root out the worst practices and scrutinized the private asylums closely, publishing some highly critical reports. Many were forced to close down, while most of the remainder continued on a reduced scale, concentrating on up-market provision for private patients.

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**See Also:** Asylums; Deinstitutionalization; Ethical Issues; Eugenics; Inequality; Marketing; Mechanical Restraint; Mental Institutions, History of; Patient Rights; Policy: Medical; Sterilization.

### Further Readings

Andrews, Jonathan and Andrew Scull. *Undertaker of the Mind: John Monro and Mad-Doctoring in Eighteenth-Century England*. Berkeley: University of California Press, 2001.

Mackenzie, Charlotte. *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792–1917*. London: Routledge, 1992.

Parry-Jones, William Llywelyn. *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries*. Toronto: University of Toronto Press, 1972.

Porter, Roy. *Mind Forg'd Manacles: A History of Madness in England From the Restoration to the Regency*. London: Athlone, 1987.

# Trauma: Patient's View

The patient's view has often been neglected in psychiatric approaches to emotional trauma. Originally, most doctors did not accept that violence or catastrophes could cause long-term psychological damage. This is no longer the case, but there is still conflict, whether explicit or not, between clinicians and patients on how to understand trauma. The current diagnosis for psychological trauma is post-traumatic stress disorder (PTSD), which presents trauma as a single universal condition. However, individual, social, and cultural factors shape how people experience trauma and what events people view as traumatic, and the clinical account does not necessarily capture trauma as many patients describe it. Therapists often try to impose their view onto patients in clinical situations, and by looking for PTSD in the brain, therapists might discover new treatments—but at the potential cost of avoiding the patient's view altogether.

### The PTSD Diagnosis

The PTSD diagnosis was first entered in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980. The impetus behind the diagnosis was not just scientific but also moral and political. Proponents wanted to end a long-standing prejudice against people who claimed to suffer trauma. For example, during the World Wars I and II, most doctors did not believe that war itself could cause psychological damage in good, strong men, or if it did, the veteran's problems would quickly pass. If a man showed signs of long-term problems, it was because of his personal characteristics, not the horrors of combat; he was probably a faker or a wimp. Also, doctors thought that children and women would quickly recover from their experiences of sexual assault. Those who did not had some other psychological or personality problem.

However, the PTSD diagnosis established that rape, incest, war, and other violence and catastrophe can cause severe, long-lasting psychological suffering, regardless of individual characteristics. Certain extreme experiences could severely damage anyone's psyche. Any man, even a strong and noble man, can be ruined by combat, and even psychological healthy women can be destroyed by rape. The diagnosis offered new respect for trauma patients and shifted blame from the individual to the event, placing the cause of the trauma solely on the dreadful nature of the event.

### Clinical Ideology and the Patient's View

The PTSD diagnosis suggests a simple model of trauma: a shocking event happens and automatically causes psychological damage for some people. This model is widely accepted, almost axiomatic, but it is not without critics who argue that the model inappropriately silences patients and disregards the complexity of human suffering and coping. The model frames patients as passive victims who lack individuality and self-determination in response to violence and catastrophes. They agree that patients should not be blamed for

their suffering, but they argue that to understand trauma requires respecting a patient's view and the social and cultural processes that shape it.

The PTSD diagnosis was an attempt to better honor trauma patients' suffering. However, the diagnosis and research on the condition disregards the patient's view in fundamental ways. First, according to conventional psychiatric wisdom, the objective nature of the event, not the survivor's characteristics, is what explains PTSD. The assumption is that the person's values and beliefs matter little for understanding trauma. For example, it does not matter whether an individual soldier sees killing in war as evil or sees it as heroic.

Second, most psychiatrists and psychologists agree that PTSD exists largely outside the patient's awareness. PTSD occurs, the argument goes, because some events are so frightening or horrific that the person has no way to know what happened. The patient cannot fit the event into his or her consciousness of the world and of his or her self. Consequently, the victim records the event outside normal consciousness. Doctors and researchers disagree on exactly where the traumatic event gets recorded: in a second consciousness foreign to the patient, in the unconscious, or in the body as primitive animal-like associations among sights, smells, sounds, and emotions. Wherever the traumatic event is recorded, many experts agree that it is recorded somewhere hidden from the patient. The patient may know he or she has psychological problems but will not understand them, might not see how their suffering is related to the traumatic event, and might not even consciously recall the traumatic event.

This theory of trauma is a kind of ideology that gives therapists a sense of authority because the theory implies that only the therapist can understand what the survivor is really suffering. However, it also causes a problem for therapists because what the patient says might not fit well into what the therapist assumes to be true. Consequently, when a patient's statement does not match the therapist's ideology, clinicians may attempt to silence or ignore the patient's words. If the patient's silence threatens the therapist's perspective, he or she will provoke the patient to talk.

Clinical ideology is involved in a struggle over the patient's identity. The accepted model of PTSD suggests that researchers and therapists have privileged access to the meaning of a patient's memories, thoughts, and emotions—the things that define a person's identity, or his or her humanity. Consequently, some argue that clinical ideology threatens to dehumanize patients by not honoring their right to self-determination.

## Subjectivity and Traumatic Experience

Research has consistently shown that the nature of an event alone cannot explain PTSD. From the perspective of cultural sociology, one reason for this is that people from different social and cultural situations do not view the same kinds of events as horrific. Also, people from different cultures respond to horrific events differently. In other words, trauma is not just a product of the objective nature of the event but also of the individual's subjectivity.

PTSD is a Western idea, and many scholars have argued that the diagnosis might not be sensitive to how people in other cultures view suffering and experience distress. While psychological distress might be a common response to traumatic events for Westerners, for people of other cultures, physical problems might be a more common response to a traumatic event, or people may show symptoms of PTSD but not find them distressing or worthy of mention.

Since most Westerners do not typically experience events such as extreme violence or mass death, they may be especially shocking for individuals in that culture. However, in many cultures, extreme violence and/or mass death are expectable parts of life. For example, people who live in countries with a history of warfare often say that the violence itself is not the most distressful part of war. Rather, they are more concerned with other problems caused by war, such as hunger, poverty, geographic dislocation, the dissolution of their community, or the lack of opportunity to follow traditional burial rites or to carry out other cultural practices.

Even among Westerners, individuals differ in what they view as traumatic and how they describe and experience trauma. In *Fields of Combat*, Erin Finley illustrates that for U.S. male combat veterans, PTSD is not a single condition. How each man views his suffering is a product of his personality, social relationships, and cultural values and knowledge. For example, a veteran's ideas about manhood, a cultural artifact, influence how

he suffers. Some veterans whom Finley encountered strongly believed that a good man should be focused on success, and she found that these veterans had less severe symptoms of PTSD, possibly because their values made them more willing to confront their distressful memories. However, ideas about masculinity can make PTSD worse. Finley found that veterans who reported being highly concerned with the stereotypically masculine qualities of self-reliance and control showed more severe distress than other veterans suffering from PTSD.

Morality is deeply cultural and subjective, and research comparing cultures, as well as research focused solely on U.S. veterans, has illustrated that a person's moral values and beliefs greatly influence the individual's experience of trauma. For U.S. combat veterans, memories of moral injury, or violations of what the veteran sees as morally right related to emotions such as guilt and shame, are often more traumatic than fears of being killed.

## The Doctor's View and the Patient's View

In *The Harmony of Illusions*, Allan Young presents his study of a U.S. Department of Veterans Affairs hospital. For his study, he observed patients and therapists in an inpatient ward for veterans suffering PTSD. Doctors on the ward viewed the veteran's guilt as pathological, a symptom to be eradicated. Patients often resisted this view. They felt a person should take responsibility for his or her actions, which includes feeling guilty for having done something wrong.

This was one battle in an ongoing war between doctors and patients that Young observed in the ward. For Young, what happened on the ward was a conflict over the veteran's identity, his personal memories, thoughts, and emotions. For example, many patients who were admitted to the ward could not describe a particularly traumatic experience. Young argues that this may have occurred because the veteran's distress was due to current life circumstances, not because of an old combat experience. However, therapists pressured patients to "recover" a traumatic experience. One way therapists pressured patients was by threatening disciplinary action against veterans who were not able to describe a traumatic combat experience. Some veterans described situations of killing that they said were not particularly distressing, but therapists would not accept this interpretation. They would redefine the veteran's memory and interpret a lack of distress as "psychic numbing." The therapists would sometimes impose rules. One such rule prevented patients from using the restroom during group therapy. This rule angered the patients, who said it was abusive, but the therapists would not listen to the veterans. The therapists argued that the patients' anger was not a normal reaction to an unfair rule but a symptom of PTSD.

Though likely with more subtlety, similar therapeutic persuasion likely occurs in other clinical settings. In *Accounts of Innocence*, Joseph Davis argues that therapy for sexual assault survivors involves the therapist creating a new identity for the patient. The therapist does this by persuading the patient to adopt a new narrative that defines the person's biography in terms of the assault. First, if the therapist suspects an assault occurred, the therapist encourages the patient to remember an assault if she does not. When the patient remembers an assault, the therapist encourages the patient to recognize how harmful it was. The therapist explains to the patient that she has a distorted view of herself, which establishes that the therapist has privileged insight into the trauma. The therapist tries to convince the patient of the therapist's "undistorted" knowledge: that the patient's misfortunes and dysfunctions—problems in forming healthy relationships, anger management, depression, anxiety, etc.—are a result of the attack rather than a problem with her personality.

Second, the therapist uses the assault to define the patient's strengths, suggesting that the patient recognize that she is a survivor. The assault may have damaged her, but it did not completely destroy her. Third, the therapist uses the assault to define the patient's potential. By seeing her life through the assault, the patient redefines her identity through the damage and her own survival. In other words, the patient now has what the therapist views as a realistic consciousness of the trauma. This knowledge is supposed to be a source of liberation. The patient can draw upon her strength to escape the hold the assault has on her identity.

## The Patient's Brain

If therapists silence their patients and put words in their patients' mouths, it would be inaccurate

to blame therapists as intentionally uncaring. They do want to help. For this reason, therapists and researchers are searching for new and more efficient ways to treat PTSD. For many, the search leads them to the brain. Researchers are studying stress in rats and using brain images on humans to find out where PTSD is in the brain. Psychotherapy techniques thought to directly rewire the brain, such as cognitive-processing therapy, eye movement desensitization and reprocessing, and prolonged exposure therapy, are becoming increasingly popular, and researchers are testing medications that might treat PTSD.

By going straight to the brain, the authority of the patient's view further erodes, and psychiatry no longer has to grapple with the patient's words. Going straight to the brain has its benefits, and therapy and research need not always take into account the patient's view. However, too much emphasis on the brain is risky for the profession's knowledge of trauma and the ability to help trauma patients.

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**See Also:** Anthropology; Ethical Issues; Ethnopsychiatry; Identity; Post-Traumatic Stress Disorder; Psychiatry and Neuroscience; Trauma, Psychology of; Veterans; Violence; War.

### Further Readings

Davis, Joseph E. *Accounts of Innocence: Sexual Abuse, Trauma, and the Self*. Chicago: University of Chicago Press, 2005.

Fassin, Didier and Richard Rechtman. *The Empire of Trauma: An Inquiry Into the Condition of Victimhood*. Princeton, NJ: Princeton University Press, 2009.

Finley, Erin P. *Fields of Combat: Understanding PTSD Among Veterans of Iraq and Afghanistan*. Ithaca, NY: ILR Press, 2011.

Shay, Jonathan. *Achilles in Vietnam: Combat Trauma and the Undoing of Character*. New York: Scribner, 1994.

Summerfield, Derek. "The Social Experience of War and Some Issues for the Humanitarian Field." In *Rethinking the Trauma of War*, Patrick Bracken and Celia Petty, eds. London: Free Association Books, 1998.

Young, Allan. *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. Princeton, NJ: Princeton University Press, 1995.

# Trauma, Psychology of

The word *trauma* is derived from the Greek and was originally used in organic medicine in the sense of "lesion" or "wound." In medical terms, trauma is defined as an injury or accident that affects the whole being. There are also many psychoanalytic definitions of emotional trauma, beginning with Sigmund Freud and traditional psychoanalysis. In traditional psychoanalysis, the concept of psychological trauma is defined as traumatic neurosis, an intrapsychic phenomenon. This concept of psychological trauma was the approach most commonly adopted by the medical-psychiatric profession from the early 20th century to the end of the Vietnam War era in the United States (1962–75).

Freud, in his 1920 essay "Beyond the Pleasure Principle," described his conceptualization of "traumatic neurosis" as excitations from the outside that are powerful enough to break through the protective shield of the ego. Traumatic neurosis was believed to be the psychical consequences of excessive shock and severe somatic concussions such as railway collisions, burial under falls of earth, and the like.

### Brief History of Trauma

There is a voluminous body of literature focusing on theories of traumatic stress, including seminal contributions to trauma theories in the 20th century. Scientific interest in trauma has a long and varied history tracing back to the 6th century B.C.E. However, it was the study of "hysteria" in the late 19th century that captured public attention and spawned research that would later be the foundation of psychological trauma theory. Physicians originally thought hysteria to be a disorder found only in women, originating in the uterus. It was considered a strange disease with mysterious symptoms, often attributed to anything men found emotionally unmanageable or inexplicable in women.