

# Post Trauma: Medicalization and Damage to Social Reform

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## Abstract

While posttraumatic stress disorder has catalogued symptoms of trauma, the resulting de-contextualization has served to create complicity with power systems that contribute to the production of trauma. Women are overrepresented as targets of violence and as recipients of this diagnosis.

## Résumé

Alors que les symptômes traumatiques ont été catalogués par le trouble de stress post traumatique, la décontextualisation qui en a résulté a permis de créer une complicité entre les systèmes de pouvoir qui contribuent à la production du traumatisme. Les femmes sont surreprésentées comme cibles de violence et comme destinataires de ce diagnostique.

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Western cultures, conflicts, and development projects have all seen a recent and "staggering expansion of therapeutic intervention into all areas of society" (Furedi 2004, 11). This is partly in response to widespread violence, which frequently targets difference to regulate access and opportunity. Therapeutic intervention also reflects a growing trend to individualize trauma management strategies. Unfortunately, such medicalized approaches can obscure underlying social causes of a "disorder" and, by so doing, contribute to human suffering. Sunera Thobani (2003), for example, has argued that a direct link exists between the militarization of capital and an increase in gender-based violence within and across cultural communities. Evidence of trauma's sweeping impact can be seen in the large numbers of missing and murdered Aboriginal women in Canada (Native Women's Association of Canada 2007), pervasive domestic violence across our own and other nations, and increasing social acceptance of aggression, both locally and globally. These examples also suggest how trauma can be understood as both ordinary, reproducing the contemporary social order, and extraordinary, when the personal consequences of violence become defined as "disordered." Under these conditions, psychiatric practices have as much potential to collude with social forces, allowing or encouraging violence, as to disrupt them.

Individualized treatments are too dependent on existing hierarchies to promote widespread gender equity and social justice. As therapeutic interventions increase, so do tendencies to frame social problems as emotional ones, reinforcing heteronormative gender schemas already predisposed to view women as "emotional." Thus, posttraumatic stress disorder (PTSD) contributes to a gender bias already evident in the diagnosis of mental "disorders," and has been critiqued for the ways it participates in systematic, social control of women (Wright and Owen

2001). Although women comprise the majority of front-line mental health workers, they are also more likely than men to be diagnosed with a psychological disorder and given drugs or institutionalized in treatment protocols (Hodges 2003). Medicalized models of disorder fail to examine the mechanisms that produce such patterns and consequently mask the ways social power is implicated in who gets to pass judgment on what constitutes “disordered” behaviour and who will receive the diagnosis. Medicalized discourses of trauma are thus both simplified and elaborated in ways that reinforce oppression. Frank Furedi suggests that “traumatic experience has been converted into an all-purpose explanation for numerous forms of crime and anti-social behavior” (Furedi 2004, 29), attributing damage to targets of violence while excusing its perpetrators. Social activists who question trauma’s distribution patterns are silenced, leading to pessimism about the value of pathologizing human responses to trauma among subordinated groups.

The *Diagnostic and Statistical Manual for Mental Disorders (DSM)* is the most widely used tool for defining mental disorders, acquiring authority through its attempts to distinguish “mental disorders” from other human “troubles” (Caplan 1995). The PTSD diagnosis paradoxically normalizes and pathologizes the aftermath of violence. While the diagnosis tries to attend to individual suffering, it fails miserably at interrogating social-political-economic or even relational circumstances associated with the production and reproduction of violence and trauma. The diagnosis emphasizes personal pathology over inter-subjective effects without recognizing that people targeted by violence, individually and collectively, might find more productive ways to make meaning from their diverse and complex lives.

The remainder of this paper discusses the problems associated with a PTSD diagnosis in two major sections. The first reviews prevalence rates and addresses controversies about the disorder. It looks at the consequences of a PTSD diagnosis for women and its limitations in conditions of compounded social crises. The second

section looks more broadly at the rise of trauma as a modernist construct, examining a fundamental paradox that plagues both acceptance and rejection of the PTSD diagnosis.

### **Posttraumatic Stress Disorder—Definition and Problematics**

PTSD made its first appearance in the *DSM* nosology in 1952 under the general category of “Transient Situational Personality Disorders” as “Gross Stress Reaction” and was applied in situations where stress was related specifically to “combat” or “civilian catastrophe” (APA 1952, 40). Its inclusion was later applauded by feminists and other groups who recognized the role a “diagnosis” might play in validating women’s experiences (Burstow 2005). Early supporters appreciated acknowledgment of the suffering associated with violence and the attempts to relate causes, symptoms, and healing programs. Today, however, PTSD is increasingly viewed as a mechanism that disguises the roots of suffering. While some still find the diagnosis valuable as a tool to catalogue the effects of violence on personal and social adjustment, others lament its failure to give sufficient credence to the adaptive nature of “symptoms” that can result from exposure to hostile environments, especially among subordinated groups.

The end of the last century saw professional fields associated with PTSD diagnoses engaged in “memory wars.” These disputes strategically questioned the reliability of girls’ and women’s memories of sexual violence, reinforcing existing gender power structures (Campbell 2003). Sue Campbell argues that memory is relational, like many of the social conditions that contribute to traumatic experiences. If individuals are to deal effectively with traumatic memories they must have supportive communities, mindfully able to contextualize troubling recollections arising from fragmenting traumatic experiences (2003). During the period of intellectual discord that Campbell deconstructs, conservative scholars polarized discussions around limited evidentiary models, diverting attention away from the critical role that power relations play in shaping memory. Narrowed definitions of PTSD enabled them to do so.

## Defining the Disorder

In the most recent version of the *DSM*, PTSD appears under “Anxiety Disorders.” Characterized by “the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma” (APA 2000, 429), diagnostic features include exposure of an adult to two conditions. First, “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.” Second, “the person’s response involved intense fear, helplessness, or horror” (APA 2000, 467). Criteria are slightly modified when discussing children. Beyond identifying a traumatic event and attributing frailty to the targeted individual, the diagnosis deflects attention from the social context in which the trauma occurred (Kirk and Kutchins 1992; Kutchins and Kirk 1997). Such de-contextualization fails the target, the perpetrator, and collective capacities for healing responses. The *DSM-IV* specifies that symptoms of increased arousal—sleep difficulties, mood regulation and hyper-vigilance—must be present for longer than one month, with “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA 2000, 468). While these impairments clarify the effects of intrusive memories, they do not address uninterrupted memories of trauma or the cumulative effects of relentless social exclusions. The conflation of trauma with acute events thus masks many patterns of interpersonal and social violence.

## Controversies Surrounding PTSD Criteria and Diagnosis

Since PTSD was first included in the *DSM*, its diagnostic criteria have undergone a number of revisions. Some reflected critiques by specific groups; others resulted from new information about factors associated with exposure to and recovery from traumatic experiences. Still, PTSD remains a controversial mental health construct (Friedman et al. 2007). Critics have highlighted concerns about the definition of the stressor “A1” criterion for diagnosing PTSD (van Hooff et

al. 2009). Classifying an event as either traumatic (to satisfy A1 criterion) or non-traumatic (for example, as a life event) requires a subjective interpretation (North et al. 2009; van Hooff et al. 2009). That widespread trauma can itself be a symptom of troubled social histories (Caruth 1995) falls from view.

Extending questions about the validity of diagnostic criteria, Laura Brown (1995) has demonstrated that insidious forms of trauma can have as profound an impact on lives and communities as acute events. Societies can deliver cumulative and extensive abuses to individuals and cultural groups in ways that create predictable traumatic reactions and are then used to justify systematic regulation and dominance. Far-reaching sexual and cultural abuses in Canadian residential schools provide a compelling example. It was perfectly possible for members of dominant groups both to generate and ignore abuses in approaches that were constructed as “help,” and to interpret resistance and symptomatic effects as evidence of the need for more “help” in assimilating to colonialism.

Critics have also argued that the PTSD diagnosis serves litigious rather than clinical purposes, even though others suggest that verbal reports of traumatic exposure and PTSD symptoms may be juridically unreliable (Campbell 2003). Some believe that PTSD is not a legitimate syndrome, but a construct created by special interest groups to mobilize human rights machineries (Breslau 2005). The diagnosis has also been criticized as a Euro-American culture-bound syndrome which often ignores the fact that, for some, dealing with the aftermath of trauma may result in positive personality changes, including growth of autonomy, increased sense of power and control, and development of the strength necessary to leave abusive relationships (Mares 2008). Conversely, posttraumatic stress may so entrench negative reactionary response patterns in both personality and community that intergroup violence becomes a way of life (Erickson 1995). PTSD has been called upon both to explain the so-called proliferation of “disorderly conduct” in need of “regulation” and to offer solutions to the resulting behaviours.

Ultimately, a PTSD diagnosis cannot serve all of the needs to which it is applied. The collapse of explanation and regulation into a single diagnostic tool inevitably produces contradictory and contentious effects. Women who desire relief from the effects of violence in their lives seek healing within the diagnostic system. Insofar as institutions invested in PTSD are compliant with existing power structures and gender regimes, only limited potential for personal and social healing is possible.

### Prevalence rates

While epidemiological data is sparse, lifetime PTSD rates in Canada have been estimated to apply to 9.2% of the adult population (Van Ameringen et al. 2008). Community-based studies in the United States (US) suggest that approximately 8% of the adult population will suffer from the disorder during their lifetime (APA 2000). APA also reports that studies of at-risk individuals—those exposed at higher rates to specific types of trauma—show variable rates of PTSD, with the highest found among rape survivors, those in military combat and captivity, and people involved in politically motivated internment and genocide. Individuals in careers with high exposures to “trauma” (for example, police officers, firefighters, emergency rescue workers) are at greater risk for developing PTSD compared to those in low-risk occupations, with PTSD symptoms estimated to occur in one-third to more than half of exposed individuals (APA 2000). Lifetime exposure to traumatic events is between 50–60% in developed countries; in developing and war-torn nations the figure climbs as high as 92% (de Jong et al. 2001). While not all exposure to trauma results in a PTSD response or diagnosis, global figures suggest that between 13–40% of affected individuals will meet criteria for a PTSD diagnosis (Norris and Slone 2007).

Exposure to interpersonal violence is a strong predictor of PTSD symptoms (Norris and Slone 2007). For example, “whereas 45.9% of female rape victims are likely to develop PTSD, only 8.8% of female accident survivors develop the disorder” (Friedman et al. 2007, 7). While it is commonly recognized that

women face systematic domestic and sexual violence, less attention is paid to the ways such hostility upholds larger systems of socio-economic domination. Rather than seeking to reduce gender or other biases, efforts to mitigate the impact of violence are directed toward the dissemination of dominating knowledge models, technologies, international economic reforms, and therapeutic interventions.

### Violence against women

Global concern over violence against women (Watts and Zimmerman 2002) has led to an increase in the number of surveys investigating intimate partner violence worldwide (UN 2006). *The Beijing Declaration and The Platform for Action* inspired countries such as Australia, Canada, and the US to gather information about violence against women on a regular basis (Statistics Canada 1993; 2005; 2006; UN 2006). Findings from these studies show that between 10% and 50% of women involved in intimate partner relationships with men (that is, married, common-law, dating) have been physically assaulted by a partner; between 3% and 52% reported physical violence within the past year. Studies from other regions (for example, Latin America, Africa, Japan, India, Bangladesh) report incidences of domestic violence ranging from 10–60% (Flake and Forste 2006; Hadi 2005; Lawoko 2006; Panchanadeswaran and Koverola 2005; Yoshihama 2005). The United Kingdom (UK) and European nations have also faced rising levels of intimate partner violence (Harwin 2006). As most researchers agree, these figures represent minimum estimates. Abdullahel Hadi is not alone in suggesting that: “During the last two decades gender based violence has emerged as the most pressing intractable social problem across regional, social and cultural boundaries” (Hadi 2005, 181).

Sexual assault studies worldwide suggest that most forced sex is perpetrated by individuals known to the victim (DeKeseredy and MacLeod 1997; Gross et al. 2006; Wilcox et al. 2006). The literature about sexual violence between marriage partners is weak, perhaps because “the marriage license was historically perceived as a ‘license to rape’” (Finkelhor and

Yllo in Bergen 2004, 1408). Not only is rape now recognized internationally as one of the atrocities of war, but war is also seen to magnify the gendered structure of rape (Burn 2005). G. Tendayi Viki et al. summarize the findings from international studies: "According to the United Nations Population Fund, between 51 and 90% of women surveyed world-wide have experienced a rape or attempted rape" (Viki et al. 2006, 789).

At the root of sexual violence lie structured inequalities (Martin et al. 2006), which contribute to large numbers of women meeting criteria for a PTSD diagnosis, even though the majority of the world's women have little or no access to therapeutic care. "Perhaps no single objective would do as much to reduce the prevalence of PTSD in the population as curtailing violence. Whether political, interpersonal, sexual or non-sexual, violence is the single leading cause of PTSD in both men and women" (Norris and Slone 2007, 93). Yet disparities that lead to gender-based violence are not likely to dominate political agendas if they can be treated as personal or regarded as somehow inherent to those targeted.

Findings suggest that women are more likely to develop PTSD than are men following exposure to trauma (Kimerling et al. 2007). Timothy Johnson argues that this may result from gender identity expectations, because social selection militates against male "expressions of social distress" (Johnson 1991, 416). If recognizing distress is seen as weakness in masculine domination narratives, a PTSD diagnosis can undermine a woman's self-confidence, as well as her sense of agency and social competence, even though desire for support may be healthier than denial.

In a medicalized context, a PTSD diagnosis launches a range of prescribed approaches to treatment that function together like a social "machine," with implicit and explicit investments in the status quo. Incentives emerge for clients and professionals to adopt increasingly commercialized and pharmaceutical approaches to healing. Finding a balance between social advocacy and the relief afforded clients, who need helpful ways to interpret and cope with their responses to

trauma, requires more powerful interdisciplinary commitments to understanding the social determinants of health. The emphasis placed on human vulnerability by a PTSD diagnosis assigns people too readily to the role of helpless victims. This deflation in the perception of individual and relational healing potentials coincides with inflation of external threats—an infinitely exploitable political tool—as witnessed in the "war on terror." In Furedi's summation, "Psychological trauma is an affliction of the powerless" (Furedi 2004, 125). By narrowing its focus to acute events and individual treatments, the PTSD diagnosis serves, perversely, to accept all kinds of violence—including violence against women—as perhaps not a desirable product of modernity, but an inevitable one.

### **Modernity and Social Constructions of Trauma**

Trauma, as currently understood in the West, is a product of modernity's positivist notions of progress, traceable to the rise of industrialization, mechanized combat, risk management, and psychoanalysis, each with distinguishable gendered effects. While it is common to cite past readings of female hysterics and shell-shocked war veterans as examples of privatized femininity and publicly engaged masculinity writ large in PTSD's history, it is helpful to recall that, early in the nineteenth century, John E. Erichsen coined the contemporary use of the term "trauma" in relation to railroad accidents (Harrington 2001). This genealogy helps to situate contemporary debates more squarely in relation to processes of professionalization, capital accumulation, knowledge production and state interventions, each central to radical critiques of psychiatry since the twentieth century.

A metaphor for industrial progress, the railroad brought with it a new kind of traumatic experience: the railway accident. Affected passengers and their loved ones lost control of their fates, en masse. In efforts to regularize and distribute the risk, insurance and related forms of statistical analysis emerged. Soon, various factions became embroiled in persistent debates about somatic versus psychic origins of resulting difficulties.

Arguments about applying these labels would depend on who would “benefit” socially or financially from reading a traumatic response as either illness or malingering: the patient, the doctor, the insurance company, or the state. Of course, there were gendered implications to these interpretations. In the space of the railway train, women and men travelled together, however crudely sorted by gender, race, and class. But travel, workplace, and state welfare systems produced visible social phenomena to ground a host of stereotypes, together with “expert” avenues for identifying populations in need of services or corrective interventions, often based on “difference” and relative status. As a result, what Wolfgang Schaffner (2001) calls a “political technology of the self” was born, together with associated “rhetorics of potential trauma” (Eghigian 2001). Double-binds attaching to gendered and other identities became implicated in the ways traumatic experiences were perceived and diagnosed. In the process, engaging human trauma became part of professionalization for psychologists, psychiatrists, physicians, social workers, educators, lawyers, insurance experts, and political leaders (Mandershied 2009). Western culture became invested in trauma.

Thomas Szasz and R.D. Laing both critiqued this state of affairs (Roberts and Itten 2006). Szasz invoked the somatic/psychic binary to argue that psychiatric discourses are too easily mobilized by the state and other institutions to regulate all kinds of diverse human expression, without adequate evidence or patient consent. Overmedication of Western youth, particularly in government care, is a contemporary example. Szasz pointed out that homosexuality, once listed in the *DSM* as a disease, was removed by vote among professionals, influenced by queer activism and increasing social acceptance (Clarke 2007). Today, similar concerns have arisen around “gender identity disorder” and “pre-menstrual dysphoric disorder” (Offman and Kleinplatz 2004).

Laing was equally critical of alternately dismissive, over-determined, or even punitive forms of psychiatric “treatment,” including electroshock therapy and confinement, though he remained sensitive to the need for “asylum” when dysfunction precludes safe engagement with public space (Roberts and Itten

2006). While Szasz vilified the regulatory power of the welfare state and Laing was more troubled by the operations of capital in producing inequities of access to care, both recognized that there was something slippery and coercive about the ways bias can travel along claims of “compassion” and “help.” As Carol Tavris has argued, “If a mental disorder reliably and stereotypically fits a narrow category of people, then we should be looking at what is wrong with the conditions of the people in that category, not exclusively at their individual pathologies” (Tavris 1992, 186).

Popular culture has contributed to the ubiquitous use of terms like “trauma” and “PTSD.” Television talk shows and self-help books brim with examples. Such popularization brings sanitization. The effects of gender, socio-economic class, and cultural conditioning in traumatic experiences and the systems that deliver them are glossed over. Appropriation of therapeutic language among online “pro-ana” advocates is one troubling example. Although the therapeutic moment often demands otherwise, trauma cannot be understood exclusively in relation to the individual (Leys 2000). Rather, trauma manifests both materially and in consciousness as a cultural effect.

Patricia Yaeger (2002) questions one of the more insidious results of trauma’s social currency. She points to ethical dilemmas arising from the public consumption of sensationalized trauma and professional practices that “merely circulate” the suffering of others. Trauma and PTSD diagnoses inevitably reproduce the politics from which they emerge. In worst case scenarios, trauma symptoms can be used to justify further oppressions. Former Australian Prime Minister John Howard’s military intervention among northern Aboriginal groups is one example (HREOC 2007). His government’s actions repeated the “protectionist” colonial policies initially responsible for widespread trauma among Aboriginal peoples. The “stolen generations” in Australia and the “60s scoop” among Indigenous groups in Canada were the culmination of long-standing efforts to manipulate familial and gendered relations in colonized cultures to favour dominant systems and groups. Legacies of rampant abuses came

to light only later. Dominating interventions undermine Indigenous healing practices and culturally centred perspectives on the manufacture of disadvantage and distress (Duran et al. 1998; Mohanty 2003; Shore et al. 2009). Trauma is too easily called upon to serve the interests of the powerful.

Derek Summerfield expands on this point in his critique of the export of western PTSD diagnoses and treatment formulae. He reports how late twentieth century Cambodia became “inundated with PTSD checklists” and expatriate workers concerned that the “trauma of the Pol Pot years has not been processed” (Summerfield 1999, 1452). In response to charges of a “culture of silence” around painful histories, Cambodian activists found current economic problems more pressing (Boyden and Gibbs 1996). In this case, researchers were arriving from nations deeply implicated in poverty’s traumatic effects in the present moment. Such dissociative lack of attention to the relative positioning of the researchers and their participants shows how a focus on memory and past traumas can limit effective social action in the present. Really a form of neglect, a deficit in contextual awareness was presented as care. A focus on individuals and a temporal shift in attention from the present to the past displaced awareness of the pathology of the existing social situation.

Articulating a posttraumatic stress syndrome has had very little impact on worldwide poverty, war, or the gendered inequities that inform them. Professionalization projects and political disengagements may serve some individuals in the short run but cannot support communities or broader collaborative interests in reducing trauma over the longer term. There are too many crisis environments where treatment is unlikely to be available and situations where reactive responses to trauma will interfere with collective commitments to shared justice (Weinbaum 2006). Without culturally appropriate and gender-sensitive practices (Shore et al. 2009), a PTSD diagnosis not only fails to engage with the social reproduction of trauma, it undermines potential social supports for those affected by violence (Clapp and Beck 2009). Recently, transactional analysis has attempted

to respond to this problem by mobilizing a conscious principle of co-creativity in the therapeutic encounter (Summers and Tudor 2000).

## Conclusion

Gillian Whitlock (2000) has coined the term “discursive threshold” to demarcate some of the critical territory we have invoked in this paper. The emergence of trauma discourses and the rise of PTSD diagnoses and treatments might have included more meaningful commitments to generating new speaking positions and cultures of public debate around experiences of social violence. While pathways to social healing are not always direct, hyper-individuation of medicalized approaches to PTSD silences or weakens voices that might otherwise participate more fully in social justice efforts. The paradox of perceived empowerment and disempowerment that invests PTSD persists because the promise that the diagnosis could engage “disorder” at both personal and social levels has not yet been fulfilled. Professionals are unable to address the social causes of aggression and trauma without adequate community support for change. Whether seen as too politicized or not political enough, PTSD remains controversial because, in its current medicalized format, it contends with social troubles it cannot fully engage or resolve.

Ultimately, the medicalized model of PTSD contributes to a lack of collective public memory and understanding about the cultural operations of trauma. Thus, it short-circuits historical and contemporary accountabilities for the effects of dominating signifying systems. However controversially, PTSD has caught on like wildfire because of the ways it has been absorbed into existing power structures and has itself become symptomatic of fissures in social connection. As such, the controversies it engenders are a reflection of unresolved tensions in contemporary political realities. Deeper analysis is needed to understand traumatic memories and events, as well as how these are communicated, enfolded, and transferred in both mundane and creative processes in everyday life. As Birgit Wagner et al. (2007) argue, healthy growth following

trauma is reflected in consistent commitments to generative approaches to healing, which must exceed dominant political contingencies.

We are all operating in theatres of culturally produced selective memory. Although absent in many contexts, even when therapeutic intervention is the most immediate, humane, and ethical response available, medicalized approaches are bound to overlook social conditioning and relational possibilities for change. When a PTSD diagnosis contributes to the continued public unspeakability of precarious lives (Butler 2004), it is reduced to a spectacle of intervention, with limited long-term impact. No amount of individuated intervention can correct the basic inequities that reflect deeper social pathologies, including widespread gender violence.

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