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Unsettling trauma: from individual pathology to social pathology

John W. Lannamann and Sheila McNamee

Rather than assuming that psychological terms mirror natural categories in the world and that the task of the helping professions is to find ways to discover, diagnose and treat these categories, our goal is to inquire about the status of the categories as an aid to then focusing on therapeutic responses. To that end, we unsettle trauma by exploring its social ontology as a disorder as well as its grammar. Feminist and cultural critiques of PTSD illustrate the limitations of the dominant discourse of trauma, moving trauma from individual pathology to social pathology. We offer two illustrations from the family therapy literature that draw upon polyphony, inner dialogues and the creation of new narratives to expand beyond the pathologising potentials of the discourse of trauma.

Practitioner points

- Understanding the concept of trauma as a socially embedded construction is a necessary first step towards recognising its different applications in therapeutic work
- The dialogic/constructionist stance taken here assumes that meaning and understanding are shaped by discourse and interaction
- The taken-for-granted meanings associated with trauma need to be questioned
- Practitioners may then assess when the use of a PTSD diagnosis might import individualising and objectifying assumptions that undermine the goals of systemic family therapy

Keywords: dialogue; individualist discourse; pathologising discourse; polyphony; PTSD; relational trauma; social construction; trauma

Introduction

In a joke that is probably over-used in research methodology seminars, a drunk stumbles around in circles under the glow of a street light looking for something. When asked by a passerby what he is looking

Department of Communication, University of New Hampshire, Durham, NH 03824.
E-mail: john.lannamann@unh.edu

for, he mumbles that he has lost his keys. Asked about where he lost them, he responds with a gesture pointing some distance away into the gloomy night. 'Why don't you look there?' asks the passerby. The drunk responds, 'Because it's dark over there!' We find this to be a useful cautionary tale about how the selection of research or therapeutic methods can shape what we eventually find (or do not find). We would like to nudge the timeline in this analogy back a little to include not only the eventual therapeutic method or process of transformation, but also to question the question itself that begins the inquiry. Is it possible that the discourse used to frame the question of trauma puts us in the dark?

In short, we are inquiring about the ontological status of trauma. Adopting a social ontology or, perhaps more accurately, what Shotter (2012) refers to as a social ecology, we explore the processes that make trauma intelligible as a concept. This requires moving away from a Cartesian version of social construction where terms seem to merely name the residue of prior social action. Instead, by returning to the language and responsive interactions of therapeutic practice, we hope to explore trauma as 'something that happens to us in the course of becoming an "us"' (Shotter and Lannamann, 2002, p. 580).

Vygotsky's argument that 'Every function in the child's cultural development appears twice: first, on the social level, and later, on the individual level – first, between people (interpsychological) and then inside the child (intrapsychological) (1978, p. 57) – applies equally well to professional discourse. We suggest that, on its way to becoming a description of something impacting the wellbeing of individuals, the social origins of the term 'trauma' have been marginalised. What are the implications of importing a term whose meaning is shaped by an individualist discourse? The argument that we are making is that systemic therapy requires a fully reflexive examination of not just the methods of social transformation, but also the premises of the 'alarmed objection' (Anderson and Goolishian, 1988) that produce the call for therapeutic engagement in the first place.

Following Rorty (1979), rather than assuming that psychological terms mirror natural categories in the world and that the task of the helping professions is to find ways to discover, diagnose and treat these categories, our goal is to inquire about the status of the categories first before focusing on therapeutic responses. In that sense, our focus is pre-theoretic and certainly pre-therapeutic. Our object of study is trauma. But rather than reifying it as a natural thing in the world, we hope to move from certainty about what the term 'represents' to curiosity about how the discourse of trauma, particularly as manifested in

the diagnostic practices that identify PTSD, invites patterns of societal and professional responses that inadvertently shift resources towards solving individual problems at the expense of addressing the problems as relational and societal.

We start with an exploration of whether the taken-for-granted nature of categories such as trauma and the clinical diagnosis of post-traumatic stress disorder bring with them assumptions that may undermine systemic and social approaches to treatment.

The discourse of trauma

We are using discourse here as a term to describe the 'practices which form the objects of which they speak' (Foucault, 1972, p. 49). These practices are social and are embedded in relations of power, but they circulate in a way that is indeterminate and contribute to a system that resists closure. Adopting a critical social constructionist approach to this discourse, we hope to go beyond simply describing the discourse; if our social worlds are made through processes of communication, an appropriate next question is 'how can we make better social worlds?' (Pearce, 2007, p. 53). Stevens (2009), in his outline of a critical trauma therapy, frames this as a shift from asking what trauma 'describes' to what it 'makes' (p. 2). He argues that 'Trauma and even PTSD do not simply describe subjects and/or their experiences, they also, and perhaps more accurately, create them' (p. 2).

The discourse of trauma constructs the object 'trauma' in our social worlds and then, reflexively, gives us back ways to make sense of that object along with practices to assess it as normal or abnormal. As a discursive formation, 'trauma' is not a natural fact, but rather a way of assembling events in the world so as to make them noticeable and to make sense of them once noticed.

While there are potentially many points of entry for our discussion of trauma discourse and many approaches to discourse analysis as a method (cf. Edwards and Potter, 1992; Parker, 1998; Tseliou and Borcsa, 2018), in this article, we limit ourselves to a focus on the 'practices which form the objects', here the category of trauma. With this focus, we align with Edwards and Potter's (1992) suggestion that discursive psychology should focus on social actions related to 'fact construction' (p. 3), although we note that where their concern is primarily epistemological, ours centres more on the social ecology and the social ontology of psychological categories produced by the discourse. We

begin with broad strokes to look at the slipperiness of the term 'trauma' itself in non-professional settings. We then move to a brief overview of the history of the term in psychological literature, noting its particularly nice fit with the ascendant ideology of liberal individualism in the late twentieth century. Finally, we explore the consequences of this evolving discourse, namely, the distinguishing of post trauma effects and their treatment.

Trauma as a slippery signifier

Like any other taken-for-granted cultural term, the process of making meaning for the term 'trauma' is difficult to see since it seems to refer to a specific something out there in the world. But a quick examination of definitions of trauma immediately exposes the ambiguity of the term and thus provides some evidence that trauma is not a 'found' object but rather one that is made in discursive practices. Trauma, it turns out, can be defined as an event *or* as a reaction to an event. In referring to physical pathology, the Oxford English Dictionary offers the following definition of trauma: 'A wound, or external bodily injury in general; also, the condition caused by this' (2019). And, as defined in the psychological realm, trauma signifies both 'a psychic injury' as well as 'the state or condition so caused' (Oxford University Press, OED online, n.d.). Burstow (2005), in her critique of how the term is used in the discourse of post-traumatic stress disorder (PTSD), makes clear that the term can be used to refer to an event or a response to an event. She writes that in diagnosing PTSD, guidelines seem to 'slide between the two meanings'. She observes that it is 'often unclear whether a specific symptom is intended to be seen as a reaction to the initial event (trauma as wound) or as a reaction to the initial reaction (trauma as reaction to the wound)' (p. 440).

Historical and ideological influences

The slipperiness of the two meanings of trauma is visible in the history of the term's use in psychological discourse. Lasiuk and Hegadoren (2006) suggest that the first time 'trauma' was used in a psychiatric context rather than a surgical one was in 1889 by the German neurologist Hermann Oppenheim. Although Oppenheim understood what he called 'traumatic neurosis' to be related to the symptoms of organic illness, his explanation offered a way of translating the discourse of bodily descriptions into the realm of the mind. In this account, according to van der Kolk, Weisaeth and van der Hart (1996, p. 48), the traumatic

experience (trauma as event) causes 'subtle molecular changes in the nervous system' (trauma as individual mental condition).

Oppenheim's terminology marked a significant moment in the evolving discourse of trauma. Prior attention had been given to the consequences of what had been called 'railway spine', a condition that had been understood to be related to both the physical and the psychological effects of railway accidents. Oppenheim's recasting of these effects in a language of 'traumatic neurosis' brought the internal mental processes of the individual squarely into focus, a trend that was reflected in Charcot's (1887) early work on psychological trauma. This emphasis on the intrapsychic eventually figured in Freud's formulations about the impact of trauma, although his formulations moved even further into the realm of mental phenomena. As Van der Kolk *et al.* (1996) describe it, for Freud, 'Real-life trauma was ignored in favor of fantasy' (p. 55). Although debates continued about whether trauma as a psychological state was triggered by real or imagined causes, by the first decades of the twentieth century, the concept of trauma had gained acceptance as a description of a mental condition that mediated either real or imagined causes.

What is striking about this historical trajectory is that there are fleeting moments when we are reminded of the material and social conditions that produced the horrors, but these are incrementally absorbed into abstractions and eventually are treated as mental conditions. The gruesome effects of railway accidents re-emerge in the discipline as 'railway spine' and the brutality of war is transmuted into the condition of 'shell shock', 'battle fatigue' or 'war sailor syndrome' (Weisaeth and Eitinger, 1991). Contemporary versions of these conditions have so thoroughly erased the social and material conditions that we are left with only the abstract purity of an acronym, PTSD.

To complicate things further, the meaning of the term 'trauma' has been enveloped by the larger discourse of liberal humanism that shaped psychological discourse in the twentieth century. In their discussion of the term, van der Kolk *et al.* conclude that 'psychiatry is embedded in social forces, possibly more so than any other branch of medicine' (1996, p. 66), and this is particularly evident in its treatment of trauma.

The impact of liberal humanism on modern psychological discourse is well documented elsewhere (Hall, 1992; Sampson, 1989). Here we simply note that, in defining the person, psychology in the modern era adopted a stance of possessive individualism (Macpherson, 1962), where persons were understood as 'a conception of the individual as essentially the proprietor of his own person or capacities, owing nothing to society for them' (p. 3). Understood as a self-contained individual

(Sampson, 1993), the person becomes the repository of various internal, skin-bound personal attributes and mental conditions, including 'traumatic neurosis'. The historical shifts in thinking about trauma as a condition, along with the rise of the possessive individualist understanding of personhood, created the possibility to name, measure, and define categories of traumatic impact as disorders. In the next section, we explore the construction of trauma as pathology.

A social constructionist view of pathology

Criticisms of postmodern and social constructionist approaches (e.g. the Sokal, 1996 hoax) might suggest that ours is just one more entry in a list of approaches that deny reality and either construct a class of 'victims' of objective science (Gross and Levitt, 1994) or inadvertently blame the victim by denying causes of trauma. We argue here that, on the contrary, engaging in a close look at how an object of inquiry is constituted doubles the potential for a critical assessment of efforts in the domain of practice by demanding accountability for not only treatments but also for the diagnoses. Compared to a medicalised model of psychological disorders, a social model for understanding responses to trauma requires the extra effort of examining the role that constructing a conception of pathology plays in the eventual treatment of the effects of trauma. To ignore the social construction of the pathology does a disservice to those whose suffering is labelled as an individual problem to be treated. Instead, we ask, what are the roles of language and practice in constituting the subject of inquiry?

In his discussion of personal being, Rom Harré (1984) writes that, '[t]he fundamental human reality is conversation, effectively without beginning or end, to which from time to time, individuals may make contributions' (p. 20). He goes on to assert, 'all that is personal in our mental and emotional lives is individually appropriated from the conversations going on around us and perhaps idiosyncratically transformed …' (p. 20). These conversations are the emergent scaffolding of social constructions. Humanly made, they should be humanely functional. This is not always the case, particularly when the construction creates categories of orders and disorders.

The grammars of trauma disorder

At this point, it is useful to focus on a specific example related to trauma. Following Wittgenstein's observations about 'a whole cloud of

philosophy condensed into a drop of grammar' (1953), we might profitably examine the grammars that produce the language game of diagnosis. We are using the idea of grammar here as a tool for understanding the organisation of a particular discourse. To the extent that a discourse is a way of organising elements to construct a coherent story, a grammar shapes the possibilities for constructing that story by limiting options to what fits the story's logic. This logical grammar is rarely visible, but we can recognise when something is wrong and it shapes our thinking. For example, the statement 'I like cookies' sounds logical, whereas the statement 'Cookies like me' does not. Here, the logical grammar of 'I like cookies' suggests a way of constructing a story that positions me as an active agent who can make choices and the cookie as an inanimate object. We turn now to the grammar of trauma.

In laying out the criteria for diagnosing post-traumatic stress disorder (PTSD), the American Psychiatric Association's DSM-5 (*Diagnostic and statistical manual of mental disorders* (electronic resource), 2013) offers a set of rules and connections, making manifest what Wittgenstein might call a grammar, for identifying PTSD. Roughly structured as an antecedent-consequent proposition modelled on the language game of medical diagnosis, the grammar of DSM-5 links 'exposure to actual or threatened death, serious injury, or sexual violence' to a list of potential responses including:

- the presence of one or more 'intrusion symptoms associated with the traumatic event(s)';
- 'persistent avoidance of stimuli associated with the traumatic event(s)';
- 'negative alterations in cognitions and mood associated with the traumatic event(s)';
- 'marked alterations in arousal and reactivity associated with the traumatic event(s)'.

In order to qualify as PTSD, these responses to the traumatic event must continue 'for more than one month', must manifest in 'clinically significant distress or impairment in social, occupational, or other important areas of functioning', and must not be attributable to the 'physiological effects of a substance (e.g. medication, alcohol) or another medical condition' (*Diagnostic and statistical manual of mental disorders*, 2013).

What can be said about this language in terms of its constitutive role in constructing a distinguishable disorder?

Individualism. First, we note that the 'what is it' question can be approached by examining the 'who it is happening to' question. Here,

the authors of DSM-5 are very clear. In the introduction to the manual, they write:

> *A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.' (Diagnostic and statistical manual of mental disorders, 2013)*

Because this statement aligns with our cultural common-sense, it is not immediately obvious that a subject is being constituted *in* language, not simply described as a natural object *outside* of language. We tend to take for granted the idea that disorders are attributes of individuals. Yet focusing on the individual or individual cognition is not the only way to think about order and disorder. The narrow frame of individual cognition is useful in many contexts, but it is worth exploring how a narrow frame of observation can also limit what we find. For example, the success of a theatre director would be short-lived if she attributed the bored murmurs of audience members during the third act of a play to the attention deficit disorders of individuals in the audience. In this context, attention or lack thereof can reasonably be thought of as relational; the audience members are responding to the quality of the social interaction. The problem is not only one of individual cognition.

Our point here is not to deny the existence of responses to trauma, but rather to identify the social origins of what eventually becomes the centre of attention in subsequent attempts to process trauma. Constituting PTSD as an individual disorder is one option, but all choices have consequences. In this case, the individualist language invites therapeutic practices that involve the treatment of individuals.

In addition to seeing the subtle way that the discourse of individualism can shape the subject of inquiry, we note two other aspects of the DSM-5 grammar of diagnosis that end up constituting what and how we know PTSD. These aspects include the social construction of time as meaningful and the objectification of what might better be thought of as a complex process.

Time. DSM-5 uses a discursive model that mimics medical diagnosis. Transporting this discourse into the social realm may mask some incompatibilities or at least provide a false sense of objectivity. In a medical model, a premium is placed on the identification of biological causality where a temporal sequence is implied or stated. But the linguistic

units used to describe temporal changes at the cellular level do not have the same precision when used to describe social phenomena such as responses to trauma. The precision afforded by using the language of time when describing the gestation of embryos or the replication periods of a virus deteriorates when imported into the social realm. Here, we are struck by criterion F in the DSM-5 specification of PTSD: 'Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month' (*Diagnostic and statistical manual of mental disorders*, 2013). Here the precision of the metric 'one month' belies its ambiguity since months vary in duration. Even when dressed up in medical clothing, diagnosis in the social world is always a process of negotiating and constructing the objects of our inquiry, not discovering them. As Shotter (2011) reminds us, 'we can only look *according to* the opportunities for looking afforded us by our surroundings, there must always be *a grammar* in our looking' (p. 7). The grammar of our looking at PTSD is provided by the medical discourse of our surroundings. Yet the medical sounding reference to the 'duration of the disturbance' lacks the precision typically required of time measurements in the biological context. As Burstow (2005) puts it, 'While time can have significance with real medical diseases, in no real medical diseases does one disease magically turn into another at the 4-week mark' (p. 437). The specification of a required duration of symptoms post-trauma depends on the logic of a particular moral order, which is a social construction, not a biological measure.

Objectification. Our third observation about how the language of the DSM-5 criteria constructs PTSD has to do with how the discourse of medical diagnosis creates the illusion of 'thingness' by pulling together a large number of signifiers, associated with, but not determinant of, the signified disorder. This is consistent with Saussure's (1974) claim that the meaning of any linguistic term is not intrinsic to the term itself but arises from the structural relations of similarities and differences that make up a language system. Read this way, the DSM-5 criteria present a system of meanings. Although the medicalised discursive style of the manual invites the reader to understand the linguistic system in the same way that a medical doctor might use a list of physical criteria to diagnose a disorder of the liver, there is no single signifier that must be present in all diagnoses of PTSD. In fact, referring to a smaller set of criteria listed in the DSM-IV, Kutchins and Kirk (2003) note that 'two people who have no symptoms in common' (p. 124) can receive a diagnosis of PTSD. The problem is compounded with the updated list of precipitating events and resulting symptoms listed in DSM-5.

Galatzer-Levy and Bryant (2013) call attention to how, in spite of the well-intentioned efforts of those interested in expanding the range of precipitating events and related symptoms, the diagnosis of PTSD has become 'broad and error-prone' (p. 660). They write:

> *For the DSM–5, we found that the product of 31 possible combinations of intrusion symptoms, 3 possible combinations of avoidance symptoms, 120 possible combinations of cognitive–mood symptoms, and 57 possible combinations of hyperarousal symptoms produces 636,120 possible presentations. (p. 656)*

With a number like that, it would be surprising not to find PTSD popping up everywhere. But that is not the case because clinicians are not machines using algorithms to diagnose people. They are situated social actors who make sense using local knowledge, not simply a set of a priori rules.

So far, we have explored three ways in which the medical discourse of DSM-5 constructs PTSD. The discourse treats the individual as a natural unit of observation. Second, it treats time and duration as concepts that have a fixed meaning. And third, the discourse reduces a socially contingent process to a list of criteria, thereby giving PTSD a 'thingness' that masks the complex social interaction processes used to distinguish it. Our exploration of the social ontology of PTSD cannot stop there, though, because showing the constitutive role of language and practice ought to also raise questions about the consequences of the construction. In what follows, we identify two unintended consequences that result from using the DSM-5 discourse to construct PTSD.

A feminist critique of PTSD

The clearest formulation of the problems that arise when an individualist discourse is used to identify responses to trauma can be seen in a feminist critique of PTSD offered by Burstow (2005). We have limited our discussion here to only one example of feminist critique, although we recognise that there are many other significant examples (see Goodman *et al.*, 2004; Morrow and Hauxhurst, 1994; Sinacore-Guinn, 1994). After describing the efforts of veterans and feminists to make the effects of trauma more widely recognised so that it can be treated, Burstow demonstrates that the DSM-IV 'construction of this disorder is not only faulty, and presumptuous, but dangerous' (p. 435). She continues:

> *And herein lies a significant truth about 'mental disorders'. While psychiatrists view the DSM as a neutral tool that is simply useful in assessing and helping*

> *people who are troubled, it is a tool through which a hegemonic worldview is imposed. Moreover, it so constructs people as to legitimate injury. (p. 435)*

Burstow makes a convincing argument that the diagnostic tools used to identify responses to trauma actually construct a disorder that is harmful. It is a powerful criticism because it links the constitutive power of language with ideological practices. This is similar to Althusser's (2001) notion that when we speak and respond, we are interpellated into subject positions. What subject positions are constituted in the language of PTSD?

Burstow points out that by using the discourse of individualism, the diagnosis of PTSD produces a worldview in which people are seen as separate from their social worlds. Thus, the 'problems in living are individualized; and the complex relationship between behavior, purpose, and context disappears' (Burstow, 2005, p. 438). She offers a compelling example of this by describing how, in a world that is still full of violence against women, the response of a woman who is raped might include a range of PTSD symptoms such as re-experiencing trauma (criterion B4 in DSM-IV) upon seeing a man in the street. Burstow points out that the woman is not inventing the danger. She continues, the response is not a 'disorder'. Rather, it is an 'attunement to genuine danger' (p. 436).

Because diagnosis constructs individual disorders, there is a real danger that, as Burstow points out, 'social relations in the present' are ignored. The diagnostic discourse puts the spotlight on the individual woman who is seen as having a disorder, while the insidious operations of patriarchal power remain in the shadows. Burstow shows that this way of diagnosing a response to trauma recasts reasonable coping behaviours as symptoms of an individual's disorder. To illustrate this, she offers an example from her psychotherapy sessions with a client who was raped by a family member. The family accused the client of inventing the story. Burstow writes:

> *Before the rape and, to a lesser extent after the rape, but before the family denial, she was very trusting and had no appreciable difficulty spending time with family members. After the rape and the denial – that is, after the traumatic events (Criterion A) – she was on the alert (Criterion D4); and she was estranged from others (Criterion C5). (p. 434)*

As Burstow points out, the patient's expectable coping behaviour becomes framed by the individualist diagnosis as a symptom of a mental disorder. But clearly this way of telling the story obscures an important part of the social context. The client is responding to suddenly finding herself in 'an unsafe universe where extreme caution and distance were in order'

(Burstow, 2005, p. 434). Including the social and political context makes it possible to see this 'disordered' individual response as an appropriate response to a 'disordered' moral order.

A cultural critique of PTSD

A second unintended consequence that results from using the DSM-5 discourse to construct PTSD is that the cultural constructions belonging to the group who name the disorder become naturalised as universal human responses. Referring to the general problem of reading into another culture the taken-for-granteds of one's own culture, the anthropologist Clifford Geertz (1983) notes that 'the interpretive study of culture represents an attempt to come to terms with the diversity of the ways human beings construct their lives in the act of leading them' (p. 16). When the medicalised discourse of diagnosis is used, there is a significant chance that 'the ways human beings construct their lives *in the act of leading them*' (emphasis added) will be sacrificed in the quest for bio-medical appearing universals.

The 'cultural differences' problem is a concern raised by the authors of DSM-5, but the way it is handled can sometimes lead to the problem of looking for keys under the street light rather than in the dark where they may have been lost. Once the grammar of diagnosis is used to construct PTSD, the disorder can become objectified and counted as if it is a thing in the world rather than a way of looking at the world. The grammar of the DSM-5 carries a culturally shaped set of assumptions that position the individual as a natural unit of observation, treat time and duration as having a fixed meaning and reduce a socially contingent process to a static list of criteria.

Studies of the cross cultural validity of the diagnosis typically treat cultural differences as complicating the diagnosis of PTSD (cf. Fortuna *et al.*, 2009). For example, Hinton and Lewis-Fernandez (2011) note that PTSD 'is valid cross-culturally, in that it constitutes a cohering group of symptoms that occur in diverse cultural settings in response to trauma' but that the 'expression of PTSD is by no means identical across the globe' (p. 796). In such inquiries, there is a sense of certainty about PTSD; it is the cross-cultural *expression* of it that is treated as variable. Yet, as with any attempt to apply a concept constructed in one culture to other cultures, the question arises: is the discovered order constructed by the way of looking? That the symptoms exist and cohere is one question. What the symptoms mean is a very different question that requires an effort to understand how, as

Geertz (1983) wonders, 'human beings construct their lives in the act of leading them' (p. 3).

Systemic family therapy

The tradition of family therapy recognised the dangers of pathologising individuals long ago. And today, in most modalities of family therapy, problems such as trauma are understood in broader contextual arenas. The focus of family therapy is on assisting families in locating ways to address, deal with or manage broader social and cultural processes that contribute to personal and familial problems. In the case of trauma, for example, family therapists understand the challenges faced by a veteran returning from deployment or the child who has been raped as issues requiring attention to patterns of family interaction that assist or (inadvertently) prohibit transformation. Yet family therapists are often working in medical contexts where diagnosis is the dominant grammar and, as described above, it is useful to remain mindful of how the diagnosis of PTSD shapes therapeutic options. For therapy to be fully responsive and systemic, all aspects of social reality need attention, including the reflexive process of distinguishing disorders. To that end, we conclude with two examples of systemic family therapy that we believe resist the individualising and objectifying tendencies associated with using the PTSD construction and related discourses of trauma.

Multiple voices, inner dialogue, and the creation of new narratives

We have chosen two exemplars: one that addresses the trauma of chronic illness (Penn, 2001) and a second that addresses refugee trauma (De Haene *et al.*, 2012). Both of these illustrations are notable for the attention paid to the multiple voices that clients *and* therapists harbour. By engaging the polyphony, therapists and their clients co-construct new narratives. These polyphonic narratives are not dismissive of trauma experienced at the individual level, yet they can also open space for alternative stories of resilience and relationship. In short, these narratives locate the challenges experienced within broader cultural and social grammars.

We begin with Peggy Penn's (2001) approach to trauma arising from chronic illness. We note that, according to the specifications in DSM-5, chronic illness would not satisfy the strict diagnostic criteria for distinguishing PTSD because it does not 'involve sudden, catastrophic events' (*Diagnostic and statistical manual of mental disorders*, 2013). We follow

Penn's use of the word trauma in this context for two reasons. First, it is an early example of approaching trauma from a relational perspective and second, including the example of chronic illness provides important insights that can be applied to encounters where PTSD is identified as a presenting problem.

In her work with clients with chronic illness and their families, Penn invites their multiple voices – voices that are wrapped in the cloak of illness as well as voices that long to trust others. Part of her conversations with clients involves surfacing and strengthening the inner voices that can be silenced by the dominant narrative of illness. Penn invites these multiple voices through writing (Penn and Frankfurt, 1994), listening, the use of metaphor and by incorporating the voices of others who are close (Penn, 2001). She notes that her efforts are meant to 'break the silence' (Penn, 2001, p. 42). One method of doing this, Penn suggests, is to encourage clients to tell their stories through writing letters and then reading these out loud. In so doing, she broadens the narratives framing chronic illness and opens space to re-narrate its effects. This expansion counters the individualising tendencies invited by discourse of trauma.

When multiple voices are brought into the therapeutic conversation, struggles and dilemmas that were previously not given voice can begin to be heard. For example, Penn offers an example from her work with clients whose AIDS diagnosis contributed to a social loop involving shame. She observes that those suffering with chronic illness are thrust into a dilemma: they are compelled to keep private the very thing they need or want to talk about with their loved ones and support community. She writes that the 'double bind around speaking supports the choice not to speak, to be stoic, to do it alone… your best course is to protect others from the struggles that you must make alone… the solution is often silence' (p. 36). Writing, she suggests, allows clients to move out of the silent bind generated by the narrative of the individual as an isolated object and to develop new voices through which 'these feelings can at last be voiced and find their way back into language and into the relationship' (p. 37). Finding a way back into language and into the relationship is a key element of Penn's work. By moving from the single voiced narrative to a multi-voiced narrative, Penn shifts the focus away from individual trauma to what she refers to as 'relational trauma'. She writes that 'using the phrase "relational trauma" allows me to include other members, loved ones of the ill member who are experiencing stress and, in some cases, developing physical symptoms' (p. 34). This relational, rather than individual, approach to trauma requires

a dialogic stance and a vocabulary that goes beyond the discourse of individualism.

A second example of a family therapy approach that resists the individualising and objectifying tendencies of the PTSD label can be found in the work of De Haene *et al.* (2012). Theirs is a relational, dialogic approach to refugee care in the context of family therapy. De Haene *et al.* are critical of refugee treatment models that maintain an individualised focus. They offer an approach to family therapy with refugees where, as with Penn's work described above, the focus is on the relational impact of trauma. They draw on family and community resources to assist refugees in their adjustment to their new circumstances. Their systemic work provides an alternative to the traditional therapeutic model's 'individualising focus' and moves 'toward an emphasis on the relational impact of trauma' (p. 392). The aim of their practice is to support 'family relationships as a primary vehicle of restoring continuity' (p. 392).

De Haene *et al.* recognise that within the host culture, a therapy setting may be foreign to the refugee and this can create a power imbalance. The refugee, new to the community, may be framed as unaware or ignorant of local practices and thus in need of the therapist's expertise to move beyond the experience of trauma. If this expertise is built on a culturally shaped narrative of individualism, it is not surprising that this narrative may import the individualising grammar of pathology. Referring to this problem, De Haene *et al.* comment that this 'structured process reflects a medical model in which the diagnostic identification of a fixed construct of morbidity leads to a clearly defined treatment plan' (p, 393).

De Haene *et al.* are concerned with the 'directive expertise' associated with the medical model and point out that adopting the model has a 'potentially disempowering impact on refugee clients' (p. 393). Instead, they propose a collaborative stance where therapist and refugee clients engage in a dialogic conversation that offers alternatives to what they call the 'objectifying definitions of pathology' (p. 393).

One example of how their dialogic approach resists the objectifying definitions of pathology can be seen by comparing how open disclosure is treated in the medical model and how it is approached in a dialogic one. De Haene *et al.* note that in the standard phased models for treating trauma, clients are encouraged to revisit traumatic experiences. Open disclosure is understood to be an important mechanism in the recovery process. This is consistent with the individualising grammar of pathology, where the effect of trauma is treated as a mental disorder of the person. Surfacing the individual memory of the experience is

considered an early step in recovery. And, as Burstow (2005) notes in her critique of PTSD, remaining silent or avoiding revisiting situations associated with the trauma are understood as symptoms of an individual pathology.

But, as Burstow points out in her discussion of sexual violence, when the frame is expanded from an individual pathology to a social/political context, avoidance behaviours are reasonable responses to a still dangerous world. A similar argument is being made here by De Haene *et al.* They explore the possibility that the open disclosure called for in the phased model may ignore important cultural coping strategies. Further, they observe that silence may be an attempt to 'protect self and family members from reliving unbearable pain' (p. 394). In their dialogic approach, the authors avoid imposing preconceived notions about the necessity of open disclosure and instead work to develop a therapeutic relationship in which 'a multiplicity of voices and resources in dealing with suffering can coexist' (p. 394). The exploration of other voices moves the inquiry beyond the individual and opens a narrative space for co-authoring new narratives that respect the complex relational dimensions.

An (un)final word

A central aspect of both of the relational approaches to trauma described above is the emphasis on multiplicity and polyphony. Rather than treating the effects of trauma as a problem of individual pathology, the approaches of Penn and De Haene *et al.* explore the effects of trauma in the cacophony of cultures, families, and relationships, including the therapeutic relationship. These are dialogic approaches and as such they must embrace a narrative openness where no meanings are final and no person is contained in a single story.

De Haene *et al.* relinquish a directive stance of expertise in order to be fully present as they encounter the tensions between silence and remembering, hope and hopelessness. Because this conversation involves multiple inner and outer voices, the meaning of the traumatic event and even the identity of the client is not fixed. The philosopher and literary critic, Bakhtin (1986), captures this emergent quality in his claim that, 'Even *past* meanings … can never be stable (finalized, ended once and for all) – they will always change (be renewed) in the process of subsequent, future development of the dialogue' (American Psychiatric Association, 2013, p. 170). Penn's use of letter writing with her clients is a practical application of this insight. By encouraging clients to explore

the other voices that participate in their inner dialogues about trauma, she destabilises the oppressive single voiced narrative of trauma. Yet this does not diminish the validity of the original narrative. She writes, 'I have always felt it made more sense simply to create new voices (and therefore potentially new stories), seeing all one's relevant voices as *co-existing*' (Penn, 2001, p. 47).

Commenting on the unfinalisability of meaning and the ethics of qualitative research, Frank (2005) observes that professional training can sometimes lead to a definition of expertise that is based on finalising the person. He notes:

> *What Bakhtin calls monological discourse claims to utter the last word about the person(s) who is its subject. Such discourse occurs in many speech genres, most notably medical diagnosis – including genetic profiling – academic grading and assessment, judicial sentencing, and, crucial to our purposes, social scientific research. Examining these speech genres leads to the disturbing observation that the claim of groups to professional status depends crucially on their socially sanctioned capacity to utter monological finalizations. (p. 967)*

Frank suggests that instead of demonstrating expertise by finalising the other, researchers ought to emphasise the 'struggles of becoming' (p. 968), since these stories are continuously unfolding and are populated by a multiplicity of voices that cannot be contained in a single narrative. Frank's ethical imperative that researchers should not finalise the other applies to trauma therapy.

In this article, we have explored how using the discourse of trauma in general, and the grammar of PTSD in particular, carries the risk of importing an individualist and monologic version of personhood into therapeutic practices, in effect finalising the other. Moving towards a dialogic orientation requires a fully reflexive inquiry into the narratives of becoming. If the central questions of modernist discourse are, 'what is the cause of this behaviour/situation/phenomenon?', 'how do we control the cause?', 'how do we cure the problem?', the parallel questions of the social constructionist are, 'what are we making together?', 'how are we making this?', 'who are we becoming as we make this?' and 'how might we make a more livable future? (Pearce, 2007, p. 53).

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