

Life and Illness in Late Modern America
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The psychiatrist Colin Ross, author of *The Trauma Model*, tells us psychiatry is on the verge of a paradigm shift (2000). In the new paradigm Ross envisions, trauma starts getting the recognition it deserves. According to Ross, the most significant diagnoses will be the dissociative disorders since they recognize the impact of traumatic stress on the development of selfhood, and take seriously the construction of alter and fragmented identities as normative responses to chronically traumatic environments.

According to Ross, biological psychiatry misguidedly searches for the etiology of mental illness in genes and endogenous chemical imbalances. He argues the primary locus of mental illness is the interaction between an individual and her environment. For many of his patients, the majority of whom are women, the environment that led to mental illness was an abusive childhood. Nevertheless, he observes the effects of childhood abuse going largely ignored in North American psychiatry. Remarking on his training as a psychiatric resident, Ross observed, "The 'clinical material' I worked with was a veritable tidal wave of trauma. Yet trauma was basically ignored as a theme, factor or cause of the patients' problems. If challenged, all treatment team members would pay lip service to the biopsychosocial model. But in operational reality, the trauma histories were simply irrelevant to the inpatient treatment plan. It took me longer to learn that the trauma was also irrelevant to the outpatient treatment plan" (2000; 13).

Ross uses clinical evidence to support his proposed paradigm shift. He argues the practice of giving chronically mentally ill patients several diagnoses requiring multiple medications challenges the one-gene, one-disease model of mental illness presently advocated by psychiatry, and that also organizes the construction of the *Diagnostic and*

Statistical Manual of Mental Disorders. As Ross points out, “the separate diseases model simply cannot account for the clinical data” (2000; ii).

Ross has some good points. Most psychiatric inpatients in America today have multiple diagnoses and polypharmacy is the normative approach to maintenance of the chronically mentally ill, as real recovery is rarely envisioned as a possibility (Ross, 2000; 29). In America, a history of childhood abuse is also prevalent in both psychiatric inpatient and outpatient populations. Conservative estimates suggest that 50 to 60 percent of psychiatric inpatients and 40 to 60 percent of psychiatric outpatients have a history of physical, sexual, or emotional abuse, or neglect, or a combination of these (Herman, 1992/1997; 122). Women diagnosed with severe psychiatric disorders such as Schizophrenia, Bipolar Disorder, and Major Depressive Disorder are likely to have histories of childhood abuse. In one study of women with these diagnoses, 87% reported a history of physical abuse and 65% reported being sexually abused as children (Goodman et al., 1997). Another study of female psychiatric inpatients reported 73% had histories of either sexual or physical abuse (Spielvogal and Floyd, 1997).

Given such evidence, a paradigm shift in American psychiatry seems appropriate. As Ross’s trauma model implies, a turn to looking for environmental causes of mental illness makes sense. Yet, Ross’s trauma model continues biomedical psychiatry’s practice of looking to medicine as the model for how psychiatry ought to develop, which is where his shift looks less like a new paradigm and appears to be more a continuation of the status quo. Ross claims that, “when we see extensive comorbidity in medicine, we look for a common environmental agent driving the symptomatology. Most often the identified etiological agent is an infectious organism or a toxin...” (2000; 32). According to Ross, the toxin for the psychiatric patient is likely childhood trauma, but still the appropriate

response by psychiatry to this toxin is largely biological. Ross states, “It is not a matter of a trauma model versus a biological model. The trauma model is itself a biological model experience has a profound effect on the structure and function of the brain. This effect is modulated in part through the genome” (2000; 46). Paraphrasing Yeats, Ross tells us, “The dance is the interaction between genome and environment, and we are the dancers”(Ibid).

Here, Ross is partially correct. Responding to trauma requires a very special “dance,” but the dancer I will argue is influenced more by the stage and other dancers than imperceptible genes that tell us more about the professionalization of psychiatry than the effect of traumatic stress on the development of personhood. We can learn more about the impact of histories of childhood abuse through some of the lessons feminist and postmodern theory give us about power, language, and knowledge. I will now look briefly at how these lessons can be used to understand the ‘stage’ of healing and treatment, and what it would look like to put center on this stage the impact of power, language, and knowledge on the patient’s lived existence.

I choose Ross and his trauma model as a launching point because, unlike other attempts to explain mental illness, Ross’s model contextualizes mental illness in the suffering associated with a history of childhood abuse. By focusing on this limited understanding of the trauma model, I am omitting here very important work that critiques post-traumatic stress disorder that similarly interprets traumatic stress according to the standards of Western biomedicine. In particular, scholars such as Ashraf Kagee (2004a), Anthony Naidoo (2004b), and Derek Summerfield (1999) have developed persuasive arguments against the universal application of PTSD around the globe. A relevant point of their arguments is that American conceptions of traumatic stress as primarily biological

and psychological phenomena ignore that for many persons who have experienced extreme trauma, the more salient aspects of suffering are found in the social context and are bound by that context.

I believe such criticisms also apply to the application of Western conceptions of trauma to persons with histories of childhood abuse in America. A meaningful paradigm shift would make central the significance of *context* for the experience of traumatic stress. In particular, two contexts require examining: first, the conventional practice of relying on the mental health sciences to interpret and treat psychological suffering; and second, the daily praxis of the survivor as she attempts to create a meaningful and safe world for herself. Both of these contexts are largely ignored by Ross's trauma model as well as many explanations of traumatic stress that make central memory and dissociation.

When dissociation became the primary mechanism and explanation for surviving childhood trauma, much of the significance of context was lost. The role of relationships in the construction of selfhood was minimized and replaced with an emphasis on retrieving traumatized memories and validating those memories. This shift, as Janice Haaken has argued (1996; 1073-1075), can be witnessed in Judith Herman's two pioneering books in the trauma field, *Father-Daughter Incest* and *Trauma and Recovery*. In her first book, *Father-Daughter Incest*, published in 1981, Herman examined the relationships between the survivor, her father, her mother, and the therapists who sometimes unwittingly exacerbate suffering. The focus in this book is on the inherent possibility of incest in a society more devoted to the maintenance of patriarchy than the protection of girls and young women. In contrast, in her more recent book, *Trauma and Recovery*, published in 1992, Herman shifts the focus from the family dynamics and power alliances that was the focus of *Father-Daughter Incest* to the primacy of memory. In *Trauma and Recovery*,

Herman focuses on the treatment of trauma survivors, including the necessity of overcoming traumatic flashbacks, fluctuating identity states, and split-off ego formations that interfere with the construction of an integrated self. Assumedly, the advantage of Herman's later work is that, with an emphasis on universal psychological mechanisms like dissociation, there exists more certainty about the nature of suffering for all persons with a history of trauma (of which those with a history of childhood abuse is a subset), as well as more certainty about the best approach to recovery.

The dissociative model is also viewed as an improvement over past representations of women in psychiatry that portray the survivor of childhood abuse as hysterical, insane, or even somehow *responsible* for the abuse. It also marks an end to the denial that childhood abuse has become part of many girls' experiences of growing up in the American family. Furthermore, with the introduction of dissociative disorders, the person with a history of childhood abuse can now be understood as a rational being whose seemingly abnormal behavior is in effect an adaptive strategy to growing up in a horrific environment (See Haaken, 1996). Although seen at one time as adaptive, and even necessary for survival, psychological defenses such as dissociation are portrayed as no longer necessary in the relative safety of the survivor's adult world. Yet, we should ask, as Bonnie Burstow has, if the adult environment is truly safe, or is the continued hyperarousal and dissociative defenses appropriate given the continual victimization of women and children in America (2003). This point is particularly important to consider in light of the high rate of re-victimization in adulthood of persons with histories of childhood sexual abuse. In a recent meta-analysis of research that addressed the impact of childhood sexual abuse, it was found that the likelihood of rape as an adult ranged from 15 to 79%, depending on the study (Roodman & Clum, 2001). A history of childhood sexual abuse is

also associated with an increased likelihood of being a victim of domestic violence (Coid et al, 2001). Dissociation has often been identified as the reason for the continual victimization in these women's lives, and it is hypothesized that in threatening situations, women with histories of childhood abuse and a dissociative disorder 'check out' to the present danger as they learned in childhood as a method of survival. However, research conducted by Bonnie Kessler and Kathleen Bieschke (1999) found that dissociation was not as significant a predictor of re-victimization as feelings of shame for being vulnerable as a child and feeling defective as a result of abuse experiences. It is thus the women's self-evaluations as being inferior within a social context that are more indicative of the likelihood of further assault. As this research makes clear, identifying the psychological mechanisms associated with histories of childhood abuse may do little to rectify the problem of continual violence and oppression in the lives of a significant number of women in America.

Of course, with the introduction of diagnoses like dissociative identity disorder and PTSD, we also witness the end of diagnoses such as hysteria that relegated abuse to the level of fantasy, and the voices of women with histories of abuse are finally being heard. Memoirs abound about the experience of childhood abuse, including Sylvia Fraser's *My Father's House*, Anne Heche's *Call Me Crazy*, and more recently, Martin Moran's *The Tricky Part*. Ellen Bass and Laura Davis's book, *The Courage to Heal*, a survivor's guide for healing from the effects of childhood sexual abuse, made it to the *New York Times* bestseller list. While this is a vast improvement over silencing and stigmatization, the voices we hear are mediated by the dominant discourses of psychiatry and psychology. As critical theorists such as Michel Foucault have argued, inclusion by the dominant power structure does not necessarily lead to emancipation. We must continue to ask, as Linda

Alcoff and Laura Gray did in the 1990s, “Is the proliferation and dissemination of survivor discourse having a subversive effect on patriarchal violence? Or is it being co-opted, taken up, and used but in a manner that diminishes its subversive impact?” (1993; 261). Similarly, does the trauma model Ross envisions liberate persons with histories of childhood abuse, or rather lead to further subordination through the creation of a discourse that serves prevailing dogmas rather than the patients it purportedly treats?

In Ross’s paradigm shift, the role of power and violence in the present lives of survivors of childhood abuse has been largely swept aside. Granted, Ross does address psychiatry’s suppression of the impact of environment on the creation of mental illness. Yet this is also where Ross’s trauma model falls short, for treating the environmental causes of trauma, namely violence and profound inequities in power, is not the same as treating the resulting psychopathology of trauma. If Ross is going to use the medical model to guide his paradigm shift, he should do so rigorously. For example, treating cholera is not only about attacking the contagion within the individual body, but includes eradicating its source in the water supply as well.

While attempting to serve his patients, Ross’s trauma model seems equally devoted to serving medicine’s agenda of creating context-free, value-neutral representations of the etiology of suffering. The patient inevitably loses, as she is forced to adapt to discourses and treatments that bind the patient to mental health sciences more than her lived experiences and the larger community. In part, this occurs through the omission of the social context in the assessment of injury, be it contagion, toxin, or trauma. Specifically, medicine has a long history of ignoring both power and violence in its efforts to devise context-free representations of suffering that create a sense of certainty about the outcomes of its interventions. For those of us listening to colonized voices and taking seriously the

impact of power on the construction of knowledge, the veiled ignorance still present throughout much of biomedical psychiatry in America seems at worst, dangerous, and at best, anachronistic.

Sociologist Simon Gottschalk has portrayed biomedical psychiatry in America as an Enlightenment science attempting to adapt people to a postmodern world, thereby creating a kind of cultural schizophrenia, in which old-style methodologies create causal representations of suffering attached to bodies rather than expressed by them. With this representation of the mental health sciences, perceptions of dissociative identity disorder as *iatrogenic*, and largely created in the therapist-patient encounter, should come as no surprise. As Gottschalk points out, “If the modern self is an obsolete construct...and if the DSM is the most authoritative tool which evaluates such a construct for its ‘deficiencies,’ then, logically, this tool is inappropriate to develop an understanding of postmodern selfhood” (2000; 21). I would argue the dissociative disorders are no more iatrogenic than any other psychiatric disorder, but then they also cannot be the basis of the paradigm shift Ross envisions.

One solution, advocated by Bonnie Burstow, is to divorce biomedical psychiatry from the treatment of persons with histories of childhood abuse (2003). Perhaps this is what is required to see real recovery in this population. Another approach would be to meaningfully adapt medicine, and hence psychiatry, to the postmodern world. This shift, however, is constrained in part by the use of nineteenth century conceptions of the environment to explain twenty-first century social interactions.

The term *environment* was particularly influential during the early project of modernity and the industrialization of society—what Ulrich Beck refers to as the “first wave of modernization” (1994; 1). During this time, the term *environment* was a way to

distinguish between unadulterated, uncontrolled nature and human-constructed settings, such as large-scale institutions, the nuclear family, and in particular, the scientific laboratory. Influential was the work of nineteenth century scientists such as physiologist Claude Bernard, who initiated the practice of using the life sciences and Darwinian theory to extend our capacities for adaptation by increasing our modalities for self-regulation and autonomy (See Canguilhem, 1991). The outcome has been a long history in medicine of understanding the human being as an environment unto itself, detached not only from nature, but also potentially from any environment external to the self.

Arguments for dissociation as a psychological mechanism rely on this early modern habit of using Darwinian-style explanations of adaptation to create an understanding of dissociation as a response to an environment. The primary assumption here is that the best adaptive strategy for living in a social environment is the capacity to construct an integrated self according to genetically encoded stages of development to which the modern, middle-class family is assumedly naturally adapted to produce. Dissociative disorders, while allegedly adaptive to the extremes of childhood abuse, nevertheless imply psychopathology since the individual is impeded in her or his efforts to go through the developmental phases that would hypothetically lead to an integrated self. Conceptions of what is normal and what is pathological thus exist as fixed reference points within a preconceived social environment in which an individual is primarily responsible for her or his adaptation.

My difficulty with this construction of the relationship between individual and environment is that in modern societies today, we are aware of the risks in assuming a natural human environment exists through which all persons follow the same trajectory of development to adulthood. Instead, the dialectic between autonomy and commitment is

witnessed in the continual tension between cultural norms and the individual's interpretive possibilities of those norms. Even the notion of an integrated self seems questionable in our postmodern world. According to Gottschalk, "the solid and stable modern self loses its footing and becomes fluid, liminal and protean *selfhood*.... In postmodern thought, this selfhood is a continuous process that is constituted through the multiple and sometimes self-contradictory relationships in which one participates" (2000; 21). We could argue that the fragmented, multiple selves pathologized by theories of dissociation are normal in certain postmodern contexts. Indeed, this is the point one patient diagnosed with dissociative identity disorder made about herself: *If people would stop, look, and listen, then they could see that we are because of the real world—we reflect how it really is out there* (Cohen et al. 47, 1991).

The late modern era in which we currently live is characterized by Ulrich Beck as the "second wave of modernity," birthed by the trauma that arose from the first wave of modernity, and its efforts to dominate nature and colonize the Other (1994). The technological advances of the first wave are now out of our control. According to Beck, we inhabit a "risk" society that he contrasts with the industrial society from which the emphasis on reliable, fixed environments has been inherited (1994). The processes of globalization, and continually witnessing genocides, econocides, diasporas, global diseases, and environmental disasters, have left many uncertain about the future, which starkly contrasts with psychiatric attempts to create a fixed understanding of normal human development in relation to a relatively stable environment.

As our institutional and social structures change, so do the tactical maneuvers we have available for adapting to the varying conditions we find ourselves inhabiting. *Context* becomes a more appropriate term than *environment* to describe fluctuating world

conditions, for it signifies not only the environment, but also the circumstances that are taking place, as well as the words and phrases used to express the situation at hand. For the person with a history of childhood abuse and the prospect of re-victimization in adulthood, concepts and the contexts of their expression in the present may be more significant than memories of past abuses. Science and medicine continue to have central importance in this context-bound, postmodern world, although rather than any truth they might express, it is their capacity to continually produce new concepts that assist in navigating an ever-changing, risk-laden world that make these disciplines so significant. Michel Foucault gives an elucidating description of the new world order as a landscape of concepts in which we constantly move about in our search for information. He states, “That man lives in a conceptually architected environment does not prove that he has been diverted from life by some oversight or that a historical drama has separated him from it; but only that he lives in a certain way, that he has a relationship with his environment such that he does not have a fixed point of view of it, that he can move on an undefined territory, that he must move about to receive information, that he must move things in relation to one another in order to make them useful” (1991; 20-21). Inherent in our postmodern conceptual landscape is uncertainty, and to deny the inevitable uncertainty of life, leads only to oppression, which seems to be inherent, although suppressed, in Ross’s conception of the trauma model. Embracing the uncertainty of ever-shifting conceptual terrains, as Foucault points out, is one way of embracing life that leads to an authentic freedom not found with conceptions of stable environments to which the individual is assumedly preprogrammed to adapt. And what a very liberating dance this could be for survivors of childhood abuse, if not for all of us.

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