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From evolution to discourse: Key conceptual debates in the history and study of traumatic stress[1]

Abstract

The study of traumatic stress has a long and rich history, drawing upon many of the major strands of thinking in the discipline of psychology. The article highlights three important sets of debates arising out of the study of traumatic stress, exploring how these debates reflect ongoing dilemmas in the study of extreme stressors and the formulation of their impact on individuals and groups. The three key areas selected for discussion are firstly, the origins or causes of traumatic stress, secondly, understandings of the mechanisms by which people are theorised to become traumatised, and thirdly, the political, cultural and discursive positioning of the construct of traumatic stress. It is argued that research and writing on traumatic stress is reflective of broader tensions in psychology related to addressing concerns about scientific credibility, models of personhood and the social location of human subjects, amongst other issues. The need for integrative, cross-disciplinary and ever evolving scholarship in the area is highlighted.

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Introduction: Why is the study of traumatic stress of interest?

The study of traumatic stress over the past century and a half offers a rich tapestry against which to explore some of the major tensions and dilemmas that psychologists have faced in attempting to study human and social phenomena from a psychological perspective. The article expands upon some of the key debates framing understandings of psychological trauma over time, with some focus on the South African context, seeking to highlight just how complex the study of this psychological phenomenon has proved to be.

The field of traumatic stress studies is vast, rich and continually expanding. Having its origins in a range of different sets of scholarship, from the work of Charcot, Janet and Freud on conversion and hysteria, to investigations of "railway spine"

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by Eichsen in 1866, and Da Costa's "irritable/soldier's heart" identified during the American civil war (Kinzie & Goetz, 1996), the construct of traumatic stress has continued to highlight a range of important conceptual debates within psychology and psychiatry and beyond. In her seminal book, **Trauma and recovery**, Judith Herman (1992a) observes that traumatic stress is interesting in the way in which it reflects the strength of social movements at particular points in history. She argues that the construct has enjoyed waxing and waning degrees of recognition and that in the same way that individuals may repress traumatic memories, societies may also repress particular kinds of mass violations or tragedies, contributing to what Herman refers to as "intermittent amnesia" (1992a: 8). Herman proposes that globally the contemporary salience of the construct has to do with the confluence of three different socio-political trends. Firstly, she suggests that the entertainment of hysteria in women in late nineteenth century France was linked to the republican, anti-clerical movement with its celebration of science and secular knowledge. A second major impetus was the recognition of war neurosis or combat stress, and particularly, the political momentum produced by Vietnam Veterans' associations and the anti-war movement. Finally, Herman suggests that the feminist movement and the enablement of exposure of widespread instances of sexual violence, including rape and childhood sexual abuse, created a further context in which the impact of traumatic life events could begin to be appreciated and to gain social purchase. In South Africa, early traumatic stress conceptualizations were initially associated largely with the work of rape crisis organizations although this tended to be confined to "rape trauma syndrome". The 1980s saw the emergence of a range of professionally oriented anti-apartheid organizations, including the Organization for Appropriate Social Services in South Africa (OASSSA) (Hayes, 2000), Psychologists Against Apartheid and the Detainees Support Groups, aimed, in part, at assisting the victims of repressive force and state violence. Traumatic stress became further elaborated as activists worked to engage with the impact of detentions, torture, disappearances, injury and violent death within communities (Foster, Davis & Sandler, 1987).

Perhaps the most powerful and widespread appreciation of traumatic stress arose during the hearings of the South African Truth and Reconciliation Commission (TRC). The traumatic history of apartheid society was brought to light in revisiting of a range of "gross human rights violations" and the traumatic impact of such events for individuals, families, social units and communities was emphasized (Gobodo-Madikizela, 2002). Contemporarily there are pervasive concerns about the prevalence of violent crime, violent service delivery protests and the re-emergence of state violence, as well as an awareness of the propensity for inter-group, particularly xenophobia-related, violence. Research into these phenomena includes concerns about the traumatic stress consequences for both direct and indirect victims. It is therefore evident that particular political forces, including the recognition of gender-based violence, state sponsored violence and repression, and elevated levels of crime and xenophobia in post-apartheid South Africa, have also contributed centrally to placing traumatic stress upon the map for researchers and interventionists in this country (Kaminer & Eagle, 2010).

At present it seems difficult to imagine that the phenomenon of traumatic stress could go underground again given the hold it has taken on public consciousness, evidenced, for example, in references to traumatic stress in popular soap operas and the need for "trauma counselling or debriefing" in situations in which individuals and social units have been affected by some sort of violent or disturbing event. Reflecting on more colloquial or everyday uses of the term "trauma", Laqueur (2010: 19) notes: "having once been relatively obscure, it is now found everywhere: used in the New York Times fewer than 300 times between 1851 and 1960, it has appeared 11,000 times since". This popularisation of trauma also has its parallels in a burgeoning of scientific study into

multiple dimensions of traumatic stress. In a recent editorial comment in the **Journal of Traumatic Stress**, Schnurr (2010), writes about the status of the study of trauma some 30 years on from the introduction of Posttraumatic Stress Disorder (PTSD) into the formal psychiatric classification system of the American Psychiatric Association, the **Diagnostic and statistical manual of mental disorders (DSM)**. Scientific writing on traumatic stress has increased exponentially: "The number of publications grew over ninefold between 1980-1984 and 1995-1999, from a mere 930 to 8,606" (Schnurr, 2010: 1). Given this wealth of research and publication it is not surprising that the field is characterized by contestation, debate and a multiplicity of disciplinary perspectives.

Traumatic stress appears to have captured both the scientific and public imagination and current debates are not so much concerned with whether such a condition exists at all but rather with ongoing refinement and differentiation of the construct and what it describes. For example, one of the current strands of investigation in the contemporary literature concerns understanding where to locate prolonged, repeated, multiple, cumulative, complex, occupationally-related, and developmental, types of traumatic stress, as opposed to single incident induced (mono-causal) traumatic stress. In addition, there are calls to enrich understandings of what has been termed "historical trauma" (Gone, 2013), and of collective, cultural, and identity-related trauma (Kira, 2010). In South Africa, with its extraordinarily high rates of motor vehicle accidents, violent crime, sexual violence, trauma related deaths, and lack of safety in many communities, an interest in what has been termed "continuous (as opposed to "post") traumatic stress" has resurfaced (Eagle & Kaminer, 2013). Some of these issues will be further elaborated in the course of the discussion but at this point the introduction of this material serves to emphasize just how broad the field has become.

A wide spectrum of theoretical perspectives

Reading the traumatic stress literature (or at least a substantial proportion of it) it is sometimes difficult to comprehend that writers are describing the same phenomenon. At one extreme we have biological psychiatrists arguing that refinement of the diagnostic criteria for traumatic stress disorder is essential since: "Ideally, the entities characterized through this approach will be confirmed in the future in terms of neurobiology and neuroanatomy" (Maier, 2007: 915). At the other end of the spectrum, Laqueur (2010) critically observes that trauma is as much a moral as it is a medical category and in commenting on Fassin and Rechtman's **The empire of trauma: An enquiry into the condition of victimhood** (2009), suggests that trauma is "a 'floating signifier' that denotes any number of ills which have little in common other than the name"(2010: 19). Thus on the one hand we have the validity of traumatic stress ultimately tied to its location in neurophysiology or anatomy, and on the other, a suggestion that traumatic stress is to some extent a discursive or epiphenomenal construction with political and strategic effects. It is difficult to see how these positions might be reconciled. Between these two extremes also lie a myriad of other formulations and understandings. For example, within the psychological literature, traumatic stress has been characterised as: an evolutionary response; a dissociative condition; the product of impaired memory processing and storage; a classical conditioning response; a fear network; a failure of information processing; a condition involving cognitive distortions; a disruption to basic assumptions or core schemas; an existential rupture; evidence of ego failure or failure of "good object" relations; and as an attack on identity; amongst others. Although these different formulations of traumatic stress have arisen, in part, as a consequence of different theoretical allegiances, different models of mind and different emphases in understanding, they also highlight the presence of not easily reconcilable ontological and epistemological assumptions. In this respect the history of the identification, characterisation and formulation of traumatic stress is fascinating in the way in which it is reflective of some of the major points of tension and contestation in the

discipline of psychology more generally. The elaboration of these issues is focused around three broad questions: firstly, the possible causes of traumatic stress, secondly, how the "condition" is proposed to develop, and thirdly, how traumatic stress is contextually framed.

What are the origins or causes of traumatic stress?

A question that has run throughout the history of the study of trauma has been whether traumatic stress emerges as a consequence of exposure to extreme events or whether it represents some psychological vulnerability particular to the individual, or is a product of both of these features. Questions as to whether the origins of human conditions, functions and behaviour are internally or externally located have been with us since the first emergence of psychology as a discipline, often captured under what has historically been termed the nature/nurture debate, a construction to which all undergraduate psychology students are introduced. Contemporarily this interest may be labelled somewhat differently, such as in the terminology of gene-environment interaction.

When traumatic stress first became recognized in the form of a potential disorder, that of posttraumatic stress disorder or PTSD, it was originally postulated that the condition was only likely to emerge in response to extreme and unusual catastrophic events, events that, according to the original DSM-III, were "generally outside the range of usual human experience" and would "evoke significant symptoms of distress in almost anyone" (American Psychiatric Association (APA), 1980: 238). From this characterization it is apparent that the causal emphasis lay primarily upon the event. PTSD was understood to be a *normal response* to an *abnormal event* rather than reflecting any pathology intrinsic to the individual. This emphasis represented a departure from a history in which those suffering from traumatic stress conditions were held accountable for their own distress. For example, Freud who initially postulated that hysteria was a consequence of actual sexual violation, apparently influenced by the patriarchal climate of his times and facing censure from the medical fraternity, later came to argue that the traumatic nature of hysteria was primarily related to intrapsychic conflict stemming from the repression of sexual and incestuous desires and fantasies intrinsic to the patient (Wilson, 1994). Although this is clearly a complex debate, many feminist authors have argued that this shift in position meant that rather than the source of the pathology being located in environmental circumstances (in this instance, gender violations) the women themselves became viewed as largely responsible for their condition of distress (Herman, 1992a). A second example concerns that of the treatment of soldiers during the Second World War. As is well documented, given the appalling circumstances within which they found themselves, large numbers of combatants developed disabling physical and psychological symptoms such that they were unable to continue to function effectively on the battle front. Many of these soldiers, suffering from what would now be understood as combat stress or combat neurosis, were treated within a moralistic framework in which their condition was associated with malingering, cowardice and characterological weakness. A range of treatments were administered, designed to make their time in hospital more aversive than being in active combat (Shephard, 2001). Again, in this instance, personal rather than circumstantial factors were viewed as the source of the problem. Interestingly one still contemporarily sees traces of such prejudicial judgments in the manner in which rape survivors are often viewed as in some way having invited the assault, and men who develop PTSD symptoms may be viewed by others (or themselves) as weak and lacking in fortitude (Eagle, 2006). Later historical events, particularly exposure of the Holocaust and extreme maltreatment in Nazi concentration camps, as well as the feminist inspired documentation of gender violence and the voices of post-Vietnam anti-war organizations, mentioned earlier (Herman, 1992a; Wilson, 1994; Shephard, 2001), led to a revisiting of earlier constructions with the external source of the stress now receiving prominence as the causative agent in the development of traumatic stress

conditions. The first formal inclusion of traumatic stress as a legitimate "psychiatric" condition in DSM-III thus captures this emphasis on the extremity lying within the stressor rather than sufferer.

Subsequent versions of the DSM have all sought to further refine the diagnostic category/ies, in part by aiming to more clearly specify what constitute the traumatic events or stressors that fit what is known as "Criterion A". For example, DSM-III-R (APA, 1987) elaborated the definition of the abnormal event to include examples such as events that involved serious threat to life or physical integrity, and in DSM-IV-TR (APA, 2000) this definition was consolidated and it was also recognized that secondary exposure, such as "witnessing" or even "learning about" an event of this nature, might be sufficient to produce PTSD. Over the past few years there has been considerable deliberation about the further refinement of PTSD diagnoses for inclusion in DSM-V. A key debate has centred around the specification of the stressor criterion, Criterion A1, with concerns both about over-generality and over-specificity. Brewin, Lanius, Novac, Schnyder & Galea (2009: 371) go so far as to suggest the removal of Criterion A (both 1 and 2) from the diagnosis of PTSD altogether, arguing that "its dependence on the etiological criterion is now more of historical interest rather than practical importance". On the other hand, Kilpatrick, Resnick & Acierno (2009: 374) argue for the retention of the category, noting that "unlike most other diagnoses, PTSD is presumed to have a specific etiology, and exposure to a Criterion A stressor is considered to be a major etiological factor for the disorder although there are numerous other risk and protective factors". The status and definition of the criterion appears to reflect political or moral imperatives alongside scientific/diagnostic considerations, in that the continued inclusion of the criterion appears to provide ongoing validation of the fact that external forces or the environment has a key part to play in aetiology.

Behind some of the debate about Criterion A, has been the evidence from research over the past 30 years that in fact exposure to serious or traumatic life events is not unusual, and the further finding that "typically only a minority of individuals developed PTSD afterwards" (Brewin et al, 2009: 366), with broad estimates suggesting that generally about 25% to 30% of those exposed to traumatogenic events are likely to go on to develop PTSD (Green, 1994; Kaminer & Eagle, 2010). In South Africa, a recent survey based research study, the South African Stress and Health Study (SASH), found that nearly 75% of a broad adult sample reported exposure to some traumatic event over their lifetime, with the majority (55.6%) reporting exposure to more than one traumatic event (Williams et al, 2007). Rather unexpectedly the SASH study found the "lifetime prevalence rate of PTSD … was 2.3%, compared with about 8-9 per cent in the American population and 11.2 percent in the Mexican population, both of which have rates of trauma exposure that are similar to those found in South Africa" (Kaminer & Eagle, 2010: 55). While there are likely to be a range of factors accounting for this finding, including study design elements, what is important to the argument here is that the development of extreme forms of traumatic distress, such as PTSD, is not inevitable following exposure to traumatic life events, and this again brings in the "nature" part of the debate. Without wanting to take the discussion off track at this point into a completely new area it is worth noting that these kinds of prevalence findings also refer to the larger debate within psychology of just what constitutes "abnormality" and whether this should be defined in terms of statistical, socio-cultural or intrapersonal norms, or a combination of these features. In relation to traumatic stress what is apparent is that statistically the development of a *disorder*, involving longer term adjustment problems of a particular kind, is statistically non-normative, although broader stress responses of shorter duration and more limited symptomatology are almost universal. At the same time, the disorder is also only recognized to occur in response to an extreme form of external stressor event.

What has been demonstrated in posttraumatic stress research is that the risk factors for PTSD are remarkably complicated and require consideration of at least three different elements: individual characteristics, event characteristics and the characteristics of the recovery environment (Green, 1994). In addition, many would add that the historical and socio-political context in which the trauma is located also plays a significant part, such that Vietnam veterans who came to be understood as having taken part in an illegitimate or shameful war, as with many South African Defence Force soldiers, were differently vulnerable to trauma from the returning heroes of World War I and II in those countries that were victorious.

It is impossible in the scope of this article to do justice to the range of person and event characteristics that have been studied in relation to traumatic stress impact. Rather a few illustrative examples will be presented. It has been found that human-inflicted as opposed to trauma of "natural" origins, and trauma severity, as evidenced in the degree of life-threat, injury sustained and duration of the event, are predictive of likely PTSD (Kinzie & Goetz, 1996). Of types of trauma, rape, torture and combat stress tend to produce high prevalence rates (sometimes as high as 40 to 50% amongst rape and torture survivors) (Kaminer & Eagle, 2010). In relation to individuals exposed to traumatic stimuli, both protective (resilience building) and vulnerability factors have been studied. From twin studies there is evidence for some genetic vulnerability to trauma, via neurochemical pathways, and there has also been some research into temperamental variations, such as anxiety-proneness and general baseline arousal levels as implicated in the likely development of PTSD (Koenen, Amstadter & Nugent, 2009). Beyond this, there is evidence that a stressful life-history, particularly a prior history of traumatisation and neglect, is an important risk factor for PTSD (Cloitre et al, 2009). Personality dimensions and "cognitive style" have also been implicated in vulnerability, with an internal locus of control or strong Sense of Coherence being associated with reduced risk. In addition, demographic features, such as sex/gender, level of education and social class, have also been shown to affect the likelihood of symptom development and symptom patterns. In terms of the recovery environment the availability of social support has been strongly implicated in risk reduction. For victims of crimes and atrocities (both individual and collective) the responses of criminal and social justice systems (Danieli, 2009) may also be importantly implicated in whether people transcend or continue to suffer the impact of traumatic stressors. Although the body of work on both risk and preventative factors is well established and continues to grow, what has become evident is just how difficult it is to conduct research in this area given the multiplicity of factors at micro and macro levels that need to be taken account of, or as Brewin et al (2009: 366) suggest, the fact that "PTSD has a multifactorial etiology". This is one of the ongoing tests of psychological research in this field, just how to take account of the multiple vectors involved in researching individuals and groups in interaction with each other and their environments. If this *scope* problem were not enough, there is the added difficulty of attempting to understand psychological phenomena such as traumatic stress in interactional and evolving rather than summative and static ways.

Stress research has for some time committed to a transactional or interactional model, with the implication that stressful outcomes are the product of an ongoing process of appraisal of environmental demand (primary appraisal), personal and other resources available to meet this demand (secondary appraisal), and the likely outcomes of particular courses of action (tertiary appraisal) (Lazarus & Folkman, 1984). It is proposed that cognitive, emotional, motivational and identity-related factors, amongst others, inform this ongoing appraisal. While there has been a rather puzzling disconnection between stress research and traumatic stress research, it is evident that the role of appraisal and/or attribution is an important one in traumatic stress, as will be returned to in the next section of the discussion. In the traumatic stress literature Koenen et al

(2009) suggest that it is important to supplement the somewhat limited existing research into gene-environment interaction in PTSD. What is evident from some of the research studies that they review is that pathways for vulnerability may be extremely complicated with multiple factors in interaction contributing to particular outcomes. Thus, for example, they cite Nelson et al's (2009) study which appears to suggest that early childhood trauma produces permanent changes in neurochemistry that in turn render adults exposed to a later traumatic event, such as a natural disaster, vulnerable to PTSD onset, and that both the nature (for example, whether physical and/or sexual) and severity of child abuse, may modify this relationship. In a sample of Rwandan refugees with very high levels of PTSD prevalence (81%), genotype was shown to interact with the number of traumatic events an individual had been exposed to in predicting likely pathology. In a study into Hurricane Katrina victims it appeared that county crime-rate and county unemployment rates were implicated in whether genetic markers were associated with increased or decreased risk of PTSD (Koenen et al, 2009). Further, in a review article on dissociation following traumatic stress, Shauer and Elbert (2010) observe that peri-traumatic dissociation is a powerful predictor of likely development of PTSD. They further observe that based on evolutionary or genetically programmed responses to extreme threat (primarily vulnerability to predation), dissociation is more likely to occur when there is bodily penetration of some kind and physical restraint or entrapment. In this instance it seems that the pathway to developing PTSD, based on event characteristics, goes via the route of dissociation. These various examples offer yet further evidence of the complexity of conducting research in this area. It is evident that gene-environment interaction research tends to require access to large samples and the assessment of multiple variables and in this respect is resource intensive, making it difficult to conduct this kind of research in under-developed contexts.

The history of the study of PTSD suggests that the nature/nurture debate is still very much with us, even if within a new guise. Where there have been significant advances is in the recognition that we can only build up a comprehensive picture by following a multi-layered and multi-disciplinary approach and that models need to take account of complex interactions of multiple vectors which do not necessarily fit together in linear or summative ways. Having highlighted aspects of this first central debate in the trauma literature, the discussion turns to a second, related debate, that of how traumatic stress comes to manifest as such.

What are the mechanisms by which traumatic stress develops and how are these accessible to investigation?

As introduced earlier, the range of psychological (and other) models that have been proposed to explain the development of traumatic stress conditions, including PTSD, is very broad and diverse. One difficulty in comparing and reconciling explanatory models lies in their location in very different theoretical traditions. For example, do theorists entertain some notion of an inner self or of intrapsychic constellations which allows for an interpretive or hermeneutic understanding, as opposed to basing theory in more empirical or observation based understandings? Is traumatic stress a product of mind, brain and/or behaviour and what does this imply about consciousness and its relation to neuro-anatomy and neurophysiology? Alternatively, is the experience of being traumatized (or of PTSD as a diagnosis), a narrative or discursive construction, based primarily in language and ways of speaking which shape subjectivity and presentation? Such different theoretical traditions influence not only what comes to be known but also how this knowledge can be arrived at.

Returning first to the diagnostic category of PTSD it is noteworthy that a second significant element is encompassed under the A Criterion (A2). In DSM-IV not only was the nature of the

kind of event that could produce PTSD more narrowly outlined, in addition, the kind of "marked distress" that individuals might experience in response to such events was also refined to specify that the primary affects associated with PTSD in adults were "fear, helplessness and horror" (APA, 2000: 428). It is evident that in this respect the affective or subjective response of individuals is also centrally implicated in the characterization of the condition. While the diagnostic system has sought to capture this aspect of traumatisation in universal and specific terms, the debates about the usefulness of Criterion A in the fifth version of DSM, also extended to whether this set of affects is sufficiently comprehensive, with several contributors observing that anger or shame, for example, are also very often present in the aftermath of trauma. In their proposal to revise PTSD diagnostic criteria, Brewin et al (2009) argue that the two cardinal distinguishing features of PTSD are vulnerability to flashbacks and to nightmares. It is evident that rather than separating out Criterion A1 and A2, in their proposed definition of these symptoms they capture stressor criteria as part of what characterizes such nightmares or flashbacks. Thus they suggest that re-experiencing may be evident in the form of "repeated daytime images related to an event now perceived as having threatened someone's physical or psychological well-being, experienced as recurring in the present and accompanied by marked fear or horror." (ibid: 370). What is interesting here, in addition to the retention of the narrow affect response categories of fear and horror, is the use of the terminology "*now perceived as*". What these words appear to convey is that it is the retrospective evaluation of the event and the subjective perception of the individual, which play a significant role in the symptom picture. While psychiatric diagnoses tend to rely on objective, observable, replicable descriptors, psychological theory on traumatic stress has tended to take greater interest in the subjective or personally evaluative dimensions of traumatic stress (McCann & Pearlman, 1990). This debate about Criterion A2 thus represents a narrow version of a much bigger debate about the role of interpretation or meaning making in whether and how something is experienced as traumatically stressful.

To highlight one of the key discrepancies in the theorization of trauma impact it is useful to juxtapose behavioural and psychoanalytic understandings. In order to make this comparison it is acknowledged that somewhat reductionist versions of these stances are put forward so as to illustrate where core points of divergence lie. Associated most centrally with the work of Edna Foa and her associates (for example, Foa & Kozak, 1986; Foa & Rothbaum, 1998), it has been theorized that traumatic stress involves a kind of classical conditioning experience in which "fear networks" become established based on the association of extremely high levels of anxiety with trauma-related stimuli, and subsequent generalizations of this kind of connection to related situations and objects. Traumatic stress is thus the product of a kind of problematic associative learning, learning that becomes reinforced over time with avoidance of trauma related stimuli and re-arousal upon exposure to any reminders of the stimuli. This hypothesized fear network formulation may be backed up by neurological research which suggests that trauma related anxiety is connected to activation of the limbic system which by-passes higher level neocortical structures, leading to a kind of automatic response that is not mediated by reflection, sense making and reason (Turnbull, 2011). The theory has also been linked to evolutionary models of human behaviour under conditions of extreme threat in which it is postulated that particular kinds of nervous system responses and instinctual behaviours (freeze, flight, fight, flag, faint) are liable to occur (Shauer & Elbert, 2010). The suggestion is that traumatisation entails a kind of automatic "learning" or conditioning, based in human evolution, involving more "primitive" levels of neurological processing that have to do with threat detection and survival. Fear network theory clearly benefits from this underpinning in neuropsychology and in evolutionary theory as this kind of theoretical base is seen to provide strong theoretical credibility. The arousal levels in

response to trauma related stimuli can, for example, be mapped onto activity within particular brain areas through neuro-imaging, what might be considered a remarkable demonstration of the location of psychological experience or symptom within the brain. For some psychologists, however, although this is an important link, conditioning theory is viewed as an over-simplified way of understanding the impact of life threatening events that hold personal and social meanings beyond this. Within fear-network formulations the *content* of the stimulus response (S-R) connections is of limited interest, beyond identifying these as the targets of exposure related treatment in order to break the associative learning patterns. The emphasis is on the universal pathways for trauma transmission and on observable and measurable links.

In contrast, psychoanalytically informed trauma theorists generally place considerable weight on the precise nature of what features of the trauma stand out for the individual and evoke most affect. Viewing human functioning as ineradicably located in personal developmental history, and as shaped by unconscious and conscious aspects of the psyche, psychodynamic theorists maintain that what is traumatogenic about an event are the particular sets of meanings that the event comes to hold for the individual concerned (Laub & Auerhahn, 1993; Garland, 1998; Laub, 1998). Formulation of trauma impact requires careful exploration of the manner in which the individual describes the traumatic event and their response to it, including for example, the language they deploy, emphases, omissions, affective tone, and fantasy material; with a view to uncovering pre/unconscious associations to the trauma and the way in which intrapsychic constellations have shaped and/or mapped onto the experience. A strongly ideographic approach is maintained in which trauma impact can only be fully appreciated with a careful personal history taking, formulation of personality constellation and dynamics, and attention to unconscious as well as conscious meanings. A hermeneutic rather than an empirical descriptive approach is valued. This formulation of trauma impact is considerably harder to validate, given that the mechanisms for the emergence of traumatic conditions are tied to more hypothetical constructs, such as the notions of psychological defences or of internalized object relations. The verification of the relationship between personal meaning and traumaticity lies within the purview of the patient him/herself, a subject who is recognized to be compromised by his/her intrapsychic conflicts and degree of capacity for insight. While symptom relief may be an indicator of accurate interpretation, the degree of tie between the two is not easy to establish. Ultimately, as is the case with much interpretive work, the strength of this kind of analytic formulation is strongly reliant on the observational capacities of the practitioner and their ability to build a credible, coherent picture located within the material generated about the particular individual. Reading the detailed case studies of psychoanalytic theorists, such as Garland (1998), there does appear to be a compelling case for such hermeneutic understandings of trauma impact, and trauma-related cases continue to be documented within psychoanalytic texts and journals. However, within the global traumatic stress field, and perhaps in clinical practice more generally, psychodynamic formulations appear to be losing ground despite having been in the foreground of early theorization of trauma impact (Shottenbauer, Glass, Arnkoff & Grey, 2008). This is in large measure due to the resurgence of neuropsychological and positivist traditions of research, enabled by ever improving technological and measurement advances, and reflecting the cost efficiency driven emphasis on established best practice protocols.

Classical psychoanalytic formulations as outlined in some of Freud's early work on traumatisation suggested a more mechanistic model of impact in which it was postulated that trauma breached the barrier against external, overwhelming and unanticipated stimuli, which led to compromises in ego-functioning and cognitive disorganization, including the failure to continue to actively discriminate between signal and real anxiety. This model clearly has considerable

resonance with fear network theory and may well find similar grounding in neuropsychology or neuropsychoanalysis. Within the broad church of psychodynamic theory there is also an increasing interest in early attachment patterns and relations and the manner in which these might contribute to vulnerability to pathology in the face of later trauma exposure, as mentioned very briefly earlier. Thus there are indications that some contemporary psychodynamically oriented theorists are mindful of the need to better establish the credibility of this theoretical framework in light of current trends and developments. However, such developments cannot be at the expense of the essence of psychoanalytic ways of thinking, which in the traumatic stress field continue to entail an emphasis on the particular and unconscious meanings that traumatic events hold for individuals (or in some cases groups) (Eagle, 2013).

Although the battle between more empirically oriented behaviourists and interpretive psychodynamic theorists is a rather dated one which has been superseded by many other theoretical developments within psychology, including integrative models, it is apparent that traumatic stress formulations reflect the continuing presence of disparate perspectives in this regard.

Sitting arguably somewhere between these two extremes, is a further body of psychological work on traumatic stress located within a broadly cognitive tradition. Cognitive models and formulations of traumatic stress represent the bulk of theorization in this area and also enjoy considerable credibility in the international traumatic stress field. While it is impossible to do justice to the full range of trauma-related cognitive theories, several key perspectives are discussed. In some of the earliest theorization of trauma impact, Horowitz (1992) presented a model located both within information-processing and psychodynamic theory, maintaining that traumatic stress conditions signalled the inability of the individual to integrate trauma related material into existing long term or narrative memory. Trauma contents remain in "active memory", tending to alternately flood the individual or to be actively avoided, until it is possible to assimilate and accommodate these contents. Horowitz (1992) argued that internal models of the self, others and the world needed to be re-worked in the face of trauma exposure and that cognitive styles associated with particular personality typologies would influence the manner in which these models were available for modification. Several other theorists have also taken up the idea that trauma impact can best be understood in terms of the rupturing or invalidation of core assumptions or schemas. Based to some extent in Erikson's notion of psychosocial developmental achievements, Janoff-Bulman (1992) has argued that traumatisation involves the shattering of universal assumptions, assumptions that tend to be taken for granted and are important for everyday living free from disabling anxiety. These *basic assumptions* include the sense that the world (including the other people in it) are generally benign, that the world is meaningful (predicated on notions of predictability and controllability), and that the self is worthy (in the sense of enjoying recognition of humanity). Elaborating somewhat further on these assumptions, McCann and Pearlman (1990) propose that trauma creates ruptures to what they term "core schemas", schemas which are both common in their broad content, but also have particular salience for each individual. The core schemas pertinent to trauma impact are those of safety, trust, independence, power, esteem, intimacy and frame of reference (the last-mentioned including spiritual and existential beliefs). These kinds of cognitive models suggest that implied in the disruption of pre-existing schemas is a disruption to the person's sense of self and/or of their relation to others (often of a profound nature). There is an implication that personality or sense of self involves a degree of coherence and continuity over time. One's self cannot be disrupted unless it exists in an experiential or describable way in the first place. In this respect these models assume a modernist understanding of personality, based upon the idea of an identity than can be claimed by the individual and recognized by others. Certainly in the colloquial speech of victims

one often finds reference to this sense of a disruption to a previous identity maintained over time, as in: "*I am not the same person now as I was before this trauma*". In these kinds of models it is the de-anchoring from the known and familiar, and associated feelings of alienation and disorientation that are viewed as characteristic of traumatisation.

Other cognitive models assume a less interior and more circumscribed understanding of problematic cognitions as they pertain to traumatic stress (Resick & Schnicke, 1992). These models are located within the tradition of cognitive-behaviour therapy (CBT) and theory and tend to characterize trauma-related cognitions as in some way flawed, irrational or "faulty". For example, thoughts about the traumatic event may be understood to be over-generalized, exaggerated or overly categorical. Extending this kind of understanding of traumatic stress as produced and maintained by "disturbed thinking", Ehlers and Clark (2000) propose a cognitive model of PTSD which emphasizes the place of excessively negative appraisals of the trauma and its effects. Examples of such appraisals are: "*The next disaster will strike soon*", and, "*my body is ruined*". Ehlers and Clark give due weight to the memory and reliving problems associated with PTSD, linking their model to Brewin's (2001) model of verbally and situationally accessible memories (VAMs and SAMs), noting that that not all trauma related reactions and cognitions are accessible to verbal recollection. However, they argue that consciously identifiable negative appraisals are powerful and may shape even how events are recollected (usually so as to be consistent with negative formulations). In addition, they suggest that dysfunctional cognitive and behavioural strategies, such as avoidance of reminders of the trauma, tend to reinforce negative appraisal, in part because they prevent disconfirmation of these negative beliefs. Within these kinds of cognitive models there is again the assumption of a modernist self, a self that comes to hold these kinds of ideas about the trauma and exercises some agency in inadvertently sustaining this pathological state through active cognitive and behavioural strategies. This is not quite the same as the individual whose traumatisation comes about through automatic associative connections of a stimulus-response kind. In addition, this CBT oriented formulation of trauma assumes that the negative cognitions can be identified by means of collaborative exploration, naming and description, unlike psychoanalytically oriented theorists who assume that some of the symbolic associations to the trauma lie outside of conscious awareness. It is also worth noting that cognitive models suggest that the negative appraisals are produced or in a sense "owned" by the individual, rather than being co-constructed in dialogue or alternatively more discursively produced as the traumatized individual makes use of existing "repertoires" of expression to make sense of their trauma (as might be proposed by narrative oriented theorists). Although cognitive trauma theorists view cognitions as trauma initiated and related, they see the individual as an active sense maker rather than as a subject driven by either instinctual, unconscious, or discursive forces. All of these formulations of the mechanisms by which people become traumatized have implications for the treatment of people suffering from PTSD and trauma related conditions.

It is worth highlighting that within cognitive models of traumatisation one aspect of appraisal that has received particular emphasis is that of attribution of blame (Janoff-Bulman, 1992). It has been observed that survivors of traumatic events have a tendency to self-doubt, self-recrimination and self-blame, both in respect of their actions during the traumatic event and in respect of their subsequent responses. There has been debate as to whether some kinds of self-blame, in this instance behavioural (as opposed to characterological) self-blame, might in fact prove constructive to post-trauma adjustment (Janoff-Bulman, 1992). This is because behavioural self-blame was hypothesized to provide the victim/survivor with an increased sense of personal agency in being able to avoid future risk – "*if I do or don't do this in future I should be safe*". Although it has been

established that self-blame is seldom helpful in this kind of respect, this debate again signals subscription to a model of an autonomous and volitional self. What this illustrates rather powerfully is that most cognitive models seem to obscure or to underestimate the role of social attributions and the cultural and ideological framing of events, and the manner in which these interface with apparently personal appraisals. This brings us to a third important question in the study of traumatic stress, that of contextual location.

It is apparent that in offering explanatory models for the transmission of trauma, or of how trauma appears to get from the outside in, theorists have differed to the extent that they view psychological functioning to be determined or agentic, conscious or unconscious, rational or irrational. While they may differ in these aspects, almost all of the models of mechanisms of traumatisation nevertheless assume what could be termed a "modern" human subject, an individual with a coherent, largely consistent, autonomous identity or self. In this respect the clinical study of traumatic stress has been located largely separate from the critical and discursive theory that has influenced psychology over the past two decades. This is perhaps because this kind of theoretical perspective has been most often applied to understanding social psychological phenomena and the politics of the deployment of particular ideas or practices. Contextualizing traumatic stress from a critical psychological perspective requires stepping back to take a meta-perspective on some of the ideas discussed thus far.

How do we take account of contextual features in studying traumatic stress?

In looking at context and traumatic stress there are at least three different sets of critiques: cultural, socio-political and discursive, which are important to address.

As might be anticipated, since this, again, is a recurring debate in psychology, there is a question as to whether traumatic stress and more specifically PTSD is a universal condition or whether it is culturally specific or strongly culturally mediated (the emic/etic question). This is an important global question but of particular importance in a country such as South Africa where there are cultural differences of considerable magnitude, including in terms of race, class and ethnic identifications, urbanization, and degree of subscription to what are broadly termed "westernized" as opposed to more traditional or indigenous beliefs. While it is not possible to do justice to the cross- or multi-cultural literature on psychopathological conditions, such as PTSD, conducted by psychologists and medical anthropologists amongst others (Kleinman, 1986; De Jong, Komproe, Spinazzola, van der Kolk & van Ommeren, 2005), a few pertinent issues are flagged.

While the neurophysiological literature would suggest that traumatic stress responses are universal, there is also some evidence that manifestations of traumatic stress conditions are likely to be shaped by cultural meanings and practices and to present in somewhat different ways amongst different groups. One aspect of traumatisation that continues to attract considerable debate is the degree to which somatic symptoms are understood to be a common dimension, intrinsic to trauma presentation. It is certainly the case that for groups of people in which psyche-soma distinctions are less Cartesian, psychological symptoms of trauma impact are almost invariably accompanied by somatic symptoms, such as headaches and bodily pains. Although this kind of symptomatic impact was recognized in the qualification of PTSD in an earlier version of the DSM, it is not part of more recent systems (Wilson, 1994), but appears to warrant wider consideration. In the formulation of the idea of Complex Posttraumatic Stress (CTSD), Herman (1992b) observes (in keeping with others), that the impact of exposure to multiple traumatic events over a prolonged period (as in becoming a prisoner of war), generally involves the

development of chronic somatic problems. Such difficulties have been well documented in Holocaust survivors, for example. However, some studies in South Africa and other parts of the world suggest that somatization may be a common aspect of the response to even monocausal or brief term traumatisation and that this aspect of "cultural" presentation should be more widely acknowledged (Kaminer & Eagle, 2010). It has also been suggested that for people whose lives are characterized by ongoing hardship, often shaped by discrimination and poverty, traumatic events may fall within a continuum of suffering and may not be singled out or experienced with the same urgency as existing definitions appear to suggest.

A further cultural element concerns the role of cultural beliefs concerning misfortune and the manner in which these beliefs shape individual attributions (Eagle, 2005). Highly religious people of different faiths are likely to draw upon explanatory frameworks concerning suffering, victimization, aggression, violence and loss, located within the particular creeds of their belief systems. Alternatively, people may draw upon indigenous knowledge systems, such as what could broadly be termed an "African cosmology", in making sense of traumatic experiences. For example, it may be that falling victim to traumatic events (particularly multiple such events), is interpreted as an indication that one's ancestors have withdrawn their favour and protective function (Eagle, 2005), and that the likely origins of their displeasure need to be identified and remedied. Such culturally mediated meanings may shape attributions in important ways, even if it is recognized that individuals are not necessarily passive recipients of such interpretations (Eagle & Long, 2011). This suggests a rather different location of mechanisms of traumatisation.

There is also a further set of concerns about westernized frameworks for understanding traumatic stress and its impact that pertains to the degree to which identity is experienced as collective or individualized. If understood as the former it has been argued that trauma responses may carry a sense of group burden and collective suffering that is more than the impact of the additive weight of a number of individually symptomatic people. This conceptualization of trauma also goes beyond conventional notions of "indirect traumatisation" which tend to focus on trauma generated out of identification with close family members, friends or colleagues. What is maintained in notions of collective or historical traumatisation, is that whole groups of people, based on group identity characteristics, carry a sense of a common persecution or victimization. The idea of *historical trauma* is associated most strongly with the history of first nation people in America and the genocidal violence to which they were subjected (Gone, 2013). *Collective trauma* is the term that tends to be used about the response of groups of South Africans subject to a brutal apartheid and colonial history, as well as about the response of groups of Jewish people to the Holocaust. Such trauma may be understood to be transmitted intergenerationally via both conscious and unconscious mechanisms, such that those of generations post those directly victimized nevertheless carry the experience of trauma within themselves. In some respects identity and collective trauma come to be intertwined (Kira, 2010). Such conceptualizations of trauma may encompass a somewhat broader definition of traumatic stressors including not only relations of oppression that threaten actual survival of the group, but also more ideological forces that threaten the eradication of cultural or group identity. In this framework racism, xenophobia or fundamentalisms based on oppression may be understood to produce collective traumatisation. Kira (2010) suggests that persons may be traumatized at multiple levels including collective/social, personal/physical and role identity levels, and that which of these levels is most salient at a particular point in time will be dependent both on life history and current environment. This discussion of broadly cultural dimensions of trauma is clearly linked in to what might be termed more overtly socio-political considerations in relation to traumatic stress.

A number of writers, including Summerfield (2001), have proposed that one of the difficulties with PTSD and related psychiatric conceptualizations is that these represent the medicalization and pathologization of what might better be understood as human suffering or tragedy. Not only is this a reductionist way of understanding such suffering but it also de-politicizes the nature of human trauma, which tends to in turn obscure relations of oppression (Eagle, 2002). Summerfield (2001) observes that a disproportionate number of victims of trauma come from marginalized and disadvantaged communities and points out, for example, that many more civilians have been killed and injured in wars than active combatants. Wars also represent the exploitation of populations to serve nationalistic and, very often, commercial interests, thus the traumatisation of war victims cannot be seen as unintentional. There are clearly links between this criticism of PTSD as rendering problematic repressive and oppressive relations apolitical and the idea of collective and historical traumatisation.

It is possible, however, for the diagnosis of PTSD and related conditions to be used in the service of marginalized individuals or groups. Thus there are occasions in which PTSD diagnoses may be used strategically, for example, as a psychiatric defence in mitigation of sentence of an abused woman who murders her husband (Young, 1995). Evidence of PTSD has also been used to substantiate that individuals have been subject to terror or traumatizing conditions, as in the research conducted by Foster, Davis and Sandler (1987) on the impact of torture and detention of political activists which was used to place moral pressure on the Nationalist government; and the mental health evaluations of political refugees that corroborate their need to escape ongoing brutality from repressive regimes (Steel, Bateman Steel & Silove, 2009). One problem with these kinds of "strategic" uses of diagnoses, drawing as they do upon the scientific credibility and moral weight of a "medical condition", is that such formulations have also been misused by perpetrators of violence. Thus, for example, some agents of the South African state who were involved in brutalizing political activists, such as Eugene de Kok, have claimed to be suffering from traumatic stress, with the suggestion that they have also been in a sense casualties of political conditions and are entitled to some sympathy or empathy (Eagle, 2002). The relationship between perpetrators and victims of violence is certainly a complicated one, in which boundaries are not always clear and it needs to be acknowledged that perpetrators may also be or have been victims in the past (Roach, 2013). What is apparent is that both the de-politicization and the overt politicization of trauma stress conditions carry consequences that need to be carefully thought through.

A further stream of thinking about the socio-political location of traumatic stress has been reflected in the recent revisiting of the construct of *Continuous Traumatic Stress* (CTS), as elaborated in a 2013 special edition of **Peace and conflict: The journal of peace psychology**. A construct first introduced by those offering psychological services to activists during the repressive apartheid years in South Africa (Straker, 2013), CTS is understood to refer to the condition of, or response to, being compelled to live in a context characterised by current and future danger, in which traumatic stress is therefore not past or *post* (Eagle & Kaminer, 2013; Stevens et al, 2013). Eagle and Kaminer (2013) suggest that many contemporary populations of people, such as refugees in hostile host environments, civilians in high conflict societies and individuals living in communities in which crime is endemic, may experience CTS. One of the cardinal features of such contexts is that alongside exposure to extreme threat is an absence of social or state protections to moderate violence and to hold perpetrators accountable. In some instances the state itself may perpetrate violence against citizens, as in repressive and totalitarian regimes, but in other instances factors such as corruption, ineptitude, over-stretched services and the breakdown of social order, may contribute to the creation of such contexts. Individuals living in such environments may develop a range of (symptomatic)

responses, including high levels of anxiety and somatic conditions. However, such responses may well disappear (or remit, if thought of as symptoms), if the individual is able to relocate or to escape the environment. This latter observation suggests that while some presentations of CTS may become pathological, the condition of being traumatised is perhaps an appropriate one in response to a perverse and dangerous environment. Coping in such environments may require a (hyper)sensitivity to threat cues and a moderation of assumptions about the trustworthiness of others in one's world, features that would usually be targeted for amelioration in PTSD populations. What is considered adaptive and maladaptive in relation to trauma exposure therefore becomes to a large extent contextually determined. While CTS remains a topic ripe for ongoing research, it is apparent that the construct attempts to engage with conditions of traumatisation that are enmired with and entrenched by socio-political conditions.

As a third way of thinking about the importance of context, particularly social context, it is useful to make some reference to role of *discursive* understandings in the theorization of traumatic stress. As referred to at the outset, Laqueur (2010) in his critical review of **The empire of trauma: An inquiry into the condition of victimhood**, observes that *trauma* employed in the sense of psychic injury is at risk of becoming something of a "floating signifier", in that the construction of experience as traumatic in this sense is contextually contingent. Laqueur suggests that the recognition of forms of psychological (as opposed to physical) trauma is relatively recent and indicates that according to Didier and Rechtman (2009) "the category of trauma victim as we know it was created as a new subject category within a particular professional community" (Lacqueur, 2010: 23) with specific aims and purposes in mind. Laqueur appears concerned that even purist, overtly moral motives for employing the term may be perverted and suggests that requiring 'trauma' as a construct to do serious ethical kinds of work is somewhat misplaced. "I take trauma as it is wielded even in these communities to be largely epiphenomenal and strategic, and part of a larger story" (Laqueur, 2010: 23). It seems that in many instances the terms *trauma*, *traumatic* and *traumatized* have become over-used and commonplace, losing some of their capacity to fully capture the impact of horrifying, disastrous, brutal, repressive and sadistic acts and events, and associated human suffering. The industry that has grown up around traumatic stress study, assessment and intervention has in many instances contributed to a kind of normalization of conditions of suffering and oppression and even to investments in economic and reputational gain amongst practitioners. The burgeoning of trauma debriefing services over the last two decades despite empirical research that suggests that such interventions have little or no substantiated benefits (Rose & Bisson, 1998), is one example of how the needs of "traumatized populations" have become commercialized to a degree.

The framing of traumatic stress in particular ways, including in clinical and psychiatric terms, also renders certain forms of victimization and certain victims more legitimate than others. Trauma and victimization are structurally, ideologically and discursively located. As Agamben's (2005) increasingly widely cited work on "*bare life*" exposes, not all human life is valued equally and people of lesser worth may be understood to be less vulnerable to traumatisation. In the case of the South African TRC, for example, it has been suggested that the focus on GHRVs meant that other forms of dehumanization, such as being subject to forced removals, went largely uncensured, more self-evidently traumatic events taking priority in recognition of violations (Posel, 2006). Didier and Rechtman reflect how in response to a chemical factory explosion in Toulouse, "some were seen to have suffered more than others; politics and prejudice still determined who would be excluded from the big tent of trauma" (Laqueur, 2010: 21). Somewhat paradoxically then, to be traumatized in a recognised clinical or psychological sense, renders one more "human". At the same time the templates for occupying the position of legitimate victim may be narrow or socially

circumscribed as inferred by social positioning theory (Harre & Secord, 1972). Rape survivors who have not demonstrated sufficient resistance, for example, may be denied the right of recognition as victim since their circumstances do not fit agreed upon parameters. Interview based research on white, middle class men who had been victims of violent crime suggested that part of the reason they struggled to convey and integrate their violation was because there is an absence of social templates within which to locate these kinds of experiences (Eagle, 2006). Victimization tends to be implicitly gendered; hegemonic expressions of masculinity and victimization being fundamentally incompatible. Occupying the subject position of victim was thus deeply uncomfortable for the majority of these men, rendering their previous sense of identity unstable. It is thus apparent that there is considerable tension in how traumatisation is defined and validated and that the more narrow debates about refinement of diagnostic criteria for trauma related conditions are in a sense a micro dimension of more fundamental contestation about the social construction of trauma and traumatic stress that reflects, historical, cultural, material and ideological forces at play.

Conclusion

From this overview of the broad field of study of traumatic stress it is evident that considerable knowledge has been generated but that much of this knowledge remains contestable and/or rather compartmentalised. It is also evident that how researchers take up their positions of study of the phenomenon is significant in terms of shaping what it is that they find. As has been demonstrated in the preceding discussion, traumatic stress study reflects a wide diversity of ontological assumptions and related epistemological stances, demonstrated in a particularly broad spectrum of scholarship and theorisation. In order to read one's way through the vast literature on the topic, (including literary and philosophical writing) it is evident that one needs to be willing to try on a multitude of spectacles through which to attempt to gain a comprehensive understanding. I would suggest that for those interested in grappling with better comprehending trauma and traumatic stress there is a need to retain allegiance to multiple theoretical perspectives, including (critical) realist, hermeneutic and post-modern positions. As illustrated in the consideration of three of the "great debates" in the field of traumatic stress studies, it is arguably impossible to do justice to the depth and breadth of research and theory in this area without adopting an integrative and relativist stance, in the sense that those engaging with theory need to recognise that different registers and types of explanatory frameworks may be appropriate in different instances and locations. Contestation and debate will continue to enrich the study of traumatic stress and the discipline of psychology as a whole, however it is also evident that the entertainment of multiple perspectives and the acknowledgement of the limitations of one's own particular vantage point will be important in taking dialogue forward and in creating a credible space for psychological theory and practice in this field.

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