Toward a Radical Understanding of Trauma and Trauma Work

BONNIE BURSTOW
Ontario Institute for Studies in Education

The purpose of this article is to help pave the way for more radical counseling with traumatized individuals, communities, and nations. The author critiques the post-traumatic stress disorder conceptualization and psychiatry fundamentally, builds on and critiques feminist and other radical contributions to trauma theory, suggests directions for feminists, theorizes trauma from a radical perspective, and draws implications for practice. Conclusions include the following: A deficit trauma model is inappropriate; institutions of the state must be seen as critical in the creation of trauma; there must be a fundamental break with psychiatry; and trauma work should move in the direction of radical adult education.

Keywords: *feminist counseling; trauma*

With the emergence of feminist therapy, trauma became a central framework through which professional helpers view violence against women, with one consequence being a shift in trauma theory. Women survivors, feminist therapists, and other feminist theoreticians argued that women are traumatized by everyday violence against women just as men are traumatized in combat, and they progressively used and adapted the term *trauma*. Feminists such as Herman (1981), Russell (1984), Burstow (1992), and Brown and Root (1990) pioneered new understandings of trauma. Although some feminist practitioners saw psychiatry as inherently problematic and viewed the feminist theorizing as a sort of counterdialogue, the more influential—Herman (1992), for example—largely accepted psychiatric underpinnings, while seeing psychiatric conceptualizations as simply restrictively androcentric or otherwise privileged. Correspondingly, feminist practitioners lobbied for and in some cases succeeded in getting

VIOLENCE AGAINST WOMEN, Vol. 9 No. 11, November 2003 1293-1317
DOI: 10.1177/1077801203255555
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changes to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) (published by the American Psychiatric Association). Both types of practitioners raised relevant issues, and conventional, psychological, and even psychiatric understanding of trauma shifted accordingly. Other players are also shifting trauma theory in significant ways. Psychologists such as Danieli (1998) have introduced the concept of transgenerational trauma. Erikson (1995) has spoken of community trauma. And Indigenous people, African Americans, and Jews theorize their collective history as trauma. Such shifts notwithstanding, as Gilfus (1999) pointed out, there are serious inadequacies in the dominant and even in the less dominant conceptualizations, including feminist ones. The political is not fully integrated. Moreover, psychiatry continues to dominate. It is these limitations that motivate this article.

The primary social context in which this article is written is a world in which women, the working class, Natives, people of color, Jews, lesbians and gays, and the disabled are routinely violated both in overt physical ways and in other ways inherent in systemic oppression and where the psychological effects of this violation are often passed down from generation to generation. The primary ideological and professional context is a contested trauma terrain. It is a terrain where promising developments exist, but where there is no clear radical model and where even alternate models fall short and are compromised.

The purpose of this article is to help pave the way for more radical trauma work. The means are the following: bringing together radical insights, critiquing, shedding light on choice points, articulating a radical theory of trauma, and drawing implications for practice.

The article is grounded in my multiple experiences and locations as a feminist psychotherapist, antiracist activist, survivor of childhood sexual abuse, White woman with privilege, Jew, and academic. Conceptual underpinnings include structuralist social work, critical theory, critical adult education, antiracism, radical feminism, antipsychiatry, institutional ethnography, and feminist standpoint theory as articulated by Smith (1997).

FEMINIST CONTRIBUTIONS TO TRAUMA THEORY

Feminist contributions to trauma theory have been immense. Feminists have brought the significance of social location into trauma discourse. We have included traumatized groups previously excluded. We have "normalized" trauma. We have reframed "symptoms" as "coping skills" (Burstow, 1992), stressed the significance of witnessing and *testimonio* (Aron, 1992; Burstow, 1992; Herman, 1992), and fundamentally critiqued psychiatry (Burstow, 1992; Chesler, 1972; Smith, 1990).

POST-TRAUMATIC STRESS DISORDER (PTSD) AND THE FEMINIST ENGAGEMENT WITH PTSD

Insofar as feminists and others have been trying to extend the understanding of trauma, they have involved themselves with definitions of PTSD as set forth in respective editions of the *DSM*, in particular, *DSM-III-R* (American Psychiatric Association, 1987) and *DSM-IV* (American Psychiatric Association, 1994). A significant criterion in this regard is criterion A in *DSM-III-R*, which specifies "the person has experienced an event that is outside the range of usual human experience and would be markedly distressing to almost anyone" (p. 250). Other significant criteria include criteria B to D in both editions. Each of these criteria stipulates an attribute of trauma, then provides a list of included symptoms and identifies a precise number that must be met. For example, in *DSM-III-R* and *DSM-IV*, criterion C reads, "Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness. . . as indicated by at least three of the following" (p. 250, p. 428, respectively). What follows is a list of reactions, such as efforts to avoid thinking and restricted affect.

Feminists particularly critiqued the stipulation in criterion A in *DSM-III-R* that the traumatic event be "outside the range of usual human experience." As Brown (1995) put it,

> The range of human experience becomes the range of what is normal and usual in the lives of men of the dominant class; White,

> young, able-bodied, educated, middle class. Trauma is thus what disrupts the lives of these particular men but no other. (p. 101)

Indeed, the psychological aftermath of childhood sexual abuse, to which feminists have long extended the concept of trauma, is ruled out by this stipulation. Feminists successfully lobbied for the removal of the stipulation. As a result, criterion A in *DSM-IV* reads,

> The person has been exposed to a traumatic event in which . . (1) 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 other; (2) the person's response involved intense fear, helplessness, or horror. (p. 428)

Although this shift satisfies this particular objection, other problems raised by feminists remain. As regards criterion A, the rewording does not address a particularly fundamental objection raised by feminists, and one that takes us further into political terrain. As Root (1992), Brown (1995), Gilfus (1999), and Lewis (1999) pointed out, tying trauma to a physically dangerous event or events per se is inadequate, especially in the case of oppressed people. The point is oppressed people are routinely worn down by the insidious trauma involved in living day after day in a sexist, racist, classist, homophobic, and ableist society: being ogled by men on the street, slaving long hours and for minimum wages in a fish processing plant, hearing racist innuendoes even from one's White allies.

A related but more general criticism raised about PTSD is that it does not describe the effects of repetitive violence and victimization (Brown, 1995). What is more fundamental, PTSD is a grab bag of contextless symptoms, divorced from the complexities of people's lives and the social structures that give rise to them. As such, the diagnosis individualizes social problems and pathologizes traumatized people (Gilfus, 1999; Lewis, 1999; Root, 1992).

OTHER VOICES

Other significant theorists in the area include but are not limited to transgenerational theorists, community trauma theorists, and eco-feminists. Transgenerational theorists, such as Danieli

(1998) and Duran and Duran (1998), demonstrate that trauma can arise by virtue of belonging to a specific social group (e.g., Natives or Blacks) or by virtue of belonging to a particular family or subset of a group (e.g., children of Holocaust survivors). The significance of belonging to groups is not found in any of the *DSM* definitions. Moreover, a good part of transgenerational trauma is ruled out by criterion A. Significantly, people subject to transgenerational trauma may not have directly experienced, witnessed, or even been confronted by traumatic events. Indeed, they may have experienced nothing but the particular ways their parents respond to the world.

A more fundamental departure from dominant trauma discourse comes with the community trauma theorists. General community theorists such as Erikson (1995), Native theorists such as Duran and Duran (1998), and Holocaust theorists such as Danieli (1998) point out that it is not only individuals who are traumatized. Whole communities can be traumatized. In making this claim, community theorists are not simply meaning that all people within the community are traumatized but that the community as an integral whole is traumatized.

Eco-feminists such as Glendinning (1994) extend the concept of trauma further and create a still further rupture with the *DSM*. Glendinning has argued that the rift between person and environment has traumatized everyone who is part of "Western civilization."

PROBLEMS WITHIN FEMINIST PRAXIS (PRACTICE PLUS THEORY)

Although feminist trauma practitioners have been at the forefront in critiquing the *DSM* and pioneering more radical approaches to trauma, as already noted, there are serious inadequacies in much of feminist praxis itself. Part of the problem is not sufficiently incorporating others' insights. More fundamental is insufficiently attending to the political. Then, there are curious goals and statements, which, as will become progressively clear, bring us back to the whole question of political paradigm and of psychiatry.

Therapists with a constructivist bent—as most have, including feminist Herman (1992)—see traumatized people as insufficiently

trusting others as a result of the trauma and having a particularly distorted view of the world. Correspondingly, a fundamental therapeutic goal that they tend to posit and see as essential is survivors returning to a more "normal" orientation in which they can once again trust in the goodness of others.

There are serious problems with the unquestioned belief in normalcy and in the superior status accorded it. Two underlying assumptions that are equally problematic, are

1. The world is essentially benign and safe, and so general trust is appropriate, and
2. people who have been traumatized have a less realistic picture of the world than others.

As Lewis (1999) pointed out, the first assumption smacks of elitism. For women, Blacks, natives, Arabs, and I would add, psychiatric survivors, the world is not a safe and benign place, and so mistrust is appropriate.

The second assumption misses the point of what happens in trauma. As Brown (1995) has suggested, people who have not had the ground come out from under them, and so are not fundamentally traumatized, can walk around with a certain cloak of invulnerability, and they can edit out anything that tells them the world can get at them. What happens to a person who is badly traumatized is that the person loses that cloak of invulnerability. When a woman is raped, for instance, she loses the capacity to "edit out." She knows that life can get at her. This being so, a case could be made that the highly traumatized person actually sees the world *more* accurately than the less traumatized. That is not to say that trauma does not create its own distortions or that it is illegitimate for practitioners to help clients work on those distortions. However, decent trauma praxis simply cannot rest on a deficiency model.

An equally serious problem with much of feminist theorizing and practice may be seen in Herman (1992), despite her contributions to feminist trauma work. Herman (1992, pp. 156-159) stressed the importance of arriving at the correct "diagnosis" and warned the therapist against "conspiring" with the client "to avoid the diagnosis," noting that "some patients resist the diagnosis of a post-traumatic stress disorder" (p. 158) and that some object to any diagnosis. Correspondingly, she suggested adding a

new trauma diagnosis to the *DSM* repertoire: complex post-traumatic stress disorder. What we have here is a proposal that experts, not victims, name victims' experiences and that victims be talked into complying despite their reluctance. In other words, we have a coercive application of a psychiatric text and the pathologizing of clients who do not want the text to be applied to them. Although most feminist practitioners would not coerce so blatantly, pushing a reluctant and vulnerable client to accept a particular psychiatric category is only *part* of the psychiatric imposition that Herman recommended, and to varying degrees, most feminist practitioners go along with the rest. That is, they fundamentally engage with psychiatry via the use of psychiatric concepts such as symptoms and diagnoses, including PTSD.

Herein lies a major obstacle to truly radical work. Although critiquing psychiatry, to varying degrees, most feminist practitioners who work with trauma have accepted institutional psychiatry and a great deal of the conceptual baggage that comes with it, as do most transgenerational theorists and community theorists. They use the language, and they operate in terms of its definitions, admittedly, while pressuring psychiatry to make its definitions more socially aware and responsible. In this regard, they are seriously minimizing the problems with psychiatry, and they are obstructing radical praxis.

UNDERSTANDING INSTITUTIONAL PSYCHIATRY AND THE IMPLICATIONS OF UNDERSTANDING

As feminist sociologist Smith (1990) has clarified, institutional psychiatry is a regime of ruling. Having invented the concept of "mental disorder" and broken it down into distinct diagnostic categories, psychiatrists impose the categories on vulnerable others, while studying those others and calling the result "knowledge." On the basis of these concepts, they have the right to incarcerate and impose substances on people. The ruling is mediated through texts, such as mental health acts. The *DSM* is the key text that mediates the application of diagnoses. Essentially, it creates mental disorders. In this regard, our everyday understanding of how a traumatized person "gets" a certain mental disorder is inaccurate. It is not that there is an oppressive situation, this leads to stress,

and the stress culminates in a disorder. Rather, as Smith showed, there is an oppressive situation, and this leads to stress and other reactions. There is no disorder at this point, nor will there be, unless somebody with authority applies a psychiatric conceptualization as mediated by the *DSM*. And it is this application that creates the mental disorder. Mental disorders, whether they are called PTSD or anything else, in other words, are a function of the power of psychiatry mediated by the psychiatric text, irrespective of whether the practitioner making the judgment is a psychiatrist or a feminist practitioner. Insofar as trauma practitioners use the texts, we involve ourselves with psychiatry, thereby extending its power. We also violate the person, however benign our intentions and whatever genuine help we give in the process. That is, we take away people's power to name their experiences and subject them to a naming controlled by a powerful international institution at arms length. Moreover, we increase the possibility of the person some day being subjected to more substantial psychiatric interference, for diagnoses are an entry point to more intrusive measures. The more severe the diagnosis, the more severe the treatment it can legitimate, hence, the folly of asking psychiatry to introduce a more extreme diagnosis such as complex post-traumatic stress disorder.

What compounds the seriousness of what is happening here, the institution is inherently traumatizing. Besides that alienation from one's power to name traumatizes in subtle ways, psychiatry routinely traumatizes in ways not at all subtle. Indeed, testimony to the trauma inherent in standard incarceration, drugging, electroshock, and two- and four-point restraint may be found in ample sources, including Burstow and Weitz (1988) and Shimrat (1997).

What adds to the inadvisability of feminist trauma practitioners tying themselves to PTSD or other trauma-related diagnoses is that they cannot facilitate sensitive work, for the diagnoses are not sensitizing, nor could they be. Feminist therapists object that these diagnoses tend to be grab bags of contextless symptoms, but that is the nature of psychiatric diagnoses. Indeed, as Woolfolk (2001) has demonstrated, they are not naturalistic categories but definitional categories created by committee. As such, they cannot do justice to the psychological misery of people's lives, never mind the social conditions that give rise to the misery.

Correspondingly, given their function to separate who has an alleged disease from who does not, they force a simplistic yes or no onto the question of trauma and severely narrow the ways that trauma can be understood. As such, they are a fundamental impediment to radical trauma praxis.

WHERE DO WE GO FROM HERE?

On the basis of the preceding analysis, I am recommending that we substantially break with psychiatry, that is, that we not look to psychiatry for trauma frameworks and that we rigorously demedicalize. What is involved here is not expending energy tampering with the *DSM*, not using a deficiency model, not framing psychological and social problems in terms of diagnostic categories, and ridding practice of medical language such as *recovery*, *symptoms*, and *diagnoses* and all diagnostic names including PTSD.

Whether we should continue to use the concept of *trauma* is a more complicated question. A formidable reason to discontinue is the medical and psychiatric hegemony over it and the concomitant cooptation. Additional reasons are that there is no intrinsic link between the word and social structures and the concept is messy. Indeed, as Erikson (1995) pointed out, “trauma” refers to “wounds” and “reactions to wounds,” with the distinction between the two blurred. There are reasons to retain the term and concept nonetheless.

Arguably, the single most important of these is that trauma is a conceptualization that psychologically injured people claim for themselves. Other reasons for retaining the term are that trauma is a contested terrain and we are able to exert an influence on how it is understood. There has been important theory and practice based on it. *Trauma* is part of everyday vocabulary. Trauma is a sensitizing metaphor that conveys a sense of the overwhelming nature of the experiences. In addition, we always have the option of bringing in social context. Indeed, given that *wound* connotes violence, *trauma* and *wound* lend themselves to relating the psychological injury to violence, including violating social structures. Moreover, despite the ethnocentric nature of dominant trauma discourse, a metaphor based on physical wounds speaks to people across cultures, as evidenced in the Aboriginal concept

of "soul wound," as articulated in Duran and Duran (1998). As such, it has at least a type and a degree of cross-cultural validity and can facilitate cross-cultural praxis.

Accordingly, I recommend that we not cede the trauma territory to psychiatry but continue to build our own discourse while carefully monitoring this usage to ensure that it is serving us. In addition, I recommend that feminists and other radical theorists engaged in trauma praxis work together at theorizing trauma, for we need each other's voices, and we need to create more comprehensive radical theory if our work is to be truly emancipatory. That is, we need theory that builds on our respective knowledges, that is free of psychiatric vocabulary and conceptualization, and that explicitly theorizes social structures and their role. What follows is theorizing toward that end.

TOWARD A RADICAL UNDERSTANDING OF TRAUMA

Generally, scholars who discuss conceptual categories begin with a definition that stipulates binding criteria just as the *DSM* definition does. I ground the concept of trauma differently, for as Wittgenstein (1972) demonstrated, there are no simple essences. Moreover, working via definitions creates its own rigidity and further implicates scholars and practitioners in the relations of ruling.

Trauma is a not a disorder but a reaction to a kind of wound. It is a reaction to profoundly injurious events and situations in the real world and, indeed, to a world in which people are routinely wounded. Although traditionally applied to individuals, as theorists such as Glendinning (1994) show, it can apply with certain alterations to communities, nations, and the world itself. Whatever its application, there is a physicality to trauma. Trauma befalls *embodied* individuals, and even when there is no explicit assault on the body, people become alienated from their bodies in some respect. Correspondingly, as Erikson (1995) pointed out, in traumatized communities, it is as if the tissues of the community had been torn asunder.

We often talk about trauma as if a person or community is either traumatized or not. Although at times this is useful, another way of conceptualizing trauma is as a complex continuum on

which we are all located, with the trauma of each bearing what Wittgenstein (1972) called a "family resemblance" to the trauma of others. People further along on the continuum are more traumatized, but the situation is not straightforward. People or communities may be more traumatized in some respects and less in others.

As theorists such as Lewis (1999) demonstrate, trauma is characterized by a loss of grounding or absence of grounding. People and communities are overwhelmed, feel existentially unsafe, and find the world profoundly and imminently dangerous. As most theorists have suggested, this orientation, feeling, and interpretation are accompanied by such feelings as terror, hopelessness, helplessness, worthlessness, despair, distrust, rage, and oftentimes, guilt. Correspondingly, as Herman (1992) pointed out, to varying degrees, people are disoriented spatially and temporally. Other places and people can be projected onto the places and people present. Moreover, people or communities tend to become frozen in time, periodically reexperiencing the past or responding to the present as if it were the past. Different types of dissociation and disconnection occur, with individuals and communities dissociating from aspects of the past that are associated with the trauma; with people and communities fleeing events, history, or memory; with people dissociated from all or parts of their traumatized bodies; with thought separating from feeling; with people disconnecting from others; and with the ties that bind a community coming asunder. Moreover, trauma tends to be characterized by opposing pulls and directions. As theorists such as Herman (1992) suggest, people flee from the past, for example, while being haunted by the past, and people numb themselves, with many eventually becoming so numb that they desperately need to bring back feeling. Oftentimes, as Burstow (1992) demonstrated, the very coping strategy employed by traumatized people goes in opposing directions, with self-mutilation, for instance, both serving to numb people to unbearable psychological pain *and* to help them overcome the numbness. Moreover, as Burstow suggested, the opposing directions often reflect a kind of catch-22. Insofar as people numb and distract themselves from feeling, they can suddenly find themselves terrified, with the feeling seeming to come out of nowhere. Insofar as people flee memory, they are haunted by nightmares and flashbacks triggered by sights,

sounds, and sensations. At the same time, as Holocaust survivors have long testified, the consequences of not distracting and not dissociating can be the inability to function, utter despair, and in the long run, far more substantial dissociation.

To varying degrees, the destruction of witnessing is part of traumatization. Significantly, most of the rest of the world does not know about the traumatizing event or situation, or at least has no real appreciation of it. This being the case, the traumatized person or community feels profoundly alone. However, it is not only witnessing by *others* that is wanting. In classical trauma, to varying degrees, the traumatizing events or situations concretely preclude even *internal* witnessing. As Herman (1992) and Burstow (1992) showed, the childhood sexual abuse survivor dissociates from his or her own body and so does not totally witness the abuse. On a more extreme level, the very foundation that makes internal witnessing possible was destroyed for many Holocaust survivors. In this regard, Laub (1995) wrote,

> There was no longer an other to which one could say “Thou” in the hope of being heard. . . . But when one cannot turn to a “you” one cannot say “thou” even to oneself. The Holocaust created a world in which one *could not bear witness to oneself* [italics added]. (p. 66)

I have listed psychological conundrums and orientations that pertain to trauma because these are critical dynamics for practitioners, including radical practitioners, to understand. What is at least as critical to understand, however, is that trauma is not a free-floating feeling or set of feelings or orientation. Trauma is a concrete physical, cognitive, affective, and spiritual response by individuals and communities to events and situations that are objectively traumatizing. On a simple level, for the most part, people feel traumatized or wounded because they *have been* wounded. For the most part, traumatized people experience the world as dangerous not because they have been rendered inadequate by the trauma and, therefore, have an essentially distorted worldview. They so experience it because events or conditions have brought home how very dangerous the world is and have precluded the editing out practices by which less traumatized people construct an essentially safe and benign world. In this respect, as noted earlier, the case could be made that people and groups who are most traumatized see the world more

accurately—not less accurately—than their less traumatized counterparts. Without doubt, of course, insofar as traumatized people and populations are reexperiencing the past and are triggered, distortion is involved, and clearly working through issues can often help traumatized people feel somewhat safer. However, the terror involved in such everyday activities as walking down the street simply cannot be accounted for by reference to triggers or unresolved issues. Instructive in this regard is the woman who is terrified walking down the street a year after being raped. As Lewis (1999) pointed out, she is not walking down a neutral street, where violence against women is not a possibility. Indeed, she still lives in a sexist society where rape is an ever-present danger. In other words, the social relations in the present contain the same power dynamic as those in the past that culminated in the rape. On that level, nothing has changed. She is not wrong that she is unsafe. Her experience of lack of safety, accordingly, is not simply the result of an unfortunate trigger. It is an attunement to a basic social reality. By the same token, although the Holocaust survivor who is terrified of being rounded up is undoubtedly frozen in time, she or he is likewise attuned to a world that is far more anti-Semitic than society acknowledges.

What is implicit in all of this is that the trauma reactions known as *symptoms* are not just proclivities that somehow beset traumatized people and populations. Some are heightened awarenesses that arise by virtue of the experience. Some are dynamics that flow from the logic of the situation. Most are constructive ways of conducting oneself in fraught and often impossible situations. In this last regard, I would draw attention to such highly theorized directions as dissociation and numbing. Although, undoubtedly, they can be automatic responses, what such a conceptualization leaves out is how very often they are purposeful ways of getting by, ways, moreover, with a proven track record. As Burstow (1992) demonstrated, many survivors of childhood battery use cutting to distract themselves, to calm down, to remind themselves they are human, to scream, to protest, to resist a world that tries to control them, and it works for them. Whether traumatized people use more conventional means, or whether they slash or starve themselves, they are actively coping. As such, the so-called symptoms are best theorized as survival skills. Correspondingly, traumatized people are most adequately conceptualized as competent

practitioners of their lives, none of which means that they do not get stuck or that help is inappropriate.

Just as trauma is properly understood as a series of responses to a concrete situation—not as symptoms or free-floating feelings or orientations—traumatic events and situations must be seen as concrete events within contexts. Specific traumatic events happen to specific people in specific locations and within specific contexts, and they inevitably involve other human beings. As such, trauma is inherently political. This truth is most apparent in situations involving obvious perpetrators and obvious oppressive structures. A heterosexual man attacks a gay man. The heterosexual man is a perpetrator, and the context is patriarchy. However, even traumatization that appears neutral also involves others and is political. The underground gas leak that traumatizes a village is a case in point. Technological accidents such as this seem to have nothing to do with other people or social structures. However, we have the specific technology we have and it breaks down in the way it does because of the structures that we set up and put faith in, a reality that, in turn, has something to do with separation from nature, capitalism, and so forth. As such, trauma inherently involves others and societal structures. Even the trauma "caused" by a tornado laying waste to a village and uprooting people's houses has a significant political dimension. Although human beings did not create the tornado, the tornado occurs within a context. In a supportive context, people whose homes have not been uprooted might offer ongoing support and caring to their less fortunate neighbors, and insofar as they did, the trauma would be contained. In other contexts, people whose homes are intact might distance themselves from others whose homes are devastated, seeing the victims as potential looters. Correspondingly, governments or governing councils might provide maximum or minimum help. Insofar as people are not helped or helped inadequately, the trauma takes on whole new dimensions. The reaction of others, in other words, figures significantly in trauma.

To put it another way, traumatizing reactions by others greatly compound trauma and constitute part of the objective basis for the sense of aloneness, the terror, the worthlessness, the despair, and the collapse of witnessing. Correspondingly, these reactions are determined to some degree by the values and structures of

society. That is not to say that there would be no trauma in a noncapitalist, nonpatriarchal, nonracist society, but it would hardly have the dimensions that it currently has.

Magnification of trauma by others and by society at large occurs in manifold ways, including denying the injury, minimizing the injury, failing to accommodate, and failing to help (Burstow, 1992). What is particularly significant to questions of radical praxis, trauma is magnified exponentially in the name of help, especially by those helping institutions that occupy central locations in the relations of ruling. Moreover, trauma is systematically produced by them. As such, officially mandated institutions of help, especially arms of the state, must be understood as central players in the traumatizing of people and communities.

As noted earlier, psychiatry is particularly pivotal in this respect. Psychiatry alienates people from their capacity to name, invalidates people's conceptualizations, imposes a stigmatized identity on them, places them on paths not of their own choosing, deprives them of liberty, and imposes harmful treatments on them. With other arms of the state, however, we find parallel injury. An example is the arm in charge of "helping" the traumatized group conceptualized as refugee applicants. The patriarchal, capitalist, racist, and ableist state is not keen on letting in anyone who does not fit its agenda, consequently the laws, regulations, and structures in these areas. Texts such as immigration legislation and refugee legislation mediate how people from other lands are processed, on what tracks they are channeled, and what they must prove to gain entry. Various players are involved in the processes by which those on the refugee track or seeking to be on it are regulated. Examples are officials with the power to grant or deny entry, lawyers who argue cases, psychologists who do assessments, and refugee boards that determine whether an applicant fits the criteria and is a "legitimate" refugee. Each creates trauma. In each case, the traumatized person is forced to tell her or his story yet again, generally in minute detail, thereby becoming seriously flooded. Moreover, in what is a parody of authentic witnessing, people are alienated from their own stories as the questions asked enforce distortion, as provisions make subterfuge necessary, and as stories are reworked so as to fit the relevant texts (e.g., refugee-related legislation, the *DSM*). Further compounding the trauma is the degree to which the various

processes involved replicate the dynamics inherent in the original injury: marked power differentials, a threat to life, repeated interrogation, minute observation, and intense suspicion. Compounding this is the oppressive nature of the texts themselves, including criminalizing constructs and provisions; the racism, classism, sexism, and ableism of each of the players; and the language barrier. Whatever the determination, trauma is greatly compounded.

There is a complex relationship between trauma and systemic oppression. Oppression is the primary traumatizing condition and one to which all are subject. As Freire (1970) put it, oppression robs everyone of humanity, both oppressor and oppressed. The regimes of ruling, moreover, involve and create structures and dynamics that alienate us from the natural world, each other, and ourselves and that pathologize and regulate expectable responses to alienation and injury. As such, to varying degrees systemic oppression traumatizes everyone and the earth itself. However, it does not traumatize everyone equally. Oppressed groups are subject to special traumatization. It is not just that oppressed groups are subject to more overt violation, which is blatantly the case. Oppressed groups are subject as well to what Root (1992) called the insidious traumatization involved in living our everyday lives in a sexist, classist, racist, ableist, and homophobic society: the daily awareness of the possibility of rape or assault, the daily struggles to stretch insufficient wages so that the family eats, encountering yet another building that is not wheelchair accessible, and seeing once again in people's eyes that they do not find you fully human. To apply Freire's conceptualization, oppressed individuals are traumatized by the daily obstacles to their aspirations, by the seeming impossibility of fulfilling their ontological vocation to name the world in order to change the world, and by everyday hegemony.

Just as individual members of oppressed groups are traumatized by systemic oppression, communities themselves are also traumatized. The different expressions that this traumatization can take include the coming asunder of community, the loss of tradition and direction, pervasive despair, the need to numb through drugs, and people losing connection with each other. As Gagné (1998) suggested, all of these ways may be seen with respect to

Native communities, with colonialism functioning as the traumatizing situation.

Correspondingly, as theorists such as Duran and Duran (1998) demonstrated, people and communities are subject to transgenerational trauma. That is, they are traumatized by the trauma of earlier generations: by the transmitted stories, by the structures that are formed, by the coping strategies that are passed down, by frightening images and fragments, and by the reality of the oppression to which these point.

In oppressed communities, as Danieli (1998) suggested, transgenerational trauma is the norm, with it extending beyond the progeny of people affected directly. The trauma is historical in the sense that it is attached to historical events and conditions. Historical trauma arises from identity and shapes identity, and it is the lens through which current events are understood and current trauma experienced. By way of example, not just children of Holocaust survivors but world Jewry is traumatized by the Holocaust. The vast majority of Jews who I have asked, myself included, have acknowledged asking themselves what they would do if Jews were rounded up again, have nightmares about the Holocaust, and have imagined themselves in the death camps. By virtue of history and of having the identity *Jew*, Jews are subject to this transgenerational trauma. In turn, these questions and these images form a part of what it means to be a Jew. Moreover, they are lenses through which everyday life, especially current anti-Semitism, is experienced.

Trauma occurs in layers, with each layer affecting every other layer. Current trauma is one layer. Former traumas in one's life are more fundamental layers. Underlying one's own individual trauma history is one's group identity or identities and the historical trauma with which they are associated. Underpinning this are the structural oppressions and the institutions through which they operate: in the case of many groups, with colonialism and the North-South divide being especially critical and, with all groups, with developments such as globalization assuming increasing importance. Underpinning this is the altered human condition that non-Aboriginals have created and that affects the vast majority of groups on this earth: the condition of being cut off from nature. And underlying this are the trauma-making features of

the human condition itself, what Heidegger (1978) would call separateness, throwness, being-toward-death.

Although, unfortunately, the latter is disproportionately emphasized, trauma brings both strengths and problems. Common, albeit not invariable, strengths include the development of profound survival skills, an enhanced ability to understand other traumatized and oppressed individuals and groups, a passion for justice, a desire for a different kind of society, a certain critical realism, and what is particularly significant, a less distorted view of the world.

THE MEANING FOR RADICAL PRACTICE

Radical trauma practice is necessarily based on an awareness of the centrality of oppression in the traumatizing of human beings, communities, and the earth itself. It is also based on compassion and respect for traumatized individuals and communities: their history, their strengths, their naming, their conundrums, their choices. That is not to say that no choices or naming should be problematized. Indeed, problematizing internalized oppression is part of our mandate as radical helpers. This notwithstanding, caring, appreciation of differences, respect, and a commitment to learn about the complexities of other locations are the fundamental grounds from which problematizing proceeds. By the same token, counseling is necessarily based not only on personal but also on political empathy, that is, empathy that joins with the individual and group on the basis of social location and oppression (Burstow, 1992, p. 51). And it is predicated on the significance of the traumatized gaining or regaining the power to name, protecting self, and countering alienation.

One clear implication of my analysis is that it would generally be preferable for practitioners to use a continuum conceptualization in work with traumatized clients, inviting clients to see themselves on a trauma continuum on which everyone is located. A continuum conceptualization, of course, should not be used to equate what is blatantly unequal or to accommodate total subjectivism. In this regard, we are not traumatized by an event or condition simply because it has distressed us all our lives or because we ourselves apply the term *trauma*.

It is vital to keep on guard against falling into a deficit model. As outlined in Burstow (1992), instead of working to eliminate traumatized ways of coping, for example, counselors should honor these ways, co-investigating with the client the various purposes served. Using the knowledge so gleaned, counselors and clients can then coexplore additional ways of serving those purposes, thereby expanding the skills repertoire and making choice at least sometimes possible. Beyond this, getting rid of a deficit model entails not stressing the psychological at the expense of the political. It means that feminist counselors should be careful not to foster the victim identities that have plagued some feminist work. It means, correspondingly, that goals and modes of operating based on deficit models should be scrapped or dramatically altered. In this regard, helping clients return to a pretrauma Pollyannaish view of the world, or to create such a worldview, is misguided. Practitioners, rather, should honor and build on the wisdom of the traumatized view, using it as a possible entry point into structural issues even when it is not overtly political. Similarly, practitioners should be joining with clients in acknowledging and lamenting the utter inadequacy of conventional views. What follows is we should be helping traumatized clients in their struggles to navigate a world in which terrible things really do happen, where a potential rapist really might be around the corner, where mosques really are desecrated, and where systemic oppression continues. More generally, insofar as regaining power is central to what so much traumatized coping is about, an absolutely critical direction for radical trauma praxis is redirecting some of the focus off controlling self and onto acquiring real power in the larger world.

Given the enormous significance of group trauma, community trauma, and historical trauma, and given the disconnection from community and others that is inherent in trauma, more emphasis on community, group work, and witnessing is in order. Individual counselors can facilitate this direction by making overtures to communities, by responding to requests from communities, and by creating special educational sessions, workshops, and groups for clients. Whether through group work or in other ways, it is important that witnessing be extended beyond the therapist or counselor. In saying this, I am not denying the enormous significance of the counselor acting as witness to abuse, tyranny, or

tragedy or of the counselor holding the pain and the story. However, ultimately, the witnessing provided by a professional cannot satisfy the larger existential, social, and political needs. As such, it is important that counselors act as a bridge into a larger frame so that more witnessing happens in the real world. Use of public art, I would add, is a particularly promising direction, for it at once facilitates witnessing; generates new meaning out of old; integrates mind, body, feeling, and spirit; and creates community.

An example of art that illustrates the types of initiatives that feminist therapists could be encouraging or actively supporting is the Still Sane Project, as documented in Blackbridge and Gilhooly (1985). Gilhooly was traumatized by being subjected to ongoing electroshock for being a lesbian. Gilhooly teamed up with artist Blackbridge. Blackbridge made a series of casts of Gilhooly's body, most of them exemplifying the victimization and pain, some expressing resistance and triumph. Gilhooly wrote about her experience. Together Gilhooly and Blackbridge matched specific statements of Gilhooly's with particular body casts, placing statements on each cast. The casts now stand as concrete testimony to the violence, the trauma, and the resistance. The body casts were shown in art exhibits in the Vancouver area. Blackbridge and Gilhooly toured Canada, using slides of the sculptures to bear testimony, educate about psychiatric injury, and mobilize psychiatric survivors. They replicated the writing and the pictures in their book *Still Sane*, thereby engendering still further witnessing and resistance. Although obviously not every traumatized person would be comfortable going this far, the general direction is clear.

The Lantern Project is an example of more subtle politicizing that is embodied and that uses art, in this case one set in motion within a therapeutic frame. A colleague of mine, Emear O'Neill, put a number of lanterns in her waiting room, inviting any woman client who so wished to take one home and alter it in a way that gave expression to the deep personal transformation she had undergone. Had the art been done within the session, then used to animate dialogue between therapist and client, this use of the lanterns would probably have gone no further than art therapy. However, women worked on the lanterns on their own over an extended period. Subsequently, the therapist invited women who were not clients to take and transform a lantern. All women

had the option of keeping the lantern or returning it anonymously. The lanterns that were returned clearly bore witness to women's injury under the patriarchy and to their concomitant struggling and transformation. With everyone's permission, the lanterns were subsequently arranged so that they picked up on each other's themes and were displayed in a number of public installations. The combined works bear testimony to women's trauma and women's healing.

In general, although psychological work must, of course, be integrated, I am advocating that trauma work move more in the direction of critical adult education, with counselor and clients coexploring the traumatizing and oppressive situations and structures together and clients taking up real tasks. This direction has particular relevance when working with oppressed groups and communities. With such praxis, the counselor might or might not be able to transit to an animator role, then disengage. Examples of praxis that incorporate a witnessing component that might be encouraged or assisted include public testimonio, demonstrations that include personal testimony, theatrical or other artistic representation, and legal actions, whether against individual perpetrators, government agencies, or international corporations.

Actions that counter alienation should be encouraged and supported. Possible examples include telling one's story; naming one's own experiences; debunking myths about one's community; creating public rituals and ceremonies for expressing grief and outrage; rebuilding community ties, traditions, and models; reclaiming personal, community, or national space; reclaiming the product of one's labor; reconnecting with nature; and indeed, all environmentally responsible liberatory initiatives.

A further implication of the preceding analysis is that whether doing individual work, group work, or community work, therapists and counselors need to be aware of the different layers of trauma and traumatizing structures. Co-investigating how these play out with respect to a particular person, community, or nation is optimal. Examples of questions that might be considered or asked in this regard include What special meaning does the rape have for this client and her family in light of what happened to her mother in the residential schools? How are current colonialism and sexism implicated in the response by the criminal justice system? Insofar as *co*-investigation is not possible or helpful,

counselors can still take these different levels into account, including the complexities of historical trauma, and can be alert to openings where such issues can be touched on.

I would particularly call attention to the significance of understanding the impact of various institutions that have traumatized or might traumatize clients and the importance of helping clients protect themselves and resist. It is a common but serious mistake to downplay the traumatic impact of the various institutions of the state, either limiting the focus to a discreet traumatic event, extending the analysis only to the traumatic impact of family denial or minimization, or otherwise acting as if the state has no role. It is crucial that the traumatizing of the state and its institutions be explored and, indeed, insofar as possible, coexplored.

Illustrative of what might be done in this regard is codification work of mine, which combined co-investigation of an institution, witnessing, community building, and resistance. This particular piece of work is also instructive because it demonstrates the enormous difference between conventional and radical work and shows the value of such work even with people who demonstrably break society's rules. To clarify the vocabulary, "codifications," as adult educator Freire (1970) conceptualized them, are pictures that reflect the experience of the community in question while embodying themes and pointing to tasks to be done. *Themes* are understood as the hopes and aspirations of the people, together with whatever blocks those hopes and aspirations.

Working with supervisees, I created a codification series on prison life and led a group of ex-prisoners in dialogue about the codifications, examining one codification per session. The clients in the group had spent almost all of their lives in prison and, not surprisingly, given the profile, none was middle class. All had been subjected to the insidious traumatization inherent in years of imprisonment as well as life in poverty. Most, in addition, had been traumatized in adulthood and childhood, some by sexual abuse, some by racist assault. Significantly, clients who had never been able to talk about their trauma used the pictures to analyze the prison situation and to discuss personal traumatization both in and out of prison, including the insidious traumatization of being poor, working class, and of color in contemporary society. Co-investigating the various pictures, they explored how the justice system is traumatizing and oppressing inmates, how they

personally have been injured, and how prisons mirror the injustices of society at large. They came up with such tasks as working toward solidarity with other inmates, demonstrating against a particular prison, and contributing to Prisoner Justice Day. With the help of supervisees working under me, I subsequently supported the clients as they mobilized and took up each of these tasks.

One man was triggered by the codifications and took refuge in forms of denial that were standard for him. He asserted that the world was benign and that anyone willing to work 9 to 5 could have a fulfilling life. In other words, he took the very position that conventional therapists would see as progress. Significantly, the platitudes in question had been fed him by prison psychologists and were part of a vicious cycle: that is, believing that the world is just, working hard to get "the good life," breaking down under the daily grind, stealing, getting caught, ending up back in jail, again being told that the system is benign, and reinvesting in the capitalist myth. Nonetheless, the codifications and the dialogue had created a chink in his belief system and were about to disrupt the cycle. The client returned a couple of weeks later and tentatively began exploring the relationship between oppression, his continual return to prison, and his current pain. Significantly, he ended up leading the demonstration against the prison and getting involved in Prisoner Justice Day, bearing public witness against the system. He began turning his life around.

Just as it is important to help our clients understand the oppressive institutions that control them and to mount a resistance, it is important to help clients protect themselves from traumatizing institutions. As is obvious in this article, psychiatry is a particularly important focus in this regard, for many traumatized people have been subjected to it, colleagues routinely operate in terms of it, and traumatized people can so easily end up under its auspices. Examples of questions that therapists might consider in this regard include How specifically has psychiatry traumatized my client? Which of my clients are in danger of psychiatric intrusion? Which psychiatric frameworks have specific clients internalized? What legal knowledge, skills, and resources might best help them protect themselves? Examples of other institutions that might similarly become focal include the police, the courts, immigration, refugee review boards, and all government departments and agencies that address indigenous peoples.

What likewise follows is that it is often crucial that counselors and therapists go beyond focusing, advising, cautioning, and mentoring. They need to be prepared to intervene. Indeed, one obvious implication of radical trauma theory is that far more advocacy is necessary, both individual advocacy and systemic advocacy.

Moreover, insofar as is feasible, it is critical that counselors take proactive measures so that they are not co-opted by organs of the state that traditionally traumatize our clients. As is clear from the forgoing, I think that severing our relationship with psychiatry is particularly critical, for psychiatry is a threat to vulnerable clients. One dimension of this, as suggested earlier, is rejecting psychiatric conceptualizations. Although doing so jeopardizes insurance coverage and compensation claims, and so some therapists will choose to use them in such situations, it is important to keep in mind that use of the labels is a slippery slope and has consequences. Additional dimensions are not using psychiatry as a resource and not referring vulnerable clients to otherwise good therapists who turn to psychiatry when their clients slip into severe dissociation or alternate realities. By the same token, it is important that we not be an extension of the criminal justice system and that we guard against uncritical relationships with institutions such as refugee review boards, schools, and welfare agencies.

One final observation, given that clients can also be traumatized by other states, even when not working with refugees, per se, it can be critical to co-investigate the trauma caused by external states and their institutions: by bombing, by manipulation of markets, by debt-for-nature swaps, by rape as a practice of genocide. Correspondingly, with increased globalization, it is becoming progressively important to include the role of transnational corporations and other international bodies in the construction of trauma and to support resistance in this expanded arena.

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Bonnie Burstow, Ph.D., is a faculty member in the Department of Adult Education and Counseling Psychology at the Ontario Institute for Studies in Education. She is also a therapist in private practice, a radical who is active in the feminist movement and in such movements as antipsychiatry and prison abolition, and a writer. Her works include Radical Feminist Therapy: Working in the Context of Violence *and* Shrink-Resistant: The Struggle against Psychiatry in Canada.