Interview with George Woods, M.D. by Lee Norton, Ph.D., MSW, LCSW

George Woods, M.D., is a neuropsychiatrist in San Francisco, California. He has worked in the field of trauma for more than 30 years. He is on the faculty of Morehouse Medical College in Atlanta, Georgia, and Berkeley University in Berkeley, California, where he teaches medical and forensic courses. He has collaborated with Lee Norton, PhD, MSW, LCSW in a variety of capacities, including evaluating numerous clients in capital cases, writing entries for the Encyclopedia of Trauma (2012), and teaching at International Academy of Law and Mental Health conferences in Italy, Germany, and the Netherlands.

Dr. Norton interviewed Dr. Woods for TraumaPro about how he has seen the field of trauma change and grow over three decades, and his vision for the future.

LN: How did you become involved in the field of psychological trauma and what has most informed your theory of practice?

GW: There are four influences that have most shaped my practice. The first involves my work in Nairobi and Dar Es Salam in 1998, where I was asked to help reconstruct mental health resources after the Kenyan/Tanzanian Embassy bombing. This was my first confrontation with mass killing, and the first time I witnessed the ways in which interpersonal violence causes much more complex and enduring forms of traumatic stress. While I was stunned by the way that the bombing tore through the fabric of the culture, I was equally surprised by the indomitability of the human spirit. The intricate ways that the East Asian Africans and Native Africans worked together to restore their country was inspiring. Each ethnic group contributed every available resource, and opened their arms to all. It was in Africa that I learned not only how great the effects of trauma are, but that the most effective antidote is the strength of connection to others.

Later, in the aftermath of 9/11, you invited me to visit Intensive Trauma Therapy in Morgantown, West Virginia, where you were completing post-doctoral work with Lou Tinnin, M.D., and his wife, Linda Gant, Ph.D. This was a life-changing event. I spent two weeks completely immersed in every aspect of trauma, from conducting clinical seminars to teaching trauma intervention to second responders from New York. I was welcomed as an integral part of an interdisciplinary team that evaluated, designed intervention plans, and treated people with severe trauma. Everybody was an important part of this small community, and it was clear that we all made a difference. The most valuable lesson I left with was two-fold. I learned that the Instinctual Trauma Response is inherent in overwhelming events, and that by reversing the dissociation and completing the story--with all the sights, smells, tastes, thoughts, and emotions -- trauma is eminently treatable. This was hugely liberating, and I have never approached trauma the same way since.

In addition to my experiences in Africa and at ITT, my work evaluating inmates in American prisons has had a profound impact upon my view of the role of trauma in mental illness and my treatment philosophy. I have interviewed hundreds of criminal defendants, and with very few exceptions have found significant trauma histories comprising deprivation, abuse, concentrated poverty, ostracism and humiliation, lack of
basic resources, community violence, isolation, natural disaster, generational histories of mental illness, and loss of essential care givers. These factors prevent children from learning to believe that the world is essentially a safe place, and that adults are reliable resources. Trauma robs children of the ability to learn how to regulate their thoughts, sensations, and emotions. Traumatic material is recorded non-verbally, so what they have no means of expressing in words is acted out in self-defeating or aggressive ways. As a result, many of these children end up in the social welfare and criminal justice systems, and eventually graduate to prisons. Seldom are they evaluated or treated for traumatic stress conditions. I am convinced that preventing, detecting, and treating trauma early can save millions of dollars each year, and not only provide children with the quality of life they deserve but enable them to become healthy, productive members of their families and communities.

Finally, my work with neurodevelopmentally disordered patients, including those with intellectual disabilities and traumatic brain injuries, has directed my interest toward the nexus between trauma and global function. We now know that neuroplasticity plays a significant role in what and how we learn, and that neurodevelopmental and traumatic brain injuries can be reversed far more than medical science had once thought possible.

LN: What are some of the most important changes you have seen in field of trauma?

GW: The most monumental shift has been from disbelief in to validation of the nature and course of traumatic stress. Prior to WWI, clinicians and researchers recognized the effects of traumatic stress. Their initial efforts were aimed at discerning whether trauma was a neurological or psychological condition. Freud at first acknowledged the correlation between child sexual abuse and hysterical symptoms, but quickly recanted in the face of professional and political opposition, which ultimately lead to hysteria being relegated to the status of malingering. In WWII neurological and psychological causes were explored again, along with methods of treating flashbacks. Hypnosis and sodium amytal were used to translate images into words. Still, many thought that trauma victims were simply weak-willed or cowardly. It wasn't until the Vietnam War, where the effects of Guerilla warfare were exacerbated by a hostile public reception of returning veterans, that trauma was examined systematically. I was just beginning my career, and I felt helpless in the face of so many untreated veterans who were stigmatized and disbelieved. Pioneers like Mardi Horowitz and Charles Figley are mental health heroes for their courage in aligning with and advocating for veterans who suffered from PTSD. They and others like them became the collective voice of veterans in desperate need of treatment. Equally important was the work of Susan Brownmiller, Diane Russell, and Lenore Walker, who recognized the effects of rape, intimidation and child abuse as forms of traumatic stress. Research from the 1960's and 1970's lead to an understanding of the traumatic stress, dissociation and related problems caused by living in urban war zones. Jim Garbarino and Alex Kotlowitz speak eloquently about the ravages of community violence. I think that history will consider eradicating denial about and establishing diagnostic clarity with regard to traumatic stress as some of the most important scientific accomplishments of the 20th century. Yet, to see how little we understand about effective and efficient treatment is humbling.
LN: What directions do we need to pursue now?

There are several, and I will talk briefly about each.

The first has to do with understanding the very limited role that medication plays in effective trauma treatment. We medical doctors treat the symptoms, but not the causes of trauma. We use many anti-anxiolytics and anti-depressants, along with medications that ameliorate impulsive and self-injurious behaviors. But trauma affects global functioning -- cognition, executive function, emotions, body sensations, and our ability to use our innate skills -- and the most effective treatments involve binding together unlinked traumatic memories so that they are organized temporally, and we have verbally encoded not only what has happened, but the meaning of these experiences. Medication is incapable of making meaning of suffering; consequently, its role should be constrained to treating secondary symptoms in order to prepare the person to complete trauma resolution work. Too, moving away from medication-based treatment leads to multidisciplinary and multi-modal interventions that effect the best outcomes. Thus, we look at trauma through a many-faceted lens by which we can at once consider the neuroendocrinological, physiological, anatomical, biochemical, and socio-cultural implications of trauma, and meet these with comprehensive, individualized treatment programs.

Another thread we need to pursue involves better understanding the complexity of traumatic stress and dissociative conditions. We would do well to follow Judith Herman's advice to consider a diagnosis such as DESNOS (disorders of extreme stress not otherwise specified) to explain the mental, physical and emotional symptoms, and the profound changes in personality caused by trauma. Looking at trauma as a physiologically and emotionally dysregulating disorder, and not just one of stress, clarifies symptoms, and creates a more direct way of thinking about effective treatments.

Third, we must move away from classifications systems -- as the National Institute of Mental Health has done -- and focus on understanding core symptoms. We now know that single, severe symptoms can be as debilitating as a complex of symptoms, and that trauma can present itself in myriad ways, depending on the nature of the trauma, when it occurred, and whether it was identified and responded to. We need further research into the nuances of traumatic and dissociative conditions so that we can treat them more effectively and efficiently.

Related to all of this is the cultural implication of trauma. Having moved away from the anxiety model of trauma, we see that one size does not fit all. We must explore how trauma expresses itself differently in separate individuals -- even those raised in the same community or family. In fact, as regards trauma, no two childhoods are the same. We must examine the cultural and social factors that affect contagion and resiliency. What role do values, mores, social skills, and socioeconomic factors play in determining who is most likely to be affected by trauma, and in what ways and who is most likely to be resilient? We need to know this information in order to design programs aimed at early detection, treatment, and prevention.
And fourth, there is a relationship between trauma and issues of cognitive and physical disability that has yet to be explored. I think it is terribly important that we combine the work of disability professionals with that of macro- and micro-trauma professionals in order to see the ways in which trauma can have an additive effect upon individuals with disabilities and vice versa. I think that in the next 20 year we will see with pristine clarity the intricate ways in which biography becomes biology, and how biology affects how we develop mentally and physically.

LN: How did you become involved in IATP?

GW: Naturally you have played a large role in that. We have worked together for over 25 years, and have had parallel learning curves with regard to trauma, especially as it relates to forensics. So, when the Board asked if I would lend my neuropsychiatric expertise I was honored to be a part of this project.

LN: What is your vision for IATP and how do you see your role?

GW: I think that IATP is an idea whose time has come. It brings together theory and practice powerfully. I believe that IATP will play a critical role not only in training professionals, but in providing a community to sustain health and growth for trauma practitioners. As a neuropsychiatrist, I still have much to learn about the social, cultural, and psychological aspects of trauma. In the meantime, I am glad to share what I have learned about the mind-body relationship, and the biological and physiological dynamic of trauma to this global community.