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A Critical Psychological Critique and Reformulation

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What is traumatization?

A Critical Psychological critique and reformulation

Bodil Maria Pedersen

Abstract

Inspired by critical psychology this article explores and challenges two central issues in psychology: The use of diagnoses and that of trauma. These concepts - and related practices - are not as straight-forward as is often assumed in mainstream psychology. On the contrary, they have complex and far-reaching problematic implications for our understanding of agency, difficulties, dilemmas and suffering of concrete subjects, as well as for our practices. This article discusses the conceptualisation of Posttraumatic Stress Disorder (PTSD), which is in widespread use in most countries. Using this diagnosis as an example, some problems concerning diagnoses in general are introduced. Drawing on a study of women exposed to sexualised coercion, 'symptoms' of PTSD are reinterpreted. Trauma is understood as processes of a personal and overpowering sense of loss of control in specific times and places, and thus as embedded in the conduct of everyday lives. 'Symptoms' of PTSD are therefore reinterpreted as aspects of overpowering and violent personal meanings and as situated consequences of loss of control. Violent experiences and their consequences do not simply provoke 'reactions', as is assumed in the use of the diagnosis. As a result, its description of recurring thoughts and feelings concerning 'traumatising events' may be understood as recurring specific and personal attempts at dealing with, and learning from, violent loss of control.

Keywords

trauma, critical psychology, violent experiences, conduct of everyday life

Introduction

At least since Freud, psychology has been concerned with phenomena that are conceptualised as trauma. But its preferred topics, concepts, and comprehension of diverse phenomena change over time. In Denmark, during a period where much attention was on personal development, 'psychological crises' was a widely used concept. This concept included much of what is today known as a trauma, such as the loss of a close relative, disease, or experiencing a tsunami, as well as the idea that this may contribute to development. Conversely, focus is now on identifying who and what is thought to be in need of professional treatment, and therefore on differentiating between what is seen as normal and what is not. Consequently, there is also a great focus on diagnoses.

The diagnosis Post Traumatic Stress Disorder, PTSD for short, has commonly replaced the concept of crisis. Before the diagnosis was developed, 'symptoms' were categorised through diverse concepts. Thus 'shell shock' was a commonly used during World War I. The concept was converted to PTSD in connection with difficulties experienced by veterans of the first Iraq war. In order to obtain compensation, insurance companies, among others, required a diagnosis. The fact that problems, in practice, are at the origins of changes in psychological theory – among these also the construction of new diagnoses – is a common occurrence. This also occurred in the study of women's perspectives on being exposed to rape and other forms of sexualised coercion, on which this article draws. I will later return to this study; first, a little about PTSD and diagnoses in general.

The PTSD diagnosis

The concept of PTSD covers a whole range of difficulties thought to be caused by experiences of violent events, also called traumatic events. They include events that result in physical trauma, threats to one's life, or other threats to one's physical integrity as well as to that of others. But the diagnosis is also frequently used more comprehensively. Having difficulties, and having experienced what is seen as events similar hereto, may then be followed by a process of diagnosis - a process seen as useful and desirable by many professionals.

The 'symptoms' assumed to develop as consequences of the experience of a 'traumatic event' are largely described through 3 main categories:

- Constant re-experiences of the traumatic event
- Repeated attempts at avoiding stimuli related to the trauma

- Repeated symptoms of accelerating vigilance that were not present before the trauma

Re-experiencing is amongst other escribed as uncontrollable memories of the event, dreams about it or flashbacks (sudden and very vivid fantasies) of parts and/or of the whole event.

Phenomena that are described as difficulties in concentrating, experiencing oneself as an outside reality, indifference, diverse fearful reactions, and sleeping problems are several of the phenomena that are similarly understood as associated with PTSD. When they are described in connection with the diagnosis, they are classified as symptoms.

Descriptions and classifications are routinely changed in revisions of diagnostic manuals. But the sketch above covers the main themes included in the diagnosis.

Problems of diagnoses

Diagnoses portray persons' difficulties independently of their personal perspectives, and independently of the connections of these difficulties to their conduct of life. The diagnoses describe very diverse difficulties that may have many diverse explanations, and may arise in many situated and dissimilar constellations of contexts. Thus, diagnoses do not grasp difficulties as embedded in the person's development of more or less purposeful and intentional, personal aspects of their conduct of life. Since emphasis is on what is generalized, but not on that which is personally most important in a given time and place, implications that may be essential for a concrete diagnosed person risk being disregarded. Hence, many do not recognise themselves in diagnostic depictions. However, this is generally not considered to be a major problem. It may even be assumed to be a part of their condition: they may be seen as being in denial. Such lack of recognition is thus seen as proving that the use of the diagnosis is appropriate. Simultaneously, others that have previous knowledge about the diagnosis PTSD, and who have been exposed to experiences that are usually considered 'traumatising', do not understand why they do not experience the difficulties it describes. Practice as well as my study show that they sometimes even think that something is not right with their own (re)actions.

Diagnoses appear in manuals of diseases. 'Symptoms' may therefore be regarded as expressions of a disease. As an example, PTSD is often regarded as a non-deliberate, or even as a physiological and pathological reaction. When persons who have been diagnosed are considered as suffering from something that seems to be a disease, we are in danger of "

Nevertheless, it can at times be experienced as a relief to be assigned a diagnosis. It may be experienced as a recognition of one's difficulties, and explanation for what is 'wrong'. When the difficulties are considered to be a disease, one is not responsible for them, and may hope that others will be able to do something about them.

Currently, PTSD is used to characterise everything from the problems of the victims of tsunamis, the aftermaths of life in prostitution, or difficulties after rape and other forms of sexualised coercion, to difficulties experienced in connection with serious diseases. Thus, PTSD has been extended from being associated with difficulties undergone in connection with participation in war, to be linked to a long list of diverse events, situations and violent situations in of the conduct of life such as natural catastrophes, social occurrences and acts, as well as recurrent experiences in the course of lives, such as disease and death. When the diagnosis is used this broadly, more and more experiences are generalised and defined as traumatising, and are thus expected to result in PTSD. Consequently, there is a tendency to an increased use of the diagnosis, and even to a kind of circular interpretation of the relation between 'causes', 'symptoms' and diagnosis.

PTSD has been called a 'catch all' diagnosis by Lindner (2004), who studied its use by medical practitioners. Her informants criticised the diagnosis for blinding them to essential problems of diagnosed patients. Other practitioners have reached the same conclusion, even pointing out that a diagnosis could possibly increase patients' difficulties. In addition to having been subjected to a violent experience that made them feel powerless, they now 'have a psychological disease', with regards to which they also feel powerless. Since the difficulties are mainly understood as existing inside the person, the use of PTSD as a description of personal difficulties may contribute to making their difficulties more permanent.

Normalising difficulties

But could the descriptions inherent in the diagnosis of PTSD not be of any use at all? Yes and no.

PTSD is described as a 'syndrome', a collection of diverse difficulties that persons may have when they have had personal painful experiences. Yet, the descriptions of the diagnosis may be useful in spotting, and normalising, such difficulties. After a violent experience these difficulties are quite common. Therefore, they can be used in understanding that others may also have

comparable difficulties. As one participant in my study said, you are not “going crazy” because you experience such difficulties, meaning you are not abnormal.

But to make use of the descriptions of the ‘symptoms’, they must be disconnected from the oversimplifications of the diagnosis, as well as from the tendency to generalise and pathologize. The ‘symptoms’ may also be embedded in what may seem to be everyday occurrences, and the ways in which ‘symptoms’ acquire personal meanings must be understood. As an illustration, a low score on an examination for a person for whom grades are very important may be involved in giving rise to experiences of difficulties similar to PTSD. Another person for whom the examination has quite different meanings will not experience similar difficulties.

Overpowering loss of control

The illustration above indicates that experiences of one or several of the difficulties that are described by PTSD are experiences most persons suffer from in diverse contexts in the course of their lives. In the following, I will chiefly refer to reflexions that arose as part of my study with women exposed to rape and other forms of sexualised coercion.

In diagnostic terms, these women had been exposed to what would be considered a ‘traumatic event’. Consequently, they were persons whose difficulties, anguish, or agony would often be categorized with the help of the concept of PTSD. Conversely, my study draws on the personal perspectives of women. It includes experiences presented by 40 women in a series of counselling sessions, group sessions, as well as in 15 follow-up interviews.

When we examine their personal perspectives on the events, as well as which significance and implications they had, we uncover aspects of difficulties and sufferings the diagnosis does not help them or us to understand. However, such aspects may support further research into what is commonly described by PTSD.

All participants of the study experienced the situations of coercion as unfamiliar and unexpected situations, in which quick action and reflexion was necessary, and in which they were simultaneously confused as to what to do. This meant that their possible course of action and reflexions were violently reduced. The situation was experienced as a critical loss of control. But sexualised coercion and its personal meanings are diverse and not always equally personally overpowering and violent, nor in the same ways. The physical and psychological use of power by the perpetrator, and the loss of control of the victimised person exposed, may for example be very different from situated

events to situated events. Thus, the participants of the study did not all describe the situation as *very physically* violent. Similarly, the personal meanings of the situations changed with the course of events in the aftermaths. Some women even experienced the aftermaths as more restricting and oppressive than the situation of coercion itself. As illustrated above with the example of the low exam scores, the development of personal meanings is embedded in the concrete situation of coercion as well as in the constellations of later implications. The meanings were connected to each woman's personal constellation of experiences and conduct of life. Hence, the women's emotional, cognitive and more practical difficulties, and their experiences of (loss of) control, as well as the meanings they attributed hereto, were remarkably divergent. The diversity of personal meanings the women attributed to the aspect of sexualisation, were conspicuous instances hereof.

Some implications

Some of the women in the study pulled through relatively quickly; others had great difficulties over a longer period of time. Several of the women who had greatest difficulties were those who experienced several serious difficulties in their conduct of life in the aftermaths. Previous experiences with difficulties, especially such as those described by PTSD, had surprising implications. It is a frequent assumption that what is regularly defined as re-traumatisation may aggravate difficulties. Conflicting herewith, former experiences of the possibilities of dealing with such difficulties appeared to be helpful.

To be exposed to sexualised coercion had, as mentioned earlier, many and diverse practical implications for the women's conduct of everyday life. Because they felt insecure and became vigilant, some lost their jobs. Others lost their work because employers did not want to 'take responsibility for someone in such a difficult situation'. The same occurred in educational institutions. Many also had problems concerning living arrangements. They were short of means because of complications concerning grants as well as work, and due to expenses related to the aftermaths of the overpowering situations.

Their experiences of coercion often meant that their freedom of movement and their relations to others were seriously constrained. This was not only connected to their loss of self-confidence, but also to the changing (inter)action of others. Friends, colleagues, and families could become overprotective or, conversely blame the women for what had happened. Thus, the women could experience anger from partners or others who believed that the situation was their own fault, or even that they were lying to hide episodes of infidelity. Several

women had been exposed to coercion from friends or acquaintances and kept fearing to meet them. For such reasons, and because they, for a while, did not wish to participate in flirting and other sexualised everyday practices of their peers, many became increasingly isolated and sometimes marginalised.

Furthermore, some of the women who reported the events of coercion to the police were subjected to suspicious, time-consuming, difficult, and lengthy questioning and investigations. Some were also bullied, threatened or pursued by perpetrators or by common friends. In one case, the perpetrator and his friends 'punished' a young woman by exposing her to sexualised coercion once more.

Meanings are maintained and changed

For the women, such experiences in their diverse constellations were, just like the instances of coercion, unfamiliar, violent and violently constraining. Although at times less violent, over extended periods of time, this limited their conduct of everyday lives. Their agency in everyday life and their expectations hereof were affected, and they could grow increasingly insecure. As such, the experiences added force to their apprehension of experiencing further overpowering and violent difficulties. They contributed to their experiences of emotional, cognitive and other agency related difficulties, including those described by the diagnosis of PTSD.

Several months after having ended counselling, a young woman returned to the centre where the study took place. She feared that she was having a 'relapse'. It turned out that the 'relapse' was only indirectly related to the experience of sexualised coercion.

Most of us recognise that an experience apparently continues to have similar and strong emotional connotations, or that a specific connotation becomes more intense. Is this brought about by our suffering from a condition that may be identified by a diagnosis? Or do our lives and the ways in which we conduct them, not rather keep our feelings and thoughts alive in patterns that we interpret as identical with – or directly related to - the original experience? The young woman above associated her current troubles to the situation of coercion, but in connection with further counselling sessions it seemed that her difficulties were more closely related to isolation, loss of orientation and self-confidence related to her giving up her studies and her job.

Most of us also recognise that situations that, at a certain point of our lives were experienced as important, sad, frightening, painful or joyous, change their meanings and implications. We often express this by saying that change comes with time, and that time heals all wounds. But time is not empty. With time we

participate in changed or new contexts. The substance and personal meanings of our experiences change with what time encompasses, as well as with our practices in time. Thus, implications of our previous experiences, like those of the woman above, acquire new personal meanings.

But experiences are not simply 'given' in situations. They are personally achieved: *achieved* in connection with situated historical conditions and with their embedded implications. We actively reflect on courses of events by drawing on previous experiences, on experiences we are having at the moment as well as on experiences we fear or wish to have in the future. This is the way we attribute them their personal meanings. This is equally valid for 'traumatising events', that is, for experiences related to overpowering and violent loss of agency. Thus, whether and how one is trapped in the initial meanings of violent experiences, or wither these meanings are changed and become gradually less overpowering and violently restricting, becomes comprehensible only through a non-diagnostic perspective.

Personal formation of experience

I write formation of meanings and experiences instead of 'traumatising events'. I do so, because the vital issue here is not a unique event that typically causes specific and predictable individual meanings and implications. The vital issue is that completely diverse courses of events experienced by this or these specific persons may be experienced as violent losses of control and become threats to their conduct of everyday life. We therefore cannot understand personal meanings of violent experiences without appreciating how they are embedded in concrete and diverse situations such as an exam, a tsunami, or a disease. Neither may we understand them without appreciating the social meanings they are attributed in the unique situated life of a person. The constrictions and difficulties in such processes, and the meanings and implications of these processes shape persons and are shaped by persons in specific ways. For these reasons, they are also painful in specifically personal ways. A conceptualisation of this kind is essential for our capacity to help and support people in need.

Furthermore, I have used the concept of experience to emphasize that the issue represents a chain of diverse situations in which we become participants, though not always intentionally. As with other experiences, we reflect more or less consciously and deliberately on that in which we participate and have participated. If we do something as banal as spilling a glass of water, we will reflect on why it happened, and on how it may have been avoided. The more overpowering and violent the implications of situations are for us, the less

unavoidable they were and seem in the aftermaths, the more violently we may be overwhelmed by feelings, thoughts, and more or less deliberate reflexions of what happened. Such change- and development-related reflexions are sometimes misunderstood as feelings of guilt or shame.

Then, because I do not conceptualise personal suffering related to the development of knowledge and experience as signs of a pathological condition, I equally write ‘experiences with difficulties’ instead of ‘symptoms’.

Reinterpretation of difficulties

Returning to the difficulties described with the concept of PTSD, we may now understand them in another, more dynamic and social perspective. All women experienced unexpected difficulties after sexualised coercion; some only resolved the difficulties – among these also the ones associated with PTSD – only very slowly. For these women, sexualised coercion had many other and overpowering violent meanings and implications, like the ones described above. This is the light in which we must interpret their difficulties, as well as those of others.

Not all violent experiences have all – nor all the same - repercussions as the ones frequently connected to sexualised coercion. But many experience similar consequences such as isolation or being blamed, consequences that restrict their conduct of life and contribute to new difficulties. Additionally, violent situations, whether experienced as such by the person directly exposed to them or by others, may become what can be named *non-events*. Such situations are situations that are perceived as so dramatic that they cannot, or must not, be mentioned, or conversely that they are made light of. Simultaneously, while the exposed persons are subjected to specific forms of exclusion, the situations may also seem unreal to them. These may be followed by many kinds of social difficulties and dilemmas, especially when they, like sexualised coercion, are defined as traumatic. It is a well-known experience that relatives and friends suddenly act differently without making the reasons clear. Therefore, one may, as the women in the study describe, “get out of line” with family, friends and colleagues, in work and in leisure. If it even – like in the exam example – is an experience that is not usually considered violent and overpowering, it may be incomprehensible to oneself and others that one’s feelings and thoughts are so violent and overpowering. Consequently, these feelings may be experienced as especially painful and even shameful.

When the women, and others who have been exposed to overpowering experiences, again and again reflect on what they could have done differently, it

is frequently understood as a symptom of PTSD, or as an expression of unnecessary and unproductive feelings of guilt. But this may be re-interpreted as more or less intentional attempts at grasping what happened, as well as at changing and developing one's experience hereof. The situations and their significance are not forgotten, but the experiences one has had may be changed into comprehension and knowledge that may be used in strategies of action. This may subsequently replace un-reflected and overpowering experiences, which continuously trigger constricting anxiety and fear.

Until we have developed strategies of action for violent situations we have experienced, we often avoid situations that may give rise to fear. When women did not know when or where the perpetrator might turn up, avoidance may represent a well-founded attempt at steering clear of unrelenting high levels of anxiety and fear, as well as at avoiding real danger. Directed at real threats, continuous vigilance may similarly be a meaningful course of action. It may be the answer to a threatening everyday life in which one's options are experienced as utterly changed and diminished. Thus, as part of a current and situated strategy of action, it may be re-interpreted as purposeful vigilance, and not just understood as an unintended biological reaction symptomatic of a disease-like condition.

New challenges

Diagnoses like PTSD profess to be objective statements about persons, but because what we study are situated personal perspectives and conduct of lives, and because researchers are also situated, no body of knowledge in psychology will ever be objective.

The clinicians interviewed by Lindner (2004) were critical of the ostensible - and intended - objectivity and generalisability of the diagnosis, that is of relating to people as mere objects of study and treatment. If we, like these clinicians, understand persons as complex subjects and explore more closely what they have to tell us about their lives, we may discern narratives quite different from those we normally perceive when looking through the PTSD lens. The power of such testimonials will by far surpass the limited and limiting observations made with the use of a diagnosis.

As exemplification, we may consider a documentary aired by a Danish broadcasting station. Several years after the events, it described the aftermath of an explosion in a firework factory. Interviewed researchers concluded that many children who had witnessed the explosion still suffered from "clinical or sub-clinical PTSD".

Subsequently, a father was interviewed. He reported that his children were now doing fine, but that it had taken a long time: in the same breath, he said that many practicalities in the life of the family, such as housing, had only been solved recently. His children had lived 3 years with the consequences of the accident. Like many of the participant in my study, they had not been able to conduct their lives as relatively safe and predictable, because their lives were not. In the context of the discussion in this article, their experiences do not appear 'abnormal' nor 'pathological'.

The diverse difficulties one may experience in the wake of violent and overpowering situations are often called 'primary traumatisation', while those subsequently in evidence are called 'secondary traumatisation'. This terminology corresponds with the time sequence of the experiences. But regarding their significance, the latter are at times primary. Because of the overpowering and violent succession of situations and experiences, a person is in need of holding on to or changing - in any case to re-secure - her/his perspective on her-/himself, on life, and on the conduct of their life. Doing so in a changed and changing everyday life, and in an often unpredictable reality, may become a long and winding venture. So far, this seems to have been the case for the children in the newstory mentioned above, as well as for the women exposed to sexualised coercion.

But persons who have experienced overpowering and violent situations, and who experience painful feelings and thoughts, are often expected to 'recover quickly'. Paradoxically, they are also met with expectations of showing their feelings, talk about them, and take their time to deal with them. If they do not, what they have experienced is perceived as being 'probably not that serious'.

My study raises an imperative question: Is the fact that our super-effective life does not give space and time for persons to be periodically less flexible and effective one of the reasons why violent experiences become overpowering? I wonder how often those exposed to such successions of experiences must suffer marginalisation?

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