to prescription drugs. Anna sincerely did not recall her wild brutalization of her children, now openly discussed for the first time, but she did remember frequent blackouts from the drugs. Two months after that family session, Michael flew with his mother and father to Hazeldon hospital in Minnesota, where Anna fully "detoxed" for the first time in thirty-two years. At Hazeldon, the staff gave her a dual diagnosis of addiction and depression, the closest current psychiatric label to covert depression. They also noted a history of both depression and addiction throughout Anna and her husband's family.

Was Michael's covert depression genetic or environmental? From nature or nurture? Inherited or transmitted through trauma? The answer from all but those in the most extreme camps would be, both. For several decades, researchers in epidemiology, the science of tracking the course of disease, have been able to demonstrate that major depression runs genetically in families. By taking close family histories, and by studying identical twins raised in different settings, investigators have shown that there is a strong genetic component to major depression, independent of one's environment. Studies about the genetic basis of minor depression, however, proved far less convincing. Dissatisfied with these results, epidemiologist George Winokur tried factoring into his thymia, alcoholism, and "antisocial personality." He called this *Depression Spectrum Disease*. In all but a few aspects, Winokur's Depression Spectrum Disease is another name for covert depression. Winokur found that as soon as one broadened the scope of resulting brew, Depression Spectrum Disease, could easily be shown to have a genetic basis. Winokur also considered gender dis-

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tinctions in his research. In several studies, he and his colleagues found evidence of a genetic link between depression and alcoholism, with the former linked to women, the latter to men. Winokur deduced from epidemiology what I have concluded from clinical data, that addictions and depression may not be distinct disorders but variants of the same disorder expressed differently along gender lines. Where I differ slightly from Winokur's conclusion is in his equating covert depression with minor depression. Anyone who has struggled with a severe addiction would not agree that his disorder is minor. Covert depression keeps a core depression at bay. One seldom finds major depression and the defenses of covert depression operating at the same time, for the simple reason that the defenses work, at least partially, to keep the depression looking minor. Once the defenses fail or the person stops self-medicating, the overt depression that emerges can look very much like major depression. This was the case for Michael, when his relationship to Virginia no longer soothed him, and for Damien Corleis, when he backed away from sex addiction to his wife. Both of these men were either hospitalized or near to it. The same can be said for William Styron, who was flooded with an utterly debilitating depression once he stopped drinking.

If the research is clear that both forms of depression, overt and covert, almost certainly have a biological basis, then one might wonder why we should concern ourselves with issues of childhood trauma at all. If the disease is simply inherited like other genetic disorders, an exclusive focus on medical rather than psychological issues would seem appropriate. While some researchers do take that position, others passionately counter it. The controversy concerning the question of nature and nurture, therapy or drugs, has been so hotly disputed that even in the midst of his own life-threatening struggle, William Styron could not resist tweaking his helpers about the absurdity of their argument. He writes: "The intense and sometimes comically strident factionalism that exists in present day psychiatry—the schism between the believers in psychotherapy and the adherents of psychopharmacology—resembles the medical quarrels of the eighteenth century (to bleed

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or not to bleed) and almost defines the inexplicable nature of the disorder."

The relationship between biology and psychology has never been as simple as the debate about it would imply. Both sides of the "nature/nurture" argument are wrong. The problem stems from framing the debate as if the influence of biology goes only one way—up, from our bodies to our minds. New research shows that the relationship between brain and body runs in both directions. It has long been accepted that changes in our biochemistry, caused by illness, medication, or intoxicants, can effect our psychological states. But what has been less appreciated, until recently, is that changes affecting our psychological states may alter our biochemistries as well, even the very structures of our brains. Under certain circumstances these alterations can be permanent.

At the State University of New York at Stony Brook, Fritz Henn and Emmeline Edwards looked at the effect of environment on laboratory rats in a series of experiments that were as elegant as they were compelling. First, Henn and Edwards induced depression in a group of perfectly normal rats by giving them small electric shocks from which they could not escape. After an initial stage of protest, the rats eventually "gave up." They became despondent, isolated, and had trouble eating and sleeping. In other words, they displayed many of the "vegetative" (biological) symptoms that people do when plagued with "major" depression. The researchers next found that the brains of these rats had been altered. One part of the rats' brains had grown more than normally sensitive to a certain neurotransmitter, while another part was now less than normally sensitive to it.

Henn and Edwards gave these "depressed" rats the same antidepressants used by people. In about two weeks, the usual amount of time it takes for the medication to begin working, the rats' depressions cleared up. No longer helpless, they quickly learned to press a lever inside the cage and stop the shock. At about the same time, their brain abnormalities returned to normal. The emotional experience of helplessness changed the physiology of these rats and, conversely, a physiological change, medication, cleared up their emotional distress.

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Henn and his colleagues followed up on this experiment by taking a different group of rats and stressing the new group into a state of depression. The same brain abnormality resulted, but this time, the researchers "treated" their little patients without medication. With a technique that mimicked psychotherapy, the researchers taught the rats how to escape their helplessness. A medical student knit the rats tiny sweaters with sleeves that fit over their front paws. A long string was left trailing from the rats' sleeves. By pulling the string, as on a marionette, researchers could coax the rats into pressing a lever, teaching them how to end their shock. As the rats learned to gain control over their circumstances, much as psychotherapy patients learn how to gain control over theirs, the rats' depressions subsided, and so did their brain abnormalities. Environmental factors produced changes in the brain that were reversed with equal success by altering the rats' neurochemistry and by affecting their learning. The relationship between physiology and psychology, body and mind, appears to be a reciprocal one. The wounded eight-year-old that Michael visualized and began to nurture that evening in men's group may exist not only in Michael's mind but also in his neurology.

A substantial and growing body of research teaches us that early childhood trauma and loss will have, as one researcher stated it, "lifelong psychobiological consequences." Primate infants who are separated from their mothers have been shown to have abnormal changes in levels of the brain neurotransmitter serotonin, a chemical whose imbalance has long been associated with depression, and which is affected by Prozac. Adrenal enzymes also change with maternal separation, as do blood cortisol levels, heart rate, body temperature, and sleep. Researcher Bessel van der Kolk notes that: "These changes are not transient or mild, and their persistence suggests that long-term neurobiological alterations underlie the psychological effects of early separation." In several experiments monkeys who suffered early isolation apparently adjusted well under normal circumstances, but proved to be markedly more vulnerable to both physical illness and severe depression when placed in a challenging situation, or faced again with loss. Antidepressant

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medications ameliorate or even reverse both the physiological signs and the behavioral changes that accompany early maternal separation in monkeys, leading some biologists to speculate that early maternal deprivation in monkeys might prove a good working model for depression in humans. These observations have implications for our understanding of addictions as well. If early maternal separation produces upset in monkeys, opioids, like morphine, relieve it. In fact, no substance has been shown to be more effective in alleviating such distress. Monkeys that had been isolated in youth display increased sensitivity to amphetamines and opioids, as well as increased alcohol consumption, when compared to normally raised controls. And these changes accelerate when the monkeys are put under stress.

Research on the biology of trauma is beginning to teach us that even apparently mild childhood injuries can produce lasting physiological change. But the harmful effects of trauma often go unrecognized. As a culture historically dominated by male values, we have always tended, and still tend, to deny vulnerability, and consequently, to deny the existence of trauma. Sigmund Freud was the first psychotherapist on record to document patients' reports of childhood trauma and sexual abuse. In one of the most famous mistakes of the twentieth century, Freud decided that his female patients, often daughters of friends and colleagues, were lying. Freud states flatly that his mind would not accept the idea that the decent men he knew could do the things these young women reported. Consequently, he did what most of us have done throughout history when faced with trauma survivors: he disbelieved and blamed them.

The issue of trauma did not surface again until tens of thousands of "shell-shocked" soldiers forced us to consider the topic once more during World War I. At first, we tried to deny the reality of psychological injury, blaming physical injury instead. The term *shell shock* derives from the mistaken theory that the distress occurs as a result of a concussion from explosives. When it became clear that our soldiers were not physically but emotionally overwhelmed, the typical response took over. We blamed them. The

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public rhetoric shifted from the language of medicine to the language of moral weakness. Shell-shocked soldiers lacked "fiber." They were frail malingerers or, more bluntly, cowards. The new medical specialty of psychiatry, brought out of relative obscurity into the mainstream because of the need to treat these combat veterans, dressed up essentially the same sentiments in technical garb, offering the picture of the "neurotically susceptible" "infantile" male. Not until the grassroots movement of Vietnam veterans forced the medical establishment to stop blaming the victim, did we as a culture acknowledge for the first time that any man, no matter how "well adjusted," could be overwhelmed if subjected to enough stress. The new diagnosis of *post traumatic stress disorder* was born.

As with depression, we tend to give credence to only the most extreme forms of trauma. We are no longer surprised, as we might have been a generation ago, to learn that virtually all of the men interred in notoriously cruel Japanese prisoner of war camps during World War II still have psychological symptoms close to fifty years later. We now grasp the lasting effects of such public, catastrophic injury—political captivity, torture, earthquakes, floods—just as we grasp the long-term effects of severe and blatant child abuse. But we are still reluctant to accept trauma or abuse in its subtler forms. And yet disqualifying the pain of subtler hurts ignores the fact that the most obvious injuries are not necessarily the ones that do the most harm. The flagrancy of childhood trauma does not always directly correlate with the extent of later damage.

The occasional brutal attacks Michael remembers irresistibly command our attention. But the compelling image of that boy chased with knives obscures the reality that on the other three hundred and sixty-odd days of the year Michael lived in a perfectionistic, constricted, mind-numbing atmosphere. Which of these two environmental forces, one deep and dramatic, the other ordinary and chronic, did him most harm? There is no simple answer.

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Compared to what we usually think of as dramatic trauma, the kinds of injuries most boys sustain as an accepted part of growing up male tend to seem relatively mild. But I believe that the more we learn about the effects of childhood trauma, the more plausible the existence of such damage becomes. While it is true that children can be remarkably flexible, the research on the biology of trauma reminds us that, when compared to adults, they are nevertheless still delicate. And relatively delicate injury may harm. Stereotypically when we think of trauma, we think of the public catastrophic events that can overwhelm an adult, what some trauma experts called "Type I" trauma. But what most distinguishes childhood trauma from occurrences like combat stress is simply that the injury occurs to children. "Be kind to me, Lord," reads the epigram for the National Children's Defense Fund, "My boat is so small and the sea is so wide." A child's personality and his neurology—the little boat he must navigate in—are still developing. Relatively mild childhood injury can have long-lasting effects because it occurs while the very structures of the personality, body, and brain are being formed—or malformed. A growing body of evidence indicates that a heightened state of arousal—the body's inherent "fight or flight" reaction to stress—in small children may have permanent physiological consequences. Stressed children have a harder time modulating feelings, negotiating conflict, and "settling down" than other children, and this seems particularly true for males who appear, if anything, even more sensitive than females to injury or deprivation.

When a child is injured by his own caregiver, as is overwhelmingly often the case, danger is delivered to the child by the very persons he depends and relies on for protection. This tragic dilemma sets up an excruciating bind that lies at the heart of the child's trauma experience—the desperate need to reestablish a loving connection to his or her own abuser. When Michael sat shivering alone on his rock in the woods, the thing he remembered fantasizing about most was the theme of magic rescue. He, the brave prince, would swoop down upon the evil castle with ray guns of love and rescue

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the frozen princess. At forty-five years old, it had not occurred to him, until I pointed it out, that the frozen princess he so wished to liberate was his own addicted mother.

Finally, unlike adult trauma, childhood damage may not result merely from violation. Most of the animal research does not concern early assault so much as early deprivation. In working with traumatized men, I make a distinction between *active* versus *passive* injury. *Active trauma* is usually a boundary violation of some kind, a clearly toxic interaction. *Passive trauma*, on the other hand, is a form of physical or emotional neglect. Rather than a violent presence, passive trauma may be defined as a violent lack—the absence of nurture and responsibilities normally expected of a caregiver; the absence of connection. In an instance of active trauma, a boy might come home with a badly scraped knee and torn, bloody pants only to have his father scream at him for ruining his clothes. In an instance of passive trauma, a boy would show up with a badly scraped knee, and the father would promise to be there in a moment only to stay on a business call for another ten minutes while the boy waits beside him, bleeding. When we think of childhood trauma, we tend to think first of active trauma, although it is extreme neglect that causes the majority of the cases of children being taken from their homes. While there are no reliable estimates of the prevalence of even extreme passive trauma, most domestic violence experts estimate it occurs at least twice as frequently as active abuse. Richard Gelles, a pioneer of violence research, estimates that one in eleven children—4 to 5 million each year—suffers some form of extreme neglect. Just as with active abuse, however, issues of neglect do not need to be extreme to cause harm. And, just as with active trauma, passive trauma may be psychological as well as physical. Good parenting requires three elements: nurturing, limit setting, and guidance. A parent who is too absorbed to supply any one of these neglects the legitimate needs of the child. My client Ryan brought that point home to me one Wednesday night group.

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When it is his turn, Ryan "checks in" with the tale of a "small roadside epiphany." Coming home from a party, Lilly, his wife, expressed anger and hurt at the way Ryan, affectionate in private, would frequently "disown and shun" her at public gatherings.

"She told me it felt as if I wanted to act like I didn't know her," Ryan tells us. "In the past, I would have gotten defensive and probably started a fight, but this time I was so . . . I don't know, so stunned. Because I knew she was right, you see. I pulled over on the side of the road and shut off the car." With a few years of therapy behind him, Ryan allowed himself to recognize not only the truth of Lilly's account and the pain it caused her, but also his own feelings and remembered associations. Ryan's parents rarely demonstrated physical affection for one another and, while they had shown physical nurture to him as a young boy and still did to his sister, they stopped displaying such affection for him at the age of six or seven.

Sitting on the side of the road, Ryan recalled a vivid memory of himself as a boy of seven or eight, crying hysterically in the middle of the kitchen asking for a "pickup," while his family bustled around him preparing dinner as if he simply wasn't there. "It was as though my parents made a decision one day to stop, although I'm sure they didn't because they didn't talk about things like that. I don't think my father touched me again, except maybe once or twice every few years he would totally lose it and throw me against a wall. I think that was it."

I lead Ryan through a quick guided imagery exercise, asking him to close his eyes and see himself lifting his own infant son in the air and laughing together, a scene he had described many times to the group. I ask him to note the joy, the sheer pleasure in each of their faces. Then I ask him to imagine himself as a child being touched with such joy by his own father. Ryan begins to cry, softly, silently. "That was your birthright," I tell him. "His thrill to be with you. You deserved that." Beside Ryan, Tom also begins to cry quietly. When I ask what triggered his feelings, he recalls that on the afternoon of his MBA graduation, his father hugged him and said he loved him for the first time in his life. "I was twenty-six

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years old," he muses. "Even a BA wasn't enough to get it out of him. I had to earn a fucking graduate degree." Tom smiles ruefully, tears still in his eyes. "If I'm still in this damn group when I have a child, I swear I am going to tell that precious creature I care about him or her at least once a day, do you hear me? At least once a day. If I don't, you can drag me out of the house and knock some goddamn sense into me."

Categorizing such neglect as trauma does not trivialize the nature of trauma. I think not touching a child for decades at a time is a form of injury. I think withholding any expression of love until a young boy is a grown man is a form of emotional violence. And I believe that the violence men level against themselves and others is bred from just such circumstances. Ryan first came to therapy after a year of alcohol abuse and several instances of hitting his fiancée. He lost the relationship but, with my help, entered treatment for his drinking and underlying depression. When Tom was referred to me for a consultation, he was suicidally depressed and on the verge of an emergency hospitalization. These men are not whining. Their injuries are not shallow. Minimizing their distress is not merely wrong; it is dangerous.

And yet, as a father of sons myself, inculcated as much as anyone else by the mores of masculinity, I know firsthand how easily we slip into the passive traumatization of boys.

Justin, my five-year old son, is very proud to have me, rather than his mother, attending his ice skating lesson. This is his eighth week and the first and only time this season I can free my schedule in the middle of a working day to be there.

Skating has been hard for him. Very athletic, Justin is used to sports coming easily and unused to having to work at something. He dislikes doing things badly, even from the start, and his mother has had to push him to keep him on the ice. I thought he had conquered his fears and shame. But now he appears to have regressed again, perhaps because I am there instead of Mom. He skates over to me and says he wants out of the lesson. His feet hurt, he complains. His shoes don't feel right. Thoroughly embarrassed in front of the other parents, I stand firm, nicely but clearly insisting that

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he "Go back out and try." Finally, he just sits down on the ice at the side of the rink and cries. Begrudgingly, I go and gather him up. Imagine how I felt when I pulled off his skates and found two nickel-sized blisters, one on each heel. In my rush to get him dressed on time, I had put his skates on the wrong feet.

Parents are human, myself included, and may this be the worst thing that ever happens to Justin. But nevertheless, one needs to ask, I needed to ask, "Would I have been as firm and unsympathetic to a daughter?" I honestly think not. When I ignored Justin as he sank lower and lower into despair, I abandoned him. Not lurid and awful, it was nevertheless the kind of abandonment that boys experience frequently. Studies indicate that from the moment of birth, boys are spoken to less than girls, comforted less, nurtured less. Passive trauma in boys is rarely extreme; it is however, pervasive.

The band Michael erected around his heart might well have been a necessary reaction to the extraordinary, unacknowledged threat to his life. This would fit the classic definition of Type I trauma, the kind so out of the bounds of the ordinary that it shatters our basic assumptions about life and safety. And yet Michael's band around the heart might just as equally have been the result of the persistent erosion of connection to self that characterized much of his ordinary life, and much of the ordinary life of many boys in our culture. This is Type II trauma, chronic and persistent, which occurs when childhood structures first form. Both types of trauma probably left their signature in Michael's body, his neurochemistry, perhaps even the structure of his brain, exacerbating what may have already been an inherited vulnerability to depression.

Six months have passed since I first met Michael and Virginia—four months since he came into the group, and two since he flew with his mother to her first treatment. He shows me a letter she has written to him:

I look back in horror, as the recognition of what I have done can no longer be held back, not even from myself. I don't know how I will ever forgive myself. I don't dare even think about asking for

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you or your sisters' forgiveness. It's like waking up from a bad dream, except that it's infinitely worse because the dream is real and the damage is real and here I am with thirty-two years beneath me, like an abyss. It is so vast, the size of it, I can hardly take it in or fully comprehend it. And of course, as I'm sure you imagine, I want desperately to run. So, what else is new?

In the midst of all this, one of my few consolations is that you have taken the steps you must in order to save yourself. You always were a brave boy! I don't know if I can be as brave by half, but I will try. I don't know what else I could possibly offer you now. Be well. You are in my prayers.

In Wednesday night group, Michael informs us that there are signs his mother has taken up drugs once again, but he is not despondent. Recovery often plays itself out in ragged chapters. Later, Michael shares a moment he had with his two daughters. He was dropping the girls off at their mother's new apartment. He bent down on the sidewalk by his car to give them a hug and he started to cry.

"Why are you crying, Daddy?" asked five-year-old Elene.

"Because," he told her, "now you are going to be with Mommy for a few days and I'm sad to miss you."

She had reached up to wipe away his tears. "Don't be sad, Daddy. Even when I'm with Mom, I still love you."

"I know that," he said, hugging her. "I know you do. But you know, it's really okay if Daddy cries. Its okay if people get sad and it's okay if they cry." Michael told the group that he had thought, as he watched his daughters dawdle their way up the path to their mother, that if he had learned to cry twenty years ago, he might not have been standing there watching them go.

I tell Michael I think his feet are firmly planted upon the dark path, the path that leads all the way down before it breaks into resplendent sunlight. "In the middle of the journey of our lives," Dante said beginning his voyage, "I found myself upon a dark path."

Michael suffered in an untreated depressed and addicted family,

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a situation someone of either sex might have been in. And yet his story rings unmistakably as a boy's story. The heroic, denying, covertly dependent defenses he erected between himself and his own experience, while possible for a women, strike one as familiarly male; strike one, in fact; as only slight exaggerations of much of what we have come to define as male. Michael's story is completely his own. The band around his heart, however, is a shared condition.