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Ways of Being in Trauma-Based Society: Discovering the Politics and Moral Culture of the Trauma Industry Through Hermeneutic Interpretation of Evidence-Supported PTSD Treatment Manuals

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Ways of Being in Trauma-Based Society:

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Hermeneutic Interpretation of Evidence-Supported PTSD Treatment Manuals

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Sarah Peregrine Lord

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Ways of Being in Trauma-Based Society:

Discovering the Politics and Moral Culture of the Trauma Industry Through

Hermeneutic Interpretation of Evidence-Supported PTSD Treatment Manuals

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Antioch University Seattle at Seattle, WA in partial fulfillment
of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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Abstract

Ways of Being in Trauma-Based Society: Discovering the Politics and Moral

Culture of the Trauma Industry Through Hermeneutic Interpretation of

Evidence-Supported PTSD Treatment Manuals

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Seattle, WA

One-hundred percent of evidence-supported psychotherapy treatments for trauma related

disorders involve the therapist learning from and retaining fidelity to a treatment manual.

Through a hermeneutic qualitative textual interpretation of three widely utilized

evidence-supported trauma treatment manuals, I identified themes that suggested a

particular constitution of the contemporary way of being—a traumatized self—and how

this traumatized self comes to light through psychotherapeutic practice as described by

the manuals. The manuals included: 1) a trauma focused cognitive-behavioral therapy for

children; 2) an eye-movement desensitization and reprocessing therapy for adults; and,

3) an early intervention and debriefing therapy series for post-traumatic stress disorder

and other trauma related problems of military service members. Through the

interpretation, I conceptualized trauma as a way of human being in contemporary culture,

and in particular, as an unacknowledged way of expressing enactments of dissociated,

unformulated, or unarticulated political arrangements and events. I identified and

interpreted the following shared themes and exemplars across the three manuals:

mind-brain as protector and the political use of cognitivist ideology; the healed trauma

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survivor as functional worker; trauma as universal and culture-free; and, indoctrination into a social void of scientistic managed care. I discussed how trauma treatment manuals instantiate how to be human in contemporary society through compliance with managed care and the embodiment of scientistic and cognitivist ideology. I then discussed how the way of being that contemporary society creates and idealizes is one in which people easily assume the identity of trauma survivor: an enterprising, functional and fiercely individual member of a warrior cult. In the warrior cult society, to think or talk about social causes and public solutions to daily political suffering is thought of as either non-germane or dangerous; individuals are seen as free from all dependencies and social ties, able to overcome personal and public adversity by arming or forifying their brain and replacing thoughts in their computer-like mind. In conclusion, I raised questions about how evidence-based trauma therapies may contribute to perpetuating a particular constitution of self that has disavowed society's violent ethics and practices. The electronic version of this dissertation is at OhioLink ETD Center, www.ohiolink.edu/etd

Acknowledgements

My experience of mainstream education in clinical psychology has been characterized by an emphasis on competencies, compliance, computerized forms, and learning to survive financially in a managed care world. Thinking critically, historically, and morally about our practice is not nearly as important as it should be. I can't imagine graduating and not being concerned about the state of the field, and I am thankful to have had the guidance in this process to retain this concern. As my mentor and Chair, Dr. Philip Cushman reminded me throughout my training that the pain of participating in this world while questioning it is much more preferable to the pain of denial, dissociation, and withdrawal. The challenge is not to be defeated when we are confused and afraid—we must be free to think. Thank you Dr. Cushman for helping me to articulate my experience, connect with other political psychologists and scholars, and for giving me the confidence to write with honesty.

Thank you to my Committee members, Drs. Jennifer Tolleson and Lynne Layton, for their thoughtful reviews, supportive comments, and for providing a model of courageous, politically engaged, and critically thinking women in the field. I have immense respect for your work and it's been a privilege to work with you.

I have been so thankful to have a partner who has a genuine curiosity in what I am learning. Rich, I have no words to express the immense amount of appreciation for your sacrifices and support throughout my education. There were times when writing this dissertation that I felt despair, anger, and exhaustion, but I never felt alone. I could not have done this without you.

To my parents, friends and family members—thanks for your endless love and patience.

To my future child—you were with me from the beginning to end of writing this dissertation. Thank you for being such a good baby during the pregnancy so I could become your Dr. Mom.

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Introduction

We live in a trauma-based society. 44.6% of news coverage is devoted to crime and disaster, compared to other topics like community interest (13%), education (4.1%) or regional government (0.6%) (Federal Communications Commission [FCC], 2011). The word "trauma" was cited in U.K. newspapers under 500 times a year in the early 1990s and is now cited over 5500 times a year (Furedi, 2004). Many popular television shows and movies from the United States (U.S.) center on disaster, war, and violence, and sometimes the protagonists even describe themselves as suffering from posttraumatic stress disorder (PTSD) after events they experienced (e.g., Nicholas Brody on *Homeland,* Dr. Owen Hunt on *Grey's Anatomy,* Starbuck on *Battlestar Galactica,* Hank on *Breaking Bad,* the imprisoned women in *Orange is the New Black,* the shell-shocked valet in *Downton Abbey,* and Katniss in *Hunger Games: Catching Fire).* An international Google trends analysis revealed that the relative interest on a scale for the search term "PTSD" has risen from 60% to 97% (a 37% increase) from 2004 to 2013 (Google.com). Massive-multiplayer online videogames like *Second Life* now include PTSD treatment centers where an avatar can participate in a manual-based therapy with other avatars; after the avatars are cured they can resume their activities in the virtual world (University of Southern California [USC], 2012).

In June 2013, an Amazon.com book-title search for the word "trauma" revealed 13,662 results with titles such as: *Eight keys to safe trauma recovery: Take charge strategies to empower your healing* (Rothschild, 2010), *Trauma-proofing your kids* (Levine & Kline, 2008), *Trauma junkie* (Hudson, 2001), *Life after trauma* (Rosenbloom, Williams, & Watkins, 1999), and *The trauma of everyday life* (Epstein, 2013). The books

ranged from personal accounts of emergency aide workers, to self-help books, to treatment manuals, and medical compendiums. When narrowing the search to "PTSD manual," over 250 different titles for step-by-step trauma intervention manuals emerged (e.g., *An operators manual for combat PTSD* (Hart, 2000), *The trauma tool kit: Healing PTSD from the inside out* (Pease Banitt, 2012), and *When war comes home: Christ-centered healing for wives of combat veterans* (Adsit, Adsit, & Waddell, 2008). It seems that we are obsessed with creating, destroying, protecting, curing, and consuming trauma.

Following the U.S. cultural obsession with trauma, the study and treatment of PTSD has become a burgeoning industry in what Nikolas Rose (1989) calls the psi disciplines: psychiatry, psychology, and other mental health related fields. The American Psychological Association (APA) first officially recognized PTSD as a psychiatric disorder in 1980. Since then, the rate of diagnosis and cultural interest in this disorder has increased to the point that PTSD became known as the diagnosis of the 90s (Farrell, 1998).

Currently there is a perceived epidemic of PTSD in which approximately 37 million Americans are exposed to trauma annually and 5.2 million are diagnosed with PTSD each year (Bonnie, Fulco, & Liverman, 1998; Dowd, Keenan, & Bratton, 2002). There is now seemingly endless funding from government agencies and pharmaceutical corporations to research and treat this growing national and increasingly international epidemic of trauma (Congressional Budget Office [CBO], 2012). For example, in 2012, the U.S. Veterans Administration (VA) and Department of Defense (DoD) funded over $100 million dollars in PTSD research. When the sequester and budget resolution in 2013

led to major federal budget reductions, PTSD research for the DoD was earmarked as protected (Basu, 2013).

Not only do federal institutions grant large sums to conduct research, there is also a proliferation of smaller research projects focused on understanding PTSD. In 2013, ClinicalTrials.gov, a site designed to track all NIH funded trials internationally, identified 807 registered research trials—531 based in the U.S.—that focused on interventions for PTSD (National Library of Medicine, 2013). Between 1990 and 2013, staff at the National Center for Posttraumatic Stress Disorder index over twenty thousand research articles, reports.

The majority of studies funded in the past two years were designed to find biological indicators of the trauma (called bio-markers) and to identify prevention strategies, interventions, and treatments for PTSD (American Forces Press Service [AFPS], 2012). In 2012, an interdisciplinary team from the University of Pennsylvania and the Children's Hospital of Philadelphia received over $3.5 million in DoD funds to identify the neural circuits in the brain affected by stress exposure and to identify biomarkers for resilience to stress (Baum, 2012).

While researchers have continued to move towards brain-based and neurochemical interventions, there is also increasing interest in modular, brief psychotherapeutic treatments that are compatible with managed care settings. These treatments can be easily disseminated, trained via a treatment manual, and evaluated for effectiveness. Models for PTSD therapy that are amenable to a brief-treatment format (three to five sessions), dismantling (i.e., where the therapy can be delivered in single or multiple module treatments depending on the capacity of the clinic), and delivery by any

health care provider have been assessed in both controlled research (Bryant, 2007) and in real-world settings (Roy-Byrne et al., 2005). Presently, 100% of well-established evidence-supported psychotherapeutic treatments for trauma disorders involve the practitioner-therapist learning from and continuing to retain fidelity to a specific trauma treatment manual in their therapeutic practice (Bisson & Andrew, 2007; Department of Defense [DoD], 2010; Foa, Keane, & Friedman, 2000; Foa, Keane, Friedman, & Cohen, 2008; Forbes et al., 2010; Rosen et al., 2004; Substance Abuse and Mental Health Services Administration [SAMHSA], 2013; World Health Organization [WHO], 2013).

The obsession with PTSD that grew out of the U.S. and Europe has now been exported internationally and may be "homogenizing the way the world goes mad" (Watters, 2011, p. 1). There has been a recent surge in the Western world to send psychological first-aid all over the globe after a crisis. In particular, trauma therapists are sent to resolve the problems of genocide, civil war, and a range of natural disasters (Fassin & Rechtman, 2009). Medical anthropologist Allan Young reflected that "PTSD has displaced hunger as the first thing the Western general public thinks about when a war or other emergency is in the news. We were spreading these ideas around the globe so effectively that PTSD was becoming the way the entire world conceived of psychological trauma. The spread of the PTSD diagnosis to every corner of the world may, in the end, be the greatest success story of globalization" (Watters, 2011, p. 71).

For example, after the 2004 tsunami in Sri Lanka, numerous directors of mental health agencies from the U.S., Europe, and Australia initiated a call for global action to address psychological damage from PTSD. Pharmaceutical representatives and people from non-government organizations sent resources and therapists to the country. Many

mental health experts were quoted saying that the biggest problem facing Sri Lanka's government leaders would be a "second tsunami" of PTSD (Watters, 2011, p. 70).

When therapists arrived in Sri Lanka they brought manual-based treatments, and as several scholars and anthropologists have since pointed out, they also brought assumptions of personhood, time, memory, a source of moral authority and ideas about how people become broken by disaster and healed through Western mental treatments (Bracken, Giller, & Summerfield, 1995; Fassin & Rechtman, 2009; Watters, 2011).

We are attracted to trauma as the root of dysfunction in our lives. My intention for this study was to place trauma at the beginning rather than the end of social understandings of suffering and wonder about how trauma has become essential to a way of human being. Questioning something that is so ubiquitous and culturally precious may feel foreign at a minimum. This study will no doubt raise some discomfort as I ask the reader and myself to let trauma fall out of everydayness (cf. Heidegger, 1996)—to notice what it feels like to ask questions about something so commonplace in our lives.

My intention was not to discount those who consider themselves trauma survivors or expound a discourse about trauma as a myth. We are affected by and engage with trauma in ways that fundamentally constitute and shape our lives. The object of my study was to examine the world that gives rise to trauma culture; a world that maintains concepts like victims, survivors, perpetrators, rescuers, PTSD, trauma and traumatic stress.

I have selected to analyze evidence-based trauma treatment manuals as exemplars of contemporary trauma culture because they have become such an integral component of contemporary psychotherapy. How therapy is being conceived, trained, practiced and

exported across the world is increasingly determined by a manual rather than mentorship and supervision; what constitutes good therapy, what it means to be disordered and healed, is represented in these texts. Studying the messages embedded in these manuals and thinking about the world that gave rise to them is imperative given their increasing utilization and the continued cultural obsession with trauma, especially within the U.S. but increasingly internationally since the 1980s.

Although there has been much mainstream, quantitative psychological research performed on the efficacy and effectiveness of popular trauma treatments, there has been a relative absence of critical, hermeneutic studies about the understandings of the good, the prescriptive and proscriptive elements implicit in trauma treatments and how treatment techniques bring about compliance with those embedded understandings. Furthermore, studies have rarely explored what we can learn from all that about the social world that gives rise to the concept of trauma, the identity of trauma victims and the taken for granted acceptance of trauma treatments—in other words, a trauma-based society. Therefore there is a need for further interpretation of trauma culture and the practice of trauma therapy from a hermeneutic perspective.

It is not enough to realize and identify that trauma abounds in the social world. An aim of my study was to describe how contemporary society identifies and understands trauma, to interpret what it means, what it stands for, what it substitutes for, and the many political meanings—especially discomforting or dangerous political meanings—it contains. I have conceptualized trauma as a way of human being in contemporary culture, and in particular, as an accepted way of expressing enactments of dissociated, unformulated or unarticulated political arrangements and events. In a more general sense,

through my interpretation of trauma treatment manuals, I treat trauma as a system of references to historical discourse and traditions that are relevant to contemporary practice. One of my primary hopes in conducting this study was that through thinking about trauma from historical, philosophical and moral perspectives, alternative, perhaps previously unformulated insights, about how we think and act in this traumatized world may come to light.

Background and Literature Review

To understand trauma treatment manuals as a system of references to historical discourse and the social world, one must outline the precedents in history for the practice, social concerns, and purposes of the texts (Stigliano, 1989). In this section, I review literature that presents the mainstream conceptualization of trauma in psychotherapy as a mental health disorder. This conceptualization is reproduced by the majority of evidence-supported trauma treatment manuals today, including those analyzed in this study. I also present a history of trauma related disorders that the treatment manuals and the majority of trauma-related treatment texts in psychotherapy refer to when describing the theoretical orientation to or rationale for trauma treatment. I then present four key moments in the history of traumatology that the majority of trauma-related treatment texts in someway refer to, reproduce or re-appropriate the conceptualization of trauma that was developed during these moments in history.

After presentation of this general background and history of trauma treatment, I present background literature that is specific to the themes I identify and discuss in the results and discussion chapters. This is followed by a presentation of the theoretical background of the methods, the design, importance, and purpose of the study, as well as the areas of inquiry and research questions. Overall, the purpose of the Background and Literature Review chapter is to describe the social and historical context that gives rise to contemporary trauma culture. I also comment on how psychotherapy has historically simultaneously reflected and produced particular understandings of trauma and human being; these understandings are reproduced and shaped by the trauma treatment manuals that I interpreted in this study.

Context for Trauma Culture

      Trauma as a medical, mental health disorder in mainstream psychotherapy. PTSD has become the poster child of trauma mental health disorders since the 1980s and is presently representative of the mainstream conceptualization of trauma as a psychological phenomenon. This section describes how persons who are suffering from a range of different problems might first encounter being understood as traumatized, having a trauma disorder, and meeting criteria for PTSD in contemporary society. Often this process occurs through psychological assessment and education about how one's problems should be understood as a trauma-related mental health disorder. Given the widespread nature of trauma culture which I described in the Introduction, exposure to assessment and education about being traumatized can occur in a range of subtle ways just by living in contemporary society; however, explicit transformation by labeling a person as a trauma survivor or as having PTSD often occurs at primary care doctors' appointments, through referral to psychotherapy, and increasingly through self-help and diagnostic materials found on the internet, books and other media.

      For the purposes of this study, describing the mainstream conceptualization of trauma as a mental health disorder is particularly important because meeting diagnostic criteria for PTSD is currently a prerequisite for receiving most evidence-supported trauma-focused psychotherapy treatment. The three trauma treatment manuals that I analyzed in this study center primarily around treating PTSD and related traumatic stress symptoms (e.g., subclinical traumatic stress, sleep disorders and acute stress responses).

      I have withheld from significant discussion and critique of the mainstream conceptualization in this Background chapter because this will be included in the

description of my interpretation of trauma treatment manuals; however, in this section I begin to describe some of the ways of human being that are suggested by the mainstream conceptualization. In the results and discussion chapters, I further elaborate these taken for granted assumptions of human being in trauma culture. Thus this section provides necessary background to understanding the historical context that gave rise to mainstream conceptualizations of trauma, and the practice of manualized trauma treatment. Here I review the PTSD diagnosis, its etiology as explained through psychoeducation and cognitive-neurobiological theory, protective and risk factors associated with PTSD, epidemiological data on prevalence and treatment standards for trauma related disorders.

   PTSD diagnostic criteria. It is important to understand the diagnostic criteria for PTSD because who is understood as traumatized and deserving of trauma treatment often begins in psychotherapy or a primary care physician's office with an initial assessment of traumatic symptoms and diagnosis of PTSD. All evidence-based trauma treatments listed in Table 1 require initial assessment of trauma symptomology for treatment planning purposes. Treatments that are utilized in managed care settings often require an assessment of PTSD symptoms for billing purposes. For example, the U.S. Veteran's Administration requires that patients[1] meet criteria for PTSD in order to receive treatment and related services for any problematic symptoms post-deployment (Rosen et al., 2004).

   The trauma treatment manuals that I interpreted in this study were written before the *Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5)*

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[1] The person seeking, participating in or receiving psychotherapy from a therapist has been referred to in a range of ways historically (e.g., Foucault, 1973). In contemporary psychotherapy, the words "patient", "client," and "consumer" are used in a range of different clinical contexts. Throughout this study I have used the word patient unless otherwise indicated.

(2013) was released and thus all refer to the APA's *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition- Text Revision (DSM-IV-TR)* diagnostic criteria for PTSD. In the *DSM-IV-TR,* PTSD was defined by clusters of intrusive, avoidance/numbing and arousal symptoms that occur after a traumatizing or life-threatening event in which one experiences fear, horror, and helplessness (American Psychological Association [APA], 2000, pp. 463–468). To meet criteria for PTSD one needed to meet Criterion A: the experience of fear, horror and helplessness after exposure to a traumatic event, and Criteria B, C, and D: one intrusive symptom (e.g., intrusive memories, distressing dreams, flashbacks, or extreme physiological reactivity), three avoidance symptoms (e.g., avoiding thoughts, activities, people, emotional numbing, inability to remember the trauma, and sense of foreshortened future), and two arousal symptoms (e.g., difficulty sleeping, outbursts of anger, difficulty concentrating, hyperviglance and exaggerated startle response). These symptoms needed to occur for at least one month to be diagnosed as PTSD (Criterion E). Symptoms occurring for less than one month post-trauma were considered under the acute stress disorder diagnosis in *DSM-IV-TR* (pp. 469–472).

In 2013, the APA released the *DSM-5,* which has likely changed the way practitioners understand trauma and who is considered traumatized since its publication. The *DSM-5* included an entirely new section of diagnostic criteria: Trauma- and Stressor-Related Disorders (APA, 2013b, p. 265)*.* Attachment disorder, PTSD, acute stress disorder and adjustment disorder were grouped under this new section, and a new diagnosis was added: disinhibited social engagement disorder. Previously, trauma related disorders like PTSD had been categorized as anxiety disorders in the *DSM-IV-TR* (APA,

2000). The *DSM-5* task force explained the creation of this new trauma section by describing the wide range of variation of expression of clinical distress following exposure to catastrophic or aversive events (APA, 2013b). They stated that while the majority of stress-related symptomology can be categorized under anxiety and fear-based responses, many individuals exhibit more prominent anhedonic and dysphoric, externalizing angry and aggressive, or dissociative symptoms. The heterogeneity of trauma symptomology, according to the developers of the *DSM-5,* meant that the expression of PTSD and other trauma related disorders was too unique to be considered under anxiety disorders (p. 265).

Other notable changes to the PTSD diagnosis occurred in the *DSM-5*. First, PTSD was revised to include four clusters of symptoms instead of three. Avoidance symptom Criterion C was divided into two clusters as distinct criteria: avoidance, and persistent negative changes in both cognition and mood. The latter cluster was expanded to include negative emotional states such as dysphonia, anger, guilt and shame and PTSD related cognitions including exaggerated negative beliefs like: "I am bad," "People in authority can't be trusted," and "The world is completely dangerous" (p. 272). Second, the subjective reaction of fear, horror and helplessness from Criterion A was removed; one was still required to experience a traumatic event to meet Criterion A but need not have specific subjective reactions at the time the event occurred. The implication of removing Criterion A is that one may not feel frightened, helpless or horrified during a traumatic

event, but can develop PTSD symptoms later without these specific subjective experiences.[2]

The third major change from the *DSM-IV-TR* to the *DSM-5* was the addition of distinct criteria to diagnose PTSD in children six years of age and younger. Previously children needed to meet the same symptom categories as adults. Proponents of expanding child disorders in the *DSM-5* believed that earlier versions of PTSD criteria led to under-diagnosis of children because many of the symptoms were defined in terms of adult cognitive processes, like thought avoidance, which often needed to be expressed verbally and thus could not be assessed in pre-verbal children (Nemeroff et al., 2013). For children to meet criteria of PTSD in the *DSM-5* they must meet a revised version Criterion A which, in addition to the adult criteria, includes hearing about a traumatic event occurring to a parent or primary caregiver. Criteria B, C, and D include presence of one intrusive symptom (e.g., intrusive memories expressed in play or dreams, dissociative reactions, psychological distress to cues that resemble trauma, and physiological reactions), one avoidant symptom or one negative alteration in cognition (e.g., socially withdrawn behavior, negative emotional states), and two arousal symptoms (e.g., hyperviglance, temper tantrums, sleep disturbance). Like adult PTSD, these symptoms must exist for at least one month in order to be diagnosed (Criterion E).

The changes in the DSM-5 reflect the cultural conceptualization of traumatic experiences as a mental disorder that is unique from other psychopathology (e.g., in a

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[2] In practice, this means the patient can still meet diagnostic criteria for PTSD even if they do not believe they experienced a traumatizing event. The new definition thus allows the diagnostician's interpretation of the event as traumatic to take primacy over the patient's subjective experience of the event.

separate trauma disorder section) and as a common problem for adults and children (i.e., it does not require the patient subjective experience of a uniquely horrific event).

  Traumatic events that cause PTSD. Given the emphasis on Criterion A in the *DSM-IV-TR* diagnostic category for PTSD, many manual-based trauma therapies begin with an assessment of the amount and kind of traumatic events that the patient experienced. The number of traumatic events experienced by a patient is often assessed as part of the standard diagnostic procedure before beginning any trauma-focused psychotherapy treatment. All of the manuals that I analyzed in this study began or ended treatment with a formal assessment of PTSD symptoms and traumatic events experienced. The traumatic events that meet Criterion A for PTSD in the *DSM-IV-TR* and *DSM-5* for child and adult PTSD fall into broad categories including: accidents, natural disaster, war, directly witnessing harm or threat of harm to others, and experiencing harm or threat of harm to self. These categories are reflected in several widely utilized standardized assessments of cumulative trauma burden including the Traumatic Events Questionnaire (TEQ) (Vrana & Lauterbach, 1994), Traumatic Life Events Questionnaire (TLEQ) (Kubany et al., 2000), and the Stressful Life Events Screening Questionnaire (SLESQ) (Goodman, 1998) and in structured clinical interviewers such as the Composite International Diagnostic Interview (CIDI) in the U.S. National Comorbidity Survey (Kessler et al., 1994) and the Structured Clinical Interview for the *DSM-IV* (SCID) (First, Spitzer, Gibbon, & Williams, 1995). These traumatic event assessments were developed through content analyses of case studies and clinical screenings in which all possible traumatic events prior to onset of PTSD symptoms were identified.

Traumatic events that can lead to PTSD symptoms that are incorporated on the above traumatic event assessments are quite wide ranging. They include: serving as a peacekeeper or relief worker in a war zone or a place of ongoing terror, being an unarmed civilian in a place with war, revolution, military coup or invasion, being a refugee, being kidnapped or held captive, exposure to toxic chemical substances that caused serious harm, life-threatening illness, life-threatening automobile accidents, work-related life threatening accident, natural disaster like flood, hurricane or earthquake, man-made disaster "like a fire started by a cigarette or bomb explosion" (WHO, 2001), life threatening illness, child abuse, domestic violence, being repeatedly ridiculed, ignored or told "you were no good" by a parent, family member or romantic partner, assault, armed robbery or mugging, rape, sexual assault, stalking, unexpected death of close family member, illness of close family member, being a victim of torture, witnessing domestic violence as a child, witnessing someone be badly injured or killed, seeing a dead body, accidently killing someone or seriously injuring them, purposefully injuring torturing or killing another person, and seeing carnage of mutilated bodies and mass killings. The traumatic event questionnaires conclude with catch-all trauma categories such as asking the participant to list any other extremely traumatic or life threatening event not asked about.

Though only one event is needed to meet Criterion A, traumatic event questionnaires function as trauma checklists where the total number of events experienced is referred to as the patient's cumulative trauma burden. Epidemiology studies often compare cumulative trauma burden as a metric of traumatic exposure for different populations (e.g., Blanco, 2011). It is also important to note that the traumatic

events on these scales are considered relative to each other and thus are not weighted for being more or less tragic (e.g., being an unarmed civilian during a military coup carries the same psychometric weight—a count of one—as being in a motor vehicle accident or being ridiculed by a family member).

Trauma explained through popular PTSD psychoeducation. Prior to referring a client to trauma treatment or beginning a manual-based therapy, clinicians often educate potential patients about the nature of posttraumatic stress symptoms by reading from PTSD psychoeducational texts such as informatory pamphlets, textbooks, and websites; psychoeducation is also a standard part of the majority of evidence-supported trauma treatments (SAMHSA, 2013). The manuals that I analyzed in this study included psychoeducation that was similar to that described here.

The following is an example psychoeducational excerpt from the National Institutes of Mental Health (NIMH) website in an online article titled "What is PTSD?":

> When in danger, it's natural to feel afraid. This fear triggers many split-second changes in the body to prepare to defend against the danger or to avoid it. This "fight-or-flight" response is a healthy reaction meant to protect a person from harm. But in post-traumatic stress disorder (PTSD), this reaction is changed or damaged. People who have PTSD may feel stressed or frightened even when they're no longer in danger. (National Institute of Mental Health [NIMH], 2013)

Thus, according to the NIMH, a goal of educating PTSD patients about their disorder is to remind them that they are not necessarily in danger when they experience symptoms, rather their survival instincts have gone awry.

It is also common for PTSD psychoeducational texts to extend the metaphor of trying to survive midst lions and other predators in the African Savannah. For example, in Zayfert and Becker's (2006) cognitive behavioral treatment manual the psychoeducation section asked the patient to imagine himself or herself in Africa on a vacation. The

therapist was instructed to ask the patient to imagine they volunteered to go to get water

from the watering hole where a lion awaits. The therapist was then instructed to walk the

patient through all the emotions and reactions that surge through the patient's body after

seeing the lion by following this script:

> Therapist: Do you notice anything else when you are faced with the lion and your fight-flight response is activated?
>
> Kate [Patient]: Well, I tend to feel kind of queasy and light headed. How can that be helpful?
>
> Therapist: Well the thing to keep in mind is that when survival is at stake your body is going to pull all its resources toward helping you get away and divert resources from non-urgent matters like digesting and storing food for future energy, thinking, problem solving or planning for the future. […] Whereas before you were focused on getting water, now your only thought is, "I've got to get out of here!" or "I'm gone die!" Staying focused on the threat is important. (p. 67)

In this quotation, the therapist explained to the patient why survival

instincts are helpful when seeing a lion but can hinder when away from the lion

(e.g., problem solving and planning for the future the patient needs brain

functions that were turned off during the survival situation). The script continued

by describing what would happen when the patient leaves Africa:

> Therapist: When you return home from Africa, you notice that you feel nervous every evening around dusk, the same time you met the lion at the watering hole. You even have a panic attack when an orange tabby cat walks in front of you; just the sight of an orange fuzzy creature triggers your fear. These situations and objects have become *triggers* or *cues* that remind you of the lion and activate your fear. […] Unfortunately many of these triggers are serving as false alarms. Rather than keeping you safe, they prevent you from enjoying life. […]
>
> Kate: Hmm. That really makes sense. You know, sometimes my anxiety dos come from out of the blue. Are you saying there are triggers and I just don't know it?
>
> Therapist: Exactly. (pp. 69-70)

In this script, the therapist helped the patient learn where her mysterious anxiety was coming from by relating the process to an instinctual or primitive survival mechanism that was malfunctioning and transformed everyday experiences into trauma "triggers."

This type of psychoeducation sets the stage for the taken for granted assumptions about trauma culture that are communicated to the patient during trauma treatment. In these examples some of the surface-level assumptions about human being in trauma culture include: response to everyday experiences can initiate a biologically-based, natural, universal response that is designed for survival, anything in the world can become a trauma trigger, and these responses have existed in the same form throughout time (as long as our ancestors lived on the Serengeti) and are hardwired in our brain. Some of the more subtle or deeper assumptions about human being in trauma culture include: traumatic and social events are reified and located internally in a universal form, when persons feel traumatized therapists tell them not to trust their instincts (e.g., that they are danger) but to understand this is a survival mechanism that is gone awry and can be rest by therapy. In this study, I further explore these kinds of assumptions about human being in trauma culture within the local and historical context of evidence-based trauma treatment manuals.

Cognitive-neurobiological framework for understanding trauma disorders. The diagnostic description of PTSD in the *DSM-IV-R* and *DSM-5* and the psychoeducational texts previously described exemplify a cognitive-neurobiological orientation to trauma as medical pathology. From a mainstream, empirical perspective, the central tenants this approach with respect to trauma center on the cognitive-neurobiological model of threat

reactions. This model is mentioned in numerous trauma treatment manuals and books about trauma (e.g., Bryant & Harvey, 2000; Cozolino, 2002; van der Kolk, McFarlane, & Weiseth, 2012) including those analyzed in this study. While behaviorists like Walter Cannon first described the fight-or-flight reaction, Joseph LeDoux (1994) developed the cognitive, neurobiological model of threat reactions associated with PTSD.

LeDoux theorized that humans have evolved to be able respond to fear without conscious thought (LeDoux, 1994; Nader, Schafe, & Le Doux, 2000). The evolutionary theory of brain development supported in LeDoux's research suggested that the layered structures of the brain reveal our evolution as mammals. The brainstem or "reptilian brain" is concerned with self-preservation, the intermediate brain or limbic system is concerned with emotions and memory, and finally the neocortex including the frontal lobe is involved with intellectual tasks.

According to LeDoux's research, the primary structure of the brain involved in response to a traumatic event is the amygdala located in the limbic system (Nader et al., 2000). When humans perceive danger the thalamus receives the stimulus and directs a response to the amygdala. The amygdala rapidly responds sending signals to the autonomic nervous system (ANS) to begin to respond to the threat; all of this is before conscious or intellectual thought occurs in the cortex. A graphic that is commonly used to describe how traumatic memories become embossed in the brain via cortical pathways in the limbic system is represented in Figure 1. In the figure, the person, represented as a brain with eyes on the left, sees the snake and messages are sent to the brain stem before any conscious thought can occur. The frontal cortex inactivity is represented by an absence of arrows leading from the eyes to the top of the brain.
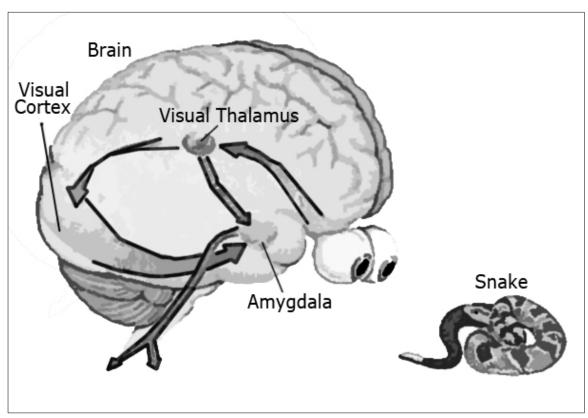
Figure 1. Le Doux's (1994) cognitive model of fear responses.

LeDoux (1994) included neurochemical and neurological correlates of fear responses in his model, such as the catecholamine norepinephrine. As the amygdala triggers the release of norepinephrine, this catalyzes an increase in blood pressure and heart rate, which triggers the release of glucose and lipid breakdown, and dilates our blood vessels to prepare us to respond to an attack. The energy of the body is diverted away from cognitive processes to the instinctual responses of the reptilian brain. When the rational abilities of the cortex are over-ridden, what cognitive psychologists would call the conscious, integrated, and sequential narrative memories of the traumatic event are also disrupted. The usual memory consolidation process that occurs between the amygdala, hippocampus and cortex does not occur. Instead, what has been coined "hyper-consolidation" of the memory occurs. In this process, what would typically remain a soft association of sensory information to later be integrated into long-term

memory is instead deeply and quickly embossed into our long-term memory as driven by the norandrogenic responses of the amygdala (Nader et al., 2000).

The physiological state post-trauma allows for hyper-memory of fragments of an event (e.g., sounds, images) that might otherwise be remembered differently in a non-traumatic event. Though memory of trauma is intensified, it paradoxically may remain largely unconscious (only triggered by a sound or smell) because of the inhibition of the frontal lobes and atypical processing (Nader et al., 2000).

One of the messages about human being that is taken for granted in Le Doux's (1994) model is that traumatic events that occur in a social and political world can become represented psychologically and biologically in the individual person. In LeDoux's model, the idea of the unconscious or split-off traumatic memory is introduced as if it were part of an intrinsic and universal biological function; the historical tradition for this idea I describe in the *History of trauma as a mental health disorder* (pp. 47-99) section of this study.

PTSD born from neurochemical imbalance. Mainstream approaches to understanding trauma disorders embrace the cognitive neurobiological framework proposed by LeDoux, which suggest that the psychological effects of experiencing trauma are primarily the result of a neurochemical imbalance or physiological or genetic predisposition to being traumatized. The previously mentioned NIMH (2013) psychoeducational article called "What is PTSD?" continued with a sub-section titled Causes of PTSD:

> Genes. Currently, many scientists are focusing on genes that play a role in creating fear memories. Understanding how fear memories are created may help to refine or find new interventions for reducing the symptoms of PTSD. For example, PTSD researchers have pinpointed genes that make: Stathmin, a

protein needed to form fear memories. […] Researchers have also found a version of the 5-HTTLPR gene, which controls levels of serotonin—a brain chemical related to mood-that appears to fuel the fear response. Like other mental disorders, it is likely that many genes with small effects are at work in PTSD.

   Brain Areas. Studying parts of the brain involved in dealing with fear and stress also helps researchers to better understand possible causes of PTSD. One such brain structure is the amygdala, known for its role in emotion, learning, and memory. The amygdala appears to be active in fear acquisition, or learning to fear an event (such as touching a hot stove), as well as in the early stages of fear extinction, or learning not to fear. Storing extinction memories and dampening the original fear response appears to involve the prefrontal cortex (PFC) area of the brain, involved in tasks such as decision-making, problem solving, and judgment. […]. The ventromedial PFC helps sustain long-term extinction of fearful memories, and the size of this brain area may affect its ability to do so. Individual differences in these genes or brain areas may only set the stage for PTSD without actually causing symptoms. Environmental factors, such as childhood trauma, head injury, or a history of mental illness, may further increase a person's risk by affecting the early growth of the brain. Also, personality and cognitive factors, such as optimism and the tendency to view challenges in a positive or negative way, as well as social factors, such as the availability and use of social support, appear to influence how people adjust to trauma. More research may show what combinations of these or perhaps other factors could be used someday to predict who will develop PTSD following a traumatic event. (p. 1)

All causes of PTSD that the NIMH presently (2013-2014) recognizes are presented above; indeed, according to the NIMH, there are now only two causes of PTSD: genes and brain areas. The traumatic event itself or any other environmental, relational or social experiences are not listed as causes but acknowledged as risk factors. Notably a positive attitude is listed as a protective factor. Because the genes and brain areas have, as the article said, "set the stage" for PTSD, the taken for granted assumption about human being in contemporary trauma culture that is suggested in the article is that if one's genetic composition and brain are healthy and large enough when exposed to any stressful event PTSD may not develop.

Localizing PTSD in the brain on a micro-level has been one of the primary foci of new research on PTSD (AFPS, 2012; Baum, 2012). Over the 10-year development of *DSM-5,* one of the primary aims of the revised manual was to identify the biomarkers in our DNA for major disorders such as PTSD, depression and schizophrenia. In a special issue of *BMC Medicine* focusing on current controversies surrounding the *DSM-5,* Nemeroff et al. (2013) described how the "unbridled enthusiasm [for biomarker identification] followed on the heels of the sequencing of the human genome and the then-existing strong belief that many complex diseases in medicine would be simplified by the results of genome-wide association studies" (p. 1). Alas this promise was not reached by the development of the *DSM-5* and instead understanding of genetic basis for disease became more complex or "sophisticated" due to emerging disciplines like "epigenetics, non-coding RNAs, microRNAs, transcriptomics and protemotics" (p. 1). The authors noted that the scientific community's enthusiasm for identifying direct links from genetics to mental health disorders was reminiscent of the burgeoning field of brain imaging studies, which produced much data about neurobiology related to mental health disorders yet no findings which could be incorporated into a diagnostic manual. Nemeroff et al. (2013) concluded that it is difficult to find the genetic determinants of disease, but cited trauma as a major factor that alters gene expression.[3]

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[3] They also suggested that the controversy surrounding inclusion of biomarkers in the *DSM-5* was pithy and if psychology were less politically active and more like a medical science, the field would readily accept the move to biological markers for disorder. The authors stated,

> Do the American Neurological Association or the American Cancer Society have demonstrations outside their national meetings protesting their disease classifications? Do they have those in their ranks refusing to use the new ICD-10 disease classification? Clearly not. Was the *DSM-5* handed down to our field on

Despite the inability to find specific biomarkers to include in the *DSM-5*, the authors discussed the enhanced benefits of the cross-reference between the *DSM-5* and the *International Classification of Diseases-10th edition* (*ICD-10*). Now all mental health disorders in the *DSM-5* can be identified according to *ICD-10* medical diagnostic criteria, further positioning mental health and psychology as a medical discipline. (Pragmatically from a managed care perspective this also means that mental disorders can be billed following the established medical billing system).

Nemeroff et al.'s (2013) final quote in the article was "Will the *DSM-6* include sensitive and specific diagnostic tests that are biological based for schizophrenia, bipolar disorder and PTSD, to name a few? We all certainly hope so!" (p. 3). In an unintentional journal formatting formality, following their concluding sentence expressing hope for identifying PTSD biomarkers, the authors' competing financial interests were listed in a block of text. These included: consultation for nine pharmaceutical development firms, stockholding of five biological pharmaceutical intervention companies, equity and income from eight additional pharmaceutical firms, two patents for transdermal delivery of lithium and assessing antidepressant drug therapy, and finally serving on the board of Anxiety Disorders Association of America (ADAA), Skyland Trail, and AstraZeneca Pharmaceuticals (2009); and board of directors of American Foundation for Suicide Prevention, Mt. Cook Pharma (2010), NovaDel (2011), Skyland Trail, Gratitude

tablets from Mount Sinai? Of course not. […] Overall is it an improvement over the *DSM-IV*? Yes, but perhaps not what we all wished for at this stage in our field. Will the *DSM-6* include sensitive and specific diagnostic tests that are biological based for schizophrenia, bipolar disorder and PTSD, to name a few? We all certainly hope so. (p. 3)

America, and ADAA.   Nemeroff et al.'s final quote juxtaposed with their competing

financial interests in the article almost perfectly captures what Nikolas Rose (2006) has

called the contemporary shift to an economy of "neurochemical selves," where variations

in mood, emotions, desires and thoughts are increasingly being understood as variations

in brain chemicals that can only be managed by proprietary treatments.

Rose (2006) discussed how health has become a central ethical principle in

contemporary society and has recently taken the shape of somatic individuality in such a

way that the self is understood in terms of biological health, "we understand ourselves,

speak about ourselves and act upon ourselves as the kind of beings whose characteristics

are shaped by our biology" (Rose, N. S., 2006, p. 480). The shift to a neurochemical self

has allowed society to become amenable to economies of vitality. Nikolas Rose described

the practices that allow the neurochemical self to be transformed into an economy of

vitality as occurring in a phased process where persons or companies who stand to profit

from disease (e.g., pharmaceutical companies, insurance companies, patent holders,

shareholders): a) identify social ills and cultural discontent; b) link this discontent to

psychological disorders that can be cured by their products; and, c) then incorporate the

social narratives into advertising (both in direct-to-consumer ads and in sponsored

clinical trainings) linked to the product. This can occur on a more subtle level in

academia and clinical training when, for example, a trauma research study describes

symptoms that may be a reflection of the social and political world as medical problems

that reside purely in the individual brain or neurons.

In addition to linking social problems to products, Nikolas Rose (2006) also

described how psychological symptoms are further concretized and broken down into "a

series of distinct and discreet objects- that can be isolated, delimited, stored, accumulated, mobilized and exchanged … -in the service of many distinct objectives" (p. 7). This fracturing of neurochemical self into many distinct components further allows health companies and corporations to market and profit from each piece that comprises this cultural construction of a healthy neurochemical self. In this construction, no longer does it make sense to pursue a one-size fits all treatment for general anxiety, but to find specific treatments for each sub-classification of anxiety (e.g., PTSD, acute stress, panic) and symptom specific treatments within that (e.g., prazosin for PTSD related nightmares, mortazipine for PTSD-related insomnia; see, e.g., Rosen et al., 2004).

Nikolas Rose (2006) suggested that when social problems are reified and located in the brain as distinct medical problems, these problems and the related sense of a healthy self can then be manipulated psychopharmaceuticals and evidence-supported psychotherapies that target brain function. Rose suggested that psychiatrists and researchers, like those on the *DSM-5* task force, have created novel links between truth and commodification in which life becomes amenable to economic relations (e.g., community problems are now understood as pieces of a brain can be modified and profited from). In this world, parts of the neurochemical self can be healed and strengthened, where others may be processed, and yet others are stored and utilized for other functions. The taken for granted nature of the neurochemical self has allowed for the creation of modular, brain-based mental health treatments for trauma, like the treatments described by the manuals that are analyzed in this study.

The PTSD epidemic. The likelihood of a person being diagnosed with PTSD and encountering the mainstream conceptualization of trauma as a medical, biologically

based disorder is increasing. The majority of trauma-focused psychological and medical journals have framed PTSD as a public health epidemic where over half of the world's population may be vulnerable to experiencing a traumatic event that could lead to PTSD. The website for the National Center for PTSD proclaims that over 60% of people will experience at least one trauma in their lives and 5.2 million adults retain the diagnosis of PTSD each year in the U.S. (National Center for PTSD [NCP], 2007). Trauma treatment papers commonly begin with statistics about PTSD such as: 37 million Americans, including one quarter of the U.S. population of children and adolescents, make a visit to the emergency room each year as the result of a traumatic accident (Bonnie et al., 1998; Dowd et al., 2002). Studies have shown that within the first year after a traumatic accident, ten to forty percent of individuals develop symptoms consistent with PTSD (Zatzick et al., 2004). In this section, I review epidemiology literature that reports PTSD prevalence in the U.S. and internationally.

In a comprehensive review of epidemiological studies of PTSD, Blanco (2011) noted that rates of conditional lifetime prevalence for PTSD across the U.S. varied considerably in the general population (e.g., 8.8% in a study of young adults in mid-Atlantic City to 23.6% for young adults in Detroit). Measurements of conditional PTSD lifetime prevalence include persons who continue to meet PTSD criteria long after exposure to the initial trauma and throughout their lives. In Latin America, the conditional probability for lifetime PTSD in Mexico between 1990 and 1992 was 15% and in Chile it was 4.4%.

According to the National Comorbidity Survey (NCS), a national study conducted between 1990 and 1992, which many epidemiologic claims about PTSD in the U.S. are

currently based upon, women are twice as likely to develop PTSD than men (10% vs.

5%) despite being exposed to fewer traumatic events in their lifetime (51.2% vs. 60.7%)

(Kessler et al., 1994). This rate was replicated in later studies conducted from 2000 to

2002 (Breslau, Wilcox, Storr , Lucia, & Anthony, 2004; Kessler et al., 2005). In Europe,

a cross-national European Study of the Epidemiology of Mental Disorders examined

rates of PTSD in six Western Europe countries (Belgium, France, Germany, Italy, the

Netherlands and Spain) and found that lifetime prevalence of PTSD was on average

1.9%, with women having over twice the rate prevalence than men (2.9% vs. 9%). In

Australia, the National Survey of Mental Health and Wellbeing found that men and

women had a relatively equal lifetime prevalence of PTSD (1.2% for men and 1.4% for

women).

When examining the diagnostic trends from an epidemiologic stance, it is

apparent that since the 1990s the U.S. has had the highest rates of PTSD diagnosis when

compared to other countries in national surveys of mental health. Across counties

surveyed, with the exception of Australia, women were reported as being exposed to less

traumatic events but developed PTSD at a rate two times or more than men. The literature

provides minimal to no context and explanation as to why these trends in trauma

pathology diagnosis are occurring. Some of the studies note that certain groups may have

more biological vulnerabilities to PTSD or may be exposed to more trauma due to

geographic location. Blanco (2011) reported that the majority of studies reviewed

attributed the discrepancy in high rates of PTSD between women and men as primarily

due to women experiencing more sexual trauma.

When examining the studies involved in the analyses, the Australian study was the only study to control for type and numbers of traumatic events, in addition to the amount of time that passed since the event occurred; when these factors were controlled for all effects for male and female gender disappeared. Thus the PTSD epidemic may affect women and men equally or not depending on the statistical analysis utilized and the sample selected; however, the common understanding in the scientific community nationally (as reflected in the National Center for PTSD and NCS reports) is that women develop PTSD more than men when faced with a trauma. The majority of studies use the phrase women "develop" PTSD rather than are more frequently diagnosed with PTSD, assuming that all other factors being equal (or even with women experiencing less traumatic events) women are somehow more susceptible to PTSD. [4]

The PTSD epidemiology research has yet to extend to countries with prolonged civil war or genocide (e.g., Sri Lanka, Rwanda, Darfur, Iraq). Thus the previous estimates of prevalence are based on countries where the relative national stability has been present for the past twenty years. There have also been limited large-scale epidemiologic studies conducted on differences between rates of PTSD diagnosis and ethnic and racial groups. A follow-up study to the NCS called the NCS-R (N = 5424) found that lifetime prevalence was highest for non-Hispanic blacks (7.1%), followed by non-Hispanic whites (6.8%) and Hispanics (5.9%) (Kessler et al., 2005). The NCS-R and the epidemiology studies reviewed by Blanco (2011) included surprisingly little detail about these

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[4] It should also be noted that the majority of studies examining PTSD prevalence rates across genders examined those who identified (or were forced to identify due to survey design) as a women or men; no queer gendered (e.g., pangender, bi-gendered, non-gendered, gender fluid, other-gendered, cis-gendered) or transgendered persons were identified in the analysis.

discrepancies and also did not appear to make distinctions between race, nationality, immigration status, and ethnicity when reporting trends.

Given the dearth of national and international epidemiologic data on ethnic and racial differences, I reviewed some smaller national studies. Within these studies, American Indian and Alaskan Native (AI/AN) persons were the racial group that was identified as being the most likely to experience a traumatic event in their lifetime and develop PTSD. In the Southwestern American Indian community the prevalence of lifetime PTSD (21%) and traumatic event exposure (81%) was considerably higher than in the general U.S. population (Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997). Another study of two reservation-based populations observed the lifetime rates of exposure to at least one traumatic event ranged from 62% to 70% (Manson, Beals, Klein, Croy, & AI-SUPERPFP Team, 2005). In one study of approximately 3,000 trauma survivors treated at 69 hospitals nationwide, AI/ANs had the highest risk of all racial and ethnic groups for experiencing symptoms consistent with PTSD twelve months after their injury (Zatzick et al., 2007).

In the U.S., Australia, and Germany numerous studies have reported a link between socioeconomic class and PTSD where those who are considered low socioeconomic status according to national standards and who live in regions of the country where the majority of the population lives below the poverty line are more likely to have high rates of lifetime PTSD. These studies attribute this discrepancy to high rates of assault and violence between people described as having low socioeconomic status (Blanco, 2011).

The final factor associated with high-risk of PTSD is mental health disorder co-morbidity with one or more additional psychiatric diagnosis (Blanco, 2011). 20. 87.5% of those with PTSD have one other diagnosis and 77.5% have two or more additional diagnoses (Blanco, 2011). The diagnoses most commonly associated with PTSD are mood and dissociative disorders. Alcohol and drug dependence are also commonly co-morbid with PTSD at a rate of 31.2%. Factors that have not consistently been identified as risk factors or trends in PTSD epidemiologic data include: marital status and education. Sexual orientation has not been examined on an epidemiologic level as being linked to PTSD diagnoses.

The epidemiological data paints a picture of whom is most likely to included in evidence-based treatments refer to as a "target population" for PTSD intervention. The review of the literature indicated that PTSD target populations are most likely to include women, African-American, and American Indian persons, immigrants, and persons identified as low socioeconomic status. People considered to be a part of this target population group are theoretically the most likely to receive an evidence-based PTSD treatment given the wide dissemination of brief, evidence-based, manualized treatments in community-based clinics.[5]

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[5] In reality, those who are identified as the most deserving of PTSD treatment (according to the literature), are also the least likely to receive it (Trusz, Wagner, Russo, Love, & Zatzick, 2011). A range of issues prevent this group from being interested in or able to access treatment such as logistical barriers (e.g., not able to take time off work, insurance does not reimburse, no transport to clinic), clinical barriers (e.g., where treatments pre-screen out patients with comorbidities such as psychosis and alcohol dependence), stigma, and disinterest in treatment (Trusz et al., 2011). Some populations are not only not interested in receiving treatment, they find the majority of evidence-based treatments culturally incongruent and even colonial in nature (Gone, 2007).

Overall, it is important to consider epidemiological data when attempting to understand how trauma-culture that is communicated and reproduced in evidence-based treatments. The data suggests that evidence-based treatments are marketed to therapists and clinics that serve specific groups of people who are considered to be the most traumatized. The groups that identified as most likely to develop PTSD are also the most historically underprivileged and politically marginalized in the U.S., yet, as I will explore throughout this study, social and political interpretations why these trends in pathology occur (or are seen as such) are largely absent from the mainstream understanding of trauma as a mental health disorder. For example, PTSD epidemiology literature suggested that women and American Indians are significantly more likely to develop PTSD after a traumatic event when compared to men and other ethnics groups. They are in a sense seen as being more vulnerable to develop pathology after exposure or even mentally weaker than other groups. Yet when studies control for the type and number of traumatic events, in addition to the amount of time that passed since the event occurred, all effects for gender disappear. This that mainstream interpretation of PTSD epidemiology reflects and perpetuating a particular understanding about U.S. society isn't necessarily supported by the data. It would be more accurate to say that women, black, AI/AN, immigrants and persons living below the poverty line are more likely to receive a PTSD diagnosis after a traumatic event, but that these groups may not have an inherent vulnerability or predisposition to develop PTSD symptoms.

From a hermeneutic perspective, U.S. society extends the boundaries of the medical and biological understanding of trauma more deeply into historically marginalized groups—as if to explain political and social inequities and power

arrangements as a product of an internal, brain-based, and pathological weakness and vulnerability to traumatic events. The implications for this understanding of PTSD and trauma are explored further through the interpretation of the trauma manuals in this study.

PTSD prevalence in the military. Within the military, several large-scale studies have found average PTSD prevalence estimates from 14-16% post-deployment (Hoge et al., 2004; Tanielian & Jaycox, 2008). These studies note that they may underestimate prevalence because of stigma and the potential negative consequences associated with disclosing mental health difficulties.

In a review of 177 studies of military PTSD prevalence, Gates et al. (2012) compared immediate post-deployment assessments of PTSD (i.e., within a month after deployment) and lifetime prevalence of PTSD. In immediate post-deployment settings after the Vietnam War, PTSD prevalence ranged from 4 to 18% (mean of approximately 11%) and a lifetime prevalence of PTSD of 10 to 35% (mean of approximately 15%). After the Gulf War, post-deployment rates of PTSD a ranged from 3 to 33%. Overall, Female veterans and Kuwaiti veterans had the highest mean rates of PTSD (20 and 33% respectively). During Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) in Iraq, 21.8% of nearly 300,000 OEF/OIF veterans who first received care at a VA between 2002 and 2008 were diagnosed with PTSD. Other studies on OEF/OIF post-deployment have revealed rates of PTSD prevalence from 4 to 33% with the average being around 15%. No lifetime studies of PTSD prevalence have been conducted (perhaps because OEF continues in at the present moment and limited retrospective or longitudinal data can be assessed).

Similar to the epidemiology studies on civilian PTSD, women in the military experience lower levels of combat exposure but have significantly higher rates of PTSD (Gates et al., 2012). Also like the civilian literature, the discrepancy between male and female prevalence of PTSD in the military has been attributed to high rates of military sexual trauma (Gates et al., 2012).

PTSD within the military is reported to be similar across ethnic groups with African-American veterans being slightly more likely to be diagnosed with PTSD than Caucasian or Hispanic veterans (14% versus 13%) (Gates et al., 2012). AI/AN veterans also had a higher prevalence of PTSD than Caucasian veterans.

Factors that have been associated with a strong effect for increased risk of PTSD in the military include: severe combat exposure, perceived life threat, combat-related injury, peritraumatic distress or dissociation, and post-trauma factors including: lack of social support, negative homecoming experience and exposure to additional life stressors upon returning home (Gates et al., 2012). Intermediate effects are found for: lower intelligence, lower education, lower military rank, lower socioeconomic status, prior trauma, prior psychiatric history, family psychiatric history, behavioral problems in childhood and child abuse (Gates et al., 2012).

Bracken (2002) reviewed the work of several scholars who have argued that wartime trauma is not inevitably associated with psychiatric morbidity and PTSD diagnosis of veterans. In communities where the violence was prompted by public outcry (e.g., 1970s riots of Northern Ireland) and in wars where neighbors and friends took care of soldiers involved in fighting (e.g., Spanish Civil war of 1939) there were notably less reported psychiatric problems when compared to wars that were staged by the

government from the top-down (i.e., where government recruits its unwilling citizens). In these cases where a government has staged wars with limited public support or in cases where the government works systematically to undermine social cohesion and solidarity (e.g., conflicts in South America in the 1970s and 1980s) rates of community distress increase. Thus, Bracken argued that patterns in trauma pathology reflect the social and political context of the violence; the more engaged the community the less likely its members experience pathological symptoms of PTSD.

The work of Bracken (2002) and other scholars (e.g., Brave Heart, 2003; Fassin & Rechtman, 2009; Sommers & Satel, 2006; Watters, 2011) have highlighted the context and culturally dependent nature of PTSD; however, the majority of evidence-supported treatment manuals were designed based on the assumption that PTSD is worldwide, or even culturally universal epidemic that can be treated systematically using Western developed psychological treatments. The assumption that trauma is a universally experienced phenomenon that expresses itself as PTSD symptoms and can be treated with a manual-based treatment is one example of a taken for granted assumption about human being in trauma-based society that I describe in this study.

PTSD and trauma related diagnoses treatment standards. International organizations have embraced the concept of PTSD as a worldwide epidemic and have contributed to the promotion of evidence-based treatments as a response to the epidemic. The organizations that define best practices for trauma treatment nationally and internationally include but are not limited to the: World Health Organization (WHO), Institute of Medicine (IoM), U.S. Department of Health and Human Services (DHHS) and Substance Abuse and Mental Health Services Administration (SAMHSA), National

Institutes of Health (NIH), U.S. Department of Veterans Affairs, International Society for

Traumatic Stress (ISTSS), National Child Traumatic Stress Network (NCTSN), The

RAND Corporation, United Kingdom (U.K.) National Institute of Health and Clinical

Excellence (NICE), National Collaborating Center for Mental Health (NCCMH) and

Cochrane Collaborative. These organizations are predominantly English speaking and are

based in the U.S. or U.K. (the only exception is WHO which is based in Geneva,

Switzerland). Several scholars have documented the impact the Euro-American

domination over the trauma industry and the Western exportation of mental health

(Fassin & Rechtman, 2009; Furedi, 2004; Gone, 2007; Rose, N. S., 2006; Smith, 1999;

Sommers & Satel, 2006; Watters, 2011).

All evidence-based psychotherapy treatments that are recommended by these

organizations have met the effect size criteria of well-established or probably efficacious

treatments (Chambless et al., 1998; Chambless & Hollon, 1998).[6] Current best-practices

for PTSD treatment defined by these organizations include evidence-supported

psychotherapy from manual-based treatment models and if needed, augmentation with

psychotropic medications (e.g., SSRIs, SNRIs, mirtazapine) (Bisson & Andrew, 2007;

DoD, 2010; Foa et al., 2000; Foa et al., 2008; Forbes et al., 2010; Rosen et al., 2004;

SAMHSA, 2013; World Health Organization [WHO], 2013). When reviewing the

evidence-based psychotherapies recommended by the national and international

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[6] In clinical research, there is a difference between efficacy and effectiveness. Efficacious treatments are those that have been demonstrated to lead to significant symptom reduction in controlled research settings (e.g., randomized control trial with highly trained psychologists and engaged patients who are paid to attend the therapy for research in a university clinic). Effective treatments are those that that have been demonstrated to work when disseminated to clinicians working in a range of settings and with real-world populations (e.g., in a community-based clinic or hospital with bachelors or masters-level staff that have attended one workshop training).

organizations listed above, three primary treatment approaches are consistently recommended: exposure-based therapies (trauma focused cognitive behavioral therapy with prolonged, imaginal or in vivo exposure, e.g., Foa, Chrestman, & Gilboa-Schechtman, 2009), cognitive-based therapies (cognitive processing therapy, e.g., Resick & Schnicke, 1993), and eye-movement desensitization and reprocessing therapy (EMDR; e.g., Shapiro, 2001). Some organizations such as WHO, NICE, and The Cochrane Collaborative, recommend only trauma-focused cognitive behavioral therapy (TF-CBT) and EMDR as first-line treatments.

The IoM (2009) was perhaps the most conservative in their recommendations for PTSD treatment. After reviewing 2,800 abstracts and identifying 90 randomized control trials, 53 psychotherapy studies and 37 pharmacotherapy studies with adequate design and effect size for further assessment, the IoM concluded that there was only enough evidence for exposure-based therapies; evidence for EMDR and cognitive-based therapies was not considered adequate (Institute of Medicine Committee on Treatment of Posttraumatic Stress, 2008). Furthermore, the IoM could not recommend treatment with any pharmacotherapies primarily because the research was almost exclusively funded by drug companies, individuals who developed the therapies, or their close collaborators.

Presently, all evidence-supported psychotherapy treatments recommended by these organizations are trained to practicing therapist via a manual of treatment protocols. Similarly, these organizations recommend that therapists are periodically assessed for treatment fidelity according to manual guidelines (i.e., therapists are evaluated on manual adherence when in training and when performing therapy). A comprehensive list of all

evidence-based trauma treatments that are currently (2013-2014) recommended in the U.S. by SAMHSA can be found in Table 1.

With the exceptions one treatment, Kognito Family of Heroes, that is intended to be administered via a computer without a therapist, all treatments recommended by SAMHSA involve the therapist learning from and retaining adherence to a treatment manual.

When reviewing the list of child and adult civilian trauma treatments found in Table 1, it is apparent that certain therapeutic approaches are completely excluded. Most of the organizations' treatment recommendations are based on the findings of meta-analyses of treatment efficacy. The meta-analyses include data from many randomized control trials evaluating trauma treatments that have large enough effect sizes and adequate design to be included in a meta-analyses. Many approaches to trauma treatment have not had sufficient evidence from randomized-control trials to become endorsed as best practices (e.g., gestalt, relational psychoanalytic, attachment-based, object-relations, play therapy, interpersonal).[7] This was the case in widely-cited Cochrane Collaborative

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[7] Often meta-analyses of treatment effectiveness reveal relatively little difference between psychotherapeutic treatment modalities; they tend o show moderate effectiveness for all psychotherapy treatments that could be included in the analysis. This phenomenon is referred to as the dodo bird verdict in reference to Lois Carroll's *Alice in Wonderland* where "everybody wins" the race. The decision to include an evaluation of a psychotherapy treatment in a meta-analysis hinges on whether the approach has enough data from randomized control studies to achieve a moderate effect size. Many psychotherapeutic approaches have not received funding for research trials for a variety of reasons (e.g., NIH preference to fund brief interventions that can be widely disseminated and administered by anyone). Some approaches are not amenable to limited longitudinal analyses (i.e., outcomes determined from 6-months to one year) and specifically reject the technicist approaches that are geared towards managed care. Psychotherapeutic approaches that do not have enough data to be evaluated in meta-analyses fail to win even the Dodo bird verdict, and are thus excluded from the list of best practices.

reviews (Bisson & Andrew, 2007; Rose, S., Bisson, Churchill, & Wessely, 2002; Rose, S., Bisson, & Wessely, 2003) and other meta-analyses (Bradley, Greene, Russ, Dutra, & Westen, 2005; Brewin, Andrews, & Valentine, 2000; Forbes et al., 2010) that all ultimately recommended TF-CBT and EMDR as first-line treatments for PTSD in part due to the availability of adequate research data to include in the analyses.

Table 1

Evidence-Supported Treatments (EST) for Posttraumatic Stress and Trauma-Related Symptoms (2013)

Intervention Title (Year validated as EST)	Evidence-supported Treatment Targets[2]	Ages	Setting(s)	N = Recommended sessions and format (total minutes per session)
Boston Consortium Model: Trauma-Informed Substance Abuse Treatment for Women (2009)	• Substance use • Mental health symptomatology • Posttraumatic stress symptoms • HIV sexual risk behaviors • Perceived power in relationships	26–55	Residential Outpatient	25 group (60–80)
Child and Family Traumatic Stress Intervention (2012)	• Posttraumatic stress symptoms • Anxiety symptoms • PTSD diagnostic symptoms	6–17	Outpatient	4–5 individual (60)
Child-Parent Psychotherapy (CPP) (2010)	• Child PTSD symptoms • Child behavior problems • Children's representational models • Attachment security • Maternal PTSD symptoms • Maternal mental health symptoms	0–55	Home Other community settings	50 dyad: parent-child (varies)
Cognitive Behavioral Intervention for Trauma in Schools (CBITS) (2010)	• PTSD symptoms • Depression symptoms • Psychosocial dysfunction	6–12	School	10 child group, 1–3 individual (varies)

Table 1 (continued)

Evidence-Supported Treatments (EST) for Posttraumatic Stress and Trauma-Related Symptoms (2013)

Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT): Empowering Families Who Are at Risk for Physical Abuse (2011)	• Children's PTSD symptoms • Parenting skills	6–55	Outpatient	16–20 individual and dyad: parent–child (120)
Coordinated Anxiety Learning and Management (CALM) Tools for Living Program (2012)	• General symptoms of anxiety • Disorder-specific symptoms of anxiety • Symptoms of depression • Functional status	18–55+	Outpatient	6 individual, computer-based (6–90); 6 with primary care doctor
Eye Movement Desensitization and Reprocessing (2010) [1]	• PTSD symptoms • Anxiety symptoms • Depression symptoms • Global mental health functioning	18–55+	Outpatient	1–3 individual (60 – 90); additional depending on level of severity
Grief and Trauma Intervention (GTI) for Children (2011)	• Posttraumatic stress symptoms • Depression symptoms • Internalizing and externalizing behaviors	6–12	Home School	9 individual, 1 dyad: parent–child (60)
I Feel Better Now! Program (2011)	• Trauma-related symptoms • Problem behaviors	6–12	School	2 individual, 7 group, 1 dyad parent-child (60)

Table 1 (continued)

Evidence-Supported Treatments (EST) for Posttraumatic Stress and Trauma-Related Symptoms (2013)

Kognito Family of Heroes (2012)	• Preparedness to recognize signs of post-deployment stress • Preparedness to discuss concern with veteran and motivate him or her to seek help at a VA hospital or Vet center • Self-efficacy in motivating veteran to seek help at a VA hospital or Vet center • Intention to approach veteran to discuss concerns • Intention to mention the VA as a helpful resource	18–55+	Home	1 individual, computer-based (60)
Living in the Face of Trauma (LIFT): An Intervention for Coping With HIV and Trauma (2010)	• Traumatic stress symptoms • HIV sexual risk behaviors • Substance use	26-55	Outpatient	15 group (90)
Preschool PTSD Treatment (PPT) (2012)	• PTSD symptoms	0-12	Outpatient	12 individual (45-60)
Prolonged Exposure Therapy for Posttraumatic Stress Disorders (2007)	• Severity of PTSD symptoms • Depression symptoms • Social adjustment • Anxiety symptoms • PTSD diagnostic status	18-55+	Outpatient, Other community settings	8 to 15 individual (90)

Table 1 (continued)

Evidence-Supported Treatments (EST) for Posttraumatic Stress and Trauma-Related Symptoms (2013)

Real Life Heroes (2007)	• Trauma symptoms • Problem behaviors • Feelings of security with primary caregiver	6-17	Residential, Outpatient, Home	25-72 individual (Varies)
Seeking Safety (2006)	• Substance use • Trauma-related symptoms • Psychopathology • Treatment retention	13-55	Inpatient, Residential, Outpatient	5 group or individual (60)
SITCAP-ART (2010)	• Trauma-related symptoms • Internalizing and externalizing behaviors	13-25	Residential, Outpatient	10-11 group or individual (75)
Surviving Cancer Competently Intervention Program (2008)	• Teen posttraumatic stress symptoms • Parent posttraumatic stress symptoms • Current anxiety level of parents	6-55+	Outpatient	4 group (120+)

Table 1 (continued)

Evidence-Supported Treatments (EST) for Posttraumatic Stress and Trauma-Related Symptoms (2013)

Trauma Focused Coping (Multimodality Trauma Treatment) (2011)	• PTSD symptoms • Symptoms of depression • Anxiety • Anger • Locus of control • General mental health functioning related to trauma and its treatment	6-17	School	14 group (50)
Trauma Recovery and Empowerment Model (TREM) (2006)	• Severity of problems related to substance use • Psychological problems/symptoms • Trauma symptoms	18 – 55	Residential, Outpatient	24-29 group (Varies)
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (2008)[1]	• Child behavior problems • Child PTSD symptoms • Child depression • Child feelings of shame • Parental emotional reaction to child's experience of sexual abuse	0-55	Outpatient	12-16 individual and dyad: parent-child (90)
Traumatic Incident Reduction (2011)	• PTSD symptoms • Depression • Anxiety • Expectancy of success	13-55+	Outpatient, Correctional	1-10 individual (90 to 120)

Note. PTSD indicates post-traumatic stress disorder; VA indicates Veteran's Administration. [1] Selected for interpretation in this study. [2] Some treatments target PTSD symptoms and diagnostic status whereas others target post-traumatic stress symptoms that do not meet full diagnostic criteria for PTSD.

In sum, the two primary treatments for PTSD that are recommended by reputable organizations that set national and international best-practice treatment standards are exposure-based trauma focused psychotherapy and EMDR. These treatments are often recommended in conjunction with psychopharmacotherapy; however, some organizations have questioned the efficacy of psychotropic medication for treating PTSD. Details regarding the structure and specific content of EMDR and TF-CBT are found in the associated treatment training manuals (e.g., Shapiro, 2001; Cohen, Mannarino, & Deblinger, 2006) and will be explored further as an object of study in this study. The important point to note here is that regardless of culture or location in the world, the organizations that set treatment standards internationally have recommended the use of evidence-based trauma treatment (trained via manuals) as a response to community suffering, national disasters, terrorism, war, and all other events that have been compressed under the label of trauma.

Summary of contemporary mainstream understanding of trauma as a mental health disorder. In this section I described the mainstream psychological understanding of trauma as a mental health disorder. This perspective is reflected and reproduced by evidence-based trauma treatment manuals, including the three I interpret in this study. To summarize this conceptualization, in the psi disciplines, trauma is described as an event that produces fear, horror or helplessness and can lead to a pathological, brain-based medical disorder such as PTSD. These disorders are described within a cognitive-neurobiological framework in mainstream psychology. Within this framework, fear-based reactions to trauma are understood as normal, innate, or instinctual processes. PTSD is considered an abnormal response to a horrifying event because fight-

or-flight instinctual responses occur long after exposure to the event, even in situations that are considered to be non-dangerous. PTSD can include reactions such as avoidance to otherwise benign stimuli that have been associated with the trauma known as triggers. If these reactions occur longer than one month, they may fit the diagnostic category of PTSD; less than one month and they are considered under the acute stress disorder criteria. In mainstream trauma theory, as it is represented in psychoeducational texts about PTSD, traumatic events are described as becoming inscribed and stored within the individual trauma victim (e.g., in memory, the brain or psyche depending on the approach) as an intrusive, bad, and/or unconscious representation.

The causes of PTSD are presently understood as genetic and brain based variation that predispose one to vulnerability to PTSD after a traumatic event. Traumatic events that can lead to PTSD are extremely wide ranging from catastrophic natural disasters, genocide, torture and war to car accidents, sexual assault, seeing a dead body, hearing of a loved ones illness, and experiencing invalidation or criticism from a loved one. Each of these events constitutes one trauma. In the *DSM-5*, the subjective experience of the event as creating fear, horror or helplessness has been excluded from the diagnostic criteria. Also in the *DSM-5* children can be easily diagnosed with PTSD with the addition of child criteria including developmentally adjusted expressions of traumatic sequelae (e.g., replaying the traumatic events in play).

PTSD epidemiology reported between 40 and 60% of all people will experience a traumatic event and over 5.2 million adults will retain the diagnosis of PTSD each year. Within the military, rates of PTSD post-deployment have ranged from 4% to 33%. According to the majority of scientific research, one is more likely to develop PTSD after

a traumatic event if one is female, an immigrant, African-American or American Indian, living in the U.S. and identified as being of low socioeconomic status. There are additional risk factors that are strongly associated with increased PTSD diagnosis for military populations such as lack of support, negative homecoming experiences and additional traumatic events upon returning from deployment.

The national and international organizations that set practice standards in psychology recommend evidence-supported psychotherapy treatments for trauma that are manual-based. The primary treatments recommended for PTSD included EMDR and TF-CBT. Regardless of culture or location in the world, the organizations that set treatment standards internationally have recommended the use of these two trauma treatments, which are trained via manuals, as a response to community suffering, national disasters, terrorism, war, and all other events that have been compressed under the label of trauma.

The mainstream understanding also includes certain taken for granted understandings about what it means to be human in trauma-based society, which are further explored in interpretation of three selected evidence-based trauma treatment manuals in this study. In this section I highlighted a few of the taken for granted assumptions about human being in trauma-based society that were embedded in the PTSD diagnosis, psychoeducational texts, neuro-cognitive models of fear, and epidemiology data that I reviewed. These assumptions included, but are not limited to:

1. Trauma is a universally experienced phenomenon in which disturbing events in the world become reified and embossed in the individual psyche and brain and are expressed as post-traumatic stress symptoms, such as those described in the *DSM-IV* diagnosis of PTSD;

2. Variations in mood, emotions, desires and thoughts are understood as variations in brain chemicals or problems with brain structures that can only be managed by proprietary treatments such as modular, brain-based mental health treatments for trauma; and,

3. Descriptions of trauma related mental health disorders and victimhood extend to historically marginalized groups in such a way as if to explain political and social inequities and power arrangements as a product of an internal, brain-based, and pathological weakness and vulnerability to trauma.

The history of trauma as a mental health disorder. How did we arrive at this contemporary understanding of trauma as a mental health disorder? In this section, I attempt to address this question by first describing the normative history of trauma disorders that is commonly presented by trauma historians and is referred to in many treatment manuals. It is beyond the scope of this study to provide a comprehensive review of the history of trauma and each conceptualization; however, to provide depth to the history, I have focused on four specific events that are described in nearly all historical accounts of trauma as a mental health disorder: Freud and Ferenczi's psychoanalytic conceptualizations of trauma, studies of Holocaust survivors, the emergence of PTSD in post-Vietnam era, and feminist psychology's reestablishment of PTSD as a primary diagnosis for sexual assault and incest survivors.

The normative history of trauma disorders (circa 1980). I reviewed authors that have written about the history and shifting conceptualization of trauma as a mental health

disorder and summarized their developmental narrative in Appendix A.[8] This narrative

can be seen as the history of trauma disorders that has been prominent in mainstream

psychology since the 1980s after the Vietnam War.

By each trauma conceptualization in Appendix A, I have provided a footnote that

lists the original source (when it could be located) followed by historians and other

authors in the psi disciplines who considered the conceptualization as important to

present within a history of trauma disorders. I excluded conceptualizations from

Appendix A that were mentioned by one or none of the trauma historians or trauma-

focused authors I reviewed. I also included the dates that trauma diagnoses appeared in

the *DSM* and the researchers who contributed to the disorder's inclusion in the manual.

Some notable exclusions in the history presented included: 19th Century Indian Wars,

American Indian and Alaskan Native dislocation and oppression, trauma research on

slavery, research on survivors of the atomic bomb in Hiroshima and Nagasaki, studies on

torture, the Armenian Holocaust, and the majority of child development research. I am

sure there are many other events that have also escaped mention in this history.

There are some surface-level trends apparent from Appendix A. It can be

observed that interest in trauma appears to rise around war, industrialization,

developments in new technologies and major political upheavals or movements. The

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[8] The majority of the authors I reviewed cited and referred to primary texts, which when available, I read and quoted from directly when defining the traumatic construct in Appendix A. I quoted directly from the texts in attempt to retain some historical context and authenticity to the language of the time in contrast to language used by some historians who tend to insert vocabulary from mainstream the cognitive-behavioral trauma psychoeducation into past conceptualizations; this language remains in some descriptions when I could not locate the primary text. The appendix also provides a gross comparison of some of the major political events of the time, which were notably absent from some presentations.

population of clinical interest shifted from "feeble-minded" women, "inebriates" and soldiers, to normal persons in extraordinary situations (war, genocide, chronic abuse), and most recently to children. While Freud discussed the role of childhood trauma in adult neurosis (and Ferenczi challenged Freud's perspective), the child as a traumatized patient of consistent mainstream focus emerged more in the 1940s with Bowlby's attachment research and with Judith Herman's research on child abuse. It was not until 2013 that the *DSM-5* included specific child criteria for PTSD.

Key events in the normative history of trauma. There are four key historical events in the normative history of trauma disorders that are mentioned repeatedly in both traditional, scientific and mainstream accounts of PTSD history as well as postmodern, critical and hermeneutic accounts of understanding trauma: Freud and Ferenczi's psychoanalytic conceptualizations of trauma, studies of Holocaust survivors, the emergence of PTSD in post-Vietnam era, and feminist psychology's reestablishment of PTSD as a primary diagnosis for sexual assault and incest survivors. These events are not necessarily directly represented in the normative history of trauma (Appendix A) and yet they permeate the majority of theory and treatments from the 20th century. While there are many other key events and conceptualizations of trauma throughout history, these four historical moments have been selected for discussion because they are mentioned ubiquitously by all of the trauma historians I reviewed (see citations in Appendix A). Description of these events here is important to contextualize the contemporary understanding of trauma and how psychotherapy has shifted over time to its present instantiation in evidence-based, manualized trauma treatments.

Freud and Ferenczi's psychoanalytic conceptualizations of trauma. Freud was referenced in all histories of trauma I reviewed to the extent that authors often glibly reflected on Freud's centrality to the discussion on trauma, "It all begins with Freud, of course. And the more I read of contemporary trauma theories, the more I believe that Freud had already said a great deal" (Kaplan, 2005, p. 25); and, "Freud won't go away" (Roth, 2012, p. 117). According to Hoffer (1991), "if Sigmund Freud was the father of psychoanalysis, Sándor Ferenczi was the mother" (p. 466) in that Freud represented the intellectual and authoritarian perspective and Ferenczi represented the relational, experiential and romantic elements of psychoanalysis . This subsection reviews Freud's development and abandonment of the seduction theory in the context of the late 1800s as well as Ferenczi's theories on incest, familial violence and child rape as causes of neurosis.

In 1895, Sigmund Freud wrote in a now famous private letter to Wilhelm Fleiss, "I am on the scent of the following strict precondition for hysteria, namely, that a primary sexual experience (before puberty), accompanied by revulsion and fright, must have taken place" (Reisner, 2003, p. 387). Freud's idea that childhood sexual trauma was the dominant and singular source of neuroses has now come to be known as the "seduction hypothesis." With entire symposiums, books and articles devoted singularly to its interpretation, the seduction hypothesis has been the focus of many psychoanalytic debates.[9] As another example of U.S. cultural obsession with trauma (or within a psychoanalytic approach one might even say fetishizing of trauma), the contemporary psychoanalytic profession is riveted on reconstructing and deconstructing how and why

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[9] This is particularly intriguing considering that mention of the hypothesis appears as the focus of only three of Freud's papers—all published in 1896 (Meyers, 2006).

Freud developed the seduction hypothesis, exploring what it meant and means for

psychology, and revisiting the debate between Freud and Ferenczi about trauma.

Makari (1998) described Freud as a visionary who challenged the medical

zeitgeist,

> In the 1890's when Freud was attempting to solve the riddle of hysteria […]. He was writing about highly contested ground, and any hypothesis was freighted with implications for his own identity within his intellectual, professional and societal communities […]. Freud was deeply concerned with his relationship to the medical and scientific community, whose dominant ideology was, of course, 19th century natural science. (p. 46)

Indeed, Freud's writings on trauma emerged at a time where political, economic

and social ideology was increasingly based on rationality; the truth could be located and

extracted from the world through mental processes (e.g., Kant's filtering the world

through an innate mental structure), and more specifically, through the application of

scientific method (Cushman, 1995). Madness had exclusively become an object of

medical study and institutions devoted to its study allowed for the development of the

human sciences (Foucault, 1973).

Freud was writing during the rise of capitalism and modernity, in what Max

Weber called the "disenchantment" where mystery, nature and creation was replaced by

bureaucracy, scientific and administrative procedures (Lerner, 2003). In the modern

world, scientific procedures became authoritative over local traditions, and the rationalist

way of knowing and being entered into everyday understanding of the world, intimate

social lives, and bodies (Lakoff & Johnson, 1999; Lerner, 2003). Sciences continued to

embrace some of the Enlightenment ideals. For example, in the 1860s, thirty years prior

to Freud's writing the seduction hypothesis, trauma was discussed in the medical

community as if it was an imprint or fixed disease-like pathogen in the brain that could be

identified, localized, and possibly contained or removed. The idea that objects, germs, or ideas enter the mind was predicated on the philosophical assumptions of structuralism (Kant) and dualism (Descartes) that mind and matter are separate, and human experiences are reified, can be known, and manipulated.[10]

Freud's seduction hypothesis emerged when the medical community believed they could still uncover the root or cause of neurosis in the mind and body; it was desirable and possible for doctors to contain and treat these causes. The ideology of science that gripped the medical community only allowed certain scientific questions about trauma to emerge. Asking "Where is trauma located in the brain?" was an acceptable, powerful, respectful to understanding and healing humans. The answers to this question re-affirmed that indeed trauma is located and knowable in the brain.

The late 1800s also embraced the Victorian Era belief that good and healthy persons can contain and dominate their internal, wild, physical-emotional world through rational mental processes (Cushman, 1995). This meant that a healthy person looked like a compliant industrial factory worker or restrained obedient woman (Foucault, 1995). A

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[10] Looking to the primary texts of Réne Descartes, the tradition of traumatic naturalism in the 1800s continued to follow the premises of traumatic association that Descartes (1649/1911) wrote about:

> People's unusual aversions, which make them unable to tolerate the smell of roses or the presence of a cat or similar things, come only from having been badly shocked by some such objects at the beginning of life […]. The smell of roses may have given a child a headache while he was still in the cradle, or a cat might have frightened him badly, without anyone having been aware of it and without him having had any memory of it afterwards, though the idea of the Aversion he had then for the roses or the cat may remain imprinted in his brain to the end of life. (Descartes, 1649/1911, as cited in Good, 2006, p. 7)

Descartes's aversion centers on a biological "shock" or headache, thus the internal world of the headache within the brain creates and defines what is traumatic.

diseased person was unable to control their emotions and bodies. Healers like

psychiatrists came to assist their weak minds in the process of control. It is important to

note that the rise in interest of hysteria also coincided with the industrialization, which

provided social conditions for train and machine accidents, large-scale wars and a

growing bourgeoisie class (where the bourgeoisie family became the site of female

hysteria).

From 1885 to 86, Freud received a travelling fellowship to study with Jean-Martin

Charcot, a physician who rediscovered Mesmer's treatments of hysterical women with

hypnosis (Good, 2006). In the late 1800's hysteria was in seen in the medical and

psychological community as directly related to the effects of the uterus contaminating

other bodily systems, particularly the mind (Cushman, 1995). Similarly, Charcot believed

that hysteria was a type of neurosis of the brain that was caused by psychic trauma in

hereditarily predisposed persons (Good, 2006). He believed that trauma, like Mesmer's

hypnotic induction, created a hypnoid phenomenon in which patients were more

susceptible to unconscious suggestion, including erotic and sexual vulnerability

(Cushman, 1995; Good, 2006). Once in a hypnotic auto-suggestive state, Charcot thought

a particular event would become a fixed idea (*idées fixes*) in the unconscious; this fixed

idea that was at the root of neurosis, what he called traumatic hysteria (Cushman, 1995;

Good, 2006). With the majority of Charcot's hysterical patients being women, he also

found that certain points, mainly in erogenous zones on a women's body, could set off

hysterical fits.[11] Thus throughout Charcot's work there was a connection between what

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[11] Herman (1997) described Charcot's scientific approach to the study of hysteria as one
where he often paid attention to minute shifts in symptoms but was disconnected from the
humanity and emotional experience of his patients (e.g., Charcot described their speech

was seen as sexual, hysteric and traumatic, but he denied that hysteria was in itself a

sexual neurosis, by citing that men and children also become hysteric (Cushman, 1995).

Charcot's work reflected the simultaneous urge to locate the root of hysteria in

female fertility and sexuality, while also seeking to create a broad universal theory that

explained why neurosis might exist in all humans, including men and children. In

Germany, the diagnosis of hysteria was only briefly used for both women and men before

an alternative diagnoses emerged for working-class men (Lerner, 2003). The symptoms

of disorders like railway spine, diagnosed in 1889 by John Eric Erichsen, that came from

witnessing machine accidents while working on the railroad were strikingly similar to

those experienced by hysterical women (e.g., shaking, stuttering, tics, tremors, paralyses,

and disturbances in sight, hearing and movement) (Lerner, 2003). Male reactions to

trauma were described as direct neurological shock from industrial, factory and military

work. Men were not completely exempt from the diagnosis of hysteria, but Lerner (2003)

explained how a conscious political and social effort was made to shift the cause of

neurosis from mental weakness due to the female reproductive system (as in women) to

one of an inevitable violating environmental cause (for men).

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as "vocalizations"). During one Tuesday Lecture, he placed a woman in a hypnotic trance
to demonstrate a convulsive hysterical attack and asked interns to press on her ovarian
region. According to Herman (1997), Charcot said,

> "Let us press again on the hysterogenic point." The woman cried out,
> "Mother, I am frightened." Charcot narrated, "Here we go again.
> Occasionally subjects even bite their tongues but this would be rare. Look
> at the arched back, which is so described in textbooks. Note the emotional
> outburst. If we let things go unabated we will soon return to the epileptoid
> behavior." The patient again cried, "Oh! Mother!" and Charcot continued,
> "Again, note these screams. You could say it is a lot of noise over
> nothing." (p. 11)

During the time of this divergence in the classification of mental disorders for men and women, the middle-class in Europe was rapidly changing due to the industrial revolution in the late 1850s. For example, by 1910, 60% of Germans were living in the cities. Industrialization brought widespread economic change and lifestyle shifts in which men who used to work on farms were filing into heavily managed factories (like those described by Foucault, 1973). The signifiers of modernity at this time became filthy factories and squalid living conditions, which were often blamed for increases in suicide, alcoholism, criminal behavior and mental disease. The social question for the body politic became how to peacefully integrate the proletariat into the cities and into this industrial lifestyle without a revolution or widespread disorder and decline.

The psychiatric community as feared that asylums would not be able to hold the ever-expanding numbers of mentally ill. In Germany, they called the period between 1880 and 1910 the *Irrenboom* or "boom in insanity" (Lerner, 2003, p. 19). This fear spurred leading German psychiatrists including Emil Kraepelin and Ernst Rudin to promote national health and fitness through direct state intervention in hygiene, marriage and reproduction; thus began the early eugenics movement.[12] Around this same time eugenic ideas were also flourishing in Britain, Scandinavia, the Soviet Union and United States (e.g., Beard, 1881) included phenotypic, racially-based descriptions of those who are more prone to neurasthenia). Thus as psychiatry absorbed, shaped and propagated the

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[12] According to Lerner (2003), in 1899 psychiatrist Paul Nacke was the first to recommend the sterilization of who he called "inferiors" as treatment for mental disorder. The predominant treatments recommended by the Racial Hygiene Association of 1908 included a state commission to pursue research in genealogy, heredity and racial "regeneration." The motto of the group became "recognize, cure, prevent," which later become the slogan for the Fourth International Congress on Caring for the Mentally Ill, a eugenics conference, held in Berlin in 1910.

class prejudices of the turn-of-the-century, a moral and economic category of inferiority

was retained in medical descriptions of trauma related disorders. (This is evident when

looking at the final column of Appendix A; almost all symptomatic persons are somehow

predisposed to mental frailty).

As industrialism flourished and insanity boomed across Europe, neurologists at

the time, including Charcot, Oppenheim[13], Freud and Breuer (Freud's mentor, friend and

collaborator), attempted to localize and define the source of middle-class neurosis. Freud

and Breuer had come to an understanding of traumatic paralyses as a psychical event that

left an indelible source of excitation in the subconscious memory, separated from

awareness (Makari & Greenberg, 2006). In 1893, Freud wrote to Breuer, "any impression

in which the nervous system has difficulty in disposing of by means of associative

thinking or of motor reaction becomes a psychical trauma" (Preliminary

Communications, 1893, as cited in Reisner, 2003, p. 384). The trauma, as a foreign body

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[13] Hermann Oppenheim was a German neurologist who believed that the etiology of trauma was different and distinct from hysteria. He posited that shocking experience of the traumatic events instantaneously created minute lesions in the brain and central nervous system, which were undetectable and hence untreatable (Lerner, 2003). He wrote that the "physical trauma is only partially responsible. An important—and in many cases the major role—is played by the psyche: terror, emotional shock. Even in cases where there is no external sound, the injury has direct consequences" (Oppenheim, as cited in Lerner, 2003, p. 2).

Oppenheim's trauma theory, perhaps more than other theories at the time, directly linked the environment of industrialization and of terror to the experience of mental ills. He wrote that his inability to treat the disorder was personally saddening as a physician. Though we must hold our contemporary interpretations of lightly, it is possible that Oppenheim's reported sadness from the inability to treat the effects of railway spine reflects the limits of the cultural clearing (cf. Heidegger, 1996) (e.g., if neurologists cannot see the microscopic holes in the brain, they cannot be treated and there is nothing to be done). The traumatic clearing was severely limited by medical conceptualization.

and source of energy, continued to create symptoms in the form of hysteria and especially a type of hysterical reminiscences.

In Breuer's conceptualization, hysterical people were prone to a fantastical reverie when they remembered the trauma. He believed this reverie produced a twilight mental state that splits the consciousness. In contrast to Charcot and Janet, splitting was not seen as a form of inherent mental weakness, but a product of the twilight state that accompanied memories of the trauma. In other words, he believed patients who are hysteric and traumatized appear weak-minded when their mental activity has become divided. Breuer noted, "This is especially true of people who are of a very lively disposition, to whom monotonous, simple and uninteresting occupation is torture" (Breuer & Freud, 1895, as cited in Reisner, 2003 p. 231). He reported that bright young women often experienced hysteria and splitting after what were considered to be minor traumatic events and that these women were somehow unable to respond to the traumas of daily life (e.g., boredom, rote tasks) with the appropriate affect; thus, these experiences were split off into a separate consciousness. He aimed to permit the release of affect in his treatment (catharsis).

In 1893, Freud directly challenged and separated from Charcot's work. He wrote that the treatment of fixed ideas was "medieval" and that Charcot had simply replaced "the daemon of clerical phantasy with a psychological formula" (Good, 2006, p. 16). In collaboration with Breuer, Freud moved away from the fixed idea hypothesis and instead suggested that mental splitting occurred when "an incompatibility took place in…emotional life—that is to say an idea or feeling which aroused such a distressing affect that the subject decided to forget about it because he had no confidence in his

power to resolve the contradiction between that incompatible idea and his ego by means of thought activity" (Freud, 1894, as cited in Makari & Greenberg, 2006, p. 47). In order to integrate the fractured psyche, Freud's treatment at that time centered on analysis of the history of conflicting elements of the environment, person and emotional world (Reisner, 2003).

Freud's rejection of Charcot's conceptualizations of neurological pain as an explanation for hysteria and move to conceptualizing hysteria as the product of psychic overwhelm and emotional incomprehensibility is perhaps one of his most important contributions to trauma theory (and arguably to the field of psychotherapy). Freud's attendance to the way that life can psychically mark the individual initiated a sea change in psychiatric conceptualizations of pathology and distress.

The famous letter to Fleiss in which Freud further attempted to identify the root cause of hysteria as being childhood sexual seduction signified yet another shift in Freud's understanding of trauma. In *Further Remarks on the Neuro-Psychoses of Defense,* Freud elaborated the seduction hypothesis, describing how any pathology resulting from childhood sexual trauma must occur before the ages of 8 to 10 and that "their content must consist of an actual irritation of the genitals (of processes resembling copulation)" (Greenberg, 2001, p. 70). Freud explained his rationale for this root cause in the *Aetiology of Hysteria,* where he claimed that all eighteen female hysterics that he had treated had discovered repressed or unconscious histories of childhood seduction. He believed that these "coitus-like acts," which Freud also characterized as attacks, assaults or abuse, could be done to a child by strangers, care takers, relatives or from one child to another (Greenberg, 2001). Believing that his hypothesis would illuminate cases of child

abuse in Europe he wrote, "It is expected that increased attention to the subject will very soon confirm the great frequency of sexual experiences and sexual activity in childhood" (Freud, 1896, as cited in Greenberg, 2001, p. 207).

Two-months after his father's death in 1896, Freud wrote privately that he no longer believed that perpetrators of sexual abuse could be strangers, nursemaids or other children and the only perpetrator was the father. A year later, he wrote another letter that has become known as Freud's abandonment of the seduction hypothesis. He described how paternal childhood sexual abuse could not account for or be the root cause of hysteria. Freud cited evidence for his rejection of the hypothesis including an inability to account for the high incidences of hysteria with paternal seduction, limited unconscious surfacing of paternal seduction in cases of psychosis, and the inability to distinguish true abuse and unconscious fantasized seduction with his patients (Makari, 1998). Freud also felt that many of his patients falsely accepted the seduction hypothesis as unconscious fantasy and he was unable to cure them from this belief.

Renick (2006) reflected in a symposium on the seduction hypothesis, "We wonder why we are talking about seduction hypothesis today and it seems we don't know why, but we know it's important" (p. 107). Most trauma historians readily describe Freud's seduction hypothesis as the foundation for trauma theory in psychotherapy but there is wide variation in how the hypothesis is used to rationalize or provide a tradition for contemporary trauma theory as well as the degree to which the historical, political and social context of Freud's writing is mentioned. What is perhaps most relevant about the seduction hypothesis to contemporary theories on trauma is Freud's move away from understanding psychic trauma as an organic medical disorder to understanding humans as

permanently psychologically affected and changed by life when it is overwhelming and incomprehensible.

In 1932, over 30 years after Freud's so called abandonment of the seduction hypothesis, Sándor Ferenczi, a student, ex-analysand and deep admirer of Freud, presented a paper titled "Confusion of Tongues" on the unjust neglect of rape and incest in families as a pathogenic root of neurosis (Ferenczi, 1988). Ferenczi argued that neurosis was the result of childhood violence, incest and rape that was ignored or obscured by the parents and family. Diverging from Freud's final perspective on the seduction hypothesis, Ferenczi stated that the sexual abuse experienced by children from their families and caretakers was real and prevalent in all social classes. He believed sexual trauma could be truthfully recounted by patients and did not exist only in fantasy or the unconscious. Ferenczi's theory also concretized the idea of the individual perpetrator (i.e., the bad guy) as a root cause of traumatic neurosis; no longer was trauma seen as a product of individual mental weakness or fantasy, but the result of a family member taking advantage of and being violent to an innocent child and denying that these acts occurred.

The 1980s and 90s in the U.S. brought a resurgence of interest and respect for Ferenczi's work (see e.g., Gay 1988; Hoffer, 1991; Masson, 1984; Roazen, 1976). This increased by the mid-1990s around the same time that Herman and feminist psychologists sought to establish the veracity of trauma and epidemic of child abuse to combat the ideas of false memory syndrome and the idea that trauma was purely fantasy that emerged in the late 1980s (see The false memory debate and feminist appropriation section in this study, pp. 87-97). Though Ferenczi was revived and in some ways re-appropriated by

trauma theorists in the 90s as providing theoretical legitimacy to the veracity of sexual

abuse as a cause of neurosis, it is important to note that Ferenczi never used broad terms

like child sexual trauma or abuse. He did not homogenize the violent and sexual

experiences of his patients but instead provided specific descriptions like, "real violence,"

"incestuous seductions," "real rape of girls who have hardly grown out of age of infants,"

and "enforced homosexual acts" (Ferenczi, 1988, p. 201).[14] Ferenczi (1988) described

how one might expect children to react these acts with "hatred, disgust, and energetic

refusal" (p. 200), but instead they become paralyzed by enormous anxiety where they

feel,

> physically and morally helpless, their personalities are not sufficiently
> consolidated in order to be able to protest. […] The same anxiety, however, if it
> reaches a certain maximum, compels the to subordinate themselves like automata
> to the will of the aggressor, to divine each one of his desires and to gratify these;
> completely oblivious of themselves they identify themselves with the aggressor.
> (p. 201)

Thus, Ferenczi (1988) posited that a key feature of neurotic sequelae from sexual

trauma was the introjection of the guilty feelings of the adult, which can lead to enormous

confusion and splitting between the child's conceptualization of being both innocent and

culpable in the act. With repeated abuse the child can become, "a mechanical, obedient

automaton or becomes defiant but is unable to account for the reasons of his defiance"

(Ferenczi, 1988, p. 201). The child can seem willing to please and adoring of the parent,

while also ardently desiring to be free of the oppressive love; this Ferenczi called the

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[14] In addition to being careful not to appropriate the historical horizon of Ferenczi's time
with the vernacular of abuse from the 1990s, it is also important to note the words
Ferenczi used specifically given his theoretical emphasis on life's experiential details.
Ferenczi was interested in the particulars of his patients' experience and he rejected
overly general, intellectualized, or abstract descriptions (Ferenczi, 1919). Describing rape
and incest using terms like trauma or abuse would perhaps have been understood by
Ferenczi as a form of defensive distancing from the violence and local experiences of
childhood.

child's "situation of tenderness" (p. 201). The abusive relationship between parent and child Ferenczi characterized as the "confusion of tongues"–- confusion between the adult's guilt-laden acts of passion and the innocent child's submission to these acts and unarticulated introjection of the parent's guilt.

Ferenczi's theory also described why children can be confused as more mature and thus vulnerable to continued sexual exploitation by the parent. He explained that the parent can see the child as a precocious lover because,

> When subjected to a sexual attack, under the pressure of such traumatic urgency, the child can develop instantaneously all the emotions of a mature adult and all the potential qualities dormant in him that normally belong to marriage, maternity and fatherhood. […] The fear of the uninhibited, almost mad adult changes the child so to speak, into a psychiatrist and, in order to become one and defend himself against the dangers coming from people without self-control, he must know how to identify himself completely with them. Indeed it is unbelievable how much we can still learn from our wise children, the neurotics. (pp. 203-204)

Finally, Ferenczi noted that in addition to the ties of passionate love and punishment from the adult, the child is bound to their abuser by the "terrorism of suffering" (p. 205), in which they feel the compulsion to make right the problems in their family and continue to accept the neglecting of their needs and meet those of the family.

Although the psychological community later heralded Ferenczi's recognition of child sexual abuse, there was great controversy about his presentation of "The Confusion of Tongues" paper; this mainly followed Freud's outright rejection of the paper, in which he stated it was merely a repetition of the earlier abandon seduction hypothesis (Aron & Harris, 2010). Several of Freud's followers, knowing that Freud did not accept Ferenczi's theory, had even attempted to persuade Ferenczi from not reading the paper (Aron & Harris, 2010). Even before the presentation of "The Confusion of Tongues" Ferenczi and Freud had a complicated relationship (e.g., where Freud analyzed Ferenczi and then

Ferenczi later requested to analyze Freud but was rejected). The details of Freud and

Ferenczi's relationship have been summarized elsewhere (e.g., Aron & Harris, 2010).

Ferenczi was criticized not only for his presentation of sexual trauma as the root

of neurosis, but also for his emphasis on analysts "entering a game" (Ferenczi, 1931,

p.129) with the patient to relive early childhood experiences. Ferenczi supported

enactments of regression and the analyst's engagement with a child-like state of adult

patients to eventually create a healing relationship that the adult had been deprived of as a

child. Freud critiqued Ferenczi's willingness to participate in regressive enactment,

fearing that this could lead to indulging the patient's fantasies of sexual acting out or

gratification with the analyst. Ferenczi, on the other hand, saw the purely verbal form of

psychoanalysis as a repetition of trauma of neglect and distance of the patient's parents,

> The analytical situation—i.e. the restrained coolness, the professional
> hypocrisy and—hidden behind it but never revealed—a dislike of the
> patient which, nevertheless, he felt in all his being—such a situation was
> not essentially different from that which in his childhood had led to the
> illness…Small wonder that our efforts produced no better results than the
> original trauma. (Ferenczi, 1988, p. 199)

Ferenczi's (1988) acknowledgement that the trauma could be repeated in the

therapeutic relationship has been identified by relational psychoanalysts as the first

recognition of interpersonal or two-person psychoanalysis (Aron & Harris, 2010). This

awareness of what are now called enactments (cf. McLaughlin 1991, Jacobs, 1996, &

Schafer 1992) in therapy that emerged from Ferenczi's trauma theory of neurosis makes

his contribution unique from Freud's perspective on neurosis. Ferenczi acknowledged the

repetition of the patient's psychic life in the relationship with the analyst in such a way

that both parties participated and enacted the traumatic relationship. Aron and Harris

(2010) wrote that Ferenczi was "not content with the idea that countertransference is only

a response to the patient's pathology; he emphasizes the analysts own character traits and how these inevitably play a part in the establishment of transference and countertransference. Furthermore, the patient can observe these countertransference responses and character traits of the analyst and react to them" (p. 19). Hoffman (1983) credited Ferenczi as being the first to point out the ways in which the patient becomes interpreter of the analyst's countertransference experience.

Although the psychoanalytic community continues to mourn and reinterpret the debate between Ferenczi and Freud, it is also important to move outside of the intricacies of their relationship and understand the broad political context at the time Ferenczi presented "Confusion of Tongues." One year after Ferenczi presented his paper Hitler was appointed Chancellor of Germany and the first concentration camp was established (Goss, 2014). By the 1930s, fascism was growing rapidly in Europe and there was concern about the political threat of progressives, and in particular, intellectual Jews like Freud and Ferenczi. The political oppression of the time paralleled Ferenczi's description of traumatic neurosis, where persons came to act like mechanical automatons—abused children at the wills of an aggressor—and the violence that Jews were beginning to endure was unrecognized by the global community. In retrospect, this time period was the most appropriate but also dangerous time for psychoanalytic theories of trauma and abuse to emerge—dangerous in that descriptions of neurosis like Ferenczi's could be seen as a form of resistance and commentary (e.g., breaking the enactment of violence by articulating how the suffering of innocent persons can be ignored).

The political context of Ferenczi's work outside of his relationship with Freud and psychoanalytic community is little discussed, but it is likely and possible that the

ostracization that Ferenczi endured after the presentation of *Confusion of Tongues*—

fissures that were seen as intellectual rejection led by Freud—were heightened by fear

about the political implications of what it would mean for psychoanalysis to return to

considering Freud's seduction hypothesis, the widespread nature of incest, or to accept

Ferenczi's more experimental, emotional and romantic forms of practice. In the context

of growing intolerance and political instability, what would it mean for psychoanalysis to

acknowledge unrecognized suffering—one coming from repeated distortion of events

from the parent rather than a neurological or internal failure of a mentally weak person to

integrate the traumatic event?

Though Ferenczi is widely cited in the psychoanalytic community, and

particularly in interpersonal or relational schools today, he is not often acknowledged as

broadly by trauma scholars when compared to Freud. It is unclear why this is the case;

perhaps this is a vestige of Ferenczi's lack of acceptance by Freudian psychoanalysts or

location outside of mainstream psychology given his later association with feminist and

relational movements and recognition of emotionality and enactment in therapy.

Remembering the atrocities of World War II: Holocaust survivor studies. The

Second World War (WWII) involved two of the most significant atrocities in our recent

history: the Holocaust and nuclear bomb. Since WWII many writers have reckoned with

the imperative to remember the lessons of these events. Leo Etinger, a psychiatrist who

studied survivors of the Nazi concentration camps, wrote:

> War and victims are something the community wants to forget; a veil of oblivion
> is drawn over everything painful and unpleasant. We find two sides face to face;
> on one side the victims who perhaps wish to forget but cannot, and on the other
> all those with strong, often unconscious motives who very intensely both wish to
> forget and succeed in doing so. The contrast…is frequently very painful for both

sides. The Weakest one…remains the losing party in this silent and unequal dialogue. (Etinger, as cited in Herman, 1997, p. 8)

It is likely that the Holocaust would have been forgotten or been excluded from consideration in psychology trauma studies was it not for the dedicated work of Jewish psychoanalysts and psychologists beginning in the late 1960s including Dori Laub, Sohshana Felman, Judith Kestenberg, Eva Fogleman, Victor Frankl, Leo Etinger, Henry Grunebaum, Martin Bergman, Milton Jucovy, and William Neiderland, among others. These clinicians consciously brought the Holocaust and its survivors into the purview of psychology so that the atrocities committed would always be remembered. Many horrific events, genocide, and exploitation for which the U.S. was directly responsible (e.g., slavery and dropping the bomb on Hiroshima and Nagasaki) have not been recognized in this history as traumatic events, especially to the extent that the Holocaust has. [15] The efforts of their work are apparent today as trauma histories often mention Holocaust survivors as a major influence especially in the understanding of how trauma can be indelibly embossed in memory. Within this frame, memory of the trauma of the Holocaust is seen as immutable, exact and etched into memory exactly as it was experienced. While traumatic memories are sometimes seen as inaccessible until therapy breaks through the reenactments, dissociation or repression of these memories, the traumatic reenactment literally conveys "both the truth of an event and the truth of its

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[15] For example, Holocaust survivors are referred to as "survivors" and their progeny as the children or grandchildren of survivors, yet we continue refer to generations of "ex-slaves" or grandchildren of "slaves" rather than survivors; the culture of trauma has not extended to slavery and other atrocities in the same way as it has to the Holocaust. For a review of systematic exclusion of African American history and slavery from the history of psychology see Guthrie (2004) *Even the Rat Was White.* There are also few psychologists who have taken extensive interest in the effects of the U.S. dropping the atomic bomb on Hiroshima such as Lifton's books: *On Death and Death Symbolism: The Hiroshima Disaster* (1964) and *Death in Life: Survivors of Hiroshima* (1987), as well as Well's *Hiroshima in America: Fifty Years of Denial* (1995).

incomprehensibility" (Caruth, 1995, pp. 153-154). The literal nature of trauma representation for these scholars stems from the post-Holocaust assumption that any attempt to represent the trauma (and specifically the trauma of concentration camps) is distortive. As Dori Laub (1991) explained, "One might say that there was […] historically no witness to the Holocaust, either from outside or from inside the event…The historical imperative to bear witness could essentially not be met during the actual occurrence" (p. 66-68). The ethic to bear witness and take responsibility for the truth is embodied in a quote by Elie Wiesel, Holocaust survivor and author, who once said, "If someone else could have written my stories. I would not have written them. I have written them in order to testify. My role is the role of the witness…Not to tell or to tell another story is… to commit perjury" (Wiesel, 1984, as cited in Felman & Laub, 1992, p. 204).

In the 1980s and 90s, Bessel van Der Kolk, Judith Herman and Cathy Caruth based their clinical work and research on the trauma theory on testimonies of Holocaust survivors. In 1984, van der Kolk and colleagues conducted a descriptive study in which patients diagnosed with combat related PTSD and persons suffering from lifelong nightmares were compared (van der Kolk, Blitz, Burr, Sherry, & Hartmann, 1984). The subjects were given a variety of psychiatric tests including the Rorschach and semi-structured psychiatric interviews and asked to spend a few nights in a sleep laboratory for all night EEG monitoring. They concluded that the dreams of the combat-related PTSD nightmares were distinct from those nightmare suffers in that the dreams were literal replaying of the same traumatic memories suffered in combat with no other latent or manifest content; the dreams were not bizarre or unreal, nor did they vary in subject. van

der Kolk and colleagues concluded that the intrusive symptoms of flashbacks, nightmares and memories were literal memories of the traumatic events. In *Traumatic Stress* (2012)*,* van der Kolk further characterized traumatic stress as the literal inscription or engraving of a traumatic event on the mind in such a way that it is not integrated into ordinary awareness but exists in a dissociated, literal form where it resists symbolization, meaning and other processes of integration which might typically occur for non-traumatic memories (van der Kolk, McFarlane, & Weiseth, 2012).[16] While van der Kolk did not write about the Holocaust directly in his randomized control trials, his book briefly discussed the connection between the resistance to symbolization and the Holocaust.

Cathy Caruth (1995) similarly conceptualized trauma and argued that while there have been historical variations in the definitions of posttraumatic stress, to be traumatized is essentially to be possessed by the image of an event. Traumatic symptoms thus cannot be interpreted as distortions of reality, or as lending of unconscious meaning, or repression; traumatic dreams and memories are literally the return of the event in which one was traumatized. She said, "[The traumatized] carry an impossible history within them, or they become themselves the symptom of a history that they cannot entirely possess" (p. 5).

Dori Laub (1991), a psychiatrist who was a child survivor of the Holocaust himself, devoted his clinical practice to the analysis of trauma survivors, and in particular survivors of the Holocaust who had immigrated to the U.S. In 1981, he co-founded the

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[16] The traumatic polarities central to the false memory debate (i.e., trauma as either complete fantasy and introjection of perpetrator guilt or as a veridical etching of a completely real event) have been noted by scholars like Leys (2000) as a problematic trend in trauma culture in psychology. Leys described one of the primary consequences of characterizing trauma as an either/or experience of fantasy or truth was the loss of meaning and complexity in understanding trauma.

Video Archive for Holocaust Testimonies, which involved videotaping the testimonies of Holocaust survivors as he interviewed them. Many survivors described the phenomena of the imperative to tell their story as a means of survival, "We wanted to survive so as to live one day after Hitler, in order to be able to tell our story" (Laub, 1991, p. 78). Despite the moral imperative to tell the story of the Holocaust, most of the survivors interviewed also reflected on how in the U.S. they were only able or willing to provide testimony almost forty-years after the end of WWII.

In contrast to the U.S., documentation of Holocaust survivors in Europe by survivors began even while the Holocaust continued, wherever Jewish community life emerged so did documentation of the Holocaust (Jockusch, 2012). After the liberation in 1945, historical commissions to systematically document the horrors of the Holocaust were organized by Jewish leaders in major urban centers in Europe, including Munich, Vienna, and Warsaw. The commissions attempted to gather testimony from survivors directly but found that many survivors would or could not talk to them about their experiences. Stories were almost always collected from Jewish community members who had taken it upon themselves to document the histories of survivors in their community. The purpose of the commissions' collection included commemoration, documenting Holocaust and life before the Holocaust from the Jewish perspective, bringing war-criminals to justice, to heal through public, moral dialogue about the Holocaust, and to ensure that post-war suffering of Jewish peoples were not ignored or downplayed politically (Jockush, 2012).

While in Europe documentation of survivors began immediately through a vocal community, in the U.S. Holocaust survivor studies did not emerge until decades later,

with the peak interest in Holocaust studies emerging in early 1990s.[17] In the 1950s a few

psychiatrists reported that Holocaust survivors would have shorter life spans and suffer

permanent psychological damage as a result of involvement in the war (Jockusch, 2012).

In the early 1960s, psychiatrists, psychologists and social scientists began reporting on

and following the lives of survivors but these reports were met with little critique or

discussion. In general, Holocaust survivors avoided giving testimony to researchers and

scientists.[18]

Laub (1991) in his efforts to document Holocaust testimony described how he

feared that if the survivors did not tell their story they would become victims of

"distorted memory" and delusion to the point where "not telling the story served as

perpetuation of its tyranny" (p. 79). He pointed to the core delusion, "Hitler's crime was

not only the killing of the Jews, but getting the Jews to believe they deserved it" (Laub,

1991, p. 79). The collapse of witnessing was central to Laub's interpretation of the horror

of the Holocaust and the treatment for this trauma was to listen to and witness the stories.

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[17] Though historians have described Holocaust documentation and discussion as more
prevalent in strong Jewish communities in Europe and internationally when compared to
the U.S., Laub has given lectures in which he described a group of elderly Holocaust
survivors who had been hospitalized for psychosis for years in a psychiatric ward in
Israel who had never been asked about their Holocaust history (Layton, 2014). He
discussed how in Israel was difficult for the community to acknowledge and think about
the Holocaust.

[18] This perhaps goes without saying, but the survivors' fear of talking to scientists no
doubt came from Nazi experimentation on the Jews during the Holocaust. These so-
called medical experiments were so unethical, gruesome and torturous that one result of
the Nuremberg Trials was the drafting of ethics guidelines and construction of oversight
boards for medical and social research to ensure that such atrocities would not be
committed again (the Nuremberg Codes). Those survivors who did talk about their
experiences to psychiatrists often only did so to Jewish psychoanalysts who had a vested
interest in the Holocaust (Jockush, 2012).

In *Testimony* (1992), Shoshanna Felman and Dori Laub interpreted the Holocaust as a crisis of witnessing. They extended the definition of testimony beyond its legal roots and into a discursive practice of clinical healing. Laub and Felman were also interested in how testimony, represented in literary works and art, make us encounter strangeness. Felman analyzed film, art and literary works, namely those of Camus, from the lens of testimonial imperative. In *Testimony* (1992), Laub took a clinical approach to testimony and asserted that while the Holocaust has been heavily documented, "the trauma—as a known event and not simply as an overwhelming shock—has not been truly witnessed yet, not been taken cognizance of" (p. 57). The process of therapy became for Laub a witnessing and knowing of the event in narrative form for the first time for both the trauma survivor and the therapist, "Through [the therapist's] very listening he comes to partially experience trauma in himself…The listener has to feel the victim's victories, defeats and silences, know them from within, so that they can assume the form of testimony" (Felman & Laub, 1992, p. 58). Laub explained how listening beyond the facts, to the secrets of survival, to the silences and events the survivors could not know consciously, to the resistance to experimentation, "through her very testimony [the patient] is breaking out of Auschwitz even by her very talking" (Felman & Laub, 1992, p. 62).

Laub and Felman (1992) suggested that what was traumatic about the Holocaust, beyond the facts of violence, was the public and private refusal to acknowledge and witness testimony; a collective silence in the face of tragedy. Though trauma scholars in the normative history do not recognize Camus, *The Plague* (1948) and *The Fall* (1956) were discussed in *Testimony* (1992) as descriptions of the imperative to witness. Camus

was an anarchist and participant in the French Resistance against the Nazi German occupation during World War II; he participated in the publication of underground newspapers during this time period. In August 1945, he was one of the few French editors to publically express disgust and opposition to the U.S. dropping the bomb on Hiroshima.

Following Laub and Felman's (1992) interest in Camus and his relevance to the Holocaust studies and remembrance of World War II in trauma studies, here I review Camus' (1946) essay "Neither Victims Nor Executioners." This particular work was also referenced later by Vietnam trauma scholars (e.g., Lifton, 1973) and thus is important to include in this review of key moments in trauma history.

Immediately after World War II, Camus (1946) wrote about the world as facing collective tragedy—tragedy promoted by the government and dissociated through collective silence by the public. [19] He believed that the rise of national security ideology led to technologies that increased the lethality of murder and distanced executioners from the consequences of murder.

Camus (1946) believed that isolation via modern technologies and the abstraction of bureaucratic procedures allowed for murder to become depersonalized. People were viewed as consumers or spectators that could be appealed to by fear, rather than by interest in social relationships. Obedience to the national security state was valued over

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[19] The essay was written at a time before unmanned drone attacks occurred on a regular basis as they do now in 2013. While our present technologies have allowed for murder to occur so remotely that a teenager in New Jersey can command an airstrike across the world, like scoring points on a video game, and return home for dinner. In the mid 1940s these technologies were perhaps less distant, but equally as problematic. Camus (1946) described them as: comfortable air-conditioned rooms filled with working men calculating risk and designing bombs to be dropped in a remote area of the globe.

individual responsibility for social policy. In the world Camus (1946) described, he does

not mention the word trauma but names what have presently become considered

traumatic events in contemporary society: murder, violence, and war. While these actions

are condemnable, Camus argued society has been complicit in allowing these tragedies to

occur without dialogue and action. To Camus these collective tragedies could only exist

when people become so frightened that they stop reflecting about the world they live in,

"Mankind's long dialogue has just come to an end… The result is that –-besides those

who have not spoken out because they thought it useless—a vast conspiracy of silence

has spread all about us, a conspiracy accepted by those who are frightened and who

rationalize their fears in order to hide them from themselves, a conspiracy fostered by

those whose interest it is to do so" (Camus, 1946, p. 28). He continued:

> …who can deny we live in a state of terror? We live in terror because persuasion
> is no longer possible; because man has been wholly submerged in History;
> because he can no longer tap that part of his nature, as real as the historical part,
> which he recaptures in contemplating the beauty of nature and of human faces;
> because we live in a world of abstractions, of bureaus and machines, of absolute
> ideas and of crude messianism. We suffocate among people who think they are
> absolutely right, whether in their machines or in their ideas. And for all who can
> live only in an atmosphere of human dialogue and sociability, this silence is the
> end of the world. (Camus, 1946, pp. 28-29) [20]

Camus (1946) wrote about how overcoming the terror that grips daily life requires

the ability to reflect and to act accordingly, yet the atmosphere of terror that gripped the

cold war could not encourage reflection. In the final conclusion of his essay, Camus

asked in that "midst of a murderous world" could society agree to reflect on society's

violent actions and then make a choice: to live as neither victims nor executioners; to live

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[20] When Camus writes about History I believe he is referring to culturally constructed
historical narratives rather than lived experience. Camus believes Histories have
rationalized war. He suggests that we do not think about the life experiences of having a
mother, a friend or a child and how those who we murder are also mothers, friends and
children.

in way where our actions are not in contradiction to the end we seek: life. After making this choice, members of society might better be able to distinguish those who accept the consequences of being murderers and those who refuse to do so.

In sum, the ethic of the Holocaust that was translated into trauma-focused psychotherapy was that of the therapist and patient witnessing the testimony of the incomprehensible together in the therapy room. The Jewish psychiatrists movement to study the Holocaust was a public form of witnessing—an intentional political movement to never forget. One application of this ethic in the theory of trauma (especially of those promoted by Laub, van der Kolk, Herman, and Caruth) was the indelible, veracious, etching of the trauma into memory. While the memory of the trauma may be repressed or dissociated, its enactment reflects the simultaneously true yet incomprehensible reality of the horrors of this time. Camus (1946) extended the conscious reflection and dialogue about one's role in living in a murderous world. The major themes of Camus' work (1946, 1948, 1956) include: taking responsibility, speaking the truth about atrocities that occurred, and not seeking a means in contradiction to the end we seek.

The only part of the Holocaust tradition of trauma research that remains in mainstream contemporary trauma theory is the etching of trauma into memory (e.g. in studies that tacitly embrace antimimetic trauma theory) and the need to bring conscious narrative to unconscious traumatic memories (e.g., in narrative and exposure-based therapies). Rarely are these concepts directly tied to the historical context of the Holocaust or the Jewish movement to remember; nor do they extend into the political and moral territory that Camus opened. While the direct ties to history are unapparent, the results of Holocaust trauma research are represented in Appendix A beginning in the

1980s with Bessel van der Kolk's research on PTSD; his definition notably preceded and heavily influenced the formulation of the formal diagnosis in the *DSM-III*. The context of the Holocaust or the consequences of nuclear war are absent from this definition of PTSD and its representation in mainstream trauma history but the message of absorbing an indelible and veracious trauma remains in the description of the pathology.

In their attempts to continue the tradition of remembrance and witnessing, trauma scholars like van der Kolk, Caruth, and Herman in an unforeseen way also contributed heavily to the construct of trauma as an empirical, reified object in the brain (see Leys (2000) for continued discussion of this phenomenon). To understand how this shift came about it is also important to understand the context of the post-Vietnam era when these scholars were working and the rise of false memory phenomenon in the 1990s.

The rise of PTSD in the Post-Vietnam era. After World War I, American scientists established the National Research Council (NRC) that reported on the scientific discoveries psychologists made during the war; this field came to be recognized as applied psychology (Samelson, 1974). The wartime effort created renewed interest in applied psychology as a market for assessment, namely in personality and intelligence testing for the military. The NRC publicized the role of psychologists in providing army mental tests. Robert Yerkes, the APA president at the time, offered psychologists service in designing and providing assessment to eliminate "feeble minded and unstable recruits" (Samelson, 1974, p. 109). As war continued the field of psychology benefited; more psychologists were needed to provide assessment.

World War II (WWII) saw the first large-scale systematic screening for psychiatric disposition to mental collapse. Of the 18 million men who volunteered for

military service in WWII, 29% were rejected as unfit for combat for physical reasons and another 18.5% were rejected for neuropsychiatric disorders and emotional problems (Gabriel, 1990). Despite these attempts to eliminate the weak minded from the military, psychiatric causalities were the largest single category of military disabilities granted by the government after WWII (Gabriel, 1990).[21]

In comparison to WWII, scholars have suggested that in Vietnam the degree of exposure to actual battle contact was low. Of the 2.8 million men who saw service in Vietnam only 280,000 engaged in direct combat (Gabriel, 1990). When attacks did occur they were described as ambushes lasting less than two minutes. Though in a quantitative sense combat exposure was less than WWII, the Vietnam War was undoubtedly brutal and gratuitous in unexpected ways that were incomparable to much of WWII. The Vietnam War was essentially jungle based guerilla warfare, which usually took the form of U.S. troops moving between basecamps, looking for the enemy: the Viet Cong (Tick, 2005). The Viet Cong organized guerilla and army units manned by peasants in the areas they controlled. The enemy was often indistinguishable from civilians; in villages the enemy often refused to do battle and the majority of the time they were actually civilians.

Marin (1981) attributed the gross depravity of the Vietnam War to the military being unprepared for guerilla warfare and two fundamental differences in the type of violence when compared to other wars: a) programmatic, widespread and intentional policies that included the slaughter of civilian populations (perhaps only comparable to

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[21] One interesting (though perhaps unsurprising) finding was that men who were already diagnosed with aggressive psychopathic personalities were the only persons to remain mentally unbroken after thirty-five days of exposure to battle; those were screened as being mentally sound quickly degenerated from exposure to war and other factors such as lack of food and sleep (Gabriel, 1990).

the WWII firebombing of Dresden), and b) the common spontaneous development of arbitrary violence, like the massacre Vietnamese civilians in My Lai. This also included recreational violence, such as American GIs gunning down women or children for fun. While there is no systematic documentation of these events, stories from veterans reveal that they were granted implicit permission to act out at will gratuitous acts of violence to the people of Vietnam.

One solider who participated in the My Lai massacre wrote:

The predominant emotional tone here is all-encompassing absurdity and moral inversion. The absurdity has to do with being alien and profoundly lost, yet at the same time locked into a situation as meaningless and unreal as it is deadly. The moral inversion, eventuating in the sense of evil, has to do not only with the absolute reversal of ethical standards, but also with its occurrence in absurdity, without inner justification, so that the killing is rendered naked. (Lifton, 1973, p. 37)

Another solider described passing the time by engaging in "body races" which involved collecting the dead bodies of Vietnamese troops, smashing their pelvises and spines with entrenching tools, tying the bodies into balls with belts and straps and rolling them down the hill as a platoon to see whose corpse would get to the bottom first (Young, 1995, p 144). When this solider was asked if body races were an atrocity, he said he had no particular feelings about it.

Edward Tick (2005), psychologist and anti-war activist, described an interview with a solider, Isaac Bonilla, who eventually died from exposure to Agent Orange. Bonilla's role was to translate orders to Puerto Rican soldiers who were employed as "tunnel rats" to fight in hand-to-hand combat with the Viet Cong in their underground tunnels. The Puerto Rican soldiers who didn't speak English were seen as more expendable and were supposedly chosen as tunnel rats for their smaller size when compared to white officers. Bonilla was in charge of translating, and thus giving the

orders to the Puerto Rican GIs. He described often wanting to refuse but was told, "Give

that order or you'll go into the tunnels yourself" (p. 114). The Puerto Rican soldiers,

Bonilla's friends, would beg him for an alternate assignment, Bonilla answered in

Spanish that it was not his order and that they had either to take their chances in the

tunnel or to run away into the jungle. Tick (2005) wrote, "Once he did refuse to pass the

order. His lieutenant put a pistol to his head and told him, 'Deliver it or die.' He delivered

it" (p. 114).

These examples are just a small selection of the atrocities of the Vietnam War that

have been reported. They reveal how the morality of the war was constantly in question,

yet orders were often carried out regardless of soldiers' commitment to the war. This

moral doublethink (cf. Orwell, *1984*) is reflected in the now famous quote from an

unnamed officer in Vietnam, "We had to destroy this village in order to save it" and

Defense Secretary Robert McNamara's dictum, "In order to do good, you may have to do

evil" (Morris, Williams, Ahlberg, Bilson, & Glass, 2004).

From the start of the Vietnam War the total number of evacuations for psychiatric

reasons was at 6% until 1970 and 1971 when the intensity of battle fell off and the

number of psychiatric evacuations rose to 50% (Gabriel, 1990). As the need for

psychiatric treatment rose, Robert Lifton's (1973) book characterizing the soldiers'

reaction to war was used as a basis for the creation of post-Vietnam syndrome, which

later became known as PTSD. Lifton described how his work was attributed to have first

identified PTSD because he was the first to suggest there would be lasting psychological

effects from the war in a testimony to the U.S. Senate subcommittee on the Vietnam War

in January 1980 (Lifton, 1973). In fact, Lifton did not advocate for the general use of a

category of symptoms to describe veteran's reactions to the war. While he noted there was indeed psychological impact that was often expressed in a particular pattern, he argued that PTSD was "a dubious, easily-abused category, especially in its ready equation of effects of war with a clinical condition (a 'syndrome')" (Tick, 2005, p. 420).

It is clear from Lifton's (1973) book that creating a diagnosis was not his agenda. He described the shifting role of soldiers in Vietnam who were no longer expected to be heroes but a member of a warrior class whose acts of killing were intended to maintain social order (i.e., killing in the service of promoting life). He identified the ways that soldiers were ritually socialized to become numb to individual acts of violence and to lose sense of a larger purpose, morality or identity outside of the warrior ethic. Despite Lifton's protests about utilization of his work in legitimizing PTSD as a mental health disorder, people perceived his book as advocating for diagnostic recognition.

While there is no consensus on figures, by the end of the war approximately 500,000 to 1.5 million Veterans were diagnosed with PTSD (see rates reported in the PTSD prevalence in the military section of this study, pp. 29-32). While several authors note the paradoxical shift in rates of mental health problems increasing in 1971 when exposure to combat decreased, this was also the year that (thanks to Daniel Ellsberg's courageous whistleblowing) selections from the Pentagon Papers were reprinted by *New York Times* (Ellsberg, 2003). The Pentagon Papers led to public awareness and eventually outrage that the war was fought under false pretenses. Soldiers who perhaps expected to return as heroes continued to feel conflicted about their actions in the war and were greeted with political protest upon returning home. While the this protest was directed at leaders rather than soldiers (e.g., chants of "Hey, hey, LBJ how many kids did you kill

today?"), the cultural perception of Vietnam veterans homecoming is still ingrained, "A Vietnam veteran, arriving home from the war, gets off a plane only to be greeted by an angry mob of antiwar protesters yelling, 'Murderer!' and 'Baby killer!' Then out of the crowd comes someone who spits in the veteran's face" (Ulin, 1998). According to Jerry Lembcke (1998) no incidents of spitting on veterans have ever been documented. He believed the spitting image was contrived as right wing propaganda to further polarize anti-war efforts and veterans and discredit the core of anti-war peace movements. Lembcke argued that U.S. society's attachment to this image reflects lingering national confusion over war.

After the Vietnam War, psychiatrist Peter Marin published an essay in 1981 in *Psychology Today* that many veterans still refer to, entitled "Living in Moral Pain." Marin declared that upon returning from Vietnam veterans had learned a "terrible and demanding wisdom"—the irreversibility of a type of knowledge where one's actions of killing and maiming in war irrevocably determined the destiny of victims such that there was no way to deny one's responsibility or culpability for those mistakes. In theory, Marin suggested the knowledge could bring veterans deeper in their community, but instead it isolated them and "locks them simultaneously into a seriousness and silence that are as much of a cause of pain as are their past actions;" the veterans raised questions that the nation did not want to confront. Marin aptly stated, they raised questions "for which, as a society we have no answers" (p. 74).

The American Psychiatric Association recognized the diagnosis of PTSD in 1980. The diagnosis first emerged as "delayed stress syndrome" where long after the wars end veterans who were previously thought to be well began to exhibit flashbacks,

nightmares, uncontrollable anger, paranoia, anxiety and depression (Marin, 1981).

Review of the literature on case studies of veterans revealed psychiatrists' use language

that diffused the moral content of veteran's experience (e.g., refusal to kill during war

was reframed as "acute combat reaction" and the effects of genocide were called "stress")

(Marin, 1981). Through the ideology of cognitive psychological terms, the horrors of war

were masked. As Marin said, the psychiatrists' responsibility thus perversely became "to

keep soldiers in the mood for killing" (p. 72). VA therapists, aware of the moral pain the

veterans experienced, moved to "deresponsibilize" their patients or get them to blame

external causes rather than moral choice. Marin describes how guilt was transformed to

"survivors guilt" –-"shame not for what was done, but for having outlived one's

comrades" (p. 72).

Soon after the introduction of PTSD into the psychiatric nosology in 1980, reports

emerged that portrayed the disorder having occurred throughout human history (Young,

1995). For example, in the *Diary of Samuel Pepys* the author describes his reaction to the

Great Fire of London in 1666; this was reinterpreted through the lens of PTSD symptoms

and incorporated into the normative history of PTSD (Young, 1995). Shakespeare's *King*

Henry IV, Part 1 was seen as referring to PTSD as well as *Homer's Odyssey,* and the

Gilgamesh (Ben-Ezra, 2004). This tradition continues today with ever-emerging

interpretations of history as experienced through the lens of PTSD (see e.g., Ben-Ezra,

2004; Birmes et al., 2010; Breithaupt, 2005; Jones & Wessely, 2006; Wilson, J. P.,

1994).[22]

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[22] These histories are not purely constructive, indeed there must be some similarities in
human distress reactions to war throughout history; yet, as authors like Young (1995) and
Samelson (1974) suggest the specific expression of traumatic symptomology prior to the

Allan Young (1995), in an ethnography of PTSD, argued that the diagnosis achieved general acceptance only after the Vietnam War and the disorder is not in fact timeless and does not possess intrinsic unity; the normative history of trauma disorders that culminates in the discovery of PTSD (Appendix A) he called a "harmony of illusions" constructed from research. Young spent between 1986 and 1988 researching in a psychiatric unit of the VA Medical System now known as the National Center for the Treatment of PTSD (National Center). Amazingly, he was permitted to attend all therapeutic sessions for the purposes of completing his study. He described in detail the early diagnostic process for PTSD (i.e., meeting *DSM-III* criteria for PTSD from a clinical interview, Minnesota Multiphasic Personality Inventory subscales, review of military records, and behavioral observations). He witnessed how wide variation of symptom expression and war stories were considered under the umbrella of trauma and PTSD. During each intake at the National Center, a team of psychiatrists and psychologists carefully considered each case before the diagnosis could be assigned. Through the diagnostic assessment process, what were once unique stories with complex moral dimensions (e.g., the difference between "body races" and Bonilla's attempt to protect his soldiers by resisting translation) were flattened in order to be represented in the PTSD symptom profile. Young reflected on how the diagnostic team believed they would have easier time diagnosing PTSD if they could somehow bypass the things that the men said about themselves and their past. This indeed occurred through the invention of PTSD screening and checklists that are currently used for screening in the military

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1980s was embedded in the political and social life at the time (see description of nostalgia in Appendix A). The history that emerged around the 1980s presented in Appendix A suggests that PTSD, in its contemporary form, has existed thousands of years ago and it was simply undiscovered.

(e.g., Weathers, Litz, Herman, Huska, & Keane's, 1993, Posttraumatic Stress Disorder

Checklist [PCL]). The checklists identify symptoms but prompt for no narratives about

actual war experiences.[23]

The technologies of parsimonious diagnosis were soon translated into the

technologies of treatment, such that all men with the PTSD diagnosis were placed into

identical regimens of therapy.[24] In addition to relaxation therapy, a film series with

therapeutic discussions and autobiography sessions weekly, veterans were assigned daily

group psychotherapy, psychodynamic individual therapy twice a week, and cognitive

skills sessions as needed. This became the National Center's model therapy following

Congress's mandate Public Law 98-528 to provide specialized treatment for PTSD,

distribute findings related to the diagnosis, and conduct research (Veterans' Health Care

Act of 1984, 1984).

The congressional mandate also came with a strong incentive to create a

distinctive treatment program from other VA centers, in part to justify the large staff and

budget (Young, 1995). While it was not difficult to construct the program, fulfilling the

secondary mandate of Congress—identify mechanisms underlying PTSD—was more

challenging. Thus Young described the National Center's primary contribution to PTSD

was a "knowledge-product" (p. 188) to somehow link the narratives of veterans and their

observed behaviors to the symptoms of PTSD and to the mental structures that were at

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[23] Now even the brief PTSD checklists have been reduced from 17 to 3 or 4 items for ease of dissemination (Engel et al., 2008). Thus what once took hours of face-to-face time with veterans and careful decision from a team, was reduced to less than a half-hour and now takes a matter of minutes.

[24] At the time of Young's research, manual-based, brief (5-session) and evidence-supported approaches to PTSD had not yet emerged, so what Young viewed as perhaps one-size-fits all treatment approaches would today be viewed as a luxury.

the time theoretically associated with PTSD. Young described how the development of

this knowledge product, the naturalization and universalizing of PTSD, occurred in

stages:

> *Stage one.* Therapists elicit etiological narratives from patients during
> group and individual psychotherapy. They re-narrate the patients'
> accounts and use the new stories to explain (to the patients and to
> themselves) the meaning of the patients' current behavior at the center.
>   *Stage two.* Each therapist provides the clinical director with a
> double account of what has happened at stage one: an account of the
> patient's narrative and behavior and an account of the [therapist's]
> perceptions […]. This takes place during weekly supervision and at the
> "debriefings following each group psychotherapy session. Stage two
> mirrors stage one, in the sense that the therapist's narrative is re-narrated
> by someone (the clinical director) with privileged access to the meaning of
> the narrator's words.
>   *Stage three.* The knowledge product of stage two is inscribed in
> documents for internal circulation, for a quarterly PTSD newsletter edited
> at the center, and for papers presented at VA conferences and annual
> meetings of professional groups […]. (p. 188)

This staged process reveals how each veteran's personal narrative was stripped of

context and transformed into words such as stress responses and acting out. Through this

process, trauma became reified as a horrifying event (of any kind) and the soldiers

reactions were seen as universal, biologically based, or innate symptoms that fit within

the forthcoming *DSM-III* PTSD description. One can also observe in this process how the

PTSD ideology was translated into published documents whereas the actual stories of

veterans were not distributed. In this way the research served the creation of the PTSD

origin myth in which history is transformed to sanitize the growing complexity, danger

and confusion of our time (cf. Cushman, 1995; Samelson, 1974). PTSD research, with the

promise of curing disease and finding truth, thus obscured the role of psychology in

shaping and retaining the sociopolitical conditions that lead to mental distress, especially

for veterans and those who have been historically underprivileged.

While most of Young's (1995) account of the creation of PTSD paints a grim picture of war psychology, he also described in detail the different efforts of patients and therapists to resist these stages of the therapeutic process by acting out. These behaviors tested the structure of the VA and were described by the National Center as unconscious urges and conflicts. All patients' acting out was uniformly responded to with increased discipline and control. Young related the story of a patient interrupting a group process by accusing his primary therapist of pressuring him to talk about his traumatic experiences. This initiated the therapeutic process of limit setting, which involved the patient's required appearance in front of an multidisciplinary treatment plan (MDTP) panel. At MDTP meetings the binding treatment goals were set and then announced at a community meeting. Thus what was seen as helping veterans (e.g., setting treatment goals) placed them in a double-bind: to question or reject their treatment goals was to suggest that they have failed treatment, which resulted in further restriction, diagnosis of pathology, and more of the treatment they were rebelling against in the first place.

Young's (1995) accounts of patients rebelling against their MDTP plans are eerily reminiscent of McMurphy rebelling from Nurse Ratched in Kesey's (1962/2002) *One Flew Over the Cuckoo's Nest;*[25] however, unlike the portrayal of Nurse Ratched, the treating therapists at the National Center were not often seen (and probably did not view themselves) as power-tripping prison guards. In fact, from Young's descriptions, it's likely that the majority of researchers and therapists at the National Center were extremely well meaning and hoped their treatments would alleviate suffering. To view

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[25] *One Flew Over the Cuckoo's Nest* was written in the peak of the civil rights movement and during the conversation about deinstitutionalization of asylums in the US. The book was banned from schools in at least six states during the Vietnam era.

the history of PTSD's development as a maniacal plan to devalue Veterans, restrain their anger against the government, or continue to fund future war effort would be overly simplistic; however, the counter position to this story, a purely patriotic effort to use science to cure suffering is equally obtuse. While there has been discussion of how the soldiers struggled to reckon with the moral pain they bore in a society that couldn't bear to take responsibility for its mistakes, there is limited literature on how the therapists conducting these restrictive treatments also operated within what they believed was a moral imperative to help the soldiers. The nuances of this history from a moral perspective and local context, including the gory details, must be considered, as scholars Lifton, Young, Marin, Tick and others have demonstrated; they have taken steps to restore the depth of history to the diagnosis of PTSD.

In sum, scholars who have studied the Vietnam War from a moral and ethnographic perspective have chronicled how the diagnosis of PTSD and its corresponding treatment were developed in such a way to alleviate responsibility from the government, society and veterans from the atrocities of war. Most veterans developed symptoms in 1971, perhaps not coincidentally after the publication of the Pentagon Papers. Veterans felt betrayed by their government and returned to a country not as heroes but as victims of the state or, worse, as war criminals. The process of diagnosis developed by the National Center for PTSD served to eliminate the collection and publication of the unique histories of veterans by replacing their narratives with psychoeducational scripts, void of moral content, about the process of contracting PTSD from the war. The war was framed as inevitable and without fault and its consequences as a natural mental disorder that could be treated. The treatment employed at the National

Center was seen as the model scientific treatment of PTSD for Veterans Administration hospitals across the country.

Congressional mandates and an outpouring of research funding further supported the communication of the research-developed narratives that promoted psychotherapy, rather than community action or policy change, as the primary treatment for the problems of war. It was this effort and a shift in cultural consciousness about the nature of trauma that surrounded the development of the normative history of trauma (Appendix A). Prior to the 1980s this history cannot be located in its comprehensive form, from inclusion of nostalgia, soldier's heart, shell shock the seduction theory to the diagnosis of PTSD (see citations under Appendix A for histories that cite each disorder; all publications are dated in the post-Vietnam era or later).

The false memory debate and the feminist appropriation of trauma diagnoses. In the early 1990s, repeated cases of women uncovering long-forgotten memories of child sexual abuse began emerging in the news and sparked controversy around a phenomenon known as false memory syndrome. The question became were these memories falsified by women for personal gain or indeed could a traumatic event be repressed and uncovered through trauma processing therapies. The research of Elizabeth Loftus contributed to a third hypothesis that perhaps these memories were actually introduced or altered by therapists during the therapy sessions. The false memory controversy brought together the interests of law, politics, and psychology such that cognitive scientists, feminist advocates and psychologists and lawyers began publically debating the nature of trauma, and specifically of how traumatic memories are stored and recalled.

In response to the false memory controversy Judith Herman (1992) and other feminist psychiatrists and psychologists like Laura S. Brown (e.g., Pope & Brown, 1996) argued that traumatic memories could indeed be repressed and also recalled with accuracy, similar to the phenomenon of a Vietnam veteran experiencing a flashback. Herman and Brown's thesis was that many women who had been diagnosed with disorders like bipolar were actually suffering from a form of PTSD. They argued that there was an implicit male bias in defining PTSD and that symptoms experienced by veterans in ways that excluded symptoms commonly experienced by victims of domestic violence and survivors of child sexual abuse and incest. Around this same time there was a revival of interest in Ferenczi's trauma theory of neurosis, which also emphasized child sexual abuse and incest, and the problems of familial distortion or denial of abuse (e.g., Masson, 1984; Hoffer, 1991).

In her best-seller, *Trauma and Recovery* (1997), Herman described how traumas that are considered "acts of God," (p. 7) like natural disasters, are morally unambiguous whereas events of human design, like domestic violence and sexual abuse, put society in a place to take sides with the victim or the perpetrator. To side with the perpetrator was to see no evil in the acts of trauma. Herman believed this stance was easier for society to accept, whereas taking the side of the victim asked society to share the burden of pain and demanded action. Herman, like Laub, invoked the role of testimony, "the only way to begin to make our experiences known to ourselves was to start with the testimony about the concrete conditions of our lives" (Herman, 2000, p.1). Herman drew an analogy from the Holocaust to an epidemic of violence against women and described how secrecy and silence were the perpetrators first line of defense in promoting the forgetting of trauma,

before blatantly attacking the credibility of the victim. The more devalued the victim is in society, the more likely it is that the bystander will side with the perpetrator in invalidating and silencing her reality. Following the lessons learned from Holocaust studies, Herman wrote about how psychological trauma is about rendering the victim not credible and invisible.

Herman's aim in writing *Trauma and Recovery* was to establish that the traumatic events women experience are credible and real by aligning the interests of the feminist movement, patients who have experienced invalidation, and investigators conducting psychological research on trauma (namely that of van der Kolk and Brown). She argued that the study of psychological trauma is inherently a political enterprise because it calls attention to the experience of oppressed persons. Without the support of political movement for human rights, Herman (1997) wrote, "the process of bearing witness inevitably gives way to the active process of forgetting" (p. 9). In her book, Herman (1997) reinterpreted the normative history of trauma including Freud's seduction hypothesis and the discovery of shell shock from her position within the feminist movement. The aim of recounting this history, she reflected in the afterword to her book, was in part to ensure that the field of traumatic studies would not be disappeared like stories of the Holocaust survivors.

Herman (1997) is also famous for coining the term "complex PTSD" for the experience of persons who have experienced prolonged, repeated trauma. She believed that the diagnosis of PTSD as it was defined in the Vietnam era was derived from "circumscribed events" like combat, disaster and rape and did not capture the experience of living for years or a lifetime with a perpetrator of violence, such as in child abuse (p.

119). She again made analogies to the Holocaust experience saying that complex PTSD

occurred under conditions of captivity including concentration camps, slave labor camps

and prisons; these same conditions occurred in the unseen domestic captivity of abused

women and children. She proposed new criteria for complex PTSD including subjection

to totalitarian control over a prolonged period (months to years) (p. 121). Herman's work

had an impressive effect politically and in forensic psychology to the extent that the

defense of women's suffering often invoked PTSD and complex trauma diagnoses in the

courtroom (Alpert, Brown, & Courtois, 1998; Pope & Brown, 1996).

A key facet of complex PTSD was the deconstruction of identity and the self,

"The identity formed prior to the trauma is irrevocably destroyed" (p. 56) and "the victim

of chronic trauma may feel herself to be changed irrevocably, or she may lose the sense

she has any self at all" (p. 86). Fragmentation and the creation of a "double-self" is

another consequence of trauma—the self that experienced the trauma is irreconcilable

with identity and thus must be split off in order for the victim to survive (p. 107). The

trauma "invades and erodes the personality" (p. 86) to the extent that the victim's identity

is seemingly replaced by reenactments of the trauma and she continues to be imprisoned:

> Many abused children cling to the hope that growing up will bring escape and
> freedom. But the personality formed in the environment of coercive control is not
> well adapted to adult life. The survivor is left with fundamental problems in basic
> trust, autonomy, and initiative. She approaches the task of early
> adulthood—establishing independence and intimacy—burdened by major
> impairments in self-care, in cognition and in memory, in identity, and in the
> capacity to form stable relationships. She is still a prisoner of her childhood;
> attempting to create a new life, she reencounters the trauma. (p. 110)

In the 1990s, Herman reflected on the loss of the social and political context of

her work as the field of traumatology grew; she referred to this as the "price of

respectability" (Herman, 2000, p. 4) and insinuated that researchers could not gain

funding for the truly interesting questions that arise from clinical work with trauma:

> If you want to keep it clean, it's nice to have some nice, clean auto accident
> victim study. And hopefully not where there's any sort of corporate liability in the
> accident, corporate negligence, but where it was truly an accident. And then you
> don't have to get into any of this murky, messy, social issue stuff. And you can
> just do a nice psychobiological study … I'm not against it. I just think that's not
> where the really interesting questions lie. (Herman, 2000, p. 4)

While Herman and others ensured that women would be recognized as

traumatized, now the suffering of middle-class white women has arguably become

exclusively recognized as trauma (Haaken, 1995; Leary, 2005; Tolleson, personal

communication, October 17, 2013). Jan Haaken (1995) writing in the midst of the false

memory debate suggested that narratives of sexual abuse became the only officially

recognized accounts that grant legitimacy to women's experiences of suffering. Haaken

viewed the false memory debate as an indictment of middle-class life. She argued that the

feminist, adult child survivor movement sought to broaden trauma to include a

dysfunctional middle-class American family. In other words, one needn't come from a

background of poverty or a "broken" family in order to be the target of sexual abuse.

Haaken reflected that historically, public concern over child abuse has emerged during

periods of great social change where the family becomes the locus of generational

struggles. The third wave feminist movement found empowerment in the language of

trauma and carved out a space for women's suffering to be heard in a new light. Haaken

conceptualized the sharp increase in reported incest allegations and sexual abuse that

followed this movement as a cultural metaphor for other female boundary violations

within the family, including but not limited to sexual abuse. Narcissistic, detached, and

physically abusive parents may have created just as much damage to their daughters as

those who are sexually abused, yet, Haaken pointed out, only sexual abuse became the officially recognized trauma for women. Thus identifying as a sexually abused and traumatized woman provided a socially sanctioned way to break out from familial entrapments in the 1990s.

Haaken (1995) was careful not to suggest that incest and sexual abuse allegations were untrue, but unlike the veridical accounts of trauma presented by Herman, Caruth, van der Kolk and others, Haaken argued that the clinical significance of sexual abuse memories can be often ambiguous even when there is a clear, demonstrated history of sexual abuse. She suggested that the false memory phenomenon was no doubt influenced by the immense power of sexual abuse metaphors for women in the 90s to the extent that both patient and therapist may have "appropriate[d] sexual abuse narratives" to fill in gaps of memory (p. 192). Haaken described how therapy that focused exclusively on veridical trauma-based elaborations could intensify women's fears of powerful feelings and desires. Instead, she suggested that in therapy the capacity for fantasy must be recognized and explored along with the history of trauma without reducing one to the other. In this way the fantasy and the irrational feelings can become less frightening and more accessible to creative interpretation.

Similar to Haaken, Cushman (1995) wondered if the word abuse had become a catchall phrase for unarticulated, unnamed or unnoticed problems at this time. Cushman's thesis on abuse was that contemporary culture has come to exclusively rely on trauma theory to articulate a multitude of social problems in the late 20th century American social terrain. In this terrain only dyadic relationships show up, and as a result of many types of damage and oppression do not come to light. It is difficult to see and especially

to productively discuss political and moral issues except when concerned within the dyad—either the parent-child dyad, husband-wife dyad, or the dangerous perpetrating stranger-youngster dyad. Political problems, such as war, racism, poverty, misogyny or heterosexism might get collapsed or conflated into the only concept recognized and thus available: the dyad. As a result important political action gets undermined and public attention gets focused only on what happens within the smallest of relational stages.

While white middle-class women's suffering in the 1990s became increasingly recognized as traumatized, African-Americans, Latinos and American Indians were less likely to be seen as traumatized and were more often considered to be criminals or as being unengaged or un-amenable to treatment following a traumatic event (Fine, 2012; Gone, 2007, 2009; Leary, 2005). Similar to Haaken's identification of sexual trauma as the accepted dialogic space for women to express suffering, Michelle Fine (2012) suggested that women today are expected to and often do accept that the failings of society are indeed due to their individual problems. Fine called this a cultural "hyper-responsibilization" and scrutiny of women, and especially of women of color. Her research highlights how ironically women of color, immigrants and persons living in poverty are seen as more likely to meet criteria for PTSD according to the epidemiological research but do not often receive the label of traumatized because their testimony is not seen as trustworthy. Depending on the needs of the institutions in power, they are seen as liars or criminals or as trauma victims.[26]

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[26] Fine (2012) described the vignette of a recent news story from New York in which Dominique Strauss-Kahn, the managing director of the International Monetary Fund and presidential candidate in France, sexually assaulted Nafissato Diallo, a maid at the New York Hotel Sofitel who was an asylum seeker from Guinea living in the Bronx. In comparison to the debate about false memories that centered largely on middle-class

Joy deGrurey Leary (2005) in her book *Post-traumatic Slave Syndrome* has also

documented the historical exclusion of African-Americans from the diagnosis of PTSD in

the U.S. When referring to the history of war-stress related diagnoses in the Civil War,

like shell shock and soldier's heart, she wrote, "I don't remember reading about any

counseling centers that were set up for freed slaves after the Civil War" (p. 120).

Similarly, when viewing the lists of events that constitute the *DSM-IV-TR's* PTSD

Criterion A, the experience of slavery or history of slavery in one's family does not

appear as a legitimate stressful event or trauma listed in the standard assessments of

traumatic life events.

To acknowledge the experience of descendants of slaves, Leary (2005) created

her traumatic diagnosis: posttraumatic slave syndrome (PTSS), which she defined as the

result of multigenerational trauma resulting from centuries of slavery and continued

oppression from institutionalized racism. She added that the diagnosis includes an

absence of opportunity to access the benefits available in society. The behavior patterns

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white, therapy-going women, in this example there were major differences in power,
class, nationality and race. Diallo was not offered the privilege of the PTSD diagnosis,
nor was her testimony seen as somehow more legitimate because it involved sexual
assault. Instead, she was accused of hanging out with "unsavory characters" such as men
who are in prison for dealing drugs. She was also accused of lying about gang rape in her
home country to establish asylum in the U.S. and categorized as an inconsistent mother
with unstable housing and invalid documentation. Despite medical evidence, material
evidence in the hotel and personal testimony, Diallo's case was considered "not
credible." Even though Strauss-Kahn was responsible for previous documented cases of
sexual aggression (some of which were acknowledged by his wife as seduction), she was
seen as a liar.

Fine has responded to the epidemic of trauma by resuscitating politically engaged
psychology that does not produce science that recapitulates the status quo of the
neoliberal state. Her set of commitments to reclaiming scientific evidence in a socially
responsible way can be found at the website for the Public Science Project at the
Graduate Center, CUNY (www.publicscience.com).

resulting from PTSS include three clusters: vacant esteem, ever-present anger, and racist socialization. Vacant esteem refers to believing that oneself has little or no worth. Rebuilding self-esteem is an activity for white persons who find intrinsic worth and the idea of self as a container worth filling.[27] Leary pointed to the disproportionate number of African American's in the prison system; when African-Americans don't fit society's conceptualization of a healthy self they are seen as criminals, academically deficient and sexually irresponsible. Rather than being turned into objects for healing, African-American distress is seen as dysfunctional and criminal to the point where it is unworthy of healing.

Leary (2005) recommended that African-Americans attend therapy under her diagnosis of PTSS, rather than being excluded from mental health treatment entirely (e.g., as criminals) or conceptualized within the culturally white contemporary notion of PTSD that is decontextualized from the history of slavery. She also recommended that to treat PTSS African-Americans must engage in their faith and religion, contribute to their community by learning to trust and rely upon each other and establish leadership in areas like politics, education and social activism.

Using a somewhat similar strategy of feminists like Judith Herman to legitimate women's suffering as trauma, Leary's work can be seen as appropriating the cultural discourse of trauma to make the suffering of African-American's more visible. Leary

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[27] When considering this symptom in light of questions arising from hermeneutic historical analysis (e.g., Cushman, 1995): What is seen as a healthy or unhealthy person and how do healers maintain the health of the society? Leary's answer appears to be that African-Americans feel and can be seen by society as not worthy of healing or possessing the notion of "self" that is promoted by the majority society. When white women do not fit within the normative conceptualization of mental health they are seen as unhealthy or possessing an individualized mental health problem of PTSD; black women and men on the other hand cannot be seen within the clearing of psychological maintenance.

does not entirely "use the masters tools" (cf. Audre Lorde) by transforming the history of slavery into an ahistorical diagnostic category. Instead, her description of PTSS intentionally situates the traumatic symptoms of African Americans within history and traditional and local culture, thereby by rejecting the white and mainstream definition of PTSD.

In sum, following a similar process to that the VA used to reduce the vilification of soldiers through PTSD diagnosis, Herman, Brown and other feminist psychologists and psychiatrists legitimated the experiences of abused women and children that were previously doubted as false memories or bipolar symptoms. They appropriated post-war trauma theory and the vernacular of PTSD to describe the experiences of incest and abuse. The indelibility and veracity of the trauma was a key aspect of the feminist trauma approach; this also fit with van der Kolk's biologically oriented studies that emerged around the same time where trauma was seen as etched into memory and the brain in an unaltered form. It is notable that Brown, Herman, Caruth and van der Kolk are Jewish and all consciously reference the Holocaust studies in their research following the imperative of testimony and remembrance.

Another central tenant of Herman's approach, which she connected to Charcot, Freud, Janet and Ferenczi, was how trauma necessarily led to a split in the self. This split was sometimes so extreme that parts of the self could be come fractured, multiplied or void; the trauma filled these spaces and in many ways became an inescapable way of being in the 1990s for women (e.g., "attempting to create a new life; she reencounters the trauma"). Thus, a primary consequence of the feminist trauma movement was recognition

of a new dialogic space for women to express discontent and suffering: through the language of trauma and sexual abuse.

As pointed out by Haaken, Cushman, Fine, Leary and others, since the 1990s the suffering of white, middle-class women indeed became understood within the framework of trauma to the extent that other possibilities for discontent with the family or world could not come to light. Leary (2005) and Fine (2012) argued that despite the seeming inescapabilty and universality of traumatic recognition for women, women of color and those in poverty were not often considered traumatized when suffering but were more often given the label of criminal or liar. Fine especially emphasized how the expansion of trauma culture after the feminist movement allowed the failings of neoliberal society to fall further under the purview of women's individual problems and responsibility. Leary argued that while African American women and men have been excluded from the dominant trauma culture, their suffering is intrinsically tied to the history of slavery and cannot continue to be treated as ahistorical, invisible, or worse, criminalized. Thus, since 1990s women's suffering through trauma has become further removed from the political roots of the feminist movement. Yet this history continues to define what suffering is recognized as trauma for women in contemporary trauma culture; the tradition defines the limits of the cultural clearing of suffering and how women express discontent with the world.

Summary of key events in the normative history of trauma. Four events are mentioned in almost every account of the history of trauma and by any psychologist or psychiatrist who has contributed heavily to the study of traumatology: Freud and Ferenczi's psychoanalytic conceptualizations of trauma, Holocaust studies, PTSD in

Vietnam veterans and feminist psychology's reestablishment of PTSD as a primary diagnosis of sexual assault and incest survivors. The description of these four events was not intended to provide a comprehensive or complete picture of traumatology history (see Appendix A for all conceptualizations) but to focus on a selected few events that are mentioned frequently. It is notable that these events occurred in reaction to developments in technologies, especially those of violence or control, and periods of political upheaval and great human suffering such as the industrial revolution in Europe, World Wars I & II, the atomic bomb, the Holocaust, and the Vietnam War.

In the 1980s, the diagnosis of PTSD that had been associated with industrialism and war was extended to describe chronic abuse of women and children as part of a political movement initiated by second-wave feminists Judith Herman, Laura Brown and other feminist psychologists and psychiatrists. It was also in the 1980s, following the inclusion of PTSD in the *DSM* that the normative history of trauma (Appendix A) was constructed; this history identified the existence of PTSD in historical works and medical diaries perhaps since the beginning of humanity.

Through my review of trauma research, Freud's mention was ubiquitous in this history whereas Ferenczi's is mentioned primarily in psychoanalytic circles. Herman's work has been removed from its ties to social and political movements, including Holocaust studies and the feminist movement, and instead has been subsumed into mainstream trauma theory. The veridical theoretical tenants of Herman's work are now represented in cognitive-behavioral and neurobiological trauma theory (e.g., the NIMH psychoeducational scripts). By the end of the 1990s, a wide range of events had come to constitute trauma (from the holocaust to child abuse to a car crash). The diagnosis had

become associated with legitimate and truthful suffering, as well as with fundamentally shaping and constituting the traumatic self.

Specific Background Information Relevant to Results

The following background sections are germane to the results chapters; they provide the historical, philosophical and theoretical context to some of the taken-for granted assumptions about trauma culture that I identified in my interpretation: the ideal of the functional worker-patient; narcissism as self-maintenance in the 20th century; the fantasy of a return to pre-traumatic innocence; the structure of cult indoctrination; and, the specific uses of trauma as universal and culture-free construct.

Rather than go into depth about the history of these assumptions in the results section, I have provided the background information here. Thus, these sections may appear disconnected from immediate relevance (and each other) but I return to them in the results and discussion sections.

The functional worker-patient ideal: From Foucault to neoliberalism. Paul Lerner (2003) in *Hysterical Men: War, psychiatry and the politics of trauma in Germany, 1890-1930* presented case studies of German veterans from World War I who attempted to claim pension from the government for nervous pains. Lerner described the case of one solider, Franz Müller, who was discharged from the army for "nervous shock." In his final pension review Müller said, "I was a healthy man when I became a solider, and I was discharged a cripple…Had I never been a solider, and never been in the war, I would not have these nervous pains" (p. 224). The medical experts that decided Müller's case challenged his traumatic narrative and pointed to a preexisting medical condition in which he had "insufficiently formed testicles" and "unsatisfactory development of his

secondary sex traits" (p. 224). Müller was seen as a weak neurotic man who was not

masculine enough, and perhaps suffered more like a hysterical woman than a veteran

with nervous shock. The court concluded that "like countless neurotics," the war was not

the cause but an excuse "with which the neurotic once again hopes to fulfill his wish of

escaping the difficulties of daily life" (p. 225). Thus it was fairly common in World War I

for those who suffered from anything like posttraumatic shock to be discounted as weak,

feminine war profiteers that simply didn't have enough stamina to participate in the

demands of everyday life. The court saw the extraordinary conditions of war as somehow

normal, and the normal responses to war as pathological or contrived efforts to escape

work.

Lerner (2003) concluded that German psychiatry in the late 1800s was uniquely

brutal and nationalistic in a way that foreshadowed the Nazi regime. Psychiatry's role

was emphasized in "a broader modernization process, a general tendency of increased

medical control over individual life and the eclipsing of subjectivity in a faceless

administrative modernity" (p. 250). Despite the brutality of this time period, Lerner also

suggested that this history has continued to permeate the medical materialism of trauma

in which mental suffering from war is stigmatized more than physical wounds. He argued

that the functional ideal of the "worker-patient" who contributes to society and continues

to work despite traumatic suffering, is sometimes the still unspoken desire of

contemporary trauma treatment.

The cultural construction of the worker-patient in a time of increasing

industrialization and modernization in Europe was most notably studied by Michel

Foucault. In *History of Madness* (1973)*,* Foucault was critical of any historical gaze that

somehow naturalized the present state of mental pathology, such as that of the idealized worker-patient. In contrast to normative histories of pathology, the *History of Madness* was a history of limits—a description of how a culture rejects something as exterior and thus asserts its values. Foucault analyzed how conceptualizations of madness have shifted over the years in response to systems of institutional exclusion and new modes of social control.

Beginning with the Renaissance era (1440 to 1600), Foucault's (1973) history revealed how madness was once perceived as indicating the boundaries of reason and order. Madness revealed to humanity knowledge about the ordered world and underlying chaos. It played a cultural role to indicate discrepancies between human ideals and practice; this was often interpreted within a Christian framework in Europe in which the mad were seen as channeling a religious experience. While the mad revealed the limits of reason, this was not purely pathological; the mad brought an alternate, albeit sometimes frightening, vision or wisdom about humanity. At this time, mad people were sent out of the cities to live in remote areas or villages.

In the 17th century, madness shifted to be seen as rejecting rather than commenting on reason. Places of confinement for the mad emerged throughout Europe. Foucault (1973) pointed out that these institutions were not medical establishments, but like prisons in which the blasphemous, deviant and unemployed were considered to have consciously chosen to reject truth and reason. Thus the basis for confinement at this time was on ethical and not medical grounds. Over time, as medicine became increasingly under the influence of the new empirical sciences, a transition was made where madness became an object of medical study. The insane were confined and could be manipulated

or observed by doctors in the medical profession. Madness transitioned from moral deviancy to a scientific phenomenon.

By the 19th century, madness had exclusively become an object of medical study. Institutions devoted to its study emerged: insane asylums and psychiatric hospitals. Foucault (1973) described how asylums allowed for the development of the human sciences. The space of cure and of exclusion became paired in social practice to the extent that it seemed almost natural to lock-up the mad in order to cure them. Similarly, psychiatrists, like Philippe Pineal, were later celebrated as philanthropists for freeing the mad when it was the medical profession that led to continued confinement as treatment in the first place.

Foucault (1973, 1987, 1995) observed by 20th century that clinics, hospitals, schools, prisons and factories had become standardized and resembled each other in their shape. Factories were designed after fortresses in which workers were admitted at the sound of a bell and placed into partitioned, individual workstations that were designed for one function. At the end of the day, the workers were released simultaneously by their supervisors at the sound of the bell. Factories concentrated production, reduced distractions (e.g., theft, interruptions, conversations between workers) and separated workers from each other to reduce the potential of an uprising or any other community organizing. Similarly, in schools pupils were separated into classrooms depending on the function of what they needed to learn (e.g., art, history, literature) and within these partitioned groups sometimes further subdivided based on achievement to increase competition. Where previous classroom models allowed for teachers to spend time with each pupil individually depending on what they were learning (the remainder of the class

sitting idle), the new arrangement of the classroom meant the teacher could oversee the class at all times and efficiently teach everyone the same subject. Medical patients were also transferred from their home into a ward with countless others who could then be efficiently administered medicine on the same schedule.

The structuring of social spaces, like the factory, school, and clinic, according to Foucault was designed to "carve out individual segments and established operational links; they mark places and indicate values; they guarantee the obedience of individuals, but also a better economy of time and gesture" (Foucault, 1987, p. 94). Persons within these systems were seen as increasingly similar, pulled to a norm, and in some ways replaceable or expendable; all pupils in the classroom learn the same content, all workers are interchangeable and are prescribed their role by the station at which they work.

Eventually the structure of the capitalist social space became associated with concepts like efficiency and safety to the extent that the arrangements of the factory became common sense for the workplace, hospital and school. Foucault noted how the continuation of these arrangements need not be through top-down enforcement of a managerial time-table and active separation of workers but through appeal to common sense; how else could life be structured? (Foucault, Martin, Gutman, & Hutton, 1988). Thus, Foucault (1987) suggested that the ideal of the functional worker-patient was not just promoted through a mechanism of reproducing and absorbing discourse in a top-down manner (e.g., from the state to the therapist to the patient) but many forms of daily and social life, such as through living in physical spaces that structured social interaction (cf. *dispostif)*.

In addition to living in social spaces, Foucault also described how language is used in social interactions to transform life into something that is amenable to treatment in for-profit structures, like private hospitals and clinics. In *Birth of the Clinic* (1973), Foucault coined the term "clinical gaze" (p. 115) to describe the reification of the human body and disease as an object that can be known and separated from the person and the social world, such that it can be subject to manipulation and utilization. He most often used this term to describe pathologizing human experience by defining sickness as something that could only be treated by doctors in hospitals, and thus transformed life into an economy that maintained the clinic's power structure. He said, "The hospital became viable for private initiative from the moment that sickness, which had come to seek a cure, was turned into a spectacle. Helping ended up by paying, thanks to the virtues of the clinical gaze" (Foucault, 1973, p. 103). Foucault emphasized the role of language and the naming of disorder as a particularly powerful element in how helping is transformed into an economy.

To summarize, in Foucault's (1973, 1987, 1995) interpretation, most mental pathology, including traumatic stress, was a diagnosis of social control. Persons who might otherwise be given help from their community were considered objects of study or medical treatment and excluded from their community and cultural privileges of society. This exclusion occurred in cultural practice through social and spatial isolation in which those who were considered mad were physically separated from their community to receive care in treatment centers under supervised guidelines. Exclusion also occurred through utilization of procedural and instrumental language for disorders and pathology that was adopted in clinics. Foucault described how human experience could be labeled

in a way that made it amenable to manipulation, treatment and financial gain in private clinics and hospitals. He described how practices of social control eventually became institutionalized and applied through a form of self-surveillance in which self-care or -management of mental health came to fit with what is good and is common sense about human being.

Scholars who have followed Foucault and critically analyzed the functional and instrumental culture that gave rise to the worker-patient in psychotherapy from a social constructivist perspective have identified two primary features of this culture: a) the disembedding of social identity from political, local, and moral tradition and context, and b) individuals and communities lives are increasingly governed via technologies and the role of the expert (e.g., Binkley, 2011; Cushman & Gilford, 2000; Layton, 2010, 2013; Rose, N. S., 1989, 2007). Managed care and evidence-based practices today in many ways functions similarly to factories, prisons and schools that Foucault observed, in which patients are seen as modular objects fitting within "care decision trees" or treatment plans to maximize efficiency and reduce costs for health care corporations. Within this framework, traumatic events continue to be transformed from social phenomenon to objects of scientific study that need to be adequately treated/controlled through various medical technologies. Patients have learned to fit themselves neatly within treatment decision trees and modular care by requesting specific medications and self-diagnosing; what it is to be a good healthy human somehow fits naturally within these practices of social control. Through a postmodern lens, the work of trauma therapies has become void of personal, local and historical value and is increasingly

becoming a prescribed, ordered treatment that could be delivered by any practitioner to any patient (e.g., by following a treatment manual).

The contemporary phenomenon of people acting in such a way that they believe it is desirable and good to fit themselves into proscriptive treatments and maximize their health by utilizing technologies and expert advice has been characterized by Nicholas Rose (2006) as a shift to somatic individuality and neurochemical self (described previously on p. 23) and by Binkley (2011) as the cultural ideal of "the enterprising self." Binkley argued that contemporary life is "lived through a dynamic enterprise in which others appear, not as objects of psychological investment toward a relation of mutuality, but as pure resources in an environment of opportunity [the] neoliberal psy[che] disposes the healthy individual to further maximize her or his own emotional potentials through the manipulation of life-elements" (pp. 92-93).[28]

Binkely's description of the enterprising self focused particularly on the role of neoliberal governmentality in everyday psychotherapy practice.[29] One consequence of neoliberal thinking has been what Binkley (2011) called "the marketization of social relations" (p. 92) where reconciliation and public social practice is recast in a negative light as dependency and docility that halt the entrepreneurial spirit of individuals to meet

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[28] Both Binkley (2011) and N. S. Rose (2006)'s description of the enterprising and neurochemical self is reminiscent of Heidegger's (1954) notion of standing reserve, where life and the world are transformed into instrumental resources, and of Foucault's (1975) description of the clinical gaze, which I present at the end of this section.
[29] Economist John Williamson defined neoliberalism as moving control of the economy from the public sector and government to the private sector and corporations (Williamson, 1990). Neoliberal theory supports free market capitalism where the private market determines value rather than a collective group, publically elected government or regulatory oversight system [cf. Adam Smith's (1777) concept of the invisible hand of supply and demand]. In neoliberal culture responsibility for social well-being has been removed by the state and replaced with private resources or not replaced at all (Fine, 2007).

their potential optimal production in the system. To be considered functional within a neoliberal capitalist system one must contribute works of value to the system; failure to survive in the system is a threat to life and survival. Thus, in neoliberal theory, there is emphasis on individual choices and works as being related to success or failure. If someone is not happy, is impoverished, is starving or suffering, the theory would suggest that this is ultimately due to an individual failing in neoliberal functionality (e.g., they should get control of their life, return to work, etc.). Personal needs are sent to the marketplace and to the family (and particularly the dyad) rather than understood within the public sphere.

Michelle Fine (2012) has written extensively on the topic of privilege, exclusion and inclusion within neoliberal society as it pertains to mental health diagnoses and research. Critics of neoliberalism, like Fine, have pointed out how neoliberal policies have deliberately created substantial inequality in the U.S. through anti-unionism, anti-inflation and profiteering in the health industry. Fine wrote about the discursive psychological orientation toward privatization, punishment and scientific scrutiny in which public concerns are recast as private troubles, individual choices, the home and family. This point has also been elaborated by Lynne Layton (2010, 2013) who argued that therapists might unconsciously collude in sustaining neoliberal practice by favoring performance and achievement over comfort with dependence or "favor a kind of care of the self that disregards care for the collective good" (Layton, 2013, p. 78). Layton (2013) suggested that therapists should be normalizing social dependency rather than crafting therapy to create a human that seems to function happily regardless of their social context.

The phenomenon of a therapy that takes for granted the ideal of a functional enterprising self, disconnected from all social ties, was described by Nikolas Rose (1989) as a form of psychology that "obliges us to be free." The needs of the welfare state (i.e., the return to being a productive worker) have become represented by experts (in this case therapists) through their appeal to the enterprising spirit of individuals. Rose reminded us that the discourse of freedom through producing capitalist social goods with vigor can be contextualized as stemming from the needs of those who benefit from neoliberal social arrangements, like private insurance companies; yet, when therapists reproduce this discourse (e.g., by literally reading from a therapy manual that contains neoliberal values) the therapy reflects and reproduces these conservative political arrangements. Though this process the therapists and patients are invited to believe that neoliberal ideals are their individual values (cf. Foucault, 1987). Rose stated "Individuals are to become, as it were, entrepreneurs of themselves, shaping their own lives through the choices they make among the forms of life available to them" (Rose, N. S., 1989, p. 230).

Narcissism as self-maintenance in the 20th century. Cushman (1995) described how the ideals of early modern Enlightenment philosophers were heavily embodied by contemporary U.S. society at turn of the century—a society that was characterized by "an extreme expression in the unrelieved individualism, pragmatism, and communal isolation of the bourgeois American" (p. 63). He suggested that the loss of tradition, religious certainty, and the effects of industrialization and spread of capitalist business created a sense of vulnerability, alienation, and uncertainty that foreshadowed the societal embodiment of the post-World War II "empty self." The term self in this context refers to the hermeneutic concept of a shared understanding of what it means to be human.

Cushman (1990) described the empty self as one that experiences absences in the loss of community and tradition in an interior and cognitive way, as a lack of personal worth or conviction. The empty self strives to compensate for what has been lost politically (i.e., as a consequence of World War II) by consuming products, goods, advertising and therapy.

The early twentieth century was dominated by the sociohistorical phenomenon of the therapeutic ethos and mental hygiene movement where one could focus on improving oneself to overcome any social problem. The concerning consequence of such a movement was that personal well-being was the desirable end rather than the outcome of striving for public good (cf. Reiff, 1966). Cushman (1995) noted how the cultural shift to the empty self was reflected in advice manuals where "personal magnetism replaced craftsmanship; technique replaced moral integrity" (p. 65). Cushman suggested that the focus on solving public problems through self-care, maintenance and the development of personality that characterized early twentieth century self was similar to the psychological description of narcissism. In the results and discussion chapters, I discuss a similar point about the contemporary cultural terrain as narcissistic and self-focused, and thus in this section I have reviewed characterizations of narcissism.

McWilliams and Leppendorf (1990) reviewed major psychoanalytic theories on narcissism from 1900 through the 1980s (e.g., Ferenczi's identification of childhood grandiosity, Freud's (1914) identification of narcissism as both structural character pathology and residue of childhood grandiosity, Reich's (1933) "phallic narcissistic character" and so forth); they concluded that narcissism can take many forms but all conceptualizations have in common the effort to self-aggrandize. In particular,

McWilliams and Leppendorf discussed the early 1980s as a peak of cultural narcissism. This was when analysts had high enthusiasm for Kohut (1971, 1984, 2009) and Alice Miller's (1981) *Prisoners of Childhood* became a cult classic.

Features of narcissism that McWilliams and Leppendorf (1990) described in the article included "the illusion of self-sufficiency" (cf. Modell, 1975) or the disposition to not need others; discomfort in admitting mistakes and failures; emphasis on a grandiose self that is without need and without sin; the ideal of constant internal self-cohesiveness; and need for constant self-approval. In relationships, the focus is on the repair of the narcissist's inner self-concept and the maintenance of the illusion of perfection rather than a focus on mending relationships with other people and the external world. According to Stolorow (1975), any mental activity can be narcissistic when "its function is to maintain the structural cohesiveness, temporal stability and positive affective colouring of the self-representation" (p. 179).

Stolorow (1975) described how psychoanalytic theories on narcissism moved away from economic and drive explanations that were popular in the early 1900s to functional explanations by the 1950s. Rather than discussing narcissism as a flow of instinctual energy, psychoanalysts in the mid-20th century began to focus on how mental activities interact with or serve the id, ego and superego forces in personality. This movement in psychoanalysis to functional explanations of narcissism was part of the same cultural shift to the empty self that Cushman (1995) described. Functional psychoanalytic theories reflected the idea of an empty narcissistic self that used or consumed the world and other people (i.e., narcissistic objects) to defend against fragility and maintain self-cohesiveness.

Stolorow (1975) reviewed functional understandings of narcissism since the 1970s and pointed out that many analysts (e.g., Arlow & Brenner, 1964; Freeman, 1964; Eisnitz, 1969) have described how narcissism functions as a retreat from dreaded object relations and instinctual conflicts. Stolorow credited Reich (1953,1960) with being the first to clearly articulate the primary function of narcissism was maintenance of self-representation. Reich described how narcissistic patterns of self-inflation and craving attention served to repair damage done to self-representation by early traumatic experiences. These experiences are often the result of hateful, ignorant, disregarding or abusive relationships with a self-focused or uncompassionate primary caregiver; analysts sometimes describe the lack of regard and care in early relationships as creating a narcissistic wound, scar, or injury.

Others who drew from Reich (Arlow & Brenner, 1964, Kernberg, 1970) described clinical examples of patients who utilized both literal and social mirrors (i.e., dependent relationships that provided constant reassurance) in order to restore a sense of lost identity. Kohut (1971) described this pattern in detail and suggested that the narcissistic object was a substitute for self-esteem.

While narcissism has come to be understood as intensive self-focus in efforts to maintain a cohesive image or sense of identity, this is not always expressed as overt grandiosity. For example, analysts have described more subtle forms of narcissism in relationships, such as the rejection of compliments (e.g., the grandiose as a secret-self; cf. Horner, 1979) and masochistic acts. Stolorow (1975) wrote specifically about the narcissistic function of masochism as an unconscious omnipotent fantasy. In this fantasy, hurting oneself in a variety of ways (e.g., through self-sabotage, martyrdom or through

creating situations that elicit psychic or physical pain) can be a form of intense control and manipulation over the narcissist's fragile sense of self. Stolorow argued that the narcissistic masochistic pain may actually create a bounded or organized sense of self that the narcissist lacks—a momentary sense of being more alive and real. This kind of controlled masochistic pain may be more preferable to the pain of unpredictable and actual intimacy in relationships—intimacy that may leave the narcissist vulnerable and defensive in fear of reinjuring the narcissistic wound.

Stolorow (1975) noted that other analysts (e.g. Berliner, 1947, 1958) have discussed how narcissists can develop a masochistic character in order to retain an idealized image of their primary caregiver or parent as all good. In this scenario, self-destruction is preferable to recognizing the destruction that occurred because of the parent; it is better to defend against acknowledging the parent as actually abusive or hostile by assuming that the narcissist was control of and responsible for their disorganized and hateful sense of self. By producing failure after failure and provoking defeat, isolation and humiliation, the narcissist may eventually experience "the illusion of magical control and triumphant power over his object world" (p. 445). Thus acts of narcissistic masochism assume that the cause of both good and harmful things in the narcissists life are not due to other people or the social world, but are ultimately the product of individual actions and completely within the scope of a controlled, interior self.

When considering how narcissism may be expressed characters in therapy, McWilliams and Leppendorf (1990) described how narcissists (as patients or therapists) may approach therapy "with the corrupt premise that the point of attaining insight is to

perfect the self rather than to learn about it, accept it, and direct it" (p. 17). A narcissistic

therapy would focus on self-perfection and omnipotent control of one's social world

through self-focused or internal manipulations (e.g., responding to a social problems by

changing ones thoughts about the problem rather than talking with others about the

problem or building social relationships). I will return to discuss this concept in the

context of trauma treatment manuals in the results section.

The popularization of narcissistic therapies (i.e., those that assume the patients has

a damaged or fragile sense of self that must reach a state of self-perfection through

internal maintenance and consumption of products) and pervasive consumerist culture

that seemingly reached a peak in the U.S. by the 1980s foreshadowed the movement to

another way of being in the early 21st century, which Cushman (1995) has described as

the multiple self. The multiple self is characterized by a,

> propensity to gather about itself a number of identities that are located around the
> outside of the person, external to but identified with the individual, although this
> identification takes on a different, less essential, or intense valance than
> identifications within a deep self. This is an exterior self with less complex or
> conflicted identities to draw from — identities that cluster on, not inside, the
> individual, decorating and standing ready to appear on center stage when the need
> arises. (Cushman 1995, p. 3)

By the 21st century, the desire to fill the empty self with a deep, cohesive and

consistent identity waned. Though consumerist culture and neoliberal ideals continued to

pervade everyday life, consumption of identity took a different form in which the ideal of

self-cohesion was replaced with the ideal of multiple identities that could be selectively

employed when needed and were ready to adapt to and function in any situation. I raise

this point about the 21st century multiple self in the context of a review of narcissism

only to point out that narcissistic expressions can shift as the culturally constructed ways

of human being change. Thus narcissists expression of self-focus, aggrandizement and

understandings of human perfection as well as how the narcissist defends against forming intimate relationships and expressing vulnerability are dependent not only on the fracturing of a primary relationship or a weakened internal self-concept but the cultural clearing (cf. Heidegger, 1996) of what it means to be human.

The fantasy of a return to pre-traumatic innocence: A brief history of the child as innocent pre-world war II (pre-1939). This section provides some background into early conceptualizations of the child as innocent that predate the post-World War II (WWII) interest in child development. Beginning in World War I and after WWII the majority of child developmental theories that are still discussed today were published (e.g., Anna Freud's ego psychology and child developmental stages [1945/1969], Spitz's developmental research [1945/1965], Bowlby's attachment theory [1951], Lewin's oral triad [1950], Melanie Klein's developmental stages [1945/1989] and analytic play therapy [1955], and Erikson's life cycle model [1959/1980]). I have focused on pre-WWII conceptualizations of the child as innocent because these theories present some of the essential context for the societal wish to return children to a state of pre-traumatic innocence—an assumption that is present in many of the post-World War II theories.

David Archard (2004), professor of philosophy and public policy at Lancaster University, has identified the concept of child innocence as rooted in the Christian ideal in which children are closer to God because they only arrived recently in the world; adults are correlatively furthest from God and are closest to Nature and Society. Within Christian theology, innocence is understood on moral terms as goodness or without fault or sin; thus, trauma can be understood as a fall from innocence, tainting, or sin. Archard quoted several biblical passages that referenced a return to a childlike state, such as to

enter to Heaven once must become "as little children" (Matthew 18:3, English Standard

Version). Being without fault or sin also implies ignorance to wrongdoing. Archard

pointed out the empty vessel concept of the child is akin to Locke's *tabula rasa* and said,

"The innocence of the child is, in an important sense, an empty one" (p. 46).

Archard contrasted the Hebrew Bible's vision of the child slowly becoming

corrupted to the Christian understanding of the child born with original sin. In the

seventeenth and eighteenth century Puritanism and Calvinism thought the child was

predisposed to sin and only rigid discipline could correct child. The Proverbs read, "The

rod and reproof gives wisdom; but a child left to himself bringeth his mother to shame"

(Proverbs, 29:15, English Standard Version in Archard, 2004, p. 46). The dialectic

between child as originally sinful or innocent has also been reflected throughout literature

and theory. Archard pointed to Rousseau's *Emile* which begins with the quote

"Everything is good as it leaves the hands of the Author of things; everything degenerates

in the hands of man" (p. 46). Rousseau's work describes the child as born good and then

corrupted by human society.

The pull between needing to correct the child and the child being pure is also

reflected in the writings of rationalists like Descartes. He wrote about the fetus in the

womb:

> it seems most reasonable to think that a mind newly united to an infants body is
> wholly occupied in perceiving or feeling the ideas of pain, pleasure, heat cold and
> other similar ideas which arise from its union and intermingling with the body.
> Nonetheless, it has itself the ideas of God, itself, and all such truths are as called
> self-evident, in the same way as adult humans have when they are not attending to
> them; it does not acquire these ideas later on, as it grows older. (Matthews, 1994,
> p. 24)

Descartes's innatist belief that children are born with all knowledge, and particularly the moral knowledge and knowledge of Goodness and Sin, can be contrasted with the experientialism of Locke, who wrote:

> Let us suppose the mind to be, as we say, white paper, void of all characters, without any ideas:—How comes it to be furnished? Whence comes it by the vast store which the busy and foundless fancy of pan has painted on it with an almost endless variety? Whence has it all the *materials* of reason and knowledge? To this I answer, in one word, from EXPERIENCE. (Matthews, 1994, p. 24)

In psychoanalytic conceptualizations of children, meeting of the demands of each developmental stage somehow determined the structure of the child's personality and pathology (e.g., Freud's psychosexual development from the oral, anal, phallic, latent and genital, Klein's stages from the paranoid-schizoid to depressive, Oedipal and object related). Charcot and Janet's studies into hysteria and neurosis in the late 1800s posited that a traumatic factor from the external environment early in life could split the personality and lead to the instantiation of a traumatic kernel (e.g., the *idées fixes*) that led to hysteria (see pp. 54-55 in this study). Freud's seduction hypothesis introduced the idea that traumatic events in the outside world, in particular parental abuse and incest, could mark the child's psyche and lead to hysteria. While Freud abandon this hypothesis, concerned that the abuse reported by his patients was primarily fantasy, in the 1930s Ferenczi revived interest in sexual trauma in his paper "Confusion of Tongues". He argued that familial abuse and violence against the child was a common and real event that led to traumatic neurosis (see pp. 60-65 in this study).

While there are many nuances between their conceptualizations of childhood in Ferenczi's and Sigmund and Anna Freud's conceptual framework of child development all of their work emphasized the unformulated and at times undefended nature of the child psyche that allowed the trauma, such as the parents guilt about sexual abuse, to

become more easily introjected. Ferenczi's (1988) conceptualization in particular emphasized how the child's "personality was not completely consolidated" such that they were "completely oblivious of themselves" (p. 201) during the traumatic event to the point where identification with the perpetrator of the abuse became the only defense against the instability of trauma (e.g., knowing the abuser in this way allowed the child to alleviate the overwhelming anxiety brought on by the abuse). While I cannot do justice to a full review of psychoanalytic conceptualizations of childhood and their variations in this section, overall, children were seen in psychoanalysis as being more innocent in terms of having a more unformulated, pure, vulnerable psyche.

By the 20th century there were several theoretical models about what children came into the world with and what they learned. These theories could be roughly divided along innatist (Descartes, Christian tradition) and experientialist (Locke) lines and almost all theories had a staged model of child development; trauma was seen as changing the structure of personality or halting the child in a particular stage of development.

A third primary conceptualization of child development that emerged in the early 20th century was the recapitulation model. This model was captured by the slogan "Ontogeny recapitulates phylogeny" (cf. Haeckel and Darwin) and described the child as repeating the entire history of humanity in their development. Some scholars have noted that this theory is philosophically rooted in an Aristotelian conception of childhood that suggests four types of causality with the Final Cause of a living organism is that it only performs normally when it reaches maturity (Matthews, 1994).

In U.S. psychology, recapitulation models are most often associated with G. Stanley Hall's work: *Adolescence: Its Psychology and Its Relations to Physiology,*

Anthropology, Sociology, Sex, Crime and Religion (1916). G. Stanley Hall's writings characterized pre-adolescent children as savages that needed to learn to fear God and only with strict discipline could they mature into adults. (G. Stanley Hall later supported his research on eugenics and advocacy of selective breeding and forced sterilization using this same theory.) In 1946, recapitulation theory was brought into the mainstream by Dr. Spock who wrote in *Baby and Child Care,* which for 52 years was the best selling book second to the Bible (Brody, 1998). He wrote,

> Each child as he develops is retracting the whole history of mankind, physically and spiritually, step by step. A baby starts off in the womb as a single tiny cell, just the way the first living thing appeared in the ocean. Weeks later, as he lies in the amniotic fluid in the womb, he has gills like a fish. Toward the end of his first year of life, when he learns to clamber to his feet, he is celebrating that period millions of years ago when man's ancestors got up off of all fours. (Spock, 1946 as cited in Matthews, 1994, p. 30)

When reviewing the history of pre-traumatic childhood innocence in psychology, the philosophical traditions of innatism, experientialism, and the recapitulation model, are present in most 20th century psychological theories on development. Experientialism is perhaps best reflected in behaviorist theories in which the internal world is dependent upon and entirely shaped by the environment and experiences in the world. This is in contrast to innatism that is reflected in the early writings of Piaget (1933) and theories on language development that gained popularity in the past thirty years (e.g., Noam Chomsky's and Steven Pinker's language acquisition models).

The structure of cults and cult indoctrination. Cults are a group of people who worship a specific deity, leader or theory and dogmatically follow a doctrine. Cults include the following three major characteristics: a) a cult leader that is persuasive, charismatic, and domineering that centers veneration on themselves, b) an authoritarian

structure, that is seen as innovative and exclusive with a double-set of ethics (e.g., be open and honest to leaders but not to non-group members), and c) the practice of controlling members behaviors and worldview in a totalistic or all encompassing manner (M. T. Singer, 1995).

Hochman (1990), in his study of cults since the 1960s, described several common themes that cults possess: cults don't want to be identified or known as such, they do not want their inner workings exposed and may employ consultants and agencies to maintain their image, and they are uninterested in altruism as a moral imperative (although pseudo-altruistic activity helps image building). He described cults as interested in extracting wealth and power from its members through financial gain, and through devotion of all aspects of life and relationships (work, school, romantic) to the cult.

Cults use behavioral and ideological control via group confrontation, physical punishment or threatened expulsion, and limitation of opportunities (e.g., sleep, food, recreation and pursing individual interests) to control their members. The primary technique of ideological control and indoctrination is called "thought reform;" this is also known as brainwashing[30] or mind control in popular culture. Thought reform broadly includes a range of psychological techniques to change thinking and force an acceptance the ideas of the cult or organization (West, 1993). Thought reform is a hyper-efficient form of indoctrination that can only be achieved when secrecy impairs the indoctrinees' awareness of what is happening to them (M. T. Singer, 1995). West (1993) has suggested that the term thought reform can be used to suggest both forms coercive mental torture (e.g., forced procedures to give up basic political, social and religious beliefs), as well as

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[30] The term brainwashing was coined by a journalist who wrote about non-violent forms of Communist indoctrination of Moa Tse-Tung in China (Lifton, 1989).

seemingly benign procedures such as introducing persuasive propaganda into an environment. The term thought reform has been extended in the literature to include any procedure to induce compliant behaviors in dominated individuals that include non-violent group-based methods to change political and social views.

The primary scholars that are credited with establishing the study of cult structure and thought reform in psychology and psychiatry include Robert Lifton (1989) and his study on Maoist brainwashing following the Chinese Civil war, and Mikhael Heller (1988) and his study on mass indoctrination in Soviet Russia. Both of these scholars initially conducted ethnographies of totalitarian Communist and Socialist governments post-World War II. Although these ethnographies were context-specific, both Lifton and Heller identified social psychological principles of mass psychology, indoctrination, and thought-form that led to the development of a general model of cults as a broad social phenomenon. Other notable studies on thought reform have included Schein, Schneier, and Barker's (1961) studies of coercive persuasion, O'Neill and Demos (1977) identification of stages of indoctrination, M. T. Singer's (1995) studies on systemic manipulation of psychological and social influence, and Cushman's (1986) studies on indoctrination in restrictive groups and mass marathon psychology trainings.

Lifton's study of thought reform. Most scholars studying cults, totalitarianism, and indoctrination over the past twenty years have cited Lifton's (1951/1989) important study of reeducation camps in post-revolutionary China. Lifton described a set of behavioral techniques used to indoctrinate European civilians (e.g., missionaries, businessmen, journalists) in prisons known as reform camps and to indoctrinate Chinese intellectuals in universities that were known as revolutionary colleges. The European

civilians had been identified by police as espousing anti-Communist views and were often arrested after entering the country. Lifton interviewed 25 different European and 15 Chinese participants about their experiences in the prisons and universities that were designed to convert the prisoners to the beliefs of Mao Tse Tung's Communist practice. Lifton worked with an interpreter for the majority (11 participants) of the interviews with the Chinese intellectuals.

A critical component of thought reform was the creation of an identity crisis that could only be resolved by accepting the ideology of the group. Lifton (1989) called this the "assault upon identity" and described how the European civilians each "felt his sense of self become amorphous and impotent" (p. 45) as they progressed through stages of thought-reform. Lifton referred a set of behavioral techniques that were used to create this identity crisis, which he called thought reform milieu techniques. Lifton pointed that although he viewed the prison camps and colleges utilization of thought reform as coercive, the Chinese Communists who ran these organizations viewed their actions as "morally uplifting, harmonizing and scientifically therapeutic experiences" (p. 27).

Through his interviews, Lifton (1989) identified the following types of thought-reform techniques:

- *Milieu control:* Taking over the entire group or milieu through manipulation and control of their bodies and environment, including but not limited to controlling food, rest, schedule and communication;

- *Mystical manipulation:* Provoking a specific behavior from an individual in the group, framing it to look spontaneous, and explaining the behavior as a universal truth and infallibility of the organization;

- *The demand for purity:* Creating an idealized or perfect model to strive for in such a way that the members never feel satisfied or competent and thus increase reliance on the group leader and the official ideology to guide the members;

- *The cult of confession:* Public humiliation to degrade and make the prisoners subservient and compliant;

- *The sacred science:* The organization's ideology is said to embody a universal truth that comes from a source that transcends humankind; Questioning, doubting or disagreeing with this ideology is prohibited or seen as an indication of a personality flaw;

- *Loading the language:* Speaking in "thought-terminating clichés"; the new language serves to create intellectual confusion, maintain group cohesiveness and keep outsiders from making meaningful contact with the group;

- *Doctrine over person:* The organization respects and values its doctrine and objectives more than individuals. This can lead to situations where the brutalization of the individual is condoned or even encouraged (e.g., an individual's suffering may be attributed to misapplication or doubting of the group's doctrine); and,

- *The dispensing of existence*: Simulating fear of extinction such that deviating from training or attempting to leave the training suggests a life-or-death scenario in which they are likely to die. Being allowed to stay in

the training and receive approval from leaders for adhering to the guidelines is thus highly desired.

Through subjugation to these thought reform techniques, Lifton (1989) observed the indoctrinees go through discreet phases of identity crisis beginning with rejection and ending with identification with the group. O'Neill and Demos (1977) have labeled these stages as: resistance, non-cognitive reform, ideological action, and ritualization of ideology. In the first stage, resistance, the prisoners responded to thought reform techniques by attempting to assert their previously established views and beliefs. In the second phase, the leaders engaged in thought reform techniques to undermine existing beliefs and create an identity crisis that could only be resolved by group membership and eventually the giving up of individual beliefs for the group doctrine. In the third, ideological action phase, the indoctrinees were placed in situations in which they were encouraged to respond according to the group doctrine before acting and to reflect on the significance of their behavior. In the final, fourth phase of ritualization of ideology, the indoctrinees come to comprehend why dissent from the group doctrine was restricted and they have developed patterns of automatic thinking and behaving that are consistent with the ideology of the group (e.g., using group-specific language to respond to resistance without providing support from the group-doctrine; similar to Lifton's "thought-terminating language"). By the end of indoctrination, Lifton described how the prisoners had gone through an "agonizing drama of death and rebirth." (p. 42).

Heller's triangle of thought reform. Though a study of Soviet Russia, Heller (1988) proposed a model called the triangle or triad of thought reform that included three elements: miracle (in the ideology, miraculous powers attributed to leaders or the

activities of the cult), mystery (obscuring actual beliefs and practices), and authority

(claims on members time, talents, bodies, or property to meet group needs). In Soviet

Russia, Heller described the miracle as creation of a New Man (*homo sovieticus*) based

on the "science" of Marxism-Leninism, the secrecy involved under reporting or hiding

significant news and limiting access to knowledge that would threaten the power, and

authority through sealing off borders and destroying competing political and religious

ideologies.

Singer's studies on conditions for thought reform. Margaret T. Singer's (1995)

studies on systemic manipulation of identity also described conditions that needed to be

present for thought reform to occur. The goals of thought reform included:

1. To destabilize a person's sense of self;

2. To get the recruit to radically alter his or her worldview, version of reality, and reinterpret life; and,

3. To develop dependence on the organization.

For these goals to be met the organization must retain the following conditions,

which are similar to those identified by Heller (1988) and Lifton (1989) :

1. Keep the recruit unaware of what is going on;

2. Control the person's time, and if possible, physical environment;

3. Create a sense of powerlessness, covert fear and dependence;

4. Suppress old, pre-indoctrination behaviors and attitudes;

5. Instill new behaviors and attitudes; and,

6. Put forth a closed system of logic that does not allow input or criticism.

Studies on thought-reform in the military. Some scholars have described the

process of military socialization as a coming of age ceremony that resembles the first

phases of cult indoctrination described by Lifton (1989), Cushman (1986, 1989) and

O'Neill and Demos (1977): creation of an identity crisis that can only be resolved

through group identification. In the post-Vietnam era, and Dobrofsky (1978) wrote about

how the military is designed to re-capitulate the lifecycle where boys enter as a skinned-

head recruit, attend warrior initiation, and for some, leave the military as men—badged

and rewarded in retirement. Arkin and Dobrofsky identified phases of ritual socialization

military recruitment (e.g., enticing youth with the promises of becoming mature and

masculine, living-out fantasies of war movies, and post-war wealth) and basic training

(e.g., physically and mentally shaping future soldiers into cogs of the military machine,

bonding through survival situations, and creating a dynamic of group loyalty such that

peer misconduct is not reported). Many activities in basic training are designed such that

individual action and thinking in response to the problems presented results in failure or

punishment for the entire platoon. Thus an environment is developed in which the

recruits preexisting beliefs and culture is associated with shame and punishment, and

group conformity is rewarded.[31] Arkin and Dobrofsky's thesis was that for soldiers

between the ages of 17 and 20, a time period often seen as the transition between

adolescence and adulthood, the military creates an environment for formation of a

masculine military identity that is so powerful that soldiers are unable to give up this

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[31] Arkin and Dobrofsky (1978) identified three masculine coming-of-age archetypes that
emerged during each phase of military socialization: the heterosexual female archetype
which is to be dominated and conquered as a part of war, the team archetype in which
failing is letting down your friends and compatriots, and the family archetype in which
soldiers are prepared for ongoing separation from loved ones.

identity during the transition back to life at home. This leads to many of the problems that have now been identified as symptoms of PTSD (e.g., avoidance of relationships, anger, replaying military events).

Arkin and Dobrofsky's suggestion that the difficulties soldiers have when leaving the military identity are similar to PTSD was shared by many scholars (all writing around the same time PTSD was added to the *DSM*) who identified this same trend for persons who leave totalist cults or restrictive groups (e.g., Clark, 1979; Cushman, 1986, 1989; Etemad, 1978; Galper, 1982; Goldberg & Goldberg, 1982; Langone, 1990, M. T. Singer, 1978). West (1993) summarized the psychiatric sequelae leaving a cult as: a) sudden, drastic alteration of victim's value system; b) reduction in cognitive flexibility and adaptability, c) narrowing, blunting or distortion of affect; d) psychological regression; e) physical changes (e.g., mask-like facial expression, weight loss), f) psychopathological changes like dissociative symptoms, obsessive ruminations, delusional thinking and hallucinations.

Though scholars have challenged conceptualizing the military as a cult because of its transparency about its techniques (see Hochman, 1990), West (1993) points out that many laws and codes of ethics overtly accept the vulnerability of people to intimidation and deception; thus allowing cults to continue. A question remains if all aspects of cult thought-reform exist in an organization but the organization makes transparent that many of these experiences will occur, does this exempt the organization or group from consideration as a cult? West's (1993) point was that questions like these are often central in court cases about cult victimization, but such questions are rarely asked by therapists

and other health-professionals who are involved in the support of the cult-like organization (p. 14).

In sum, research on thought reform and cult indoctrination described techniques of manipulating physical and social environments to create intense group dependency and adherence to the doctrine of the cult. The literature outlined similar processes and conditions that occurred across cults in the 1970s as well as in totalitarian governments across the globe. All of the models of thought reform described techniques, stages, and necessary conditions for persons to give up their beliefs and sense of self in favor of a group doctrine and identity. Scholars have recognized that many of these phases are present in military organizations.

Trauma as universal and culture free. The theme of trauma as universal and culture free has been identified by critical postmodern scholars as existing in psychology and trauma-culture broadly. Fassin and Rechtman (2009) argued that trauma's universality has taken shape in two forms in the psi disciplines: through considering all people as traumatized and labeling all events as "traumas." The universalization of trauma was one way that Fassin and Rechtman (2009) have identified that those in the psi disciplines have "made use of" the category of trauma, through appropriation and reformulation for various strategic purposes (p. 12). Fassin and Rechtman pointed out the problem of considering all historical traumatic events regardless of how different the context and level of atrocity as being universal or having roots in a similar social dysfunction. The outcome of universalizing trauma is its trivialization, Fassin and Rechtman explained, "In these models, every society and every individual suffers the

traumatic experience of their past. Not only do scales of violence disappear, but their history is erased" (p. 19).

Despite the seeming universality of trauma, critical scholars have noted that certain genders, classes and races have been excluded from the humanity of trauma. While Herman and others ensured this would not be the case for women in the 1980s, now the suffering of middle-class white women has arguably become exclusively recognized as trauma (Haaken, 1995; Leary, 2005; Tolleson, personal communication, October 17, 2013). Despite being identified as the most likely to meet PTSD diagnosis, African-Americans, Latinos and American Indians are also more often seen as being unengaged or un-amenable to treatment following a traumatic event and are more often considered to be criminals rather than seen as trauma victims (Fine, 2012; Gone, 2007, 2009; Leary, 2005). Those who are considered to have the highest cumulative trauma burden and PTSD severity are also the least likely to complete evidence based PTSD treatments such as trauma-focused CBT (Trusz et al., 2011).

As mentioned previously in The PTSD Epidemic section of this study (pp. 23 – 32), one racial group particularly at risk for PTSD in the U.S. has been identified as American Indians and Alaskan Natives (AI/ANs). Despite high rates of PTSD being identified, AI/ANs are the least likely to receive services for PTSD (Gone, 2007). Gone (2007) suggests that this is true for the AI/AN population because AI/AN persons do not seek mental health services within a clinic setting; perhaps they would not be interested in bringing their child in for twelve sessions of clinic based TF-CBT with a therapist that is not from their community.

While some psychologists promote modification or cultural tailoring of EST for different cultures (cf. Derald Sue), Gone (2007) suggested that top-down approaches where preexisting therapies are modified are ultimately less acceptable to the AI/AN population and less effective than descriptive, bottom-up therapies where local cultural practices for healing are identified and evaluated by community psychologists. Rather than exporting Western mental health care, Gone (2009) recommended local methods healing be identified and supported within the community.[32]

According to Gone (2007), clinics are seen as a form of Western medical care that is complicit in the neo-colonial endeavors of Western cultural proselytization. Where mental health professionals see their jobs as "community outreach," "helping" or reducing "mental health disparities" by bringing evidence-supported mental health treatments to native communities, this is viewed by many AI/AN community members as

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[32] Gone categorized this form of community psychology as a community-based participatory research method. Gone (2009) attempted to identify healing practices used by AI/AN peoples in the treatment of historical trauma. The discursive primary treatment agenda Gone suggested was to politicize and historicize the symptoms of trauma and to reframe personal problems and social pathologies within the history of colonialism. While Gone did not dispute that AI/AN communities are at greater risk of exposure to trauma and subsequent diagnosis of PTSD, he reframed traumatic symptoms as an intergenerational accumulation of mental health problems as a result of colonial subjugation including systematic ethnic genocide and coercive cultural assimilation through government-administered and church-run schools. While many of the symptoms of historical trauma are similar to PTSD, Gone identified PTSD as a "soul wound" inflicted through the experiences of colonization (Gone, 2009, p. 752). Additional symptoms included: holding an emotional burden, experience of loss of culture and ancestral land, and dreams in which colonization is re-experienced (Brasfield, 2001). In his suggested treatment model, therapists provide psychoeducation about historical trauma that highlighted systemic factors (e.g., coercive assimilation) and interpersonal factors (e.g., maladaptive coping) with the goal of identifying shared community vulnerabilities (e.g., suppression of Native way of life) as being more problematic than individual deficits (e.g., impulse control). The aim of treatment is to reduce beliefs that symptoms were due to ahistorical personal failure or individual vulnerability rather than historical oppression.

ongoing cultural eradication. Gone (2007) described how the AI/AN ways of knowing

are fundamentally different and in fact incommensurate with scientific epistemologies

that underlie evidence-based trauma treatment, like those represented in the TF-CBT

manual. A way of being for the AI/AN people was destroyed through colonization under

the banner of bringing "civilization" to the native peoples. Techniques like thought-

replacement and psychoeducation through clinic-based psychotherapies may remind

AI/AN persons of or indeed be a modern form of this colonization.[33]

In recent cases of international natural disaster this trend of exclusion from

trauma-culture does not hold. It becomes a national or international mission, regardless of

the race or ethnic background of those affected, to ensure that PTSD does not spread; this

is even the case when mainstream Western conceptualizations of PTSD and trauma

treatment are not recognized by the culture (i.e., they have no language for trauma or

stress; see discussion in Bracken et al., 1995) or are blatantly rejected by a community

(Fassin & Rechtman, 2009; Gone, 2007, 2009; Watters, 2011). Many psychologists in the

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[33] In an interview with tribal elder Travelling Thunder, Gone asked under what conditions
would he refer one of his people to the Indian Health Service mental health center,
managed by the government. Travelling Thunder responded:

> You know, we don't do that. We never did do that… I guess it's like a war, but
> they're not using bullets anymore. They're using sophisticated modern
> technology… [It's] like ethnic cleansing, I guess you could say. They want to
> wipe us out. Wipe the Indian reservations out so they could join the melting pot of
> the modern white society. And therefore the Indian problem will be gone forever.
> That's the way they want [it], and I think they're still doing that. But they're using
> a more shrewder [sic] way than the old style of bullets. […] And I guess a lot of
> people… want to end up looking good to the Whiteman, I guess. Then it'd be a
> good thing to do: go to white psychiatrists, you know, in the Indian Health
> Service and say, 'Well, go ahead and rid me of my history, my past, and
> brainwash me forever so I can be like a Whiteman.' (p. 40)

field of multicultural psychology have decried the exportation of evidence-supported treatments as a form of modern colonialism (Bracken et al., 1995; Gone, 2007; Smith, 1999; Watters, 2011). As medical anthropologist Allan Young reflected, "PTSD has displaced hunger as the first thing the Western general public thinks about when a war or other emergency is in the news. We were spreading these ideas around the globe so effectively that PTSD was becoming the way the entire world conceived of psychological trauma. The spread of the PTSD diagnosis to every corner of the world may, in the end, be the greatest success story of globalization" (Young, as cited in Watters, 2011, p. 71).

Statement of the Problem

In the last quarter of the 20th century, the psychological concept of trauma grew enormously in acceptance and in fact became omnipresent in U.S. society. Concurrently, the most utilized psychotherapy treatments have become thought of as unquestioned, quasi-medical interventions automatically prescribed for those who fall under the definition of trauma victim; and yet, scholars who draw from the Interpretive Turn warn against accepting any social practice without historically situating it, exposing it to ideology critique, and examining its implicit moral prescriptions about how humans should comport themselves. Although there has been much mainstream, quantitative psychological research performed on the efficacy and effectiveness of popular trauma treatments, there has been a relative absence of critical, hermeneutic studies about the understandings of the good, the prescriptive and proscriptive elements implicit in trauma treatments and how treatment techniques bring about compliance with those embedded understandings. Further, studies have rarely explored what therapists can learn from all that about the social world that gives rise to the concept of trauma, the identity of trauma

victims and the taken for granted acceptance of trauma treatments—in other words, a trauma-based society. Therefore there is a need for further interpretation of trauma culture and the practice of trauma therapy from a hermeneutic perspective.

In this study I have interpreted trauma culture as it came to light in widely utilized evidence-supported trauma treatment manuals. The manuals were viewed as living documents that were and presently are intended for utilization in the therapy room. Just as psychotherapy simultaneously reflects and shapes trauma culture, the manuals both represent and shape an idealized best-practice version of trauma therapy. They included motivations for the therapist to conduct therapy, psychoeducational scripts to inform patients about why they feel traumatized, and suggested how patients should think and act as functional beings.

I focused my inquiry on what the manuals communicate about this historical moment and how their existence may unintentionally perpetuate and shape a traumatic way of being. Following the work of Bracken (2002), Cushman (1995), N. S. Rose (1989, 2007), Sampson (1981), and others, I was particularly interested in the rise of trauma-focused psychotherapy as an industry and how this industry is articulated and perpetuated through manualized therapies. I was also interested in how understandings of what it means to be a moral and good human, and especially a good trauma survivor, were communicated through the treatment as it was represented and described in the treatment manuals.

Description of the Study

I examined how trauma culture is embodied and perpetuated in psychological trauma treatments by engaging in a qualitative textual interpretation of three evidence-

supported trauma treatment manuals and associated training materials that are widely

utilized in contemporary psychotherapeutic practice. I selected manuals for interpretation

based on best practice treatment guidelines and breadth of dissemination. Because this

study focuses on how human being is understood and lived out in trauma-based society, I

selected texts that employed a range of different psychotherapeutic approaches or

techniques and were designed for use with different patient populations: child, adult and

military populations.

I used hermeneutic interpretation as a method of qualitative textual analysis. The

data interpretation proceeded from the insights of Gadamerian hermeneutic philosophy,

the literature on trauma previously reviewed and the pre-judgments about trauma

treatment and culture that I brought to the interpretation as someone trained as a therapist

living in a trauma-based society. I then discussed results of the analyses within a

hermeneutic, cultural-historical, and moral frame with particular attention to how human

being is in a traumatic and traumatizing world.

Areas of Inquiry and Research Questions

The central areas of inquiry guiding my study were:

1. How is human being defined in trauma-based society?

2. How do members of society, and especially therapists and patients, define
   ourselves in trauma and act in a trauma-based society?

3. How is trauma culture embodied and perpetuated in psychological trauma
   treatments as they are represented in evidence-supported trauma treatment
   manuals?

4.   What does the particular form of trauma we experience today, as it is represented in evidence-supported trauma treatment manuals, tell us about this historical moment?

a.   In what kind of world do "trauma treatment manuals" exist?

b.   In what kind of world do these manuals work? What does it tell us about the concept and function of trauma when a manual-based treatment can heal any trauma, from child abuse to genocide?

c.   What understandings of the good do trauma treatment manuals implicitly and unintentionally reflect and prescribe?

I asked additional specific research questions that explored the historical context and moral judgments about traumatic responses that were described in the texts. A comprehensive list of all specific research questions is provided in Appendix B.

Importance and Purpose of the Study

There is a perceived epidemic of PTSD (approximately 37 million Americans are exposed to trauma annually and 5.2 million are diagnosed with PTSD each year) and a slough of continual funding from government agencies and pharmaceutical interests (over 2 billion dollars per year since 2012 from the VA alone) to research and treat this growing national and increasingly international epidemic of trauma (Bonnie et al., 1998; CBO, 2012; Dowd et al., 2002). Current best-practices for PTSD treatment include evidence-supported psychotherapy from manual-based treatment models to the extent that 100% of evidence-supported treatments are manual-based (Bisson & Andrew, 2007; DoD, 2010; Foa et al., 2000; Foa et al., 2008; Forbes et al., 2010; Rosen et al., 2004; SAMHSA, 2013; WHO, 2013). Managed heath care organizations are now beginning to

evaluate therapist performance according to fidelity to manual-based therapy models (Schoenwald et al., 2011).

While there have been overwhelming amounts of research confirming the fact that these manuals are indeed efficacious, there has been limited examination of how the manuals embody and perpetuate cultural messages about trauma. There is a similar dearth of research conceptualizing the world in which these manual-based treatments work. While there is plenty of critique about problems with technicist approaches to therapy, there has also been limited critical analysis of the contemporary practice of evidence-supported trauma treatment through a hermeneutic lens. While I did not examine actual trauma treatment sessions, this study is the beginning of the interpretation of practice by examining the training doctrines and tools that are utilized in the everyday practice of contemporary trauma therapy: trauma-treatment manuals.

I selected to analyze treatment manuals as exemplars of contemporary trauma culture because they have become such an integral component of contemporary psychotherapy. How therapy is being conceived, trained, practiced and exported across the world has been increasingly determined by a manual rather than mentorship and supervision; what constitutes good therapy and what it means to be disordered and healed was represented in these texts. Studying the messages embedded in these manuals and thinking about the world that gave rise to them is imperative given their increasing utilization and the continued cultural obsession with trauma, especially within the U.S. but increasingly internationally since the 1980s.

Restoring the historicity and context to trauma-treatment manuals in this study is important so that these texts can be seen as products of a specific time, political interest,

industry and culture rather than as communicating ahistorical, transcultural truths about healing. The morality and industry of these treatments and their representation in manuals is important to think critically about, lest therapists, like Camus (1946) suggested, seek a means in contradiction to our end, and continue to unintentionally perpetuate the world that creates such suffering and disorder.

While in some ways therapists will be bound by cultural understanding and enacting consumption of trauma given the traditions and social world we live in and unknowingly embody, this study is important because it breaks the traumatic enactment by suggesting therapists can question and think about rather than dissociate from daily practices in trauma culture. One of my primary hopes in conducting this study was that through thinking about trauma from a historical, philosophical and moral perspective therapists may discover alternative, perhaps previously unformulated insights, about how one thinks and acts in this traumatized world.

Theoretical Framework

This study is grounded in the philosophical framework of hermeneutics: the practice of reflective interpretation. Hermeneutic inquiry involves reading a text while lightly holding interpretations and questions that arise from the reading and describing how they relate to each other, history, contemporary culture, and to the reader. In this study, I specifically draw from Gadamer's philosophical hermeneutics (Gadamer, 2004). This approach is based on the work of Hans-Georg Gadamer and his elaboration on and interpretation of Martin Heidegger's ontological hermeneutics (Heidegger,1996; Warnke, 1987). I will outline hermeneutic philosophy and the presuppositions that are inherent in hermeneutic interpretation because they are the basis of my theoretical framework. The

assumptions inherent in hermeneutics deserve explicit description because they reject

Cartesian dualism and logical-positivist thought that is the basis of most scientific inquiry

and dissertation research.

A brief history of hermeneutics. Hermeneutics was born from a tradition of

study and attempt to gain full understanding of religious texts. The tradition of scriptural

interpretation can be traced back to *Midrash* (i.e., Jewish biblical commentary on late

antiquity) and in writings of the Stoics. Hermeneutics as a specific field of study became

recognized widely in the European church and academia during the Protestant

Reformation when the Council of Trent (1545-1563) decreed Scripture is unclear without

interpretation from the church (Richardson, Fowers, & Guignon, 1999).

Romantic hermeneutics. The work of Fredrich Schleiermacher (1768-1834), a

German theologian and philosopher, is cited widely and discussed by Gadamer and other

hermeneutic thinkers as having a profound impact on the move from hermeneutics as a

technique for biblical interpretation to one applicable to every form of human discourse

(Polkinghorne, 1983). Schleiermacher asserted that the aim of hermeneutics is to view the

text with the intention "to understand a writer better than he understood himself"

(Gadamer, 2004, p. 191). In the early 1800s, Schleiermacher defined the first two

cannons of teleological hermeneutic interpretation:

1. Everything that needs a fuller determination in a given text may only be
   determined in reference to the field of language shared by the author and his
   original public.

2. The meaning of every word in a given passage has to be determined in
   reference to its coexistence with the words surrounding it. (Schleiermacher, as
   cited in Polkinghorne, 1983, pp. 219-220)

The process of hermeneutic inquiry described by Schleiermacher involved what

hermeneutic philosopher Wilhelm Dilthey (1833-1911) later coined the "hermeneutic

circle" where "the parts receive meaning from the whole and the whole receives sense from the parts," (Dilthey, as cited in Polkinghorne, 1983, p. 221).

Schleiermacher and Dilthey lived in Germany during a time period referred to as German Romanticism (beginning in 1770, peaking in 1820 and continuing to the early part of 1900s) (Taylor, 1989). There are a variety of ways to describe Romanticism and perhaps the most popular is to see this period of time as a rebellion from the neoClassical norms of the Enlightenment era, 1650 to 1800 (Taylor, 1989). Where the Enlightenment was characterized by rationalism, empiricism and a quest for order through objective methods, the zeitgeist of the Romantic period was to see life as primarily subjective and filled with transcendence, mystery, emotion and passion. The Romantic self contained an inner voice where one could find knowledge inside and more importantly from internal feelings. Similarly, God could also be accessed through the personal and internal world. Schleiermacher's cannons of hermeneutics reflect the Romantic understanding of human perception as, "a veil of appearance, a purely phenomenal realm, which conceals a deeper, underlying reality, the world as it is 'in-itself'" (Richardson, Fowers & Guignon., 1999, p. 200).

Though it is beyond the scope of this study to fully discuss, it is important to note that the shift away from Enlightenment thinking aligned with major political and social changes in Europe, like the French Revolution. Similar to the Enlightenment, the ideology of the Romantic period continued to focus on how to break the hegemony of the church and nobility, but instead of attaining freedom through reason and science, the Romantics suggested freedom could be uncovered through self-expression of one's innate, noble faculties.

Dilthey's (1978) work also embodied the Romantic belief in a psychological, inner domain. Dilthey expanded upon Schleiermacher to establish a study of general hermeneutics that could be applied to all forms of human discourse (Richardson, Fowers & Guignon, 1999, p. 200). He believed that Enlightenment philosophers like Kant produced knowledge that was ahistorical. Dilthey found Kant's methods of rational inquiry appropriate for natural sciences where objects are viewed as material things with no inner life or capacity for intentionality. Within an objectified frame, the world is made up of decontextualized objects in causal interaction; the goal of the natural sciences is to explain the events according to laws that regulate these interactions. Dilthey acknowledged that in order to map the world in terms of scientific laws, abstraction and de-contextualization of the subject and object is necessary, "if the way we experience nature, our involvement in it, and the vital feeling with which we enjoy it, recede behind the abstract apprehension of the world in terms of space, time, mass and motion. […] All these factors combine to make man exclude himself so that from his impressions, he can map out this great object, nature, as an order governed by laws" (Dilthey 1976, as cited in in Richardson, Fowers & Guignon, 1999, p. 202). Thus, while suited for mapping an abstract world, Dilthey argued that Kant's analysis was inadequate to account for the human world expressed in conversations, literature, art, poetry and our informal life philosophy (Polkinghorne, 1983). In short, because the objectified worldview requires removal of the human knower it is inadequate to explain humans. In contrast to the epistemology of scientific studies, Dilthey defined the aim of social studies as: understanding how humans interpret the meaningful situations and experiences we find ourselves in.

Dilthey (1978) believed that the totality of human life experience were not understood as unified by laws of space and time, but by meaning and purpose. For example, though the phenomenon of having dinner may be different each time it is experienced (e.g., different foods, times, places, people involved in making and eating dinner) the life-experience of having dinner is a culturally-bound and somehow unitary phenomenon that cannot be explained by reductionism to the parts that make up a dinner or elucidation of every possible physical law governing dinner-like interactions. Instead, Dilthey (1978) suggested that we understand life-experience within social historical context and identify "structures of interactive forces" or recurrent cultural patterns that are characteristic of human life (Dilthey, 1978, as cited in Polkinghorne, 1983, p. 221). Richardson, Richardson, Fowers, and Guignon (1999) described Dilthey's hermeneutics, "As an ongoing flow toward a stable meaning, [where] life involves a constant process of *interpretation and reinterpretation.*" (p. 204). He continued, "we all have a certain facticity in the sense that we are located in a specific worldly milieu and have already made choices that limit what is possible for the future. But we also have the ability to take-up up our facticity and do something with it in carrying out the goals we set for ourselves in the future" (p. 204).

Dilthey (1978) observed that in careful examination of his own life, that his experience became removed from the fabric of everyday life and that through thinking about this event the phenomenon was changed. The interpretations made about life-experience using personal life and introspection, Dilthey concluded, were somehow incorrect because they were necessarily changed through the process of reflection. From a contemporary standpoint, Dilthey's observation of the phenomenon of hermeneutic

introspection sounds like the goal of what is now described as a psychological or clinical hermeneutics (see e.g., Chang, 2010); however, this was not Dilthey's aim. He wanted to develop an objective method of understanding human phenomenon.

Despite the primacy of subjective knowledge during the Romanic period, Dilthey was not totally comfortable with the role introspection in hermeneutics. In his later writings, Dilthey wrote that he considered himself a "stubborn empiricist," and aimed to define hermeneutics as a social science that could lead to objective understanding of expressed life (Polkinghorne, 1983, p. 222). He turned away from introspection because he did not believe one's predispositions could be overcome. [34] Though Dilthey acknowledged the inescapability of the interpreter, he found that introspection as a basis for understanding life-categories was problematic. Instead he suggested that hermeneutics be only applied in the study of art, literature, social life and history and utilize these phenomenon as objects of study for human sciences.

Ontological hermeneutics. Heidegger's (1996) philosophical hermeneutics diverged from Romanic hermeneutics and Dilthey's (1978) attempt to establish a method for understanding human existence by proposing that understanding is the basic form of human existence:

> It is not a way we know the world, he said; it is the way we are. […] Heidegger maintained that to be human is to be interpretive for the very nature of the human realm is interpretive. Interpretation is not a tool for knowledge; it is the way

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[34] Interestingly, Dilthey wrote about how the death of his nephew (a traumatic event) increased the subjectivity and historically embedded nature of introspection, an in effect shattered the seemingly unitary structure of Dilthey's life experience. He wrote, "I experience something which by its intensity stands out in my consciousness. That which took place previously is also there. I am pained by the death of my nephew; I remain localized in space and the temporal process. Through introspection I now make this process an object of my observation. Can I base a science on this?" (Polkinghorne, 1983, p. 222).

human beings are. […] Experience itself is formed through interpretation of the world. Being human is a laying-open of what is hidden: we are beings who approach ourselves with the hermeneutic question "What does it mean to be?" (Polkinghorne, 1983, p. 224)

Heidegger (1996) accused Romantic hermeneutic attempts to create a method for understanding social sciences as retaining a Cartesian idea of reason in which *epiteme* (i.e., pure knowledge or ground truth) is achieved by overcoming all doubt. According to Heidegger, true understanding is the result of human engagement and there is no pure truth that lies outside of human engagement with the world; the problem of understanding is not resolved by is overcoming the condition in which we find ourselves. Heidegger asserted that it is our understanding that brings forth experience to begin with. Method, as manifested in objective science, abstracts from the truth instead of making it known, he said, "With our question, we want neither to replace the sciences nor to reform them…with our question we stand outside the sciences, and the knowledge for which our question strives in neither better nor worse but totally different" (Polkinghorne, 1983, p. 227). Thus Heidegger distinguished himself from Romantic hermeneutics who asked the question, "How can we understand others?," by asking the question that defines ontological hermeneutics, "What is the mode of being of the entity who understands?" (Richardson, Fowers & Guignon, 1999, p. 208).

Heidegger's magnum opus *Being and Time* (1927/1996) aimed to a return to the beginnings of Western philosophy and revive the forgotten Greek argument about being (Gadamer, 2004). He believed philosophy had been occupying itself with beings and failed to ask "the question of being:" how and why do beings show up as they do. Heidegger wrote *Being and Time* as an interpretation of interpreting beings; his thesis was that being itself is time (Gadamer, 2004, p. 247). He believed existence and its nature

have been tuned to become a specific existence—this existence here, "thrown into" the world (Polkinghorne, 1983, p. 225). He proposed that the understanding of being is possible at all because social practice creates a clearing in which we encounter objects, events and persons by expressing ontological distinction (i.e., a distinction between our being and beings; Gadamer, 2004, p. 248). There are some events, people and objects that we consider part our being and others that we believe are separate beings. For example, being now may mean that we see ourselves as in the world (versus inseparable from the world as part of our being). We may see the world as constituted by objects that have different meaning to us. We comprehend a chair as something to use and something to sit in rather than just pieces of wood. The way we are with the chair is part of our being in the world to the extent that we can almost take its existence, our interactions with it, its form and purpose, completely for granted. It is not until a leg of the chair gives out beneath us that the meaning of chair might "fall out of everydayness" (as Heidegger said) for us. In this scenario we might start to notice the chair as if for the first time (e.g., I was sitting above the ground). Falling out of everydayness can sometimes lead us into the hermeneutic circle where we might start to think about our social practice of living with chairs.

To approach the chair hermeneutically, one would first think about the apparent realities of the chair and how it is experienced, and then about the kind of world that would need a chair, the demands of that world, and the way someone might live in a world with chairs; ultimately one would ask: How is being with chairs? To move to a more social example, someone may see a person as a child or an adult, a friend or stranger, as a victim or survivor, as embodied by spirits or made up of organs.

Accordingly, they might talk about and interact with this person differently based on their understanding of them; when a person is considered culturally a part of one category and moves to another (e.g., child to mother, rescuer to perpetrator) being with that person changes. Social discourse affects every aspect of life, including our bodies. If we believe there is disease or evil in a certain part of the body, in one culture we may place a bowl of water with a leaf in it to remove water spirits from the air and in another we may surgically remove the arm. Thus, as scholar Anthony Stigliano (1989) wrote, "We not only merely classify and understand the world's parts in discourse; we are these discourses" (p. 49).

In sum, Heidegger's (1996) ontological hermeneutics was based on the idea that understanding is already performed for us by the world in which we exist through the social meanings contained in language. The primary task for hermeneutics is to explore how this understanding has come about. Heidegger believed that human being is not about finding a rule that governs knowledge (i.e., the aim of Enlightenment deterministic theories), nor is it about understanding the world we have made (i.e., as in existentialist or constructionist views); instead, being is "*what we make of what we find*" (Richardson, Fowers, & Guignon, 1999, p. 212). In other words, being is about interpreting our interpretations.

Philosophical hermeneutics. Gadamer extended and applied Heidegger's hermeneutics in his somewhat ironically titled book: *Truth and Method,* originally published in 1960 (Gadamer, 2004). Unlike the Romantic school of hermeneutic thought, Gadamer explicitly stated that his aim was not to develop a technique or method to describe others, "[hermeneutics] work is not to develop a procedure of understanding but

to clarify the conditions in which understanding takes places. But these conditions do not amount to a procedure or method which the interpreter must of himself bring to bear on the text; rather, they must be given" (Gadamer, 2004, p. 295).

Gadamer (2004) believed that we cannot approach the text from outside our given condition; we cannot avoid ourselves in attempting to know the text and there is no knowledge outside of the interaction between the interpreter and that which is to be understood. Gadamer posited that the knower and their previous experiences and pre-judgments (what Gadamer called prejudices) are central to the interpretation, not as a source of individual knowledge that can be readily accessed but as a reflection of the specific moment in history. He noted the limitations of attempting to explicitly acknowledge and identify one's pre-judgments, "The prejudices and fore-meanings that occupy the interpreter's consciousness are not at his free disposal. He cannot separate in advance the productive prejudices that enable understanding from the prejudices that hinder it and lead to misunderstandings" (Gadamer, 2004, p. 295). Like Heidegger, Gadamer believed that the interpreter need not access understanding; rather understanding is already performed for the interpreter by the world in which s/he exists; we are living out historical traditions and the social meanings contained in language. Gadamer accepted that the hermeneutic circle shapes and was shaped by historical traditions:

> We can understand a detail only in terms of the whole text and the historical reality itself is a text that has to be understood. […] For history is not only at its end, but we its interpreters are situated within it, as a conditioned and finite link in a continuing chain. (Gadamer, 2004, pp. 196-197)

What the interpreters brings to the text is their "historically effected consciousness" that includes their historical situation and its preceding history (i.e.,

contemporary practice and its traditions) as well as the interpreters' prejudices, such as their culturally-bound values, beliefs, experiences, and privilege (Gadamer, 2004, pp. 300-303). The process of hermeneutic interpretation, Gadamer described as a dialectic unfolding in which the interpreter engages the text given his or her horizon of understanding. Gadamer defines horizon as one's social and cultural situatedness that "limits our possibility of vision" in its historical finitude (Gadamer, 2004, p 302). The horizons thus determine what there is room for in the interpreter's culture's particular way of perceiving, and what is excluded from view.

The dialectical interaction between the prejudice and expectations of the interpreter and the meaning in the text was referred to by Gadamer (2004) as the fusion of horizons or lying between the polarity of familiarity and strangeness, "It is in the play between the traditionary [sic] text's strangeness and familiarity to us, between being historically intended, distanciated object and belonging to a tradition. *The true locus of hermeneutics is this in-between" (*p. 295). Thus the meaning of a text as it speaks to the interpreter, does not depend on the author and their original audience; it is "co-determined also by the historical situation of the interpreter and hence by the totality of the objective course of history" (p. 296).

Fusing horizons as a spatial metaphor. To elucidate the spatial metaphors of Gadamer's horizon and Heidegger's clearing I have extended these concepts here in a way that helped me to understand their meaning, and perhaps will similarly aid the reader. We, as interpreters, stand in the middle of a spotlight surrounded by darkness; the spotlight is the clearing or our culturally constructed social practice and traditions, including language. We have been placed in this particular light through no choice of our

own (cf. Heidegger's throwness). We understand ourselves as somehow different from

the spotlight yet only aware of our existence because of the light. We may be unaware we

are even standing in the spotlight of our culture because at times it seems we can only

know or be what is seen in the light. Gadamer (2004) says, "the very idea of [the

hermeneutical situation] means that we are not standing outside it and hence are unable to

have any objective knowledge of it. We always find ourselves within a situation and

throwing light on it is a task that is never entirely finished" (pp. 301-302).

To Gadamer (2004), hermeneutic interpretation is a process of walking to the edge

of this clearing, as if the interpreter is standing at the edge of the spotlight looking out to

the horizon. In this manner, the interpreter takes up the tradition of hermeneutics in a way

where s/he can obtain access to our everyday and past experiences and at the same time

open up new possibilities for the future; the spotlight becomes joined with the darkness in

a grey area, yet sight is only possible through the light. As the horizon of the darkness

and light fuse, it is as if the interpreter is shining light forward and expanding the horizon,

and thus her vision changes. Gadamer suggests that this process is not a static expansion

of an individual's light onto the world, but rather humans all stand within the spotlight

together, within human traditions and history. Furthermore, we are never bound to one

spot: as we move and our light moves, our horizons move with us. As Cushman (1995)

wrote,

> The good news is that the cultural clearing is constructed by social practices and
> therefore its horizons of understanding are somewhat moveable. The bad news is
> that the horizons of the clearing are difficult for any tradition to move quickly
> under any circumstance, and because horizons are tied to the moral vision,
> economic structures and power relations of the society, certain individuals and
> groups will forcefully resist any attempt to change. (p. 21)

Moving in-between. Hermeneutics involves movement between the horizons of the text and interpreter where fusion of the horizons represents holding the dialectic interpretation of the text as both historically familiar and strange. Stigliano (1989) has identified this process as moving between the hermeneutic moments of distanciation (i.e., seeing the text as reference to historical discourse) and appropriation (i.e., seeing the text as a reflection of the interpreters world, personal experience, or constitutive of a particular practice).

Both Heidegger and Gadamer discussed how an interpreter should enter the hermeneutic circle in the "right way" (Heidegger, 1996, p. 195) or identify the "right horizon" of inquiry for engaging in fusion (Gadamer, 2004, p. 302). Gadamer believed that, "A person who has an horizon knows the relative significance of everything within this horizon, whether it is near, far, great or small. Similarly, working out the hermeneutical situation means acquiring the right horizon of inquiry for the questions evoked by the encounter with the tradition" (p. 302). What Gadamer proposed by finding the right horizon is that interpreters become aware of appropriation and how their historical consciousness can transpose itself onto the past in such a way that it can claim the right of the historical horizon. In such situations, Gadamer suggested that the interpreter aims to seek knowledge or approaches the text with a specific theory rather than a conversation in which one is attempting to place oneself in the other's framework. Claiming the right of a horizon can also look like complete agreement with the text and judging it purely on contemporary terms or perhaps within an ahistorical light.

To avoid complete appropriation of the text, Gadamer (2004) proposes that we engage with the text in a dialogue where we acknowledge our historicity and prejudice

and also attempt to put ourselves in the position of the text (i.e., the historical situation that the text was written in and the horizon of the person writing the text); to do this we have to guard against "over hastily assimilating the past to our own expectations of meaning" (p. 305). Gadamer believed by looking past assumptions that are close at hand can we listen to the tradition of a text in a way that allows for its meaning to be heard and in a way that allows us to become aware of our horizon. This process Gadamer referred to as foregrounding.

A summary of hermeneutic history. To summarize this brief history, the philosophers I reviewed asked the following questions: How it is that humans understand? (cf. Kant, Schleiermacher), What is the most objective way to understand human life and everyday practice? (cf. Dilthey, 1978)*,* How is being? (cf. Heidegger, 1996) and, What kind of world, including personal, social and cultural histories, would allow for questions about meaning making to exist in the first place? (cf. Gadamer, 2004).

Foregrounding: The assumptions of philosophic hermeneutics. Gadamer (2004) believed that by becoming aware or "foregrounding" the assumptions that we are conscious of that the interpreter might be freer to listen to the tradition of a text in a way that allows for its meaning to be heard in distinction to one's history and traditions. To acknowledge the culturally bound and temporally embedded nature of this study, I have summarized the assumptions made by hermeneutics that informed my study methods. These assumptions have been previously referred to within this section but are explicitly summarized here for clarity and referential purposes:

1.   Knowledge is not in the world and cannot be acquired by a method.

2. There is no objective truth that is truer than any other truth; yet, there are practices that seem somehow true and known within one context and others that seem somehow untrue or unknown in another. Thus, hermeneutics does not assume all truths are equal and relative, but rather all understanding exists within human practice and must be interpreted and evaluated within human context and history.

3. Being is linguistic and language is constitutive of human life and understanding, therefore the hermeneutic approach to inquiry focuses on how language constructs understanding of any human endeavor.

4. Understanding is already performed for the interpreter by the world in which s/he exists. Interpreters are living out historical traditions and the social meanings contained in language. The first task for hermeneutics is to explore how our understanding has come about.

5. The text is an example of a culturally—and historically—bounded exemplar of human life. It is understood as a system of references to historical discourse that is lived out in practice. Just like dialogue can be read like a text, a text can be read like living human discourse. The text is not a preserved historic relic; our lives are shaped and constituted by engagement with the text.

6. The researcher is an interpreter of the text and the interpreter's job is to understand the text's meaning. In doing so, the interpreter aims to understand the people and world that gave rise to the text, its historicity and traditions.

7.   The process of hermeneutic interpretation involves moving back and forth

between understanding the parts and understanding the whole of the text;

between familiarity and strangeness. This process involves a dance

between appropriation of meaning (i.e., the text is understood relative to

the interpreter's culture and traditions) and distanciation from the text (i.e.,

the text is understood relative to its history). Gadamer suggests that this

dialogue between familiarity and strangeness may resolve in allowing for

the upholding of the dialectic between the interpreter and the text, which

in moments achieves a "fusion of horizons." In this way, interpretation is

co-determined and embedded in the historical situation of the text and the

interpreter.

8.   What the interpreter brings to the text is a historically effected

consciousness that includes: prejudices, fore-meanings, or pre-judgments

such as values, beliefs, past experiences, and privileges. The prejudices

reflect one's contemporary historical situation and embodied historical

traditions. Because the interpreter brings cultural traditions to the text

(some of which may be taken for granted) they bring "the totality of the

objective course of history" (Gadamer, 2004, p. 296).

9.   The prejudices and fore-meanings that occupy the interpreter's

consciousness are not free to his/her disposal. The interpreter cannot

separate in advance the productive prejudices that enable understanding

from those that hinder it and lead to misunderstandings. This is sometimes

achieved in what Gadamer called dialogue, which includes encountering difference, learning from it, and being affected by it.

10. The everyday world and traditions that constitute the interpreter's experience can never be made fully explicit. Similarly, the aim of hermeneutics is to bring some awareness of human practices and traditions, not to exhaustively describe or explain the practices.

Method

In this study, I followed the hermeneutic tradition of examining what has been taken for granted, what is enacted in the field of psychology and in U.S. society but not articulated, and what is unquestioned local practice in our trauma-based society. The purpose of this study was to understand ways in which trauma culture is embodied and perpetuated in psychological trauma treatments by engaging in a qualitative textual interpretation of evidence-supported trauma treatment manuals. The manuals were considered a cultural representation and continued reproduction of trauma-based society. I engaged in hermeneutic interpretation as a method of qualitative textual analysis to identify how the manuals represent and enact political, moral, and social discourse about living in trauma culture.

In this study, I attempted to move beyond positivist and ontic questions about trauma such as, "How does trauma change our brains?" and "What symptoms indicate moderate PTSD?" Instead, I examined the human traditions and practices that allow these questions to be asked in the first place. Within a hermeneutic frame, the researcher acts like a cultural anthropologist where the object of study is a text and the goal is to uncover how humans live in the type of society that would create such a text. I explored the cultural messages about traumatization, suffering, victimhood and being cured that were embedded in trauma treatment manuals and discussed their moral, cultural, and political implications. The data interpretation proceeded from the insights of Gadamerian hermeneutic philosophy, the substantiative literature on trauma, as well as from my pre-judgments about trauma culture. I then discussed results of the analyses within a historical, political, and moral frame.

Data Collection and Analysis: A Practical Application of Hermeneutic

Interpretation

Because philosophic hermeneutics resists reductionism and the procedural limitations of method, it can be philosophically incoherent to apply hermeneutic inquiry within the framework of a research methodology; yet, all hermeneutic scholars follow an interpretive process that can be described. While recognizing the limitations of procedures, scholars including Anthony Stigliano (1989), Victoria Leonard (1993), Michelle McCoy Barrett (2000) and Jeff Chang (2010) have been able to retain the philosophic assumptions of Gadamerian hermeneutics in qualitative research. These scholars have drawn from the theoretical background of philosophical hermeneutics described above and from disciplines such as nursing that regularly utilize hermeneutic methods in research (cf. Patricia Benner and Karen Plager). I followed a synthesis of the processes described by these scholars as represented in Figure 2 and described after the figure.
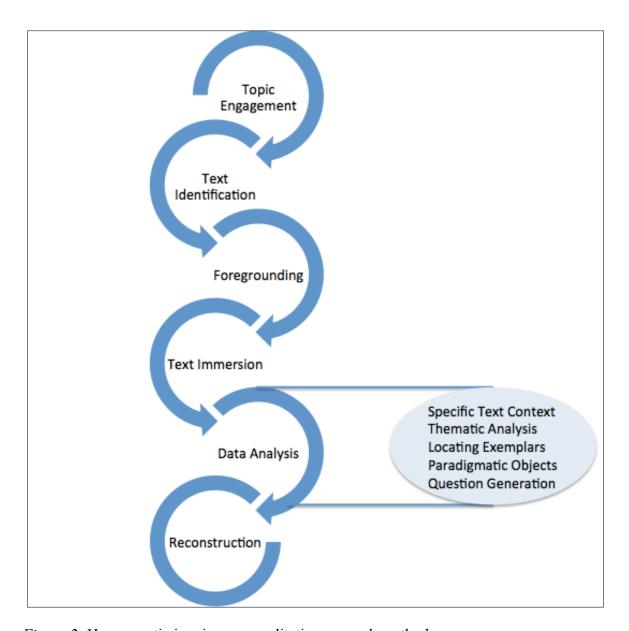
Figure 2: Hermeneutic inquiry as a qualitative research method.

Entering the circle (Spiral 1): Topic engagement. Gadamer (2004) described

the interpretive process as beginning with being addressed by the topic. Chang (2010)

and others have interpreted Gadamer's use of the word addressed to "refer to the

experience of an issue grabbing you, being captivated by an idea, or of a phenomenon

capturing your attention" (p. 24). I approached my interpretation with curiosity about the

world that gave rise to trauma treatment manuals. Before engaging in the textual

interpretation, I wrote about my past experiences that led to engagement by this topic, a summary of which is located in Foregrounding (Chapter IV, pp. 168-188). I refer to topic engagement as entering the circle and the subsequent phases of interpretation as spirals or loops around the circle of interpretation as it is represented in Figure 1.

Spiral 2: Text identification. I conducted a search for documents that were widely utilized the training and practice of trauma therapy. I did not initially set out to specifically analyze trauma treatment manuals, but given my interest in how psychology perpetuates and shapes trauma culture, it became clear that examination of the trauma treatment training process was a worthy object of study.

Treatment manuals were selected because they have become such an integral component of contemporary psychotherapy to the extent that 100% of well-established evidence-supported psychotherapeutic treatments for trauma disorders now involve the practitioner-therapist learning from and continuing to retain fidelity to a trauma treatment manual in their therapeutic practice (Bisson & Andrew, 2007; DoD, 2010; Foa et al., 2000; Foa et al., 2008; Forbes et al., 2010; Rosen et al., 2004; SAMHSA, 2013; WHO, 2013). Thus, training manuals are an ideal source to explore how political, moral and social messages about trauma-based society are communicated. They are promoted as the training doctrines and therapeutic scripts for widely accepted and practiced contemporary psychotherapy treatments; they are exemplar texts that are representative of how human being is conceived of and lived out in trauma-based society.

Training documents outline the cultural ideals of how a therapist and patient should participate in therapy; they indoctrinate novice therapists or patients into the practice and culture of trauma treatment. These texts explain what might be seen as

basics for living in trauma culture, such as detailed descriptions of what is understood by the field. Therefore I limited my text selection first to texts that were designed to assist in or directly train therapists in trauma treatment.

    Selection criteria. I conducted a search for documents that had the following qualities, listed in order of importance. I selected texts that:

a)   Described trauma theory, etiology, and were designed to train novice clinicians in trauma treatment procedures;

b)   Were publically available and widely utilized in psychotherapeutic practice including community-based treatment settings (i.e., manuals not available for public use or found only in experimental research contexts were excluded);

c)   Described accepted best-practices (i.e., with established efficacy and effectiveness) for treating trauma psychotherapeutically within the field of psychology and related mental health disciplines including social work and psychiatry;

d)   Were active training documents (versus reference materials), a self-contained training course, an instruction manual or protocol, or supplemental document to a workshop training course for trauma treatment; and,

e)   Included treatment scripts and protocols that, according to the text, the practitioner should either memorize or read verbatim during therapy. This could also include worksheet protocols where the therapist script was followed by blanks to fill in what the patient responses are to the script.

Because this study focused on how human being is in trauma-based society, I selected texts that employed a range of different psychotherapeutic approaches or techniques and were designed for use with different patient populations. While each manual was bound by a specific context and history, commonalities across the varied manuals illuminated pervasive moral, political and cultural messages about being in a traumatized world—messages that were not limited to a cultural conception about a particular population (e.g., age, employment status, type of traumatic exposure) or theoretical orientation (e.g., cognitive-behavioral, eye-movement desensitization). The goal of selecting texts with different target populations and techniques was not to obtain comprehensive representation but rather to select texts that emerged from slightly different historical and cultural contexts. I selected trauma-focused treatment texts that were aimed to train therapists in treating in children, adult civilians, and adult military personnel.

Selecting a child and adult civilian trauma treatment manual. As a proxy for acceptance in the field, I searched for trauma treatments that were peer-reviewed and met the evidence-supported effect size criteria of well-established or probably efficacious treatments for trauma symptomology and PTSD (Chambless & Hollon, 1998). In addition to established efficacy, I was interested in identifying treatments that were effective and widely disseminated in community settings and training institutions. In my search, I included all evidence-supported trauma treatments on the National Registry of Evidence Based Programs and Practices (NREPP) (SAMHSA, 2013). In addition to searching the Substance Abuse and Mental Health Services Administration (SAMHSA) funded NREPP list, I also searched for civilian trauma treatment training materials that were supported

by other national (U.S.) and international (U.K., Australia, multi-country) organizations that report on or define best practice treatments for trauma disorders see (Bisson & Andrew, 2007; DoD, 2010; Foa et al., 2000; Foa et al., 2008; Forbes et al., 2010; Rosen et al., 2004; SAMHSA, 2013; WHO, 2013). A comprehensive list of the manuals I considered can be found in Table 1.

After compiling a list of all possible trauma related treatments that met my selection criteria, I chose to include training texts and treatment manuals from trauma-focused treatments that have not only been disseminated and practiced nationally but also locally in the Seattle, Washington area. The reason for adding the local selection criteria was to be able to easily access trainers and trainees for possible future research in the practice of trauma therapy. My final selections included two texts from trauma treatment training programs that I was trained in and that are regularly recommended in coursework by my graduate training program, Antioch University- Seattle. The final text selections included: *Trauma-focused Cognitive Behavioral Therapy for Children and Adolescents* (Cohen et al., 2006) and *Basic Eye-movement Desensitization and reprocessing (EMDR) Training from the EMDR institute* (Shapiro, 2001). Each of these texts came with supplementary training material and recommended additional treatment protocols. Selections of the supplementary EMDR treatment protocols from Leeds (2009), Luber (2010), and Shapiro (2010) were included in the analyses, as well as handouts from the TF-CBT Web training (Medical University of South Carolina [MUSC], 2005).

Selecting a military-based trauma treatment manual. When selecting a trauma treatment manual that was designed for the military population, I found that when I retained the best practice selection criteria, the same treatments that were identified in

Table 1 emerged. There was only one treatment (Kognito Family of Heroes) that was both endorsed as a best practice and was specifically designed to target the military population on the NREPP list of evidence-based treatments (SAMHSA, 2013). This treatment was a one-session online roll-playing therapy with proprietary distribution that did not require a therapist. The remaining treatments were initially designed to treat civilians and have been evaluated to be effective when administered with veterans and military personnel in an outpatient context (e.g., a VA treatment center). For example, the EMDR and TF-CBT models that I already selected to analyze for the adult and child populations were also the primary recommended treatments for veterans based on VA and DoD guidelines (DoD, 2010). Because I was interested in understanding trauma culture broadly, including in military contexts, I wanted to select a military-based treatment manual that was widely disseminated and trained within a post-deployment military setting for military personnel, rather than identifying a manual that was developed for civilian populations and delivered to the military in an outpatient setting. I did not opt to analyze Kognito Family of Heroes therapy because the training manual was embedded in the one-session online therapy, was proprietary, and could not be easily accessed.

To select from a broader range of therapies for the military, I altered the selection criteria for the military-based trauma manual to include a text that:

a)   Was specifically designed for use with military populations in a post-deployment military setting;

b)   Was created as the result of research or organizational development funded by the Department of Defense, Veterans Administration or other military related federal funding agency;

c)   Had been widely disseminated and practiced within the military and easily accessible to all personnel regardless of status (e.g., officer, enlisted, non-commissioned, veteran, etc.);

d)   Targeted combat exposed military populations in theatre or in post-combat service or outpatient settings;

e)   Treated or prevented traumatic stress disorders. Prevention training includes: stress inoculation therapy, coping skill training, resiliency training, traumatic stress screening and critical-incident stress debriefing.

These selection criteria are listed in order of importance with design for the military population and wide dissemination being the most important.

Once I eliminated altered versions of the TF-CBT and EMDR manuals I had already selected for interpretation and applied these altered selection criteria, it became apparent that some of the trauma treatment and prevention protocols that were widely disseminated in the military had not been evaluated for effectiveness prior to dissemination within the military. For example, a comprehensive program evaluation of trauma prevention programs utilized in the military to-date (e.g., resiliency training and debriefing) revealed that only five out of twenty-three programs had been formally assessed for effectiveness in a military setting (Meredith et al., 2011). While many traumatic stress treatment protocols for the military involved components of efficacious practices from civilian research, the assemblies of the components into a military-based

trauma-focused treatment as a whole were not evaluated as an evidence-supported practice.[35] Given the limitation of treatment evaluation for military-based trauma treatment, I removed the selection criteria of best practice treatment when selecting the manual, and instead preferenced wide utilization within the military.

Critical-incident stress debriefing was the most widely disseminated psychotherapeutic treatment for acute-stress and for prevention of posttraumatic stress after trauma exposure in the military. I selected the *Battlemind Psychological Debriefing* training materials and treatment protocol (Adler, Castro, & McGurk, 2007). Battlemind trainings were broadly disseminated and delivered to all military personnel in the U.S. Army from 2006-2010. Detailed descriptive information regarding the structure of the small group Battlemind debriefings was explained in the Adler et al. (2007) report; this document along with an accompanying train-the-trainers, Battlemind for Leaders PowerPoint (Castro et al., 2006; Walter Reed Army Institute of Research [WRAIR], 2006c, 2008a) were considered to be the training manual for purposes of this analyses because they included all aspects needed to conduct a debriefing (e.g., room set-up, scripts, meeting structure by minute). The content of the Battlemind skills training pre- and post-deployment were published online and are considered unclassified military documents (Adler et al., 2007; Castro et al., 2006; WRAIR, 2006a, 2006b, 2006c, 2008a,

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[35] Timelines for policy initiatives set by the Surgeon General and availability of funding within the Government can lead to wide dissemination of trauma screening and treatment protocols that can be practiced for years within the military even before internal program evaluation for effectiveness is conducted. While the military is required to practice these treatments after receiving a directive, research has also shown that dissemination of the treatment or prevention protocols is limited by the interest of the local military commanders (Meredith et al., 2011).

2008b). The format of conducting the Battlemind debriefings was also published and included in the analysis (Adler, Bliese, McGurk, Hoge, & Castro,2009).

Though Battlemind was not been established as a best practice for trauma treatment, in a randomized trial, the trainings were found to decrease symptoms of posttraumatic stress (Adler et al., 2009). The training was designed for four sub-groups: warriors (i.e., soldiers), leaders (i.e., platoon leaders), spouses, and National Guard/Reservists. I selected to analyze the training manual and associated training materials for warriors and leaders.

Spiral 3: Foregrounding. The process of foregrounding has been previously described in the Theoretical Framework section (p. 83). According to Gadamer (2004), foregrounding essentially involves recognizing and describing conscious assumptions. Through foregrounding the interpreter can be more free to listen to the tradition of the text in a way that allows for its meanings to be heard in distinction to the interpreter's history and traditions. I have foregrounded the assumptions of hermeneutics and some of my personal experiences with trauma culture presented in the Chapter IV: Foregrounding: My personal experiences with trauma culture (pp. 113-133). I have also foregrounded the literature I have reviewed, including mainstream, postmodern and hermeneutic interpretations of trauma, in the Background and Literature Review chapter of the study.

Spiral 4: Immersion in texts with research questions. During the immersion phase of data analysis, I attempted to lightly hold various interpretations of the texts and approached them with awareness of the literature and recognition of the foregrounded assumptions described previously. I did not assume I would be able to bracket my

assumptions or remove my biases during the immersive reading. To first gain a gestalt impression of the texts, I read each text and recorded my general impressions and aspects that caught my attention. I noted threads that were repeated and others that stood out as some how unique or evocative. I then re-read the text with specific research questions about how therapy is prescribed and represented in the manuals (see Appendix B for specific questions). After approaching the text with the specific questions, during the analysis phase I finally considered the overarching questions listed in the Areas of Inquiry and Research Questions section (p. 80).

As I asked questions of the text, the interpretive process embodied what Stigliano (1989) noted as the two moments of hermeneutical practice: distanciation (i.e., understanding the text as a system of references to historical discourse) and appropriation (i.e., understanding the text as a reflection of this historical moment and my life). In answering the questions I engaged with the text in a dialogue where I acknowledged my historicity and prejudices, but also attempted to place myself in the position of the text and the circumstances of its creation. I moved between acting like an anthropologist trying to understand a cultural text from a semi-naïve stance, and that of someone living in the culture under-study.

Spiral 5: Data analysis as hermeneutic inquiry. My analysis of the text proceeded from the insights of Gadamerian hermeneutic philosophy and the literature on trauma previously outlined, as well as from my personal experiences of living in trauma-based society. A goal of a hermeneutic account is to reveal and communicate to others the meaning embedded in everyday practices in a way that facilitates new ways of being engaged with the problem that inspired investigation in the first place. Thus interpretation

begins with looking for commonalities and lines of inquiry in daily practices, and to find examples that embody these meanings of these practices in such a way that they are not distorted or trivialized. Following Leonard's (1993) description of hermeneutic textual interpretation, [36] I identified patterns of meaning that surfaced in the immersion phase and categorized them into: themes, specific episodes, and "paradigmatic objects."

    Thematic interpretation. After each document is read several times, lines of inquiry emerged from commonalities in the texts including themes that repeated across manuals, which I presented as shared themes, and those that were unique within each manual, which I titled according to the manual (e.g., EMDR Theme 1). Once the conceptual map for shared themes was identified, I also conducted word frequency searches to support some of my findings when a particular word or phrase was mentioned repeatedly or not at all in a given text. To conduct the word searches I utilized digital versions of the manuals that were available via CD-ROM (Luber, 2010), on Kindle (Cohen et al., 2006; Shapiro, 2001), PowerPoint, or pdf format (Adler et al., 2007; Castro et al., 2006; WRAIR, 2006a, 2006b, 2006c, 2008a, 2008b). All of the manuals were available on some format digitally that could be searched using the given computer software for the file format.

    Silences. While on the surface language seems somewhat intrinsically inclusive as it describes and constitutes cultural practice, in hermeneutic interpretation it is just as important to note what is not being communicated and said. Thus, in my thematic inquiry I attended to what was missing from the texts. From a psychodynamic perspective silences and exclusions of particular thoughts or discussion about trauma may indicate a

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[36] Leonard (1993) summarized this process from Patricia Benner (1985) and Karen Plager in their phenomenological and hermeneutic studies of nursing.

possible disavowal (i.e., simultaneous knowing and not knowing) of the consequences of

being in trauma culture (see Layton, 2010 for discussion of disavowal). The silences may

also indicate that which is practiced so commonly, and held so dear, that it is taken-for

granted; in a paradoxical way, what is said in the silences may almost be too important to

be stated. I did not include a separate analytic category for silences but noted what was

included and excluded from the presentation of the different themes in each text.

Identification of exemplars. Here I analyzed the scripts, practices, and actions

that were prescribed by the manuals together. I identified exemplars vignettes that

captured what human being is like in trauma culture in such a way that it could be

recognized in other situations that might have very different objective circumstances,

including those outside of the practice of psychotherapy. In particular, I focused on

identifying the therapeutic techniques and practices that trauma treatment manuals

prescribed to training therapists, and noted the similarity between these techniques and

practices to others in the social world. I identified shared exemplars that I found in all

three manuals as well as unique exemplars, which I titled according to the manual (e.g.,

Battlemind Exemplar 1).

Identification of paradigmatic objects. The paradigmatic object[37] refers

Heidegger's (1977) notion of an object in the clearing that focuses and gives constancy to

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[37] There does not seem to be a consistent use of terminology for this concept. I have used the word paradigmatic "object" which Polkinghorne (1983) and others (e.g., Dryfus &Wakefield, 1988) have used; however, translations of Heidegger have also described this concept as the paradigmatic "thing" or "work" (see Heidegger, 1967, 1977). Benner (1994) refers to paradigm "cases" in her writings on phenomenological interpretation. Others do not reference an object or thing and describe this concept as a Heideggerian "paradigm" (e.g., Leonard, 1989). Some have also connected Heidegger's description of paradigmatic things, objects or works to Kuhn's description of a paradigm (e.g., Dryfus, 2009). Some scholars use the terms exemplars and paradigms interchangeably (e.g.,

the clearing; it re-organizes the background against which the world shows-up.

Heidegger's (1977) classic example of a paradigmatic object was the Greek temple or

Athenian acropolis. Even though the temple was made of stone blocks that comprised it,

it was not interpreted as just a stone building, the acropolis was an essential instantiation

of what was important to Greek culture and what it meant to be Greek. Heidegger (1977)

said,

> A building, a Greek temple, portrays nothing. It simply stands there in the middle
> of the rock-cleft valley. The building encloses the figure of god […]. By means of
> the temple, the god is present in the temple. […]. It is the temple-work that first
> fits together and at the same time gathers around itself the unity of those paths and
> relations in which birth, death, disaster and bless, victory and disgrace, endurance
> and decline acquire the shape of destiny for human being. The all-governing
> expanse of this open relational context is the world of this historical people.
> (p. 167)

The temple has meaning and has come to exist in the world because of a

particular Greek way of being. Thus when one views and lives near the temple, the

temple "sets up a world" (Heidegger, 1996, p. 180) or defines the clearing of social

practice. In other words, the acropolis does not represent a Greek way of being, it actually

articulates the way of being or produces a shared way of understanding this way of being.

Dreyfus and Wakefield (1988) explained that the temple as a paradigmatic object "opens

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Caelli, 2000); and, in my judgment, refer to the concept of a paradigm when it might be
more accurate to refer to the concept of the clearing.

   If I followed Heidegger's terminology more closely I might add the word thing or
work (e.g., temple-work) for each paradigmatic concept that I present in this study. The
use of the word "object" is somewhat problematic because Heidegger comments on how
things have come to be understood through a subject-object ontology and can be known
as objects (Dryfus, 1997; Heidegger, 1954); thus the term paradigmatic object is almost
prescriptive of an ontology that is philosophically incoherent with the concept of being
that Heidegger (1996) discusses. While acknowledging these problems, I chose to refer to
the paradigmatic work or thing as an object in this study because seemed the most
practical for communicating this concept in contemporary U.S. culture.

up and organizes a multidimensional world by highlighting crucial issues that then become the locus of conflicts of interpretation and the starting point of history" (p. 279).

Given Heidegger's (1977) description of the Greek temple, I understood the role of the hermeneutic interpreter as similar to a cultural anthropologist uncovering an artifact that was central to life in the culture of study—the paradigmatic object. In this light, the interpreter would come to see the artifact, object, thing, space, work or other human-created material arrangement as reflecting and also producing a way of human being. While all things and works can be interpreted as constituting a way of being, I think Heidegger was suggesting that the paradigmatic object was highly quintessential to the culture in the way it articulates the boundaries of what it is like to be human.

Question generation. In addition to the categories outlined by Leonard (1993) and others, I added the category of question generation. The interpretation of the data will no doubt raise questions, some of which may be unanswered by the text, the interpreter (myself), and the immediate context (e.g., foregrounded assumptions). The unanswered questions may be indicative of what Donnel Stern (2010) described as an unformulated experience, where the answer is dissociated (and thus seemingly unanswerable). Answers to such questions may be first accessible only through enactment and unconscious practice. The unformulated answer to the question became meaningful and articulated only in the reconstructive phase of the hermeneutic process described below. I discussed the importance and context for each question following reconstruction.

Spiral 6: Reconstruction. Reconstruction involved considering the results of the interpretation in the context of the literature review, the histories of the training manuals, the foregrounding of hermeneutic philosophy and personal experience, and the horizon of

contemporary socio-political culture. In this phase, I reconstructed trauma culture as system of historically grounded distinctions and political practices through the interpretation of the treatment manuals. The thematic discussions and Conclusion (Chapter X) present the outcomes of the reconstructive process. I discussed the results of the analyses within a hermeneutic and historical frame and explored the moral, cultural and political implications of the results within the framework of the overarching research question: How does human being come to light in trauma-based society? My relation to the text in light of my experiences and culture (described in Chapter IV: Foregrounding) was unavoidably changed through the interpretations reflected in the results, and was further explored in the Conclusion.

Summary of Methods

In this study I have used hermeneutic inquiry as a qualitative method of applied textual interpretation. I described the practical steps involved in hermeneutic inquiry as a qualitative research method: topic engagement, text identification, literature review, text immersion, data interpretation and reconstruction. The results include descriptive information regarding each manual and the historical context of their development. Answers to the questions provided in Appendix B were considered primary, raw data and were not presented in the results.

Foregrounding: My Personal Experience With Trauma Culture

In this chapter, I make explicit some of my personal experiences, prejudices and pre-judgments about trauma culture, and more specifically, with manual-based training. Gadamer (2004) acknowledged the impossibility of escaping pre-understanding and encouraged the interpreter to foreground experiences that are "close at hand." He also believed that the interpreter will be unaware of which prejudices assist and which hinder the interpretation, and that it is impossible to be fully aware of one's pre-judgments. While this section was an attempt to foreground my prejudice, I was also aware at the time of writing that I was unconsciously affected by, embodied and lived out the discourse of trauma culture. As I engaged with the inquiry I became aware of my horizon and that of the text in such a way that trauma emerged in a new light. I discussed how my foregrounding shifted in the Conclusion (Chapter X). I wrote this piece of foregrounding in October 2013, before engaging in the interpretation of the three trauma treatment manuals:

It perhaps goes without saying that my training in psychotherapy (2006-2013) has been completely embedded in the neoliberal technicist world where students are encouraged to "help people" in ways that are ahistorical and removed from local context but are good because they are "co-constructed," "empathetic," and "client-centered." Student clinicians are being increasingly trained in procedures, charting, paperwork and ethics that will prepare us to be modular technicians in a managed care environment. Without monitoring and formal outcome measures of patient progress, our work is assumed to be somehow invalid and nonsensical (e.g., "How do you know your interventions are working?" "How can you measure your progress?"). The more

evidence-supported treatments we receive certifications in and hoard on our CVs, the better clinicians we seemingly are.

I have been fortunate to also have the supervision from psychologists who have taken a relational psychoanalytic and hermeneutic stance to clinical work (namely Drs. Karol Marshall and Philip Cushman). While sometimes feeling uncomfortable with (to at times abhorring) the practices I am learning, I am thankful that from this supervision I have learned to think about the world I am participating in (however painful that may be at times) rather than to ignore and feel comfortable about the direction of the field. Here I describe how I have approached my topic by describing some of the notable recent experiences in trauma culture that I bring to this study:

In 2012, I faced the daunting prospect of applying for an APPIC internship. I was looking forward to this year away to separate from my increasingly entrenched career in trauma research that began in 2006 as a full-time research assistant and trainee clinician for the University of Washington's Department of Psychiatry of Behavioral Sciences. By 2009, I had become a lead research coordinator in the Department. I managed several multi-site NIMH funded r01randomized-control trials assessing early interventions for post-traumatic stress, depression and substance abuse. I had also graduated from being carefully monitored and supervised for fidelity to the manual-based treatments, to training and supervising other clinicians. For example, in 2010, I co-led a workshop series for Los Angeles County to train clinicians on mass casualty disaster response and implementation of brief five-session CBT for post-traumatic stress. By 2012, I was certified as a motivational interviewing trainer and began leading quarterly continuing education trainings in this evidence-based approach for the public and the University of

Washington medical students. My first first-author paper was about assessing readiness for trauma-focused CBT (Trusz et al., 2011) and since then I have co-authored several publications about the effectiveness and dissemination of evidence-based treatments (Dunn, Lord, Lowe, Joesch, & Atkins, 2012; Krupski et al., 2012; Raskind et al., 2012; Tsosie et al., 2010; Zatzick et al., 2013; Zatzick et al., 2011; Zatzick et al., 2014; Zatzick et al., 2010). I mention these accomplishments to point out that I was very invested in researching and training evidence-based trauma treatments to the extent that I eventually became recognized, at least on a local level, as a clinical supervisor and consultant for manual-based treatments.

When I began in trauma research, I worked on projects that focused on the dissemination "stepped-care" PTSD interventions at hospitals and community mental health centers. Stepped-care is a method of treatment planning for mental health interventions that is designed, as my principal investigator once explained to me, to help a lot of people a little bit. Stepped-care is designed to provide patients with more intensive interventions as their level of acuity increases. For the studies I coordinated and also those in which I acted as a therapist, we performed the following interventions in order: crisis intervention, care management of basic-needs, alcohol and other substance abuse treatment, depression and post-traumatic stress treatment including evidence-supported psychotherapy and psychopharmacotherapy. In most stepped-care models if the patient does not respond to one level of care they should not be graduated to the next step; however, in practice this sometimes means not allowing patients access to more intensive care because they are seen as being unable to benefit from the more specialized

and perhaps demanding treatment (e.g., if they are dependent on alcohol they cannot attend five sessions of trauma focused CBT).

In traditional stepped-care models, the patient starts at the lowest step and is paired with the least trained practitioner, and as they move up the steps they gain access to more highly trained therapists. Stepped-care thus conserves financial resources for health centers by limiting access to highly trained mental health clinicians like psychologists and psychiatrists. In the initial research projects I was a part of, instead of moving patients from practitioner to practitioner as they progressed up the steps, we kept the patient with the same practitioner for all steps. In order for this to be cost-effective, the practitioner had to be inexpensive but be able to deliver all levels of care from crisis and case management to trauma-focused CBT with prolonged exposure. The question became: could the project feasibly train the front-line, bachelors-level students to preform advanced trauma treatment? The investigators believed this could be done if the novice practitioner could simply read from and retain fidelity to a treatment manual that had been shown to work in prior effectiveness trials; the sessions could be recorded and supervised by a psychologist and psychiatrist until it was clear that the novice could apply the manual in the treatment setting.

As a newly graduated psychology student when I joined the research team, I became one of a few candidates to become one of these all in one stepped-care practitioners. I was trained to fidelity in case management, motivational interviewing, behavioral activation, and trauma-focused CBT with imaginal and prolonged exposure; an ARNP worked with me in monitoring psychopharmaceutical interventions under the supervision of a psychiatrist. I found that the "lower step" treatments like case

management took more time to learn because they were not standardized and needed the communication of local knowledge from experienced social workers. The "upper step" treatments targeting depression and PTSD were highly manual-based to the extent that I was told I could read the script from the manual and by following it exactly, I could "deliver" the treatment.

Over the course of one year, I was supposed to speak with my patients once a week and deliver 10 minutes or less of motivational interviewing each time I spoke with them. Motivational interviewing was designed to target substance abuse and the motivation to attend trauma focused CBT. If the patient was able to abstain from all substances, I was instructed to deliver 5 to 20 minutes of behavioral activation and then assess readiness for entry into a course of CBT, with a maximum of five one hour sessions. Many patients did not abstain from substances and thus remained permanently stationed at the motivational interviewing and case management level until their substance abuse was adequately treated; some of these patients were allowed to augment treatment with psychopharmacotherapy. Thus the majority of my patients, all of whom had been referred for PTSD treatment (the last step) remained at the first two steps wherein I connected them with basic needs and substance abuse treatment for the majority of the trial. Less than 5% of our patients met all the criteria to receive trauma-focused CBT (Trusz et al., 2011). These patients seemed to be fairly well resourced psychologically and financially in comparison to those who we excluded from more advanced treatment; the majority of my patients were unemployed and/or homeless throughout the year I worked with them. Of the 5% that did receive trauma-focused CBT, almost all of them became "cured" from severe recurrent traumatic stress symptoms after

receiving five manual-based sessions. In these sessions, I literally read from the manual in the room. I was instructed not to prepare heavily (though I often did by re-reading the manual) and simply read from the manual when stuck. Despite my limited initial training, all of my patients improved significantly from session-to-session.

Though I retained excellent fidelity to the treatment delivery guidelines and my patients were improving, I also remember dreading some of the sessions of prolonged exposure (as I am sure my patients did) and not wanting to listen to rote rehearsals of traumatic events in great detail. I can still recall today some of the gruesome details that my patients reported; yet, by the end of treatment I, and perhaps the patients, had become so numb to hearing the same story over and over again that I believe the therapy met its goal of reducing the trauma to "just another bad memory." Though at times I hated performing the therapy, my principal investigator told me that my patients would be able to tell if I didn't believe in the treatment; he gave me the book *Persuasion and Healing* (Frank & Frank, 1993). He said if I could force myself to believe in it, or not let the patients become aware that I didn't know what I was doing, that they would be cured. (That indoctrination part, of course, wasn't written in the manual). I must have convinced myself to believe it pretty well because all of my patients performed well on their final self-report assessment; after twelve months of working together they claimed to be PTSD free. This was especially remarkable because we began therapy shortly after the traumatic event they experienced and terminated exactly on the anniversary of the traumatic event twelve months later (this was the research protocol). For patients to consistently improve month after month and have the lowest level of PTSD on the one-year anniversary of their trauma was considered a "robust" treatment effect. With these successes, I actually

did start to believe in the treatment more. I became more interested in the nuances of the treatment and eventually began to train others in how to deliver the 5-session cure.

Despite my early interest and successes in CBT treatment, my persuasive healing power as a five-session therapist waned the longer I remained in research. I began graduate school in 2008, after about two years working in this study, and became acutely aware of the disservice the profession was providing to patients by treating social and political problems like individualized, internal and medical diseases. I also became increasingly uncomfortable participating in research and found the industry to be exploitative of students who were at the core of its function.

By the end of 2010, my final cohort of trauma-focused CBT patients for some reason didn't improve by the time the 12-month assessment rolled around. This was a dramatic change from three years ago. In this particular trial, my patients had been steadily reducing symptoms and then when their final assessment came their symptoms "returned." Everyone was puzzled. My patients used to have such profound symptom reduction: What had happened? I was shocked because, while I had a growing distain for the therapy and research, I remembered feeling particularly good about this cohort of patients. They seemed engaged, thoughtful, emotionally present, and able to metabolize the trauma; they had also demonstrated many functional improvements in their life. Why were they suddenly worse at the 12-month assessment?

My first thought was this was somehow my fault (I had already picked up the narcissistic altruism of trauma research—it was my duty to rescue and heal my patients). I worried that my discomfort with scientistic research and CBT had led to some deviations in the research protocol: Had I strayed too far from the manual? I knew my

supervisors were assessing my sessions periodically with a checklist and I had been told I had excellent fidelity, but I still worried that my increasing disinterest in the therapy was to blame. In a different environment I might have taken a step back to think broadly about what it meant for my patients to get worse, but instead I was preoccupied with the possibility of my personal failure to adhere to the protocol. While obsessed about my personal failings, I also was aware that I didn't believe in the treatment as much as I used to after my first successes and on some level, I didn't want the therapy to work.

The principal investigator rationalized my patients' failure to improve as an issue with the sample: we simply hadn't picked the correct intent-to-treat population. Had the patients symptoms been more severe to begin with we would have seen a greater reduction in overall symptoms; this phenomenon is sometimes discussed in literature on treatment prevention. I accepted this explanation at the time. The treatment was correct; the problem was a flawed research design.

Around this same time, I started getting calls from patients in our first trial in 2006-2007 whom had been previously "cured." They had kept my phone number and wanted to come in for more treatment. Many of them explained they had encountered new traumas, returned to drugs, and were essentially back where they started. Others said their symptoms from their first trauma had returned shortly after completing the trial; a few said they had become lay therapists or social workers themselves. Most of them wanted return to treatment with me in some form (a few hoped if they did return that we wouldn't have to do the procedures in which they repeat details of the trauma over and over again). The principal investigator, following study protocol, directed me to refer

them to other CBT therapists in the area. As far as I know few pursued these referrals, and some continued to call me and left messages for years.

After leaving the trauma research team in 2011, I found myself continuing to wonder about my patients that "failed" to improve: what were they expressing in their final 12-month assessment? Maybe their improvement wasn't captured in our assessment of PTSD but in other dimensions that we weren't measuring. Perhaps they appeared to get worse at the end because it aligned with their trauma anniversary. Perhaps the treatment actually wasn't that effective after all. These possibilities fit within the research frame.

When I started thinking more relationally, different questions emerged: what did it mean for them to suddenly "get worse" at the end of our relationship? Perhaps they "got worse" because they were mourning our forced termination. Perhaps they were saying the treatment didn't actually work for them or they were aware that I didn't want it to work for them. Perhaps they were expressing their displeasure with the process by simply refusing to adhere to the protocol prescribed for them. Maybe they didn't feel they needed to please the research program or me by suddenly resolving all their symptoms; they would not be "cured" in five sessions. Maybe their problems didn't have to do with the single trauma they experienced. Not getting better was perhaps the last freedom they could exercise in our system of care.

Recently the paper for this study with the uncured cohort was published. The fact that no patients improved from PTSD treatment was not foregrounded in the manuscript. Instead, the patients in the intervention arm of the study incidentally reported reduced weapon use at 12-months, which was not the focus of our grant or the treatment we

evaluated. The framework of the study shifted to fit the results and was lauded as an intervention to stop school shootings and gun violence rather than a stepped-care PTSD study. An interesting discussion about what it means when evidence-based treatments don't work was avoided.

I retained my job at the university throughout graduate school, and moved between different research groups. While my first three years were focused on PTSD treatment via stepped-care protocols, the remaining two (2010-2012) I spent leading trainings and supervising new therapists in motivational interviewing. I even continued remote consulting into 2013, which ended when I was asked to help design a mobile app that could be fed audio of a therapy session and produce ratings of therapist efficacy (e.g., computer says: You have a 4 out of 5 on empathy).

Returning to the APPIC internship process, I wanted to move out of the state as a passive gesture to end my relationship with this type of evidence-supported research. At the time I believed that to leave on other terms would make no sense given my status in graduate school: who wouldn't want top-notch NIH funded randomized control trial clinical research experience on their CV?

When I applied in the APPIC internship system, I remember going through the web-based site directory and selecting "TRAUMA" as a Major Focus from the drop-down menu. This did not narrow down my choices, as nearly all sites in the APPIC directory appeared to major in trauma. I was then interested in sites that provided training in psychoanalytic therapy; there was no drop-down menu selection for this approach and I had to rely on word-of-mouth, and identification of individual supervisors at those sites. I applied to sites that I believed had supervisors with private practices in psychoanalysis.

My director of clinical training recommended I apply to at least ten to fourteen sites, so I broadened my scope to sites that maybe didn't specialize in but retained some connection to psychodynamic work.

Though I'll never know why I was selected for interviews by certain sites, I was rejected from the majority of them and asked to interview at three different county-funded clinics who specialized in community-based trauma treatment. Though each of these sites supposedly had a psychoanalytic informed supervisor I found that upon interviewing those supervisors had left or could not be worked with directly. I believe my curriculum vitae betrayed my new interests in leaving manual-based trauma treatment behind because during the interview process I found that the majority of the sites I could work for were quite interested in my CBT-based trauma work. Needless to say I ended up at a site that claimed to be somewhat broad in its views but was unified in the concern for preventing and treating child trauma according to evidence-supported care guidelines in a managed care system.

At my interview for this site, I was asked to do a "case conceptualization." I had not yet gotten to the theoretical orientation of the conceptualization but as I described some basic information about the case of a teenage boy who had been neglected I mentioned some symptoms of traumatic stress. The interviewers nodded when I said trauma, and mentioned something about how it was important that I had started by "conceptualizing" the case in terms of trauma. I realized in the moment that they saw trauma as the approach to the case conceptualization. For this case conceptualization, I need not describe trauma from a certain theoretical or clinical approach, trauma was seemingly an orientation itself.

The majority of my time on internship I worked for a county dependency court doing family evaluations that eventually contributed to the removal of children from their parents and termination of parental rights. The other half of my time I focused on child trauma treatment and attachment-based therapy with parents and their children. To fast-forward, a few months into my internship I was indirectly involved in a non-lethal shooting at our clinic. A woman was coming to our clinic and a man started screaming and shooting at her with a handgun as she walked towards the clinic. I was leaving for lunch and started to round a corner and unintentionally (and almost literally) bumped into the man. Because it happened so quickly, I was unaware that he was shooting and had a gun until someone started yelling at me to run.

When I discussed the shooting with my supervisors I was regaled with stories of how they had witnessed similar things and even been directly threatened with guns at their desk and placed on administrative leave; the fact was shootings were quite common where my placement was located and they saw their survival in this environment as a badge of honor. Indeed, there had been a shooting at a different clinic in our network only a month earlier where patients had actually been wounded.

The longer I worked at the site the more absurd I found mental-health treatment to be. My patients would leave the office and witness countless gang violence where they were the direct targets or, like me, were bystanders that lived in fear of the next time they would be almost shot. There was limited economy or opportunity for jobs outside of agriculture and drug smuggling. (The agricultural companies probably benefited from this monopoly on cheap labor to some extent and had moved some of the higher paid factory packaging jobs out of the area.) I don't mean to paint a bleak simplistic portrait of

the area; these issues are very complex and sadly I didn't have the opportunity to learn much about them.

I wanted to talk to the psychologists at my site about what we were doing and what the point of individual therapy was in this context, especially why we focused so heavily on trauma treatment. I also wanted to talk about the history of the region and how race, class, gender, and immigration status played into who was considered for trauma-focused treatment versus removal of parental rights or jail, but the topic of why we were doing what we were doing could not really be discussed. I was often met with sympathy for how difficult it was to "work in this environment" and how necessary our job was even though it was hard. People often commented how great it was that I was interested in culture and that I should continue to work to improve my multicultural competency.

I remember once sitting with my supervisor at the site talking about my personal discomfort with the power of the family assessments in the court. It seemed so strange that I, as an intern, after having only met these families for a few hours (and sometimes not at all if they didn't show) would be able to make recommendations that were supported by my supervisors and the court; recommendations that would impact the families for the rest of their lives. My supervisor reassured me that indeed we weren't that powerful and our APA Ethics Guidelines and the laws governing the court checked our power. Sometimes when I broached the subject of the fit of psychotherapy for the problems we encountered, I was met with bleeding heart dogma or even blatant Christian rhetoric about how we were "saving children." It was so good to be a trauma-focused therapist in this world.

My questioning about the appropriateness of trauma treatment started to be received as me "not believing" in trauma, being unconfident in my abilities as a therapist, or being mentally unstable. (In some ways probably all of that was true). The idea of me not thinking treatment was not appropriate was so incredulous to my supervisors that often my questions were met with education: I must simply not understand how devastating trauma is to these families, I must not see the value of disseminating evidence-supported psychological treatment to the needy.

If the fit of trauma-therapy could not be discussed, the intersection of race and culture with trauma therapy also certainly could not be mentioned (i.e., there was no commenting on the fact we were often recommending children be removed from their Hispanic families and placed with white families who lived out of the area). My status as a questioner took a turn for the worse when once with my supervisor I complained about my other supervisor's overt Christian rhetoric of saving God's children. She asked me if these conversations with the other supervisor were happening in real-life or in my head. At that moment, I realized if I didn't join their delusion I would be thought to be the delusional one.

Months after the shooting, as I felt growing isolation and continued questioning of my sanity, I called my DCT to ask to leave the site. I discussed my experiences and as soon as she heard about the shooting she began to screen me for PTSD. Resolving that my anxiety about internship was untreated PTSD from the shooting, she recommended I leave the site. She said something to the effect that I could easily get out of my contract if I said I had PTSD. I remember thinking how ironic it was she was saying this to me; yet, I also knew she was right. It would be easier for everyone involved if I was traumatized.

As a young, female student, I could get what I wanted by accepting my anger with my mentors on internship and isolation from any meaningful discussion about our work as the pathological symptoms of a trauma victim. My suffering, like that of many of the patients I worked with at that site, could be distorted and legitimated as a trauma diagnosis. The diagnosis came to symbolize everything that couldn't be said about my experiences there and about training as a psychologist.

It was tempting to embrace PTSD: it would explain away all of the issues I was raising. I could be understood by my fellow psychologists and overcome the isolation I had been feeling, they might now even be able to help me because they knew how to reduce PTSD symptoms. If on the other hand I said what I actually felt: I feeling isolated from being unable to talk or think about what we were doing here with anyone; this might have been categorized as a avoidance of talking about my trauma or at a minimum converted into a point of further "professional development" in my learning plan. I would probably get some sort of remediation recommendation, "needs to develop competency in appropriate self-care." With PTSD it wasn't my fault, it wasn't my supervisors fault—no one really had to take responsibility for what was going on at the internship site or even think about the larger community problems. My problems on internship were due to the shooting—a random event that couldn't have been prevented and could have occurred in any place at any time.

But I am talking about all this as if I had a choice to be diagnosed, like I could choose to embody PTSD symptoms for decisive or utilitarian purposes. The reality was I couldn't be seen as existing in any other way. As soon as the words "I was in a shooting" came out of my mouth and the PTSD screening assessment was completed, there was no

turning back. My anger, distrust and disappointment with the training system were now just one of many PTSD symptoms; everything I did from that point onward was PTSD related for the wrong reasons. (Perhaps even writing this dissertation and talking about the experience now could be framed as traumatic compulsion to replay intrusive memories of my experience.) Needless to say I felt trapped in the end because I would have to leave internship on the terms of a PTSD survivor. If I stayed I would be similarly pathological, a PTSD victim who opted to continue to expose myself to the traumas of the training site.

Perhaps from the DCT discussing with other faculty, news of my potential PTSD diagnosis and exposure to the shooting slowly spread through the program. About a month after the shooting, I received a call from my professor and dissertation Chair, Dr. Philip Cushman, who had heard about the trauma. We discussed how my experiences were reflective of a problematic trend in the field where persons who raise moral questions about psychology or are interested in discussing the consequences of therapy from a political and social perspective are often isolated, ignored, placated/patronized, or pathologized. We discussed how my discomfort and resistance to the training structure and procedures was eventually reinterpreted as PTSD, and how these actions might be reflective of psychologists' discomfort and dissociation from daily political struggles.

One of the most important memories of that conversation I had was talking about pain of living with and being aware of these problems while practicing as being potentially preferable to the pain of ignoring and dissociating from these realities while practicing. I found that the most painful consequence for me had been isolation and feeling unable to actually meaningfully discuss my experiences there in a way that was

connected to the social reality of Salinas. Therefore, the discussion with Dr. Cushman provided me a sense of solidarity and relief. Being able to talk about my experience in a political way was so important. I didn't fully realize how much the lack of these discussions was contributing to my despair and also to a potential reenactment of the traumatic situation—a situation where I felt pressured to accept either the role of a helpless victim or the role of trauma survivor who could process through the shooting to emerge as a positive, functional rescuer therapist that could keep helping others through the same (dysfunctional) system.

At the time I didn't realize it, but reflecting back on this experience, it was conversations like the one I had with Dr. Cushman that gave me some room to think creatively and politically about my experiences without feeling trapped in a do-or-die compliance situation. Our conversation also led to more political conversations with my friends and peers in similar training situations, which further helped me gain confidence and perspective.   In the end, I stayed at the internship site purely so I wouldn't have to go through the process of applying and getting matched to a potentially similar placement again. I guess I felt that, given the state of the field and training, this was not an issue unique to my placement, and that I was able to stay while also being thoughtful about my participation.

Another notable aspect of my training experience in manual-based treatment was the common feeling that I was being indoctrinated into a cult. This started perhaps with my principal investigator telling me to believe in the therapy so that my patients would; the content was irrelevant unless I could convince the patients I thought the therapy would work. This feeling grew when I attended my first International Society for

Traumatic Stress Studies (ISTSS) meeting. At that conference, people told me things like "you get trauma." I attended one of these with the principal investigator from the trauma trials and watched as people eagerly ran up to him to discuss the work we had been doing in stepped-care treatment.

The peak of cult-like experiences occurred for me when attending workshops for manual-based trauma treatments. The EMDR Humanitarian Assistance Program level 1 training involved lots of talk about suspending belief about the need to know why the treatment works and accepting that it does. The training included testimonials from patients who had become clinicians who would have never thought that literally have someone wave fingers in front of their face—known in EMDR as bi-lateral stimulation—would have cured them. They explained that traumatized memories are locked inside our brains like tiny crystals and EMDR breaks apart these crystals through the mechanism of bi-lateral stimulation that works for unknown reasons.

The culmination of the training was to read from the therapy manual script without any prior training and actually perform the treatment on one of our fellow learners. They claimed no further specialized clinical experience was needed to perform EMDR as long as we had the manual, and we were allowed to begin the therapy on each other during the workshop without any direct supervision. As the patient in this exercise, the trainers didn't want us to pick a "trauma with a capital T" to work on in our dyad. They hoped we would pick a benign bad memory to desensitize through EMDR. As the dyads devolved into crying and hypnotic states, the trainers acknowledged that the therapy was so powerful that it was hard to not get to the essence of "big T" trauma of our lives no matter what memory we chose.

Apparently, the "little t" trauma I chose did not fit within the basic protocol guidelines. My partner was a graduate student a few years younger than me; she proclaimed how much she hated these trainings and how vulnerable these exercises made her feel before we began. I agreed and we both proceeded anyway. She read from the manual word-for-word and I, as the patient, was asked to select a traumatic memory to process. As we proceeded through the therapy I noticed I couldn't access the memory I had selected anymore. I saw visions of myself becoming entombed in an ice coffin and looking out as the memory played like a movie behind an ice wall. One of the EMDR trainers happened to walk by during this moment and yelled to my partner, "Get her out of there! She is freezing out!" My partner nervously left her chair and the trainer sat down, removed her cardigan and started rapidly sweeping her hand from side to side in front of my face. She introduced "a protector figure" into my memory and explained to my partner that we would learn this technique in Level 2 training (and there was a different manual needed for this special scenario that we could order online or buy at the end of the training.) She then asked my protector figure to speak to my memory as if it was a tiny child. I wish at this point I had just left but I didn't for a range of reasons I can't recall. I am sure I convinced myself to stay because we were required to get Level 1 certification at my practicum site. I had learned by now that resistance to training just meant you were farther from graduating (it was if at times I had to remind myself I actually wanted to be a psychologist). In the end I did not have a transformative experience and left the exercise feeling tired and somewhat exploited.

There were a few of us who weren't totally on board with EMDR at the end of the first day of the workshop. My partner began the next day of the workshop crying about

the horrible experiential exercises we were conducting on each other in the training and how graduate school was so depleting. The rest of the trainees, who on the first day were quite skeptical of the program, by day two had somehow become EMDR converts. Everyone talked about how they had a "new relationship" with their trauma, how "it didn't have power over them," and how they were freed. Apparently this is a common experience for patients, as later in clinical practice I found many of patients asking specifically for EMDR so they could think of a bad memory and not feel anything. I also found my supervisors recommending EMDR for patients whom were so somatically bound or dissociative that they were "resistant to" or "did not have resources to engage" in therapies that overtly discussed the trauma without bi-lateral stimulation.

Overall, the second day of the training was littered with trainee success stories and advertisements for level 2 training and "special scenario" protocols; we were automatically signed up for three special post-workshop supervision sessions (which as student trainees we didn't have to pay for). I never made it to the Level 2 training. And true to cult-like form, I continue to get emails from the trainers and my old practicum director saying I will always have a spot in that Level 2 training should I ever want to accept it.

Like with my patients that seemingly got worse at the end of treatment, I wondered about my own experience of "freezing out" of the EMDR exercise and what it means when people aren't cured from evidence-supported trauma treatments. While I am sure I will continue to reflect on the meaning of these experiences, I think in this case I viewed the whole EMDR workshop as somehow coercive. I felt trapped (maybe frozen) in my training experiences; perhaps I was protecting, as Hillman and Ventura (1992)

might say, the "raw ore" of my emotional experiences from being processed and desensitized via the EMDR manual with the distressed intern-therapist across from me.

Summary of My Experiences With Trauma Culture

This section described some of my experiences in trauma culture before beginning this study (October 2013). At that time, I wrote that I believed I would approach my study of trauma treatment manuals with obvious prejudice, including distain for the manual-based training process and also curiosity about the tradition of trauma psychotherapy. Before beginning the interpretation of the treatment manuals, I wrote that I was consciously aware of the following assumptions:

1. There is a cultural understanding in the field of psychotherapy that trauma therapists are uniquely sensitive persons that get to the heart of the problem with patients (i.e., the trauma).

2. There can be a morally righteous or evangelical air to the field of trauma therapy. Therapists are seen as rescuing patients and performing the good and necessary work of therapy (cf. N. S. Rose's 2006, "moral entrepreneurship").

3. Psychologists are given immense power to shape the constitution of self and expression of symptoms (e.g., five session CBT cures). Some forms of trauma therapy maximize the power differential in the service of increasing the potency of the treatment (e.g., therapist need to educate patients about their experience of trauma through psychoeducation so they understand the rationale for treatment).

4.   While therapy can take the form of coercion and control (cf. Foucault, 1973; Szasz, 1974) the field of trauma therapy is often seen as universally good, especially when helping underprivileged traumatized patients.

5.   Trauma therapy is seen as more difficult than other forms of therapy, perhaps with the exception of treating Axis 2 disorders (though many patients diagnosed as meeting criteria for Borderline Personality Disorder are also conceptualized as victims of trauma and abuse). Those therapists who work exclusively with trauma victims often take masochistic pride in their work (e.g., in-group machismo about being strong enough to work with veterans, overly humble therapists that describe their duty to treat child sexual abuse for over 40 hours a week).

6.   It is not popular to question the fit of trauma therapy or reject trauma theory in conceptualizing patients who are seen as traumatized. These actions can be interpreted as victim blaming, patient abandonment, or the beginnings of therapist impairment.

7.   My training has been characterized by compliance. Trainees often learn a kind of doublethink (cf. Orwell's *1984*) when it comes to certain trauma treatments. When we instinctively don't want to learn or perform certain treatments on patients or each other (in training) but we do anyway in order to comply with the requirements of training programs or research protocols. We become focused on meeting requirements as if we are in a survival situation, and stop questioning the means by which we achieve these goals.

8. Most newly trained therapists today (including myself) have difficulty thinking historically about our work in part because they are not trained to do so.

9. In general, therapists tend to stop questioning and thinking about what we are doing clinically when the explanation of trauma or PTSD enters the dialogue (e.g., all clinical explanations that culminate in "because she was traumatized or has PTSD" seem to gain immediate understanding and privilege).

Results and Discussion

In Chapters V through IX of this study, I review the research findings and present my interpretation of the results. Whereas the distinction between results and discussion typically is fitting for quantitative studies, in this study I have merged the results and discussion chapters given the nature of hermeneutic interpretation in which all results are interpretations and are not assumed to be neutral or objective. Thus, each manual chapter is structured such that the results or findings from the text (e.g., the specific themes and exemplars) are followed by hermeneutic interpretation and discussion of each finding. Each chapter includes the history and context of the manual's development, as well as the themes, exemplars and questions identified in each text.

The results and discussion chapters conclude with a description of the paradigmatic object (Chapter IX) that exists across all manuals. I then revisit foregrounding and summarize the results and discussion in the conclusion through the process of reconstruction (see Figure 2; Stigliano, 1989). The basic descriptive information for each text included in the study has been provided in Table 2.

Table 2

Descriptive Information About Treatment Manuals Selected for Interpretation

Manual Title	***Treating Trauma and Traumatic Grief in Children and Adolescents (Cohen et al., 2006)***	***Eye movement desensitization and reprocessing (EMDR): Basic principles, protocols, and procedures (Shapiro, 2001)***	***Battlemind Psychological Debriefing (Adler, Castro & McGurk, 2007)***
Authors	Judith Cohen, M.D, Esther Deblinger, Ph.D., and Anthony Mannarino, Ph.D.	Francine Shapiro, Ph.D.	Amy Adler, Ph.D., Lieutenant Colonel Carl Castro, Ph.D., and Major Dennis McGurk, Ph.D.
Publication year (original year)	2005	2010 (1990)	2007
Primary funding agencies	Substance Abuse and Mental Health Services Administration; U.S. Department of Health and Human Services (SAMHSA)	Meta Development and Research Institute Inc., EMDR Institute Inc., Kaiser Permanente, National Institutes of Mental Health (NIMH)	Walter Reed Army Institute of Research, U.S. Veterans Administration, Department of Defense
Text (format)	Training manual (published book), web-based learning course (Internet), first year utilization report	Training manual (published book), workshop manual, advanced protocols (DVD or paper)	Training manual (report), associated training brochures and other training materials (PowerPoint)
Country of origin (N = countries with trained practitioners)	U.S. (60)	U.S. (40)	U.S. (2)

Table 2 (continued)

Descriptive Information About Treatment Manuals Selected for Interpretation

Manual Title	***Treating Trauma and Traumatic Grief in Children and Adolescents (Cohen et al., 2006)***	***Eye movement desensitization and reprocessing (EMDR): Basic principles, protocols, and procedures (Shapiro, 2001)***	***Battlemind Psychological Debriefing (Adler, Castro & McGurk, 2007)***
Languages available (modality of training)	English (web-based and paper manual), Dutch, German, Japanese, Korean, and Mandarin (paper manual)	English, Chinese, Danish, Dutch, French, German, Indonesian, Italian, Japanese, Norwegian, Polish, Portuguese, Spanish, Swedish, Thai, and Turkish (paper-based manual and in-person training workshops)	English and "Anglicized" English version for U.K (in-person training workshops via PowerPoint and paper-based manual)
Patient population age	0-55+	18-55+	17-40
Target utilization audience	MA or above in mental health field	MA or above in mental health field, licensed or certified through a state or national board which authorizes independent practice	"Military officers with combat deployment experience who are also trained in a behavioral health specialty… Co-facilitators could be enlisted service members with related specialties (e.g., Mental Health Specialist [68X])" (Adler et al., 2007, p. 4). Civilians may also be leaders depending on training and experience
Setting, format	Outpatient clinic, individual child and parent-child treatment	Outpatient clinic, Individual treatment	Post-combat, In-theatre, group or individual treatment

Table 2 (continued)

Descriptive Information About Treatment Manuals Selected for Interpretation

Manual Title	*Treating Trauma and Traumatic Grief in Children and Adolescents (Cohen et al., 2006)*	*Eye movement desensitization and reprocessing (EMDR): Basic principles, protocols, and procedures (Shapiro, 2001)*	*Battlemind Psychological Debriefing (Adler, Castro & McGurk, 2007)*
N = recommended sessions (total minutes per session)	12 to 16 (90)	1 to 3, more if indicated (60 – 90)	2 skills training (35), unlimited debriefing (varies)
Required implementation materials (cost)	Training manual ($35); 10-hour online introductory training (free); 2- to 3-day, on-site full clinical training (introductory and advanced training) (varies); consultation call twice a month for at least 6 months (varies); TF-CBT brief practice checklist (free)	Training manual ($62)	Training manual (free); additional PowerPoint trainings with videos and scripts for trainers/clinicians (free)
Optional implementation materials and costs	Learning collaborative (varies)	• Assorted books to support implementation in various contexts ($18-55) • EMDR book course (includes manual, an EMDR test, and 8 continuing education credits) ($154 per participant) • 7-day regional EMDR basic training at various U.S. locations ($2,000 per participant) • Assorted advanced specialty application workshops (includes continuing education credits, which vary by course) ($325 per participant) • Initial EMDR clinician certification ($350) • 2-year EMDR clinician certification renewal ($200)	None

Table 2 (continued)

Descriptive Information About Treatment Manuals Selected for Interpretation

Manual Title	*Treating Trauma and Traumatic Grief in Children and Adolescents (Cohen et al., 2006)*	*Eye movement desensitization and reprocessing (EMDR): Basic principles, protocols, and procedures (Shapiro, 2001)*	*Battlemind Psychological Debriefing (Adler, Castro & McGurk, 2007)*
Minimum total required costs (total optional costs)	$35 (varies)	$62 ($3047)	Federally funded, training cost not reported
Supplemental training materials included in analysis (format)	TF-CBT Web: http://TF-CBT.musc.edu/ (Website based on Cohen et al. (2006) book)	Luber, M. (2010). *EMDR scripted protocols with summary sheets CD-ROM version: Basics and special situations.* New York, NY: Springer Publishing Co. (PDF)	Pre-deployment training (PowerPoint with trainer notes): • Battlemind I Training (WRAIR, 2006a) • Battlemind for Leaders (WRAIR, 2008a) • Battlemind for Warriors (Adler, Castro, McGurk, 2009) Post-deployment debriefing (Adler, Castro, McGurk, 2007, 2009) (PowerPoint with trainer notes): • Battlemind II Training (WRAIR, 2006b) • Combat and Operational Stress Control Briefing on Battlemind Debrief (Castro et al., 2006) PDHRA Battlemind Assessment (PowerPoint with trainer notes): • Clinician Training to Administer DoD Deployment Mental Health Assessments (WRAIR, 2005)

| | | • PDHRA Battlemind Training (WRAIR, 2006c) |
| | | • Memorandum from Secretary of Defense on MH Assessment for Military (DoD, 2009) |

Note. MA indicates Master of Arts; MH indicates mental health; TF-CBT indicates trauma-focused cognitive behavioral therapy.

Manual 1: Treating Trauma and Traumatic Grief in Children and Adolescents

(Cohen et al., 2006)

In this chapter, I present the results and discussion of my interpretation of the

trauma-focused cognitive behavioral therapy (TF-CBT) Cohen et al. (2006) manual,

which I refer to as the TF-CBT manual or Cohen et al.'s manual. After presenting the

specific context of this manual's development, I introduce the shared themes and

exemplars[38] that were found in all three manuals (TF-CBT, EMDR and Battlemind),

After presenting the shared themes and exemplars, I then introduce the themes and

exemplars that I identified only within the TF-CBT manual. Before proceeding to the

next manual, I propose and briefly discuss questions that may be unanswered by the text,

the interpreter (myself), and the immediate context (e.g., foregrounded assumptions) but

are important to consider. Thus the structure of this chapter is as follows: shared themes

(findings followed by discussion), shared exemplars (findings followed by discussion),

TF-CBT unique themes (findings followed by discussion), TF-CBT unique exemplars

(findings followed by discussion), TF-CBT questions (questions followed by discussion),

and summary. Following the presentation of each manual, I include a final summary and

discussion in which I consider all of the manuals together in light of the areas of inquiry.

Context of the Manual's Development

Treating Trauma and Traumatic Grief in Children and Adolescents is a manual

for trauma-focused cognitive-behavioral therapy (TF-CBT) for child victims of trauma

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[38] Exemplars are stories or vignettes that capture what human being is like in trauma culture in such a way that it could be recognized in other situations that might have very different objective circumstances, including those outside of the practice of psychotherapy.

and their non-offending parents (Cohen et al., 2006). The manual is a culmination of a longstanding collaboration between clinical researchers in Pittsburgh (Cohen and Mannario) and New Jersey (Deblinger) who previously independently developed and tested trauma-focused treatment manuals for sexually abused preschoolers, school-age children and adolescents (Cohen & Mannarino, 1992, 1994; Deblinger & Heflin, 1996).

The majority of the foundational efficacy research for the manual was conducted in the 90s and was influenced by feminist psychologists who attempted to increase awareness about child abuse (Cohen & Mannarino, 1993, 1998; Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Deblinger, McLeer, & Henry, 1990). The authors also drew heavily from Edna Foa's exposure-based TF-CBT model (Foa et al., 2009) and added suggestions from community based therapists affiliated with the National Child Traumatic Stress Network (NCTSN) and the Child and Adolescent Treatment Consortium in New York City that was founded after the September 11, 2001 attacks (Cohen et al., 2006, p. 35).

Demographics of treatment population. According to evidence-based treatment guidelines, TF-CBT has demonstrated treatment efficacy with children from birth to age seventeen, and their parents ages 26-55 (SAMHSA, 2013). It's unclear why ages 18 to 26 were not reported in the SAMHSA guidelines as an appropriate age for intervention; the manual reported that the treatment can be used in community settings with any parent (not specifying parental age). TF-CBT has the most empirical support for effectiveness in treating PTSD and related problems in children when compared to all other trauma-focused psychotherapy treatments (Journal of the American Academy of Child and Adolescent Psychiatry [JAACAP], 2005; Putnam, 2003; SAMHSA, 2013; Saunders,

Berliner, & Hanson, 2004). Several randomized controlled trials have demonstrated the

efficacy of the specific TF-CBT treatment model described in the 2006 manual (Cohen &

Mannarino, 1996, 1998; Cohen, Mannarino, & Knudsen, 2004; Deblinger & Heflin,

1996), and it has been evaluated with children who have suffered a wide array of

traumatic experiences (e.g., traumatic grief, exposure to domestic or community

violence) (p. 34).

Context of the authors. All of the authors come from a background in federally

funded research and have served as professors and clinicians in U.S., East Coast

universities and their affiliated teaching hospitals. Judith Cohen is a board certified child

and adolescent psychiatrist who, since 1983, has been funded by more than a dozen

federally supported grants to conduct research related to the assessment and treatment of

traumatized children. Cohen is the Medical Director of the Center for Traumatic Stress in

Children and Adolescents at the Allegheny General Hospital in Pittsburgh. Anthony

Mannarino is a licensed clinical psychologist who was described in the manual as "a

leader in the field of child traumatic stress for the past 24 years" (p. vi). He also has been

awarded several federal grants to develop treatments for child traumatic stress and is the

Director of the Center for Traumatic Stress in Children and Adolescents at the Allegheny

General Hospital in Pittsburgh. Cohen and Mannarino were colleagues since 1998 and

collectively have received funding from a range of federal funding agencies including:

NIMH, SAMHSA, U.S. Department of Justice, National Center on Child Abuse and

Neglect, as well as local agencies including the Jewish Healthcare Foundation of

Pittsburgh and the Staunton Farm Foundation of Pittsburgh (p. xi). Esther Deblinger is a

licensed psychologist at Professor of Psychiatry at the University of Medicine and

Dentistry of New Jersey who also has conducted numerous research trials on child abuse and PTSD treatment.

Treatment goals, structure, and principles. The overarching goals of the child TF-CBT treatment presented in the manual were to reduce symptoms of PTSD and increase the developmentally appropriate functionality of the child. Specific goals were listed throughout the manual. To give a flavor of the vernacular of the text, I have paraphrased these goals here while still retaining some of the vocabulary used in the manual (I have cited the page numbers where the goals are explained in further detail). The goals of TF-CBT described in the Cohen et al. (2006) manual were to:

1) Assist the parents in regaining their role as the primary therapeutic resource and support for their children (p. 47);

2) Normalize child and parent responses to traumatic events (p. 59);

3) Reinforce accurate cognitions about what occurred (p. 59);

4) Teach the child to manage difficult affective states by teaching him or her in the use of a psychological "tool kit" to select skills from when they are distressed (pp. 95, 100);

5) Enhance problem-solving and social skills (p. 95);

6) Desensitize the child to traumatic reminders and un-pair thoughts, reminders, or discussions of the traumatic event from overwhelming negative emotions such as terror, horror, extreme helplessness, shame or rage (p. 119);

7) Enable the child to integrate traumatic experiences into the totality of his/her life (p. 119); and,

8)   Help the child to gain mastery over the most upsetting, intrusive memories and images of the trauma (p. 132).

The authors use the acronym CRAFTS for treatment planning to represent the different treatment targets: C indicated Cognitive problems; R indicated Relationship problems; A indicated Affective problems; F indicated Family problems; T indicated Traumatic behavior problems; and, S indicated Somatic problems. They also use the acronym CRAFTS to describe what they call "the values" of TF-CBT (p. 33) that should be embodied by the therapist and therapy, where C indicated Components based (emphasizing skills tailored to patient); R indicated Respect (for the individual, family, religious, community and cultural values); A indicated Adaptability (creative and flexible in adapting core components of treatment); F indicated Family involvement; T indicated Therapeutic relationships (seen as essential to restoring trust, optimism and self-esteem in traumatized children); and S indicated Self-efficacy (providing life skills and enhancing individual strengths) (p. 33). At first glance, not all of these elements fit the common understanding of the word value in terms of human ethics (e.g., a persons principles or judgment of what's important in life) but this is the terminology the manual uses to describe CRAFTS. I explore the particular values of "C" components-based and "R" respect for cultural values in Shared Theme 3 (pp. 237-247).

The TF-CBT treatment was designed to be completed in twelve to sixteen, 90-minute, weekly individual sessions between the therapist and child. Two optional joint sessions between a parent (referred to as the "non-offending parent" or "the mother" throughout the manual) and the child were also recommended. Figure 3 includes the progression of therapy across the twelve to sixteen week period broken into different

modules. Because TF-CBT was designed to be component-based it would be possible for a therapist to spend more than one session on a given module depending on the needs of the patient.
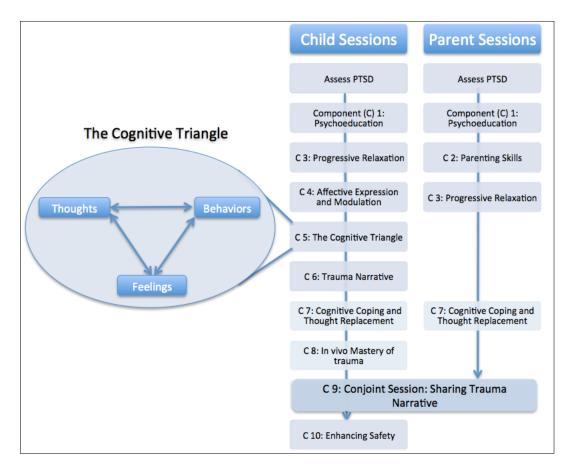
Figure 3. Cohen et al. (2006) trauma-focused cognitive behavioral therapy components.

The manual emphasized that the TF-CBT should be "child focused" (p. 36), and though parents should be incorporated into one or more sessions of TF-CBT, the identified patient is the child throughout treatment. To tailor the tailor the treatment to each individual child's and family's needs, the manual recommended the format of individual child treatment as the ideal modality for TF-CBT. The manual noted potential pitfalls of group work such as children being traumatized by other trauma stories and

their subsequent legal testimony being compromised (p. 36). Though individual treatment

was the primary modality, the parent is still seen as central to the child's well-being:

> We view the parents as an important source of support and reinforcement for the children's progress both during treatment and subsequently. Including parents in treatment is an optimal means by which to attain TF-CBT goals of enhancing parenting efficacy, parent-child communication and familial attachments. (p. 38)

The authors stated that TF-CBT was "effective in helping non-offending parents

overcome depressive symptoms as well as abuse-specific distress" (p. 36) but that

parental PTSD and stress reactions were better treated in parent individual therapy.

The presentation of trauma in the manual. Child trauma was presented in the

first chapter of the manual according to the medical model and evolutionary theory of

fear responses described in the Background and Literature Review Chapter (pp. 9-100).

The manual also described trauma pathology according to the *DSM-IV-TR* definition of

PTSD. Traumatic events were distinguished from other stressful situations using the

following criteria, "sudden or unexpected events; the shocking nature of such events;

death or threat to life or bodily integrity; and/ or the subjective feeling of intense terror,

horror, or helplessness (APA, 2000, p. 463)" (Cohen et al., 2004, p. 4). The manual

suggested that Criterion A (the subjective experience of fear, horror, helplessness) in the

PTSD diagnosis was key to understanding pathology because:

> The experience of trauma depends not only upon exposure to a traumatic event but also on the individual child's response to that event. This response variation occurs, in part, because children have unique ways of understanding traumatic events, making meaning of these events in relation to themselves, accessing familial and other forms of support, coping with the psychological and physiological stress associated with these events, and integrating these events into their larger sense of self. (p. 4)

The manual emphasized the individual and internal characteristics of the child as

the primary determinant of whether an event was traumatic, "the impact of an identical

stressor may vary considerably from child to child depending on each child's inherent

resiliency, learned coping mechanisms, and external sources of physical, emotional, and

social support" (p. 4). Similar to the mainstream medical model of trauma, the TF-CBT

manual psychoeducational texts suggested that traumatic events were represented in the

brain as if they have been etched into the physical body:

> it is not surprising that trauma events have the potential to alter brain functioning.
> When these changes in brain functioning are maintained over a long period (in
> some cases long after the traumatic events have ended), they may contribute to the
> maintenance of many of the trauma symptoms described earlier. In some cases,
> these chronic functional alterations may also contribute to structural changes in
> the brain. (p. 14)

The manual described trauma as being etched into the body but not integrated into

the "larger sense of self" (p. 4); thus, integration was one of the primary goals of the

therapy.

In addition the diagnostic description of trauma, the manual described trauma

symptoms using the image of the "sword of Damocles":

> A sense of impending doom (the "sword of Damocles" hanging over their heads)
> can impinge on children's ability to engage in developmentally appropriate tasks
> and contribute to their taking on responsibilities well beyond a maturity level
> typical for their age. (pp. 6-7)

In this quote, the trauma as the sword of Damocles forced the child away from

age-appropriate behavior. This was one example of many in the Cohen et al. (2006)

manual that described trauma as somehow robbing the child of their childhood, which I

explore further in the TF-CBT Theme 1 section (pp. 262-267).

Key sociohistorical context mentioned by the authors: September 11. The key

historical context of the manual's development was its creation in reaction to and

stemming out of research on the September 11 (9/11) terrorist attacks. On September 11,

2001 the terrorist group al-Qaeda launched four coordinated attacks targeting the World

Trade Center, the Pentagon and another location in Washington, DC (the White House or

the Capitol). In New York, the World Trade Center was destroyed after two hijacked

planes were crashed into the sides of the towers. Nearly 3,000 people died as a results of

the attacks; it was also the deadliest incident for firefighters in the history of the U.S.

(Amsel, Neria, Suh, & Marshall, 2006). Random-digit telephone surveys conducted four

to eight weeks after the attacks reported that 7.5% of adult New Yorkers in the Manhattan

area and 4.0% of adults in the Washington, DC area met criteria for PTSD (Galea et al.,

2002; Schlenger et al., 2002). In addition, 17% of the population outside of New York

City experienced acute PTSD symptoms two months after the attacks. The telephone

surveys used the PCL-C and SLESQ to determine level of traumatic exposure and PTSD

symptom severity (see pg. 14 of Background and Literature Review for further

information on these assessments).

In response to the spreading PTSD epidemic post-9/11, large scale therapist

training programs were initiated (Amsel et al., 2006; Difede, Roberts, Jayasinghe, &

Leck, 2006; Katz, Smith, Herbert, Levin, & Gross, 2006; Marshall & Galea, 2004) and

state-wide outreach and counseling programs in New York were rapidly developed and

disseminated (Shear, Jackson, Essock, Donahue, & Felton, 2006). Many of these

programs were targeted to treat children (Cohen, Mannarino, Gibson, et al., 2006; Draper,

McCleery, & Schaedle, 2006).

The authors of the TF-CBT manual (Cohen, Mannarino, and Deblinger) were

asked to set up a series of child-parent treatment centers in reaction to the attacks. It was

out of the research and work during this time the Cohen et al. (2006) manual was created.

The authors noted, "Since the events of September 11, 2001, and the establishment of the

National Child Traumatic Stress Initiative (www.nctsnet.org), funded by the Substance

Abuse and Mental Health Services Administration (SAMHSA), the number of therapists

requesting training in the TF-CBT and CTG [Childhood traumatic grief] treatment

models has increased exponentially" (Cohen et al., 2006, p. vii). While the authors

explicitly mentioned September 11 as related to sources of funding in the introduction,

the manual was promoted as a manual for children suffering from any trauma and not as

one specifically designed for agencies responding to terrorist attacks. As evidenced by

the earlier versions of the manual (Cohen & Mannarino, 1993, 1998; Deblinger et al.,

1989; Deblinger et al., 1990), and the research supporting the manual's development, the

manual was clearly intended to treat multiply traumatized children, especially those who

have suffered from sexual abuse and traumatic grief.

Despite the broad population the manual was designed to serve, it was also

apparent that the manual was drafted within the U.S. political context post-September 11.

There was recurrent mention of 9/11 in the TF-CBT manual. One example described

cases of child traumatic grief including, "complicated cases of traumatic death where the

remains are not located or identified for a prolonged period of time, as in the case of the

2001 terrorist attacks on the U.S." (p. 42). Another example discussed aggressive child

fantasies like, "therapists believing that [their patient's] acting out aggressive or revenge

fantasies (e.g. flying to the top of the World Trade Center and carrying the victims to

safety or killing the terrorists before they crashed the plane)" (p. 129).

Overall, the word "terrorism" or "terrorist" appeared in 17 different examples of

ways children and their parents can be traumatized throughout the manual. When

terrorism was not directly mentioned, disasters associated with September 11 were, such

as fire (appeared 24 times), explosions (appeared 3 times), bombs (1 time), and an airline

attack (1 time).[39] There was even a script for the therapist to coach a parent on recovery

from a terrorist attack (p. 116; see further discussion in Shared Theme 1, pp. 210-225).

The mention of terrorist-related traumas was more prevalent than common-place

traumatic events such as car accidents (appeared 4 times), physical abuse (appeared 5

times), bullying (4 times), and parental death (1 times). The traumatic events that

appeared the most in the manual included domestic violence (59 times) and sexual abuse

(89 times), which is perhaps indicative of the original versions of the manual developed

in the 90s when domestic violence and sexual abuse were exclusively the domain of

women and children's suffering (see previous discussion on pp. 92-94).

Thus, when considering the Cohen et al. manual, it is important to understand that

it is not a culturally neutral document. It reflects the local context of its development in

the East Coast of the U.S. post-September 11, and the authors direct involvement in the

response to the attacks. This especially important to consider as it pertains to the idea that

the trauma treatment represented in the manual is supposedly designed for dissemination

in all settings and countries. The implications of the manual's creation post-September 11

and its subsequent dissemination around the world (to 60 countries) are further discussed

below in Shared Theme 3 (pp. 237– 247).

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[39] In contrast to other manuals analyzed in this dissertation, the words terrorism or
terrorist appeared only once each in the EMDR (Shapiro, 2001) and Battlemind manuals
(e.g., WRAIR, 2006a). Interestingly, September 11 was not mentioned in any of the
Battlemind trainings despite the attacks being one of the primary events that instigated
the wars in Afghanistan.

Shared Theme 1: Mind-brain as Protector and the Political Use of Cognitivist Ideology

In this section, I present the first theme that was shared by all of the manuals I interpreted. All of the manuals predicated therapy on three interrelated assumptions: 1) You can change the world by changing your mind, 2) When you change your mind you change your brain; and, 3) Your brain and mind can protect you from trauma (i.e., if you have inner safety, you are safe and thus the world is safe). The main problem with these assumptions is the confusion between shifts in individual subjectivity and shifts in the social world, which can ultimately result in no change to the status quo of existing political problems and arrangements of power and domination (cf. Sampson, 1981).

Thematic findings: Mind-brain as protector and the apolitical use of cognitive ideology. This section presents quotations from the Cohen et al. (2006) manual that are representative of the theme: mind-brain as protector and the political use of cognitivist ideology. I have divided the section according to the three assumptions listed above.

You can change the world by changing your mind. A key technique utilized throughout TF-CBT was cognitive processing with thought-replacement, where the therapist was instructed to identify and direct the patient to replace post-traumatic negative or dysfunctional cognitions with positive and functional thoughts. The therapist was instructed to teach the traumatized child how to change their thoughts like changing the channel on a TV:

> The next step is to encourage the child to learn how to generate alternative thoughts that are more accurate, or more helpful, in order to feel differently. Some children may understand this concept better if the therapist compares it to changing the channel on the TV, "If you don't like what you are seeing on one

channel, you can switch to another channel to find a better show. Finding a more accurate or helpful thought may similarly involve some 'channel surfing' until you find a thought that feels better." Some young children may find the use of "thought bubbles" beneficial. (p. 110)

The following quote from the manual demonstrates a thought-replacement exercise that the therapist would conduct with child patients to teach them to change their thoughts like changing a channel:

> Scenario A [thought]: "Mom's not being fair."
> Feeling: mad,
> Behavior: You say "I hate you!" and run to your room.
> Result: Mom punishes you.
>
> Scenario B [thought]: "Mom won't be mad once she knows the truth."
> Feeling: hopeful,
> Behavior: You calmly explain to your mother that you didn't do it.
> Result: Mom apologizes for blaming you unfairly.
>
> The therapist should practice this exercise with the child by discussing several different scenarios in which the child can *change his/her feelings and behaviors by thinking differently*. If possible, these scenarios should be from the child's real life. (p. 111)

There were two primary criteria for acceptable thoughts according to the TF-CBT manual: accuracy and helpfulness. Helpfulness appeared to trump accuracy because regardless of how accurate the thought was about the trauma, the child was directed to replace it if it was deemed unhelpful by the therapist and manual:

> Accurate but unhelpful cognitions may be seen by the child or parent as "facing reality" or "accepting the truth"—that is, as something that is necessary to truly deal with the situation at hand. In fact, focusing on the most horrifying (unhelpful) realities or possible realities of the traumatic event is a *choice*, not a necessity, and doing so may impair the child's ability to cope optimally with the trauma and/or loss. (p. 137)

Parents were also instructed on how to engage in thought-replacement. Examples of positive thoughts that would ideally result from cognitive processing with a healed parent included:

- I can find things to be happy about, and this will set a good example for my child.

- Most people are good at heart, and many are trustworthy.

- Being strong means doing what you have to do, and I am doing that.

- I am a good parent; I do lots of good things for my child, including bringing [him\her] to therapy, even though it is painful.

- Things going wrong is just a part of life; facing challenges can make you stronger.

- I am facing the hardest thing that has ever happened to me, and that takes a lot of courage. (p. 104)

Many of the thought-replacement exercises were designed to encourage the child and parent to "give themselves permission" to experience happiness "midst dealing with a life of trauma:" It is very important for children to realize that they still have the capacity—and permission—to be happy. (p. 187)

> Therapists may want to point out to parents that by [giving themselves permission to be happy] they model positive coping for their children and help them believe that they can still enjoy happy moments, and deserve to do so, even in the midst of dealing with a life trauma. (p. 103)

The manual also suggested that therapists train the parents in paradoxical techniques to plan for a specific time to worry:

> Therapists can help parents give themselves permission to relax and enjoy a few stress-free moments each day, even though their child has gone through a horrible experience. […] The therapist could instruct the parent to worry about those matters in the morning only, not at night. […] When the timer goes off, she should stop thinking about those worries for the rest of the day. (p. 103)

Overall, the manual reflected a taken for granted assumption that changing one's thoughts actually was equivalent to changing one's entire life and interaction with the

world. This was described in the manual in several ways, such as getting over the past

and focusing on the future:

> The therapist should then assist the child in recognizing that no one can change
> the past because the past is over. However, all have the ability to change some
> things in the present and the future by our own actions. Most of all, we can
> change our own thoughts, feelings, and behaviors, as discussed with the child
> during the cognitive-processing component (Trauma-Focused Component 5).
> (p. 128)

The manual also discussed how thoughts can become self-fulfilling prophecies,

which if not changed could alter the entire life course of the child:

> Traumatized children may also develop cognitions that contribute to their loss of
> faith in justice, God, or a benign future. This line of thinking can lead to
> behavioral choices that become "self-fulfilling prophecies." For example, a teen
> who lost his older brother and several friends to community violence developed
> the belief that he was not going to live to see his 20th birthday. As a result, he
> began to use drugs, joined a gang, and dropped out of school. These behaviors
> greatly diminished his chances of experiencing a positive future and put him at
> increased risk for trauma. His own negative expectations or "prophecy" of self-
> failure led to the very failure he feared. (p. 12)

> ***When you change your mind, you change your brain***. The Cohen et al. manual

described talk therapy and thought-replacement as a method of re-wiring the brain and

creating physical changes:

> Some professionals believe that only certain types of therapeutic activities can
> access pathways for brain changes (e.g., directed eye movements or body therapy
> techniques), and that "talking" therapies that do not include specified, physical
> activities cannot create meaningful brain or bodily changes in traumatized
> children. We suggest that it is possible to restore adaptive psychobiological
> functioning in a variety of ways, including through the use of psychotherapeutic
> components incorporated in the TF-CBT model. (p. 15)

> According to the TF-CBT manual, talk-therapy alters the brain because

everything one does is related to brain activity:

> Children's brains and bodies are integrally involved in the development and
> manifestation of emotions, cognitive processes, and behaviors. It is important to
> understand that everything a person does, thinks, or feels is associated with some

brain activity, however transient or inconsequential. Thus it is not surprising that trauma events have the potential to alter brain functioning. (p. 14)

Not only does the brain change after trauma, the manual argued that the brain tells

us when we feel overwhelmed and cannot cope with trauma:

> For the hyperarousal symptoms (e.g., distractibility, difficulty sleeping, irritability), the child and parent can be told that these are ways that the brain and/or body indicate that the traumatic event has overwhelmed the child's physical ability to cope. (p. 61)

The next sentence argued that talking about the brain was a good way to connect

to patient and parent:

> Children and parents appreciate a straightforward explanation that can be easily comprehended, and they are more likely to form a therapeutic connection with a clinician whom they can see as down-to-earth and "real." (p. 61)

Thus Cohen et al. manual suggested that brain-based psychoeducation about

trauma should be common sense to the parent and child and talking about the brain would

actually make the therapist seem more "real." The brain-based life presented in the

manual was assumed to be so natural that younger children would more readily

understand metaphors using the brain than any other explanations about trauma or

thought, "Younger children may understand "thoughts" as "our brains talking to us""

(p. 108). During a section on progressive relaxation this was reiterated, "For younger

children: 'You might notice your brain talking to you about other things'" (p. 78).

For older children, the brain metaphor was also written into therapist scripts for

progressive relaxation techniques:

> [Mindfulness] is a way to quiet our brains and our bodies, and to feel a sense of relaxation and peacefulness. I know this may sound funny at first, but if you pay attention, you will notice that your brain likes to be busy. If you just sit quietly, you will see that thoughts start coming into your head automatically" (p. 79). The children are then encouraged to think of different scenarios and ask: "What is this person's brain telling [him/her]?" (p. 110)

Rather than tell the child to reflect on what s/he might be thinking and how s/he understands these thoughts as a human (e.g., What is this person thinking? What is this person saying? What should this person do?), the child was directed to think about what another person's brain might be telling them to do, as if the brain had ultimate agency and decision making capability for the person.

Your brain and mind can protect you from trauma (i.e., if you have inner safety, you are safe from the world). The Cohen et al. manual stated trauma symptoms, "can have a profound and long-lasting negative impact on [child] development, health, and safety" (p. 19). The last module in the TF-CBT treatment (Component 10) focused on restoring a sense of safety and preventing future trauma, "It is important to help the child express this feeling as well as to recognize the sources of support in the environment that can enhance the child's sense of safety right now" (p. 93). The safety module focused on creating environments of mental safety in an unsafe world because, "Unfortunately, we cannot and should not assure children that they will never suffer trauma again, but we can respond to children's fears by teaching them skills that will increase their feelings of self-efficacy and preparedness" (p. 157).

In one scenario, the manual presented a script that instructed the therapist to use what was essentially the Socratic method (which the manual referred to as the process of "challenging cognitive distortions;" p. 140) to convince a child who was bullied at knife-point at school that his school would be safe to return to in the future. I will refer to this script later in this section and believe it is important to reproduce here in its complete form:

When referred to treatment, this child was unable to attend school due to overwhelming anxiety about being accosted again. His recurrent thought was "Scary things happen at school—it's dangerous there."

THERAPIST: So you keep thinking that school is always scary and dangerous?
CHILD: I just don't think it, it *is* scary and dangerous. I'm never going back there again.

THERAPIST: I understand why you got scared; that was a very frightening experience to live through when it was happening.

CHILD: You got that right. I don't know why anyone goes there.

THERAPIST: Please help me understand. School is always a dangerous, scary place, 'cause every single day, something bad happens there, is that right?
CHILD: Not every day, just some days. But it could happen at any time.
THERAPIST: I'm kind of confused. How long have you been going to this school?

CHILD: This is my third year, and it's my last! I'm never going back there.
THERAPIST: Help me understand. Every day you've been there, something dangerous has happened there, right?

CHILD: Not every day, just once.

THERAPIST: You mean, you went there every day for 2 whole years, and nothing bad ever happened there until now?

CHILD: Yeah, but now it's not safe ever again.

THERAPIST: I'm still confused. From how you described it, it sounded like bad things happen so often there, they are just a part of that school, and it will never be safe there again. But now you're telling me that only one bad thing ever happened there that you know of, right? So help me understand—how is this school so dangerous?

CHILD: It wasn't before, it just feels that way now.

THERAPIST: So it's not the school itself that's scary, it's something that was different that day from every other day you went there, right? What made the school so scary that day?

CHILD: Those punks stealing my stuff made it scary. And then they threatened me.

THERAPIST: Oh, so it was those guys, those four or five guys, not the school itself?

CHILD: Yeah, but there could be other guys like them there.

THERAPIST: And if there were, what do you think they would have learned from what happened to you? Do you think what happened to those guys—having to go to court and getting kicked out of school—is something other guys would like?
CHILD: No, I guess not.

THERAPIST: So the school is safe, it's those guys who were scary. And now they're gone, and any other guys are going to be worried about messing with you, 'cause you'll get them in big trouble.

CHILD: Yeah.

THERAPIST: I bet the other kids think you're pretty brave, like a hero or something, for standing up to those bullies.

CHILD: You think?

THERAPIST: Oh, yeah! I bet when you go back to school, kids will tell you they're glad you're back and no one will want to mess with you again.

CHILD: Well . . . maybe. (p. 140)

After reading this script, the manual then instructed the therapist, "Once such distortions are identified (and new ones may develop or be verbalized for the first time at any point in therapy), cognitive-processing techniques should be employed to explore and correct them and to practice and reinforce more accurate and helpful thoughts" (p. 140). Thus, thought-replacement was seen as the modal way to ensure future safety.

Changing ones thoughts and mind was the primary method that the manual promoted as necessary to keep a child safe but it was not the only one. The final module of the TF-CBT treatment included instructions for developing a safety plan with the child and parent (e.g., listing persons who the child can contact or go to when they feel unsafe). This was presented as the last step in the treatment because the manual suggested that creating the safety plan may otherwise prompt a sense of guilt about what the child should have done during the trauma.

Another reason why safety planning was located in the last module, according to the logic of the treatment, was that the child had to first be taught how to distinguish cognitive distortions from actual threats to safety. Thus, the manual recommended that the therapist first assist the child in creating a mental protective barrier (e.g., by changing thoughts) and then assist the child to create a safety plan, that would presumably involve the community and protective adults. Here again the manual gave primacy to changing thoughts before taking action in the social world.

The Cohen et al. manual described the importance of parents creating an environment of safety. In the section titled "Enhancing the surviving parent's sense of safety" the manual suggested that if one parent has died it is important for the surviving parent, "to communicate a general sense of safety to the child and provide an environment of emotional support" (p. 115). One example featured a script that therapists could use with parents who lost their partner after a terrorist attack:

> I hear you saying that it feels like you will never be able to move on since the terrorist attacks, but I wonder how the people living in Northern Ireland or Israel manage to carry on amidst the constant fighting and terrorist attacks. Clearly, many people are choosing to stay there. There must be something positive that keeps them there. If we asked them, I wonder what they would say. What do you think they would say? … I have heard some people in these situations say things like 'This is my home, my country, and I will not let these few evil people chase me away or frighten me into not living a full life.' Others have said, 'Our way of [life/religious freedom, etc.] is worth fighting for and even worth dying to preserve. We have to give a message to terrorists—that they cannot take away our freedom or way of life—by standing up to them even when we are afraid. ' […] What might we learn from people who are living in situations that seem very unsafe from an objective viewpoint? What can they teach us about finding inner safety in our lives? (p. 116)

The final line of this script suggested that a key to responding to political instability is finding inner safety. The therapist was recommended to connect the terrorist attack to other political events in the world and to instruct the parent in repeating mantras

like "This is my home, my country, and I will not let these few evil people chase me away or frighten me into not living a full life" (p. 116).

Thematic discussion: Mind-brain as protector and the apolitical use of cognitivist ideology. The TF-CBT manual described the mind and brain as key components in healing and protecting traumatized individuals. To create inner safety in a traumatizing world, the manual relied on the therapist challenging and replacing the patient's negative thoughts with positive thoughts (referred to in the manual as cognitive processing). The manual emphasized retreating to an internal and mental state for protection and suggested that fortification of mental barriers was a way of giving permission to children and their parents to be happy, functional, and free post-trauma. I interpret this theme as a reflection of an individualistic, apolitical cognitive ideology that is prevalent in psychology today.

Cognitivism was described by Sampson (1981) as the dominant point of view in psychology in the 1980s, when PTSD and other trauma related disorders were acknowledged formally by the APA. Sampson located the roots of cognitive theory beginning with Descartes (i.e., Cartesian theory) and Kant (i.e., structuralism) in the Enlightenment Era. I will not review the assumptions of these theories here; however further discussion of the primacy of Cartesian thinking, 18th century empiricism, and 19th century structuralism and positivist thought in contemporary psychology can be found in the critical and historical writings of other scholars (e.g., Atwood, Stolorow, & Orange, 2011; Buss 1979; Cushman 1990, 1991; Danziger, 1979; Gergen, 1973; Taylor, 1989).

According to Sampson (1981), within the cognitive perspective, processes within individuals' minds are the central focus of empirical investigations and cognitive representations are the building blocks of the human mind. There are two key philosophical assumptions of cognitivism: a "subjectivist reduction," where the world is understood as being processed through structures of the "knowing subject" and an "individualistic reduction" which grants primacy to the individual knower (p. 730). Within this view reality is the product of individual cognitive operations rather than of social practice and political arrangements in historical traditions.

Sampson (1981) framed the cognitive perspective in psychology not as a theory or approach, but as an ideology. Ideology refers to "a systematically distorted or false picture of reality, one that benefits one group's interest over another" (p. 731). It is also understood as a way to conceal real interests and advantages by those in the materially dominant group (cf. Marx and Engels). Secondly, ideology is born out of and reflects a particular socio-historical consciousness and true social practice. Thus, Sampson pointed out that ideology is both "true and false" at the same time—true in that it represents the reality of a sociohistoric era and false in so as that reality may be a systematic distortion that serves the interests of some groups over others. The falseness of cognitivism, like any ideological movement, emerges when social practices or institutions become abstracted from their historical context, reified, and treated as natural, necessary, and invariant over time.

Sampson (1981) described how cognitivist ideology has led to a disturbing shift within psychology where humanity is defined by "mental events, mental activities, mental operations, mental organization and mental transformations *that are of greater*

importance than the events, activities, operations, organization or transformation of the external world" (p. 733). Within the cognitivist approach, mental events are further placed within the landscape of the putatively interior self to the extent that they are cut-off from subjective experience. When a cognitivist ideology prevails in psychology, people accept—in fact strive for—changes in their subjective experience instead of changes in their objective reality, thus allowing existing arrangements of power and domination to occur. In this sense psychology, while performing cognitivist ideology in the guise of healing, serves to maintain the isolationist status quo in neoliberal society: by shifting the way we perceive the world we overlook the need to change it and to turn to our community to make meaning of and address social problems. In a world in which cognitive psychology is dominant, the necessity to change the material arrangement of the social world does not come to light.

In the TF-CBT manual, it is apparent how the therapist was instructed to train the patient in accepting and performing cognitive ideology primarily through the techniques of thought-replacement and challenging cognitive distortions. Ultimately, the manual assumes that the family's response to both daily and major political suffering (e.g., from school bullying to September 11) can be dealt with by altering the way the child thinks (a subjectivist, individualistic reduction). This technique necessarily recapitulates the status quo of an isolationist, politically inactive and asocial environment that Sampson warns of, where persons do not act with each other or in the world, but merely change the way they think about the world.

Though problematic in its basic assumptions, it is possible that the technique of thought-replacement could be made a little more subversive and socially oriented if the

therapist suggested that individualistic and isolating thoughts were dysfunctional and instead the patient should think about the social context that reflects and reproduces their pathology (cf. Gone, 2009); yet in the TF-CBT manual this is the opposite of what is suggested. Instead there is an overwhelming emphasis on positivity and ensuring happiness regardless of the social context and the accuracy of the thoughts about the traumatic experience and the world. As the manual stated, "Accurate but unhelpful cognitions may be seen by the child or parent as "facing reality" or "accepting the truth"—that is, as something that is necessary to truly deal with the situation at hand. In fact, focusing on the most horrifying (unhelpful) realities or possible realities of the traumatic event is a *choice*, not a necessity" (p. 115). The manual encouraged delusional positive thinking and internal retreat as a preferable choice to reckoning with the horror of trauma in the community. Furthermore, the manual framed the substitution of accurate thoughts about the trauma for delusional positive thoughts as a form of political action or even nationalism (e.g., in the example of coaching the parent on how to respond to a terrorist attack by finding inner strength and repeating positive thoughts).

Another important aspect of the mind-brain protector theme in the Cohen et al. manual was the emphasis on neuroscience and brain-based therapy as being integral to healing trauma. The presentation of research on neuroscience and trauma in the manual suggested that if the wiring of the brain did not change somehow the therapy might be moot. Furthermore, the manual advocated the use of brain terminology to explain the therapy to young children (e.g., "What did that persons brain tell them?" and "What is your brain saying to you?"). The manual also subtly used the phrases "it's a choice to think about x" and "give yourself permission" in ways that suggested patients needed to

manipulate their brain and mind to allow themselves to feel happiness, as if it were just

their brain—and not the traumatic events that occurred in the social world—that was the

root of their traumatic suffering.

When reading this section I thought of the brain as Bentham's panopticon (cf.

Foucault, 1995)[40] where patients are standing in the prison yard of their lives asking their

brain if they can have permission to move and then listening intently for what their brain

says to do. Perhaps a better metaphor given the context of the manual would be the

patient as a child asking permission from their parent-brain for a cookie or their teacher-

brain for a hall-pass to be happy for the day.

The idea of placing the brain rather than the socially embedded human in therapy

has been identified by Nikolas Rose (2007) as a shift in contemporary culture to

understanding human beings as "neurochemical selves," where variations in mood,

emotions, desires and thoughts are reduced to variations in brain chemicals. Rose

discussed how health is a central ethical principle in contemporary society and has

recently taken the shape of "somatic individuality" where the self is understood in terms

of biological health, "we understand ourselves, speak about ourselves and act upon

ourselves as the kind of beings whose characteristics are shaped by our biology" (p. 480).

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[40] In *Discipline and Punish* (1995), Foucault described the transition from overt control to covert institutionalized practice and eventually to self-monitored rule adherence. The paradigmatic example of the shift to institutional and eventually internal surveillance was Jeremy Bentham's panopticon. The panopticon was a prison designed in a torus shape with a watchtower high in the center. Within this prison the guards in the watchtower could see into every surrounding cell but the prisoners could not see when they were being watched. In order to gain rewards and avoid punishment, the prisoners had to believe they were always being watched. Thus a culture of self-monitoring and self-policing was born such that no guard needed to threaten individuals with whippings and severe punishment, the prisoners self-monitored their behavior.

The shift to a neurochemical self has allowed society to become amenable to economies of vitality (see further discussion Chapter II, pg. 26). When trauma treatment research describes symptoms as residing in the brain or neurons, it necessarily suggests that these symptoms can be manipulated through psychopharmaceuticals and evidence-supported psychotherapies, like TF-CBT, that target brain function.

Writing before brain-based therapies were so popular, Ian Hacking (1998) in *Rewriting the Soul: Multiple Personality and the Sciences of Memory* argued a similar point to Rose (2007) that the contemporary self had become constituted through a scientific framework. Hacking argued that the notion of soul has been replaced with memory and moral behavior has become naturalized in the sciences (almost hardwired in the brain) rather than contingent on a relationship with the Devine. Hacking noted that the false memory debates that were prominent in the 1990s could only occur in a society where there was a shared belief that memory was reified and open to scientific investigations. Whereas these debates previously would have been on moral or spiritual grounds, they have now moved to the plane of factual knowledge. Thus, Western society understands the impact of violence and other types of suffering, not as questions of morality or responsibility, but as questions that can be answered through the science of psychology and memory. Trauma could be discussed on a moral level and responded to as social suffering as many scholars and clinicians have done (Bracken, 2002; Furedi, 2004; Gone, 2009; Hillman & Ventura, 1992; Marin, 1995; Ricoeur, 2004); however, in the manuals analyzed in this study, trauma was described mechanistically as a product of mental errors (e.g., problems with thinking) and neurological imbalance.

Shared Theme 2: Neoliberalism in Trauma Therapy: The Healed Trauma Survivor as Functional Worker

In this section, I present the second theme that was shared by all of the manuals I interpreted. Economist John Williamson defined neoliberalism as moving control of the economy from the public sector and government to the private sector and corporations (Williamson, 1990). Neoliberal theory supports free market capitalism where the private market determines value rather than a collective group, publically elected government or regulatory oversight system. One consequence of neoliberal thinking has been what Binkley (2011) calls "the marketization of social relations" where reconciliation and public social practice is recast in a negative light as dependency and docility that halt the entrepreneurial spirit of individuals to meet their potential optimal production in the system (p. 92). To be considered functional within a neoliberal capitalist system one must contribute works of value to the system; failure to survive in the system is a threat to life and survival. Thus, in neoliberal theory, there is emphasis on individual choices and productivity as resulting directly in success or failure; if someone is not happy, is impoverished, is starving or suffering, the theory would suggest that this is ultimately due to an individual failing in neoliberal functionality (e.g., they should get control of their life, return to work, etc.). I previously discussed these features from the perspectives of critical scholars in the Background and Literature Review (see Chapter II, pp. 100-109), in this section I relate these features to my interpretation of the TF-CBT manual.

In all of the manuals, trauma was a major source of reducing neoliberal functionality and thus the aim of therapy was to restore functionality in this system, like getting the patient to return to work or school. There were three primary assumptions in

the manuals that are a reflection of neoliberal culture: a) valorization of the enterprising self (cf. Binkley, 2011; Layton, 2010; Rose, N. S., 2007), b) the acontextualized nature of trauma (Layton, 2006), and c) the privileging of modular, efficient therapy designed for managed care (Cushman & Gilford, 2000).

Thematic findings: Neoliberalism in trauma therapy. This section presents quotations from the Cohen et al., TF-CBT manual that are representative of the theme: neoliberalism in trauma therapy. I have divided the section according to the three assumptions listed above.

Valorization of the enterprising self in neoliberal trauma therapy. In the Cohen et al. manual, one consequence of trauma was that the victim became frozen or "stuck on the traumatic circumstances" (p. 19) or "stuck in remembering" (p. 29). This post-traumatic stuckness was described as halting the child's natural development to move forward in society and his or her ability to "optimize adaptive functioning" (p. 31). There was an entire chapter in the manual titled "Optimizing Adaptive Functioning" which the manual defined as "the child's ability to function optimally in one's family, with friends and peers at school, in a state of physical and emotional health" (p. 41). If children have attained optimal adaptive functioning through therapy they should have attained the goals of TF-CBT mentioned previously, such as being able to "express and manage their feelings more effectively….gain a greater ability to express and modulate these frightening feelings," (p. 87), "use thought stopping to interrupt those thoughts and replace them with "perfect moment" thoughts or other positive images" (p. 104), and ultimately, "to realize that they still have the capacity—and permission—to be happy" (p. 187). A healed trauma survivor can continue on the trajectory of natural development,

which according to the manual would include maximizing "joy and happiness" (pp. 144, 184), exercising "a right to feel pleasure" (p. 85), "a right to get well" (p. 48), control over the body (e.g., "right to say no") (p. 212), and believing that the world was a "trustworthy" (p. 12) "safe place" (pp. 47, 93). The ideal developmental trajectory proposed in the TF-CBT manual thus exemplifies what Binkley (2011) referred to as the enterprising self, where life is "lived through a dynamic enterprise in which others appear, not as objects of psychological investment toward a relation of mutuality, but as pure resources in an environment of opportunity… to further maximize her or his own emotional potentials through the manipulation of life-elements" (pp. 92-93).

Following this line of inquiry in the TF-CBT manual, therapy was often framed as providing the enterprising self with "tools" (pp. 44, 100) to maximize internal and external resources, "The goal of learning the above skills is for children to be able to better manage difficult affective states. In essence, they are developing a number of "tools" to select from their "tool kit" for when they become distressed" (p. 100). A taken for granted assumption of providing tools to the child is the transformation of the world into instrumental resources (cf. standing reserve, Heidegger, 1954; see also Fowers, 2010) which is framed in therapy as an environment of opportunity. This environment is presented to the child as one that can be maximized through internal management of feeling and thoughts and the catalyzing of intrinsic rights via therapy.

Thoughts about the world that did not fit with this taken for granted assumption about an instrumentalist way of being were recommended as targets for thought replacement. For example, if one of the post-traumatic thoughts about the world was that it was unsafe and the child did not want to return to functional activities, "[the therapist]

can help the child move toward more constructive thoughts/fantasies/actions through which to make the world safer in the future" (p. 129). To facilitate the child's entrepreneurial goals in the world, "the therapist should encourage the child to write a corrective story that can be placed at the end of the trauma narrative. The therapist may prompt the child to include a page entitled "I Would Like the Story to Turn out Like This in the Future" or "What I Look Forward to in the Future," or "My Happy Ending." For example, some children hope to grow up to become a rescue worker or to work for world peace or religious tolerance" (p. 129). In these examples, the child is encouraged to become an enterprising self by eliminating negative or even realistic thoughts about the world and take advantage of what the world has to offer. The goal for the child is not to accept their life post-trauma, but to erase the trauma and become a leader in world peace.

  The acontextualized nature of trauma in neoliberal trauma therapy. Emphasis on individual subjectivity, choices and work rather than social and political context is a central tenant of neoliberal thought. In neoliberal theory, problems in the social world are often framed as an individual failure in functionality rather than as a community problem (Fine, 2012; Layton, 2010). Because the Cohen et al. manual embraced cognitivist ideology (cf. Sampson, 1981) and described trauma reactions as located within the internal individual and brain rather than the social world, almost the entire manual was void of social context outside of the dyad of parent-child or therapist-child (described in Shared Exemplar, pp. 247-262) and the mind of the individual child. I provided several examples of the lack of contextualizing in the social world in the previous sub-section Mind-Brain as Protector and the Political Use of Cognitive Ideology (pp. 210-225). In

this section want to highlight an additional example of how the manual recommended

therapists respond to patients who are having difficulty adjusting socially post-trauma.

One would think the lack of social context in this manual would make the

treatment of symptoms of social avoidance particularly problematic (i.e., How can one

treat social problems and withdrawal outside of the context of relationships and

community?). However, the manual assumed that problems of social rejection or

avoidance post-trauma were the responsibility of and located in the individual child. For

example, the manual described characteristics of traumatized children that make them

attracted to deviant peers and social isolation. One section described how traumatized

children prefer to associate with other traumatized children "because of fear of rejection

from "normal" peers; and/or because for children living with ongoing interpersonal

maltreatment, associating with troubled peers may seem more familiar or comfortable"

(p. 10).[41] Feelings of social betrayal post-trauma can lead "the child to undermine

relationships, then attribute disappointment to his/her own personal failings" (p. 12).

In the case vignette script (provided in the previous sub-section), the therapist

convinces the child that his school is safe after he was threatened with the knife. The

therapist in the script appears to have assumed that social avoidance post-trauma was

ultimately the responsibility of, and located in, the individual child by focusing on

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[41] On a side note, I found it strange that the word "troubled" was used in this quote to refer to the same children that were seen in other parts of the book as innocent victims. When I reinterpreted this sentence I realized there was an otherness suggested about the identified patient's peers, as if the therapist should be suggesting to the parents that their child is the innocent victim of trauma but other children (namely those the child will want to associate with) are troubled. A covert message sent through the psychoeducation about peer interactions was that after TF-CBT treatment children will associate with normal, age-appropriate peers; without treatment the child will remained troubled, deviant or somehow other.

changing the child's thoughts and not the school environment. After much questioning

and challenging the thoughts about whether the school is safe the child finally relents to

the therapist by changing what he thinks about the school. He also becomes convinced

that not only should he return to school but that he is also somehow a hero:

> THERAPIST: I bet the other kids think you're pretty brave, like a hero or something, for standing up to those bullies.
>
> CHILD: You think?
>
> THERAPIST: Oh, yeah! I bet when you go back to school, kids will tell you they're glad you're back and no one will want to mess with you again.
>
> CHILD: Well . . . maybe.

Given the focus on turning enterprising child trauma survivors into leaders of

world peace, one might expect the manual to end that vignette with the child saying

something like, "You're right, I feel much better now! I will go on and save the world! "

but instead even the child in the vignette appeared to uneasily accept the therapist's

argument about school safety with "Well….maybe." A more effective intervention for

school bullying would involve the actual school community with the bullies; instead, in

the Cohen et al. manual the bullied child is seen as containing the trauma and is thus

deserving of individual treatment in cognitive reprocessing. This is an example of what

human being is like in neoliberal trauma culture: when a social event produces suffering

the survivor is encouraged to change the way they see the world (e.g., become unstuck

and move forward as a functional worker)—as if the problem no longer exists because

s/he has made an internal change.

 A modular, efficient therapy designed for managed care. The first CRAFTS

value of TF-CBT treatment was the modular, components-based design of therapy (i.e., C

= Components based). The modules are represented in Figure 3 and were designed to be

spread across twelve to sixteen, ninety-minute individual sessions, with one or two conjoint child-parent sessions. The authors acknowledged that one of the primary goals of the therapy in the revised manual was "to be more responsive to the needs of community therapists" (p. xii) and to facilitate community acceptability and dissemination of the treatment. It is likely that the design of the manual and therapy in modular, ninety-minute sessions made it more amenable for dissemination in community settings because the design allows for therapists in community mental health managed care settings to easily bill insurance. For example, the 90-minute time limit of the CBT session aligns with the maximum amount that was allowed for insurance billing under psychotherapy CPT codes at the time the manual was published (90808). Since 2013, the maximum billable amount for an individual session has changed to 60 minutes (98037) (APA, 2013a; Regence, 2013a).

Having the individual child as the identified patient (rather than the family, school, neighborhood, or community) is also more amenable to billing and profitable for the clinic. For example, in 2013 the maximum allowable non-facility fee for therapy for some Regence preferred providers was: $44.13 for group or family therapy, $44.60 for multiple-family group psychotherapy, $113.15 for family psychotherapy without patient present, $140.85 for family therapy with patient present and $162.92 for individual psychotherapy with a family member (Regence, 2013b). Similarly, the average maximum allowable amount of sessions that were approved for reimbursement on many managed care psychotherapy plans are limited to twenty or less (Karon, 1995).

In sum, the very design of the therapy presented in the Cohen et al. (2006) manual was tailored for profit and reimbursement according to the guidelines of private insurance

companies that largely govern community mental health, yet this was not explicitly stated in the manual. Instead the authors stated that the therapy was designed to "respond to the needs of the community." The manual conflates the needs of the community with the needs of the profit-driven insurance companies; the actual needs of the community and community therapists are not elicited or met (e.g., there was no section of the therapy focused on the community or community needs).

This same process occurred in the manual's presentation of the CRAFTS "values" that were largely absent of social or moral human values [for examples of values and virtues in psychology see Fowers (2005)]. For example, the first value of CRAFTS—a components-based therapy—is not a human value, like integrity or non-violence, but a managed care principle that makes the therapy amenable to billing. Ironically, the manual framed the modular, component-based nature of the treatment as evidence of an appreciation for the individual patient (not the insurance companies); the components were actually presented as a solution to reduce the inherent standardized and mechanistic nature of the manual. The authors wrote that, "the model can end up sounding simplistic or mechanistic, more like a "cookbook" of ingredients and techniques than a creative and interactional therapeutic process" (p. 46). But they suggested that the cookbook problem can be overcome with components-based therapy because the therapists have the freedom to spend more or less time (within the 12 to 16 session 90-minute structure) on various primary components (illustrated in Figure 3):

> Components-based treatment emphasizes a set of central skills that progressively build on previously consolidated skills. Rather than describe a rigid session-by-session treatment approach, TF-CBT describes interrelated components, each of which should be provided in a manner, intensity, and duration that best matches the needs of the individual child and family. (p. 32)

The authors did in the end suggest that reading from the manual alone was not sufficient training, and in fact in order for therapists to become comfortable with the treatment and avoid the cookbook scenario they should take the online course and then try the therapy out:

> To truly learn about this model, therapists would benefit by putting it into practice when treating traumatized children. If you are a treatment provider, in addition to reading the book, you might also consider supplementing it by taking the free TF-CBT online training course (available at www.musc.edu/TF-CBT). (p. 51)

Thematic discussion: Neoliberalism in trauma therapy. Scholars who have critically interpreted neoliberal culture in psychotherapy have identified two primary features: a) social identity is continually removed from political, local, and moral tradition and context, and b) neoliberal culture has come to govern the lives of families, individuals and communities via technologies of therapy and the role of the expert in therapy (e.g., Binkley, 2011; Cushman & Gilford, 2000; Fine, 2012; Layton, 2010, 2013). I previously discussed these features from the perspectives of critical scholars in the Background and Literature Review chapter (pp. 100-109), here I will apply them to the interpretation of the TF-CBT manual.

The healthy enterprising self was represented in the TF-CBT manual as one that is able to manage and control emotions and thoughts in such a way that one can optimize functioning and exercise natural rights to pleasure and happiness in a safe world. A taken for granted assumption in the manual was that if a child cannot return to school or is unable to feel happiness or pleasure, they have not learned to optimize their functionality in society by controlling their individual thoughts, feelings and actions. In other words, if the world does not feel safe, fair or trustworthy to the child after trauma, it is his/her

responsibility (along with the parent) to learn the techniques in therapy to become unstuck from this mindset.

This phenomenon was described by Rose (1989) as a form of psychology that "obliges us to be free." The needs of the neoliberal state (i.e., the return to being a productive worker)[42] are represented by experts (in this case therapists) through their appeal to the enterprising spirit of individuals. Rose reminded us that the discourse of freedom through producing capitalist social goods with vigor can be contextualized as stemming from the needs of those who benefit from neoliberal social arrangements, like private insurance companies; yet, when therapists reproduce this discourse by literally reading from a therapy manual the therapy reflects and reproduces these conservative political arrangements. Through this process the therapists and patients are invited to believe that neoliberal ideals are their individual values. Rose stated "Individuals are to become, as it were, entrepreneurs of themselves, shaping their own lives through the choices they make among the forms of life available to them" (Rose, N. S., 1989, p. 230).

The TF-CBT manual can be interpreted through a Foucaultian perspective. Within the manual's technicist framework, traumatic events are transformed from social

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[42] Nikolas Rose (1989) does not use the term neoliberal state but refers instead of the needs of the welfare state. Rose described how in the first half of the 20th century the citizen (primarily in the U.S. and U.K.) was one whose obligations and power were understood as duties to the collective welfare state (e.g., social security and child welfare). He described how the individual and society would have a mutual claim to each other but that policies linked these claims to doctrines of social and mental hygiene, self-evaluation and preventative health care; the duty of the citizen became one of self-monitoring and adhering to expert advice for the greater good. Thus when Rose describes the welfare state he is describing a state in which public needs are interpreted as a moral imperative to specific type of healthy self, a self that benefits neoliberal society and does not benefit or excludes those who are seen as unhealthy or unproductive (cf. eugenics). Therefore, I have opted to substitute the term welfare state to neoliberal state in referencing Rose here so as not to confuse the actual needs of the public and community with that of the state that Rose describes.

phenomenon to objects of scientific study that need to be adequately treated/controlled through various medical technologies. Patients have learned to fit themselves neatly within treatment decision trees and modular care by completing their homework, reading their psychoeducation pamphlets, requesting specific medications and self-diagnosing. What it is to be a good healthy human somehow fits naturally within these practices of social control.

The authors acknowledged that "the model can end up sounding simplistic or mechanistic, more like a "cookbook" of ingredients and techniques than a creative and interactional therapeutic process" (p. 46). But they suggested that the cookbook problem can be overcome with components-based therapy because the therapists have the freedom to spend more or less time (within the 12 to 16 session 90-minute structure) on various primary components. I found this argument about modules as the answer to the cookbook problem so misguided given the fact that treatment is actually trained via a standardized 12-session manual (Cohen et al., 2006). How can it not be like a cookbook when the therapists are recommended to continue to read the scripts and utilize the forms from the manual throughout treatment? Especially, in lieu of mentorship and supervision, there is an emphasis on fidelity to the modules as they are represented in therapist scripts, handouts and worksheets. The utilization of these forms according to the manual ensures the standardization of care across individuals and fidelity to the manual (this will be discussed further in the Shared Exemplar sub-section of this chapter, pp. 240-255). Thus, filling out a box on a form becomes a substitution for human dialogue and exploration of trauma, and frames healing within a world of patient and therapist compliance (cf. Cushman & Gilford, 2000).

The fact that a practitioner is recommended to learn from and continue to retain fidelity to the manual should be enough evidence that the TF-CBT manual indeed a cookbook and that it is not actually tailored to individual families and needs. It seems as if the authors are caught in a difficult bind: they want to promote the therapy as somehow universal and easy to disseminate to the community (e.g., designed to treat any trauma, by any practitioner who has taken the training) but also flexible, personal and "real."

From a hermeneutic perspective, I do not view the TF-CBT therapy reproduction of neoliberal values as a form of propaganda or discourse that makes sense to patients and therapists simply because they are subtly manipulated into believing them. The neoliberal understanding of trauma as reducing functionality and the notion of healing through the enterprising self makes sense to therapists and patients not just because certain discourse (like those in the manual) lead them to value neoliberality, but because these values exist in many forms of daily life and interaction inside and outside of therapy. When considering the amount that trauma permeates culture (see Introduction pp. 1-5), one can imagine a child today watching TV where the protagonists suffer from PTSD and lead aspirational lives; this child might also hear phrases like "think positive" and "change your mind, change the world" as responses to daily problems not just in therapy but in school, at work or from their parents. This is what Heidegger meant when he said understanding is already performed by being in the world around us (Heidegger, 1996).[43]

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[43] Dryfus (2004) explained this Heideggerian concept:
> Put generally, the shared practices into which we are socialized provide a background understanding of what counts as things, what counts as human beings and what it makes sense to do, on the basis of which we can direct our actions towards particular things and people. Thus the understanding

When a child encounters trauma and the neoliberal worldview of functionality is questioned by the child or they are unable to meet the demands of the culture (e.g., they don't want to go to school), in the Cohen et al. manual the therapists' job becomes to reconstitute this functionality. Again, I would suggest that this reconstitution is not driven by the therapists wish to colonize the individual with the notions of the state (even though that may happen) or that therapist is acting with no intention (e.g., a naïve drone that simply does not realize they are recapitulating neoliberal ideals). Following the work of Cushman (1995), Bracken (2002) and other hermeneutic thinkers, I believe that therapists act out of what they see as a moral imperative to reconstitute the cultural clearing of the child by restoring what the culture sees as the good for this child. What constitutes being a good healed trauma survivor is not universal, but is necessarily tied to local context as well as the lived traditions of that context. I will continue this interpretation with regards to the therapists reconstituting what they see as childhood and being a good child in TF-CBT manual specifically under TF-CBT Themes 1-3 (pp. 210-247).

Shared Theme 3: Trauma Is Universal and Culture-Free (Versus Tied to a U. S., Western, White, and Middle-Class Context)

In this section, I present the third and final theme that was shared by all of the manuals I interpreted. In all of the manuals, trauma was presented a universal human experience that could be treated following the same culture-free treatment manual. I divided examples of this theme into the following categories: a) trauma symptoms are tied to universally experienced organ malfunction (e.g., brain problems), b) there is a

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of being creates what Heidegger calls a clearing (*Lichtung*). Heidegger calls the unnoticed way that the clearing both limits and opens up what can show up and what can be done, its "unobtrusive governance (*Waltens*). (p. 2)

flattening of all events, local experiences, and narratives of suffering to diagnostic criteria for PTSD and the word "trauma" or "traumatic events," c) the technique of thought-terminating clichés (cf. Lifton, 1989) about cultural competency are often employed, and d) there is an exclusion of forms of suffering from the definition of trauma that are not from a U.S., Western, white, and middle-class context.

Thematic findings: Trauma is universal and culture-free. This section presents quotations from the Cohen et al., TF-CBT manual that are representative this theme. I have already provided several examples of the first subtheme (a) where the manual described trauma as located in the brain and suggested that this experience was universal and based on evolutionary models of fear (pp. 143-151). Therefore this section will focus primarily on a presentation of examples from the texts of the other subthemes: b) there is a flattening of all events, local experiences, and narratives of suffering to diagnostic criteria for PTSD and the word "trauma" or "traumatic events," c) the technique of thought-terminating clichés (cf. Lifton,1989) about cultural competency are often employed, and d) there is an exclusion of forms of suffering from the definition of trauma that are not from a U.S., Western, white, female, and middle-class context.

Flattening all local experiences and narratives of suffering to diagnostic criteria for PTSD and the words **trauma** *or* **traumatic events.** Standardized assessments reduce traumatic life experiences to a number of total traumas (where all events are considered to be equal to a value of 1), the patient's interpretation of the event and related psychopathology is reframed into a check box of meeting PTSD diagnostic criteria. The first instance of the reduction of narrative, nuance and local stories of trauma in the

manual was the recommendation to begin the treatment with a standardized assessment of

trauma and PTSD:

> Entities that fund treatment and certify treatment facilities require accurate diagnosis of existing psychopathology. Careful assessment is also essential for optimal treatment planning. Methods for conducting general child psychiatric evaluations are described in detail elsewhere (AACAP, 1997), and specific instruments and techniques for evaluating childhood PTSD are also available (AACAP, 1998). (p. 20)

The standard assessments of PTSD and traumatic events that were described in

the Background and Literature Review chapter of this study (p. 9) were also

recommended in the TF-CBT manual, in addition to child-specific measures of trauma:

> Although the use of detailed semi-structured interviews is the "gold standard" for evaluating the presence of these PTSD symptoms (AACAP, 1998), these are time- and labor-intensive, and few therapists in clinical settings have the resources to use these interviews on a regular basis. Several self-report instruments for assessing children's PTSD symptoms are available, which have acceptable reliability and validity for clinical use. These include the previously mentioned UCLA PTSD Index for DSM-IV ….Two widely used child behavior measures include the Child Behavior Checklist (CBCL; Achenbach, 1991) and the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992). (pp. 21-23)

These examples demonstrate how the manual recommends that therapists

expediently administer a trauma assessment to obtain a diagnosis for billing

purposes and to reduce the "time and labor" associated with listening to patients

describe their experiences with trauma (p. 21).

The label of trauma was used throughout the manual to refer to a wide range of

social and political suffering. The introduction of the book described how the manual has

been "empirically evaluated with children who have suffered a wide array of traumatic

experiences (e.g., traumatic grief, exposure to domestic or community violence)" (p. 34).

Throughout the manual the phrase "traumatic event" was used in lieu of describing the

details of what actually occurred to the patient; this phrase occurred 67 times in the

manual. Other semi-generic terms like "abuse" and "violence" were also used frequently (over 100 times each). Specific words to describe traumatic events were more rare (e.g., murder [4 times], bullying [4 times], bombing [1 time]). As mentioned previously in this section (pp. 208-209), terrorist attacks were featured in a disproportionate way when compared to other traumas.

When searching for the word "trauma" and "traumas" in the manual I found the following adjectives that were used to describe trauma without actually naming or describing the actual event: identical (p. 4); previous/prior (pp. 8, 159); many/multiple (pp. 22, 61, 67, 135, 160, 175); on-going (p. 4); chronic (p. 4); short-lived (p. 4); child/childhood (p. 20); and interpersonal (p. 14). These adjectives appeared to categorize traumatic events not by the unique qualities of the experience but by length of time endured. Only a few of the adjectives described relationships to other people and the world (e.g., interpersonal) and none described the severity (e.g., excruciating, horrific) or made social or moral judgments about the event (e.g., abhorrent, dehumanizing, unjust).

Despite the pervasive use of the generic term trauma, an entire section of TF-CBT therapy was devoted to eliciting the trauma narrative, the story associated with the traumatic event, in great detail (pp. 119-136). The authors described how they originally conceptualized the trauma narrative as "an exposure procedure" (p. 119) for the purposes of, "neutralizing the intense negative emotions that accompany these traumatic reminders" (p. 128) and to "un-pair thoughts, reminders, or discussions of the traumatic event from overwhelming negative emotions" (p. 119). The child was encouraged to re-read his/her trauma narrative with the therapist until his/her SUDs (subjective units of

distress) drop and symptoms of PTSD reduce.[44] The manual stated, "If the child's SUDS progressively decrease during sessions in which the trauma narrative is created, this progress can be pointed out to him/her as a sign of how well the child is handling this challenging task" (p. 125). The final part of the trauma narrative module involved focusing on what the child can do, "right now to make things 'come out better' in the present or future" (p. 128). The manual continued, "The therapist should then encourage the child to think about specific ways to achieve symbolic corrective action in the present and future" (p. 128). The therapist should also, "encourage the child to write a corrective story that can be placed at the end of the trauma narrative" (p. 129).

In sum, the trauma narrative phase of treatment elicited a specific and detailed story about the child's life that was not reduced to universal symptoms or diagnosis of trauma. In addition to desensitizing the child to the details of the trauma, a primary purpose of eliciting the story is to re-write it and in some form alter the experience through positive symbolic correction and a new ending. Thus, while the manual suggested there be space in the therapy for personal details and narrative about the

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[44] Subjective units of distress (SUDS) are a quantitative measure of self-reported distress used in many exposure or desensitization-based cognitive behavioral therapies for anxiety and PTSD (McNally, 2007). To assess the level of anxiety a patients is experiencing during desensitization psychologist Joseph Wolpe (1973) developed the subjective units of distress scale (SUDS). Using SUDS, patientss subjectively rate their anxiety from 0 to 10, where 10 is shear panic and 0 is the most relaxed possible (McNally, 2007). Exposure therapies work best when the patients reports SUDs at a 7 or 8 when reporting a stressful event. If the patients's SUDS reach a 9 or 10 then this can evoke a flooding response that is so intense that, according to Le Doux's theories, the reptilian brain activates and the neocortex is no longer involved in the processing and association; the patients may go into a flight or fight response that is in fact re-traumatizing rather than therapeutic. If the SUDS are too low (e.g., 5 or below) then the desensitization will not work because the conditioned anxious response was not evoked.

trauma, this space was significantly reduced through the therapist correcting the narrative to make it more positive.

  Thought-terminating clichés about cultural competency. There was periodic emphasis on cultural competency in the manual, such as a section (just over one page in length) titled "The importance of culture in TF-CBT" (p. 40-41), the inclusion of the "R" value (i.e., cultural respect) in CRAFTS, and some troubleshooting sections focused on cultural differences between the therapist and patient. The manual used the phrase providing treatment in "cultural context" (pp. 33, 41) but neglected to actually describe what this actually would look like in therapy.

  Though the manual heavily emphasized community work and disaster response, it did not seriously consider questions like: what does it mean to be culturally respectful when one is a U.S. national, white, educated, middle-class who arrives to a community for two weeks to provide trauma relief for a disaster like Hurricane Katrina or Sri Lankan tsunamis? How does an APPIC intern who is transplanted to an Alaskan Native Indian Reservation mental health system conduct culturally respectful therapy while at the same time requiring families to send their child to 12 individual sessions of TF-CBT at a treatment center? Is it respectful to take the therapist script about standing up to terrorists in your mind (as discussed on p. 151 of the study) and say this to someone in Iraq, Spain, Darfur, Syria, or Mexico? Instead of considering questions like these, thought-terminating clichés (cf. Lifton 1956/1989) were used to avoid discussion of what it means to work with patients who therapists perceive as culturally different. Respect for "cultural context" (pp. 33, 41) and "cultural values" (pp. 32, 33) were a few of the clichés that were used to acknowledge culture but not actually promote a conversation about how

cultural respect could or should be approached in therapy. Another cliché was providing children a "symphony of support" where the therapist provides healing and the family and community provide "the cultural context in which the child can heal and grow" (p. 41).

The clichés, while somehow suggesting that the manual was culturally sensitive, also allowed for avoidance of a discussion about culture, race, class, and other political and social arrangements in such a way that there was no imperative to change the therapy or status quo of these arrangements. It's possible these clichés somehow were used to rationalize the exportation of the manual and training to the 60 countries it has been disseminated to, in addition to diverse communities nationally in the U.S.

Exclusion from the definition of trauma. How the manual excludes or includes certain persons from the description of trauma victim is highly related to how the therapist uses the manual and the recommended screening assessments of PTSD. For example, to be considered as traumatized and appropriate for trauma treatment one has to meet minimum criteria on initial assessments of PTSD. Since I didn't include observations of the therapy or assessment in this research it was difficult to ascertain how the label of "trauma" and "traumatized" was being applied in such a way that it would exclude certain persons from the therapy or the definition of trauma. If anything the manual suggested that therapists should be overly inclusive rather than exclusionary when considering children as traumatized (e.g., trauma is universal, applies to every negative life event, occurs in every culture). I did note that the structure and scripts provided in the manual almost necessarily demand that the patient conform to U.S. middle-class cultural standards by having a certain amount of resources (e.g., can take

time off of work or other obligations to bring their child to twelve to sixteen sessions of therapy) and exposure to formal education (e.g., worksheet and form literacy; basic understanding of human biology and neuroscience). Furthermore, the idea of letting a child sit with a therapist alone in a room and talk about a traumatic experience like domestic violence or sexual abuse, is not necessarily a comforting one for parents of any culture or socioeconomic status yet for some reason this idea was promoted as safe in the manual, and in fact more safe than discussing the trauma with a parent, family or community member (see further discussion in TF-CBT Theme 3: Parent as protector versus perpetrator, pp. 273-278).

It's possible that certain parents and children would not attend the treatment because they rejected the basic structure or premises of the treatment, and thus might not be considered trauma survivors. I consider this further in the discussion when thinking of therapy as recapitulating a form of colonization. Following this line of inquiry, I looked for examples in the manual of children that somehow didn't fit the definition of traumatized or didn't behave in ways the manual would expect a traumatized child to act. The following forms of resisting trauma therapy and recommended therapist responses to these problem behaviors (noted in parenthesis) were described in the manual:

- Child remains silent (ask open ended questions);

- Child resists psychoeducation (educate the parent or turn the psychoeducation into a game);

- Child doesn't want to feel better or relax (say: "Everyone has a right to feel pleasure. This is a safe place, you won't be harmed while you are here" p. 85);

- Parent doesn't believe in therapy (challenge cognitions about therapy adherence using thought-replacement, interpret resistance as part of trauma pathology: "suggest that the mother's guilty feelings about the accident might make her believe that she did not have the right to get well" (p. 48);

- Family is in crisis and doesn't see importance of trauma treatment (remind parent of outcomes on initial assessment of PTSD and the importance of trauma related work over crisis);

- Parents don't bring child to treatment (explain importance and then eventually offer "an out" p. 52);

- Parents don't think their child is improving fast enough (educate with parenting skills, reinforce caring and "maternal gestures" p. 73), and;

- Family culture embraces "inaccurate beliefs" about the trauma (identify cultural leaders in community to support therapists in thought-replacement and cognitive restructuring).

Anger and aggression were often identified as a problematic response to trauma, which I have explored further in TF-CBT Exemplar 1 (pp. 284-288).

Thematic discussion: Trauma is universal and culture-free. In sum, the TF-CBT manual reduced the unique, personal and culturally-specific expressions of trauma through the process of standardized assessment (e.g., counting total traumas, symptoms checklists), by applying the word "trauma" to all life experiences that involved suffering, through re-writing the end of the trauma narrative as one that is necessarily positive and happy, and through lack of acknowledgement of the specific cultural context (e.g., U.S.,

middle-class, white) that is embedded in and reproduced by the manual scripts and structure. The manual attempted to position itself as culturally competent and amenable to wide dissemination and exportation nationally and internationally by suggesting that all humans experience trauma similarly (e.g., have the same biological underpinnings) and by using thought-terminating clichés ("respect cultural context", provide a "symphony of support") about culture that avoid discussion of more difficult questions about encountering cultural difference in the therapy room.

The manual did not overtly exclude any child or parent from the definition of trauma, but did interpret resistance to treatment as if it was part of the trauma pathology rather than rejection of the treatment and perhaps of the traumatized label. This was often accomplished by directing the therapist to reframe the parent's response as a form of denial or guilt, by giving more education, or by assuming the thoughts were inaccurate. Despite its emphasis on cultural sensitivity, when problematic behaviors arise in treatment the manual did not propose that the therapist consider the cultural reasons for resistance, such as the therapy being a form of cultural colonization, instead techniques like psychoeducation, thought-replacement, or increased number of sessions is recommended when a child and parent are unsure about the treatment. This was the same pattern that was described by Young (1995) in the VA; when a patient resists treatment give them a more restrictive treatment plan and more therapy.

Overall, the treatment developers benefit from universalizing trauma and seeing the treatment as culture-free because it allows their manual and protocols to be used in a wide-range of settings and countries. On a political level, when personal narratives of trauma are disappeared or flattened and thus amenable to a one-size fits all treatment, it

makes responding to disasters and crises much easier: train therapists in a treatment manual and send affected persons to therapy. Thus it is not only the developers but also those who wish to retain the status quo of political and power arrangements who benefit from broad applications of the word trauma and manualized treatments. To think or talk about a trauma in more nuanced and complex ways not only takes time and responsibility on the part of the community, but also might actually lead to political change.

Shared Exemplar: Indoctrination into a Social Void of Scientistic Managed Care

Exemplars are stories or vignettes that capture what the human being is like in a particular cultural or historical situation. In this study I looked for exemplars that captured what human being is like in trauma culture in such a way that it could be recognized in other situations that might have very different objective circumstances, including those outside of the practice of psychotherapy. In particular, I focused on identifying the therapeutic techniques and practices that trauma treatment manuals prescribed to training therapists, and noted the similarity between these techniques and practices to others in the social world.

The shared exemplar, which I titled, indoctrination into a social void of scientistic managed care, has four primary features: presentation of an origin myth, locating pathology and healing within the dyad, overreliance on forms, hand-outs and PowerPoints, and directive psychoeducation and thought-replacement.

Exemplar findings: Indoctrination into a social void of scientistic managed care. This section presents quotations from the Cohen et al., TF-CBT manual that are representative of this shared exemplar. I have divided the section according to the four features listed above.

Presentation of the therapy's origin myth. Samelson (1974) coined the term

"origin myth" to describe the presentation of an apolitical, trans-historical narrative of

incremental progress towards an objective truth and science. In an origin myth, the

subject is decontextualized and presented in the form of discoveries from individual

geniuses (typically white Euro-American men) who each contributed to the development

of the contemporary understanding of psychology.[45] The purpose of an origin myth is to

provide legitimacy to contemporary psychological concepts by presenting them as facts

that have existed in the same form for hundreds or even thousands of years (e.g., as long

as our ancestors fought for food with lions in the Serengeti). Each of the manuals

included some version origin myth and often this myth was incorporated into

psychoeducation about why the patient should be attending the specific form of therapy

prescribed by the manual.

The strongest example of an origin myth in the Cohen et al. manual was in the

progressive relaxation module where TF-CBT techniques were described as being

derived from and similar to a form of ancient Indian meditation:

> It's called meditation, which is an ancient practice that Eastern religions have
> used for centuries. Studies have shown that, like belly breathing, meditation can
> reverse the effects of stress and trauma on our bodies, not just during the times

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[45] While origin myths can be characterized as embodying a positivist orientation to search
for objective truth, Samelson pointed out that even the roots of positivist philosophy have
been obscured by origin myths and re-appropriated into scientific discourse. Positivism
emerged in the chaos of post-revolutionary Europe (1850s) in which the tools of science
were promoted as a method to gain new social order and freedom from noble rule. Thus,
positivist ideology was not born from an impulse to create politically neutral and factual
knowledge; yet, in practice positivism became the "doctrine of the scientific expert" that
emphasized technology for pragmatic rather than ideological purposes (Samelson, 1974).
Contemporary understandings of the history of psychology are similarly rooted social
political context but suggest that psychological knowledge is ahistorical, universal and
factual.

that we are meditating, but all the time, if we keep practicing it. Do you have any ideas about what meditating is like? [The child may describe yoga or other impressions of meditation here.] Some people think about yoga positions that look really hard to do, or of people sitting on top of mountains in India. But the truth is, you can meditate anywhere. […] if your focus is interrupted by thoughts coming into your head, you observe your own thoughts but do not judge or act on them. (p. 79)

Here the contemporary technologies of the treatment are connected to generic or stereotyped images of "an ancient practice" (p. 79) (e.g., people sitting on top of mountains in India practicing some Eastern religion). While one could argue that the manual is trying to acknowledge these traditions, the limited amount of description (e.g., three lines about ancient Eastern practice) would suggest that this myth has been included in the manual to invoke the sense of a tradition in order to rationalize the contemporary practice.

Location of pathology and healing in the dyad. In the TF-CBT manual all human relationships were described in dyadic form. The primary dyads included: parent-child, perpetrator-victim, trauma survivor-therapist and child-protector. At times the perpetrator was described as the non-offending parent, in which case there was an assumed relationship of perpetrator as offending parent and victim as child, as well as protector as non-offending parent and victim as child. While some traumas by nature seemed to call for inclusion of the social world beyond the dyad (e.g., terrorist attacks, natural disasters), subsequent healing from social traumas was never proposed in a community or even group setting within the manual, but instead within the child/victim-therapist dyad. In fact, the manual strongly guarded against group trauma therapy treatment (Cohen et al., 2006, p. 36). The manual only called for a minimum one conjoint session between the parent, child and therapist, which was perhaps the greatest extension of the healing relationship beyond the dyad; yet, the purpose of the conjoint session was for the

therapist to transition away from healer and protector and allow the parent to step into

that role within the parent-child dyad. Outside of obvious exclusion of the social world

by heavily focusing on the dyad, there are further assumptions about human parenting

relationships (i.e., that the child's primary caregiver is a parent and that only one

participates in the healing) which are discussed further in TF-CBT Theme 4: Parents as

protectors or perpetrators (pp. 279-284).

Over-reliance on forms, handouts, and PowerPoint in therapy. The TF-CBT

manual relied heavily on quantifying human experience using technologies such as

monitoring SUDs and checklist assessments for symptom improvement. Most of these

technologies were communicated in therapy via forms and handouts. For example, after

each session the child was asked to rate their distress on a scale from 0 to 10 or 0 to 5

using a thermometer, a scale with happy faces, or something called "the symptom

tracking-child report" which compared SUDs at the start and end of each therapy session

across the 12 sessions (MUSC, 2005). These ratings were recorded on a form and

periodically presented to the child to show them they had improved over the course of

therapy. After a session the therapist was recommended to give homework in the form of

several handouts.

The primary homework in TF-CBT was entitled "Practicing the cognitive triangle

during the week" (p. 226). The interconnection between thinking, feeling and action was

represented in the manual as "The Cognitive Triangle," which I have reproduced in

Figure 3. Despite the portrayal of an equal connection between all three elements in the

figure, the triangle might have been better represented as a hierarchy with thoughts at the

top because the focus of most of the TF-CBT intervention components were on thoughts

(Components 5–7). The homework for the cognitive triangle included the cognitive

triangle at the top followed by instructions for the child to go back through their week

and think about upsetting situations and then to "ask yourself whether that thought is 1)

accurate or 2) helpful. Come up with alternative thoughts in this situation and write down

how they make you feel and whether they are accurate or helpful" (p. 226). The handout

included blank spaces for the child to identify the situation, thought, feeling, and behavior

and then write in positive and functional replacement thoughts, feelings and behaviors.

Homework also involved additional psychoeducation about trauma. For example

the manual Appendix included:

> information sheets to both the child and parent that include such information as
> how many children are sexually abused by the age of 18, what are the different
> types of sexual abuse, who molests children, and why many children do not tell
> others about the sexual abuse. These information sheets can dispel many myths
> that the child and parent have about sexual abuse and its consequences. (p. 59)

The forms were justified as a way for the therapist to provide the child and parent

with facts, as if verbal communication from the therapist was somehow less legitimate

than information via printed form:

> When the child and parent learn 'facts' about the effects of witnessing domestic
> violence or being a victim of school or community violence, etc., misinformation
> is dispelled and child and parent learn that many other families have encountered
> a similar terrifying or tragic event and that this particular family is not alone with
> regard to the difficult challenges that they now face. Sample information sheets
> are included in Appendix 1. (p. 60)

The TF-CBT manual's Appendix 1 (p. 207- 228) included two information sheets

on domestic violence, two information sheets on child sexual abuse, a relaxation handout

entitled "How stress and PTSD affect our bodies," an affective modulation handout

entitled "Ways to feel better right now," the cognitive triangle practice sheet (described

above) and a sheet with months of the year called "The circle of life" (p. 228).

Though it appeared there were plenty of handouts for a therapist to utilize during

and after session with the patient, the manual also directed the therapist to TF-CBT web

supplementary material (MUSC, 2005). I examined this resource and found the additional

handouts on types of "thinking mistakes" and more SUDs symptom tracking sheets (for

parent, child and therapist). The website also included over twenty books and websites

for parents and children to learn more about PTSD.

In sum, in an average TF-CBT therapy session the child would be given at least

one in-session handout, such as SUDs symptom tracking sheets, and one homework

assignment such as the cognitive triangle worksheet. The therapist would also use at least

one handout to monitor patient progress and potentially a CBT based treatment plan. The

parent could be provided anywhere from one to five psychoeducation handouts after an

initial session and provided with referrals to over twenty additional books.

Directive psychoeducation and cognitivist thought-replacement*.* After

administering a standardized assessment for PTSD, the manual recommended therapy

begin with the therapist telling the child and parent what their child has experienced

through a form of education called psychoeducation. The aim of psychoeducation was to,

"to normalize both the child's and parent's response to the traumatic events and to

reinforce accurate cognitions about what occurred" (p. 59) and to "provide information

about common emotional and behavioral responses to the traumatic event that the child

has experienced. Any available empirical information bearing on this issue is shared with

both the child and parent. Scientific information that documents common reactions to a

specific type of trauma provides significant emotional validation" (p. 60). Thus the first

therapy hour is spent largely with the therapist providing feedback from the initial

assessment and talking about what trauma and PTSD are based on in the TF-CBT

medical conceptualization of trauma (see Chapter II: Background and Literature Review,

pp. 9-48).

The manual recommended the therapist include the essential following elements

in initial parent psychoeducation:

- The child is having significant PTSD or other trauma-related symptoms.

- Clinical experience as well as research suggests that these PTSD and other

  trauma-related symptoms need to be addressed as early as possible to

  prevent long-term difficulties.

- Review the PTSD and other trauma-related symptoms the child is

  experiencing, based on the clinical assessment that has been completed

  prior to treatment initiation.

- Talking directly about the trauma is important in resolving these difficulties

  and integrating the experience into the child's life in an optimal way.

- This component will be implemented in a gradual, supportive manner so

  that the child will be able to tolerate the discomfort associated with such

  discussion; furthermore, it will typically not be initiated until the child has

  learned some skills to help him/her cope with the discomfort.

- The therapist will work in collaboration with the parent throughout

  treatment, and the therapist welcomes the parent's suggestions at any time.

- People of different religions, ethnicities, and cultures have different ways

  of expressing and dealing with trauma responses; the therapist is eager to

  learn from the child and parent the traditions and rituals of their culture,

religion, and family and will remain respectful of these in the treatment

process. (p. 62-63)

After establishing the rationale for the therapy via the medical model for PTSD

and supported research, the therapist proceeds through the phases of therapy outlined in

Figure 3. One of the last steps of therapy was challenge the negative and dysfunctional

cognitions the patient has learned. According to the manual,

> The term cognitive coping refers to a variety of interventions that encourage
> children and caregivers to explore their thoughts in order to ultimately challenge
> and correct cognitions that are either inaccurate or unhelpful (Beck, 1995;
> Seligman, Reivich, Jaycox, & Gillham, 1995). Knowledge and life experiences
> help individuals make sense of traumatic events. However, given children's
> limited experiential and knowledge base, they may be particularly prone to
> inaccurate or dysfunctional thoughts about traumatic experiences, and these
> thoughts can negatively influence their developing views and belief system.
> (p. 107)

Thus the primary focus of thought replacement is for the therapist to decide which

thoughts are functional, helpful and positive and which are inaccurate and unhelpful and

to train the child to replace these thoughts. Despite the child gaining a particular form of

traumatic knowledge and life experience from the traumatic event, this knowledge is

assumed to be potentially dangerous. The fear is that if the child's post-traumatic

thoughts are not replaced in therapy this will have a negative effect on their development

and belief system.

Throughout the manual the Socratic method (reframed as thought challenging or

cognitive restructuring) and thought replacement worksheets like the cognitive triangle

described earlier (Cohen et al., 2006, p. 226) were used to direct and train child patient in

how to identifying dysfunctional thoughts and replacing them with other thoughts. One

form of thought replacement in TF-CBT was called positive-self talk:

Positive self-talk consists of focusing on the child's strengths instead of the negative aspects in any given situation. […] Children may benefit from recognizing (and focusing attention on) the fact that, despite great adversity, they are coping—and are often coping quite well. Positive self-talk requires the therapist to help the child recognize the ways in which he/she is coping well and to remind the child to verbalize these ways, particularly when feeling discouraged. (pp. 92-93)

Examples of positive-self talk statements included:

- I can get through this

- Things are hard now, but they will get better

- I still have a family, and they will help me

- Lots of people care about me and my family

- Some things have changed, but lots of things are the same as they were

     before this happened (e.g., "I still do well in school, I still have friends,

     I'm still good at math"; p. 93)

In previous sections of the results I have provided additional examples of child

and parent thought-replacement (see pp. 144-149).

Another aspect of cognitive restructuring in TF-CBT was thought interruption, in

which thoughts are simply stopped rather than replaced or altered. According to the

manual,

Thought interruption is an affective modulation technique that can short-circuit the cycle of negative thinking that is often problematic for traumatized children (thoughts of the traumatic event lead to cognitive distortions, which lead to more upsetting thoughts and more cognitive distortions, and so on, or dwelling unproductively on very negative thoughts and scenarios). This technique can also prepare the child for cognitive-processing interventions because it teaches children that they can have control over their thoughts. (p. 91)

The manual acknowledged that thought interruption is contradictory to the trauma

narrative, exposure approach that the therapist should have utilized three sessions prior.

The authors suggest that thought interruption can be more functional than narrative processing when children:

> need to be focused on things going on around them, such as at school, when playing sports, or interacting with friends. Applying this technique teaches children, first and foremost, that they have control over their own thoughts—not just which thoughts they choose to focus on, but also when they focus on which thoughts. (p. 91)

> Mastering these techniques before creating the trauma narrative can help some children feel confident that if they start to feel overwhelmed while talking directly about the traumatic event, they will be able to interrupt or control these reactions. (p. 92)

Thus the primary focus of thought stopping is to train the child how to stop thinking when they are overwhelmed with traumatic symptoms and need to focus on being a functional or productive worker in school.

Exemplar discussion: Indoctrination into scientistic managed care. This exemplar had four primary features: presentation of an origin myth, locating pathology and healing within the dyad, overreliance on forms, hand-outs and PowerPoints, and directive psychoeducation and cognitivist thought-replacement. Many of these features are therapeutic techniques that shift therapy into a form of indoctrination into a world of scientistic managed care that ignores social relationships outside of the dyad and values compliance and control as good ways to be human.

To indoctrinate the patients into the culture of managed care the TF-CBT treatment begins with an assessment process where trauma is decontextualized from the social world as a set of symptoms or count of traumatic events. The way these events and symptoms are packaged via diagnostic assessment allows for easy communication to administrative bodies for treatment and planning purposes, as well as ongoing monitoring. The therapist explains patient distress according to a concrete, ahistorical and

acultural set of PTSD symptoms and informs the child patients and their parents that their experiences are part of a common and well-understood medical pathology that can be cured with the healing technologies of a 12- 16 session treatment: TF-CBT. The treatment is of course covered by the patients insurance (because it was designed to be so) and thus seems like an easy or natural fit for the child and parent to pursue.

The TF-CBT manual utilized origin myths in psychoeducational scripts to suggest to the patient and therapist that the values and practices of the therapy have existed for centuries and are part of an ancient tradition. Origin myths appeal to the patients' common sense; they believe they are practicing part of a time-tested healing tradition. Additional psychoeducation suggests that the formulation of mental illness that the therapist is presenting is biologically-based, universal, normal, common and to be expected after a trauma. Because the psychoeducation is designed to present problems that the therapy will cure (e.g., children have dysfunctional thoughts after trauma that impact their development for life, this therapy targets dysfunctional thoughts) it indoctrinates the patient to want the exact type of treatment that they will be offered. This is why forms of resistance to treatment are often met with more psychoeducation; the assumption being that if the patient were to be presented with more knowledge, science and explanation about their problem they will understand how the therapy is integral.

These techniques and ways of being are not limited to TF-CBT therapy or psychotherapy in general, which is why they have been identified as part of an exemplar. The techniques (i.e., origin myths, location of healing in the dyad, forms and handouts, and directive psychoeducation) are all ways that messages about how to be a good human are communicated by therapists serving in the role of expert in contemporary society.

Many of the techniques and practices identified in this exemplar are similar to those described by Cushman and Gilford (2000) in their article "Will managed care change our way of being?" In this paper, they described how the definition of mental health disorders, nature and length of treatment deeply affect understandings of what is healthy, normal, and good about human being. Though this article was written over 14 years ago, at the time of this study (2014), it has only increased in relevance. Managed care has significantly increased its control of psychotherapy. The article presented how diagnostic practices take for granted several contemporary assumptions about human being including: the idea that bias and prejudgment can be removed from the assessment process, that the way a patient is feeling can be observed through checklist-based forms of inquiry, that human distress and psychological life are constituted by concrete, ahistorical, acultural mental health categories, that these categories can be studied objectively by experts to determine proper planning and administration of treatment techniques, and that the therapist can apply predetermined techniques to a patient suffering from a particular diagnosis in a particular time period. The article discusses a litany of further assumptions that suggested that psychological ills are simple to understand and fix, and that the self is "highly concrete, psychologically uncomplicated, behavioral and monocultural" (p. 987). What Cushman and Guilford are suggesting is that managed care evidence-based practices reflect and shape our way of being and our understanding of the self.

What is important about these practices is that is that they rely on subtle assumptions about the patient, such as that the patient does not know what s/he has experienced and need to be educated about his or her symptoms; these assumptions have

associated moral implications and political functions. In this case, there is only room within the therapy for the psychoeducation that is written in the manual. The social understandings about the causes of trauma that emerge outside of the dyad and symptoms that do not fall within a cognitivist understanding of PTSD that gives primacy to the individual and the interior self cannot come to light within the TF-CBT therapy.

The practices also rely on instrumental technologies, such as worksheets and forms with quantitative monitoring systems, which are difficult to become aware of and resist via therapy given their directive content, scientific presentation, yet non-assuming delivery format. When I say non-assuming, I mean that patients are not forced to absorb the messages of healing in a top-down coercive manner, rather they are given a form or worksheet that can seem optional or supplementary to the therapy. Yet a patient takes the text home, leaves it on his or her kitchen counter or carries it around in his or her bag after a therapy session; the therapy grows into the daily practice of the patient's life even if s/he chooses to not to read the form or complete the homework. If the patient does choose to regard the homework, then that would mean completing daily thought monitoring with the knowledge that it will be reported back and monitored again by the therapist, their supervisor and perhaps entered into an electronic chart to monitor improvement. In the case of a child patient, it would require the parent to ensure their child is completing their thought-replacement homework everyday. The form becomes an extension of the clinical-gaze (cf. Foucault) and self-surveillance that is promoted in the manual: one should always be aware of and control their thoughts. The inclusion of worksheets and forms in the everyday life of the patient, parent and therapist means that all parties involved in therapy may embody the social practices described in the manual;

as therapy progresses and forms and psychoeducation are repeated it will only make sense to the patients to monitor their thoughts on a worksheet and for the therapists to respond to patient resistance with more forms and psychoeducation.

Like Foucault's (1995) description of the prison shifting to the asylum and then morphing into the clinic and now into self-help books, this type of self-surveillance is completed not because the patient is pressured to or can't avoid absorbing the doctrine but because forms and compliance with managed care principles is associated with healing from trauma and being a good trauma survivor. The patients want to comply and control their thoughts because they are told and have come to believe through subtle messages in therapy and in daily life (e.g., neoliberal ideals) that that is what they should do to return to society as a functional worker and a good person. Similarly, Cushman (2013) suggested that the reason that patients accept the practices suggested by evidence-based treatments, like TF-CBT, is not that they are mandated or are better than other practices but they, "fit hand-in-glove with the predominant self of the early 21st century. They seem to mainstream therapists and researchers to be unquestioningly correct because they speak the predominant language of our time" (p. 2). Cushman suggests what makes sense about evidence-based practices is the language of cognitivism and meeting the needs of the "multiple-self," which is characterized by,

> a significant attenuation of interiority. It is marked by a propensity to gather about itself a number of identities that are located around the outside of the person, external to but identified with the individual, although this identification takes on a different, less essential, or intense valance than identifications within a deep self. This is an exterior self with less complex or conflicted identities to draw from — identities that cluster on, not inside, the individual, decorating and standing ready to appear on center stage when the need arises. (p. 3)

He continued that unlike the empty self of the 20th century that was filled with a gnawing drive to consumerism, the multiple-self in the context of managed care and

evidence-based therapies is one that can present for public viewing to the social needs of the moment. When extending this concept to my interpretation of this exemplar in the TF-CBT manual, the patient is encouraged by the therapy to present as a particular type of traumatized patient whose symptoms can easily fit within a modular, predetermined checklist and whose thoughts and feelings can be simply exchanged and replaced as needed. The self is compliant, easy to make sense of, and readily adaptable or even replaceable in the moment (e.g., change your thoughts like switching the channel on the TV). The patient is prescribed modules in which a type of self that is deeply emotional is accepted (e.g., trauma narrative exposure) and in another module they are expected to restrain and shut off emotions and thoughts as needed (e.g., thought stopping, emotional regulation).

In sum, the way of human being that is reflected and reproduced by the Cohen et al. manual is highly compliant and modular. It is so amenable to management and managed care that the therapist and patient's daily life and practices reflect the decision trees and symptom monitoring technologies (e.g., SUDS, worksheets, electronic charting) that are used in treatment planning. Questions of morality and political function do not come to light through the treatment, yet there are strong moral and political messages that are communicated through the manual and are taken for granted or assumed to be natural. What it means to be good according to this manual is to respond to upsetting, confusing and violent social and political events by going to individual therapy and embodying uncomplicated, asocial, acultural symptoms that align with the cognitivist psychoeducational trauma narrative about PTSD; symptoms that can be quantitatively monitored for both therapeutic and insurance or administrative purposes. According to

my interpretation of the manual, the patient should come to present daily political distress

in such a way that their symptoms are amenable to the specific structure and assumptions

of managed care, evidence-based therapies that ultimately serve the needs of insurance

companies and not the patient or their community.

TF-CBT Theme 1: Children Are Born With Pre-Traumatic Innocence

In this section, I present the first theme that I identified only for the TF-CBT

manual and that I did not interpret for the other two manuals. While studying Cohen et

al.'s (2006) manual I interpreted the cultural practices and implicit understandings about

what a child and a parent are or should be in contemporary culture. When considering

what being a child is like in trauma-based society from the perspective of the Cohen et al.

manual, the specific theme I identified in this manual was that the cultural boundaries of

adulthood and childhood are blurred by trauma. In the context of the manual, childhood

seemed less representative of an age and more of an innocent, protected, and at times,

passive state, in which the child was not fully aware of and thus has no responsibility for

the world, their relationships, actions, and body. Trauma was described as any event that

was destructive of that innocent state, and events became more traumatic the more they

were associated with destroying the cultural qualities of childhood.

Thematic findings: Children are born with pre-traumatic innocence. The

Cohen et al. manual introduction stated, "Children may experience depressive feelings

after a trauma, which may arise in response to an abrupt loss of trust in other people and

the world (e.g., a loss of innocence, trust, faith or hope in the future)" (p. 7). The manual

reiterated, "Traumatized children may also develop cognitions that contribute to their loss

of faith in justice, God or a benign future" (p. 12). In other words, children come into the

world with an innocent faith in its working and the trauma destroys the child's blind trust in the world.

The younger the child the more they were associated with being good and having the right to protection and a good life. Infants were especially associated with innocence to the extent that the manual had a small section for working with families who have had an infant child die. The manual discussed how the family would idealize the infant, "Because the infants do not have a chance to grow-up we freeze them as 'little angels' in our minds forever" (p. 186). The manual discussed the concept of child innocence as diminishing as the child becomes an adolescent (at an undefined age somewhere between 12 and 16) when it is expected that the child will begin to act more like an adult, separate from the dyad of the parent, and engage in "age-appropriate independence and separation/individuation" (p. 39).

The phrase "age-appropriate" was used repeatedly, "children may avoid age-appropriate peer interactions, preferring to associate with peers who have emotional and/or behavioral problems" (p. 10), "it is important to recognize developmental differences between adolescents and younger children, and to encourage age-appropriate independence and separation/individuation from parental authority," (p. 39); and, "Providing *realistic, age-appropriate* reassurance is important" (p. 101).

The language about age-appropriateness increased in chapters about sexual abuse, "Some children accidentally reveal their abuse by exhibiting adult-like sexual behaviors or by sharing sexual knowledge that is beyond their years" (p. 217); and "Children may exhibit symptoms that are more specific to sexual abuse, such as repetitive sexual talk and play, age-inappropriate sexual behavior" (p. 214). An explicit definition of what

constituted age-appropriate behavior was absent but was implied to be very simple, asexual, pleasant and protected from adult-like content (namely content devoid of complexity, abstract or philosophical thinking, sexuality, anxiety, horror, or violence).

The manual described children as essentially pure, without knowledge or experience; yet, they were also described as innately rational beings, little logical thinkers, that seek order midst the chaos of trauma, "Following a traumatic event, children will typically search for an explanation for why something so terrible has happened to them or their loved ones. If no rational explanation is found, children may develop irrational beliefs about causation in order to gain some sense of control or predictability" (Cohen et al., 2006, p. 11).

The premise of treatment in the Cohen et al. manual was based on correcting the thoughts of the child (which the manual refers to as cognitive distortions) to be more rationalist and adult-like, while also rebuilding a sense of innocence, naïveté and age-appropriate behavior in therapy. The technologies that embody this premise include age-appropriate psychoeducation and thought-replacement exercises, in which the therapist provides the child a narrative about the traumatization and then identifies which of the child's thoughts are irrational and unhelpful (i.e., that deviate from the therapeutic narrative) and trains the child to stop thinking these thoughts. In practice, the therapist's message to the child about how to react to trauma is somewhat confusing: we want you to know enough about the world in a rational way to make sense of what has happened to you, but we don't want you to know so much about this world that your innocence is corrupted by the reality of guilt, shame, or horror you experienced. The message

encourages the child to engage with the therapist in order to deny the negative realities of the trauma.

Thematic discussion: Children are born with pre-traumatic innocence. The concept that trauma destroys the child's innate innocence is not timeless or natural, but embedded in a culturally constructed tradition. Several scholars have written about how the concept of childhood has shifted throughout centuries and have posed questions about what constitutes a child in the contemporary social clearing (Archard, 2004; Matthews, 1994, 2010). I summarized these views in the Specific Background Information Relevant to Results (pp. 100-132) and have referenced them to provide context, but I have not suggested that this history justifies the particular presentation of childhood in the Cohen et al. manual.

Following Gadamer's (2004) insights about the political uses of "claiming the right of the horizon" (see p. 149 in Methods)—when applied rigidly, developmental theories necessarily do not allow other possibilities about childhood to come to light. For example, to maintain that there is only one true understanding of childhood (e.g., like in the TF-CBT manual where the child possesses an empty, naïve self that needs to achieve certain developmental stages to reach maturity) is to avoid considering alternatives about the experiences of children. The history of dominant theories of child development in psychology in the 20th century suggest an overarching cultural belief that we need to have a good theory about childhood in the first place; we cannot know children without an expert, scientific theory of development. The study of children from the three primary developmental perspectives (innatism, experientialism and recapitulation, see pp. 115-119 in Background and Literature Review Chapter) has no doubt led to interesting

insights and life-changing research. However, there has been little room within the contemporary clearing for alternative lines of inquiry about children's experience, and in this case experiences with trauma, beyond knowing more about them in a scientistic way. Matthews (1994) a leading scholar in the philosophy of childhood, noted that children have fallen into what Kant called "the kingdom of ends" (p. 27) and, like Foucault's (1973) commentary on madness, children have firmly become objects of study. This typifies one of the ways of being in a contemporary, trauma-based society: societal problems can be resolved with further rational study and knowledge.

In hermeneutic terms, traumatic events allow childhood to fall out of everydayness; when this happens, questions about what a child is are demanded of society. Following Cushman's (1995) understanding that therapists usually maintain society's particular constitution of the self, the TF-CBT manual can be interpreted as the cultural script maintaining the mainstream conception of a child. The therapists' job is to reconstitute the boundaries of the cultural clearing of childhood by following the manual. When the trauma might be considered either a point of questioning or laying out of taken-for-granted assumptions in the world, it is framed in the TF-CBT manual as the site of cultural destruction and repair. The trauma must be removed, processed, and/or reintegrated in order to relocate the child within childhood or, in some cases, to assist the child in his or her cultural transition to another state or role (e.g., adulthood, adolescence, child-survivor).

In the case of the Cohen et al. manual, childhood innocence can be restored through introducing rationality and a type of naïve, age-appropriate, unknowing (and at times active rejection) of traumatic experience through the process of therapy. The

unstated primary goal of TF-CBT therapy was to reconstitute and preserve the ideal of the innocent child in an otherwise traumatic world. This brings us to the question: Why was the particular ideal of childhood innocence as a way of being important for human being at the time of the manual's creation (2001-2006) and beyond? Before approaching this question, I first discuss the other relevant themes about childhood that I identified through my readings of the manual.

TF-CBT Theme 2: Children Are Not Sexual

In this section, I present the second theme that I identified only for the TF-CBT manual and that I did not interpret for the other two manuals. While studying Cohen et al.'s (2006) manual I interpreted the cultural practices and implicit understandings about what a child and a parent are or should be in contemporary culture; one of these taken for granted assumptions was that children are not sexual. This theme could be seen as what I referred to in the Methods chapter as a "silence" (pp. 165-166), in that I interpreted a pattern of lack of discussion about child sexual behavior and sexuality in the manual.

Thematic findings: Children are not sexual. There is a plethora of information provided in the Cohen et al. manual about treating traumatic stress from sexual abuse and how to talk to children about preventing future sexual abuse (see Appendix in Cohen et al., 2006, p. 220), but there is no other mention about how to otherwise talk to children about sex, sexuality, or sexual behavior. The psychoeducation provided to children about sexual abuse in the manual primarily focuses on telling children how to possess their bodies and say "No!", "All children need to know is that their body belongs to them. If you feel uncomfortable in the way you are being treated you can tell the person, NO!" (p. 222).

While the manual emphasizes the age-appropriate nature of psychoeducation broadly, the sections about sexual abuse education are not tailored to different ages. The nuances of unique experiences of the trauma of sexual abuse from the perspective of different ages, genders, settings, families, or cultures is flattened by the manual to "just say NO" to people touching you and to sex. While it has been shown that children and adolescents are engaging in sex (Centers for Disease Control [CDC], 2011; Fine & McClelland, 2007; Foster & D'Emilio, 2012; Heins, 2001; Kehily, 2012)[46] a discussion of sex separate from the context of abuse is absent in this manual.

From the stand-point of evaluating the Cohen et al. manual as an evidence-based CBT treatment, one might expect more specific psychoeducation to be provided to

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[46] During the time the TF-CBT manual was developed and disseminated, the U.S. Centers for Disease Control surveyed children aged 15 through 18 from 2006 to 2010 about a narrow form of sexual activity—vaginal heterosexual intercourse. They found that 43% of never-married teenaged (15 through 18) females experienced heterosexual vaginal intercourse at least once. The half of the females surveyed who did have sex under the age of 18 reported having sex for the first time at age 14 or younger (18.9% before age 14 versus 9.4% between 15-17 and 8.9% between 18 and 19); 41% reported that they "really wanted it to happen at the time," 48% reported that "a part of me wanted it to happen at the time and a part of me didn't'" and 10% reported that they "didn't want it to happen at the time." 41.8% of never married males ages 15 through 18 also experienced vaginal heterosexual intercourse at least once before the age of 18. Of that group, the majority surveyed also had sexual intercourse before age 14 (8.9% before age 14 versus 3.7% between 15-17 and 4% between 18 and 19 years old). The majority of males reported that they "really wanted it to happen at the time" (62% vs. 32.5% mixed feelings and 5% didn't want it to happen). 32% of male teens in this same age group also reported having between three and five sexual partners (p. 14). For women, sexual partners were more likely to be three or more years older (17%) while men reported relatively equal distribution of their partners age (i.e., similar probability that partner was same age, younger or older than them).

Notably the CDC did not include gay, lesbian, queer or other sexual orientations in its assessment of sexual activity, nor did it include assessments of children younger than 15, or forms of sexual activity outside of vaginal intercourse. Given the amount of exclusions from the survey it is likely that the percentage of teens and possibly pre-teens engaging in some form sexual activity is greater than 43%.

children about sex and sexual activity given that early versions of the manual were designed to respond and specifically treat child sexual abuse (Cohen & Mannarino, 1992, 1993, 1998) and sexual abuse is a primary trauma of focus in many examples in the manual (89 mentions). Despite this centrality, while most psychoeducational scripts in the manual go into great detail about what should be expected from the world (e.g., how to respond to terrorist attacks, how to make a safety plan, how to change your thoughts and brain) there is not much detail about what one should expect to encounter when it comes to sex and sexuality in the world. Furthermore there was no identified framework to elicit qualitative discussions about sex from the child (other than to rehearse the trauma narrative of sexual abuse) nor was there a suggestion or framework for a broader discussion of sexuality separate from psychoeducation about abuse.

Thematic discussion: Children are not sexual. The dearth of information about sex or exploration into the child's perception of the trauma or their understandings of sex outside of sexual abuse in the Cohen et al. manual suggests that discussions about sex are unnecessary or perhaps even inappropriate. The message that may be sent to the child during TF-CBT therapy is that sex and bodies are private and should not be discussed. By not making room for discussions about sex or understanding about how sexuality intersects with childhood, identity, and trauma in ways outside of body possession and saying no, the therapy in some ways aligns with sexual trauma by retaining a narrow and secretive view about sex. Ironically and unfortunately, the message that is tacitly promoted in the manual through avoidance of other discussions about sex and sexuality is similar to the narrative that many abusers tell children (i.e., let's keep sex a secret). Archard (2004) noted that, "our justified abhorrence of sexual abuse should not blind us

either to the possibility that children can engage in sexually non-abusive activities, or to the realities of any child's actual sexuality. Indeed, talk of the child's essential innocence is in danger of being mythic, and ironically, of being sexualized" (p. 105). It is likely that there is a realm of other understandings that children may have about sex and sexuality in a post-sexual abuse scenario that go beyond body ownership and the setting up of boundaries post-trauma, but the manual doesn't make room for this exploration in therapy. What is lost in the obsession with protecting children in the TF-CBT manual is an attempt at understanding how the child sees and experiences sex, sexuality, sexual abuse and trauma given their complex experiences.

Michelle Fine (1988) has likened the emphasis on teaching children facts about body protection, like that demonstrated in the TF-CBT manual, to Foucault's (1980) analysis of sexuality as being dominated by experts and science to guise fears and political controversies; the introduction of the expert in these scenarios is often at the price of hearing about sex and bodies from the patients themselves (see also Fine & McClelland, 2007). Children's reactions to abstinence psychoeducation following sexual abuse in TF-CBT therapy have not been previously qualitatively evaluated and it might be important to hear what children think about sex and sexuality (especially those who are within the 12-18 year old ranges that according to the CDC are engaging in sex) following the TF-CBT therapy treatment.

While there has been no research on child reactions to the sexual psychoeducation (or lack thereof) in TF-CBT, prior qualitative explorations into childhood sexuality more broadly have pointed out the disconnect between society's association of child sexual experiences and sexuality with maturity, agency, and loss of innocence (e.g., thinking

about or having sex at certain ages means being out of control, naïve, or precocious) and

the child's phenomenological experiences of sexuality in which sexual behavior and

thoughts are not necessarily linked with consent culture, submission/domination (e.g.,

owning of ones body) or loss of control (e.g., Clancy, 2009; Kehily, 2012; Ringrose,

2011). Given the cultural history and traditions of childhood innocence, it is easy to place

childhood experiences of sexuality within a dialectic of passive and innocent versus

agentic and tainted, or as Kehily (2012) pointed out in her deconstructionist study of girls

sexuality, in the dialectic of "girls at risk" and "can do girls." Yet the adult emphasis on

purity, morality, and protection also places an anxious demand on a child's experiences

of sexual abuse that forces the child's understanding of the trauma and of sex into black

and white moral terms (e.g., guilty or innocent) and repetition of simplistic ideas of

protection ("Just say NO!") that are disconnected from the complexities of sexuality in

contemporary society (e.g., the role of technologies, internet, neoliberal consumer

culture). [47]

Though more qualitative explorations into sexual education and discussions of sex

in therapy with children are needed, a ten year federally funded evaluation of abstinence-

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[47] Just saying "No!" may not be an effective approach to sexual awareness and safety in
contemporary society primarily because children have been found to be encountering sex
in pervasive and complex ways, such as in entertainment and social media (Kehily, 2012;
Fine & McClelland, 2007). Increasingly in the past five years qualitative explorations
have focused on child sexual identity as it shapes and is shaped by online communities
and social networking sites (e.g., Ringrose, 2011).

It should also be noted that within psychology there are several schools of thought
about the recognition of sexuality and sexual behavior. Some see normative child
development as including curiosity about and experimentation with sex (Bancroft, 2000;
Fine & McClelland, 2007; Gebhard, Johnson, & Kinsey, 1979; Mac an Ghaill, 1994;
Thomson & Scott, 1991).

base education approaches to sex found that they are ineffective at eliciting and changing perceptions of sex and has no actual impact on sexual behavior (Trenholm et al., 2007). Like most research on harm reduction versus abstinence for any behavior, previous research has also found that the just say "No!" approach to sex is not actually effective at preventing future sexual abuse or sexual activity with children (Brückner & Bearman, 2005; Haignere, Gold, & McDanel, 1999; Kirby, 1999, 2001, 2002; Kirby et al., 1997).

I should note that the mere recognition and discussion of this theme in this study is no doubt controversial. To point out something taken for granted and culturally protected opens us as a society to understanding our traditions in a new light; this can be perceived as questioning, rejecting or threatening these traditions (Layton, 2006). In this case, children and sex, sexuality, incest and sexual abuse are tied so closely to specific cultural beliefs that we may protect and defend our stance on these issues quite strongly. On a micro-level the concern about child abuse was reflected in the manual where sexual abuse dominated the examples of trauma (89 mentions of sexual abuse versus 17 about terrorism) and the majority of funding to create the manual was secured for randomized control trials to treat child sexual abuse. On a societal level within the U.S., the importance of the taboo on child sexuality is evidenced in the current (2014) political climate of war, poverty, abortion and other national crises, when the government and the public have not abandon but continue to fight passionately political battles about sex, sexuality and women's and children's bodies.

Some scholars have interpreted the obsession with defending cultural ideals during times of distress as diverting or even locating cultural distress (e.g., war and poverty) within the child, woman and family (e.g., Fine, 2012; Haaken, 1995). When the

world is unstable the family, and in particular the ideal of the white middle-class family, becomes a locus of debate as society attempts to protect it from perceived cultural dissolution.

When studying the Cohen et al. manual it is also important to remember that the preliminary research leading to the initial development of this manual was conducted during the early and mid- 90s, following the Herman-led movement (see Chapter II: Background and Literature Review, pp. 88-98) to recognize child abuse, and in particular incest and child abuse in psychology (Herman, 1997, 2000). These early manuals were revised and combined into the Cohen et al. (2006) manual in such a way that they capture both the vernacular of abuse and of terrorism to express the daily experiences of women and children.

TF-CBT Unique Theme 3: Children Have No Agency During Traumatic Events

In this section, I present the third theme that I identified only for the TF-CBT manual and that I did not interpret for the other two manuals. While studying Cohen et al.'s (2006) manual I interpreted the cultural practices and implicit understandings about what a child and a parent are or should be in contemporary culture; one of these taken for granted assumptions was that children have limited to no agency during traumatic events.

Thematic findings: Children have no agency during traumatic events. One of the primary aims of child TF-CBT was to correct the dysfunctional or irrational thoughts that emerge after a trauma; one of the primary dysfunctional thoughts that the therapists are encouraged to challenge and eventually replace is the belief that the trauma is the child's fault. The manual stated, "Children's developmentally normal egocentric view of the world may lead to self-blame for the traumatic event, which in turn may lead to

depressive symptoms" (p. 7). To ensure that children do not blame themselves for the trauma, the therapist is instructed to tell children and their parents that: a) the child is not responsible or to blame for the action of adults or the traumatic event, and b) the child could not have done anything to prevent the trauma from happening. The manual warned the therapist, "Be careful not to say anything that sounds like you blame him/her, and be sure to emphasize that the abuse is not his or her fault" (p. 218). The therapist was instructed, "when possible it is best to postpone the active practice of [personal safety skills] until later in therapy…A great deal of focus early in treatment on personal safety skills may inadvertently encourage inappropriate feelings of responsibility and/or guilt for not having done what the therapist is now suggesting" (p. 94). The therapist should tell the child things like, "This is all very scary but the most important thing to remember is that when adults fight, it's never the child's fault. Children can't stop the fighting between the adults in their home, no matter how good they are" and "No child is responsible for what an adult does" (p. 221). With regards to sexual abuse the manual stated, "Although the question of why sexual abuse occurs is frequently asked by children and their caretakers, there is no simple answer. The main point to remember is that children and adolescents who have experienced sexual abuse and their non-offending parents are not to blame" (p. 218).

Thematic discussion: Children have no agency during traumatic events.
While it is often the case that the child could not prevent the trauma (or at least should not be charged with that responsibility), there is a subtle message about the passive nature of trauma victimization that is communicated to the child via the TF-CBT psychoeducation. Outside of the issue of whether or not the child saw the experience as

traumatic in the first place, anything the child did to lessen, prevent or perhaps exacerbate the trauma is not recognized; their agency is subtly but forcefully ignored. The developmental egocentric assumption and fear of creating guilt or responsibility for the trauma is so great that the therapists are encouraged by the manual to refrain from discussing what the child could have done (let alone what they did) to prevent the trauma from occurring until much later in the therapy.

Clancy (2009) has studied the phenomenological accounts of over two hundred adult survivors of child sexual abuse (65% women, 35% men) and made several unique observations about their perceptions of guilt and agency that have been excluded from mainstream psychoeducation about sexual abuse. She found that every victim she spoke to reported two key characteristics about childhood sexual experiences and abuse: a) the experiences had damaged them; and b) rarely did they report feeling shock, helplessness, or fear or experience the sexual abuse as forced or violent. The primary word that 92% of victims reported to characterize their experience was confusion (p. 38). 85% could sense something was wrong based on the discomfort, guilt, secrecy or other atypical behaviors that the child could sense from the perpetrator (p. 39). Most of the survivors reported perceiving agency in the sexual interactions and did not report feeling taken advantage of, manipulated or passive recipients of a sexual act. Only 5% of survivors in her study described attempted to stop the abuse.

The primary reason that the adult survivors reported not stopping or actively participating in the experience of sexual abuse as children, was that the perpetrators actions did not seem unique from other experiences of living in the world in general; as a child, things in their world and the actions of adults often didn't make sense or were

confusing. As a child, it was seen as acceptable to do what adults tell you to do even when its not totally clear why this should be the case. Furthermore, the victims described great rewards for participating, ranging from the concrete (e.g., buying a toy or ice cream) to the relational (e.g., love, attention, sense of feeling special, attachment). A few of the adult survivors also described enjoying the physical pleasure of the encounters. Others described awareness of needing to maintain the family structure and fear that not participating would lead to one of the parties being rejected from the family (e.g., the child returned to foster care, the boyfriend who makes mom happy must leave). Overall, a very small minority (less than 5%) would say they did not actively consent and willingly participate in the sexual acts and that the majority of the time this was not experienced as distressing, forceful or horrific, but as confusing at worst and rewarding at best.

To avoid what she believed was a sampling error in her first interviews, Clancy (2009) repeated her study multiple times over a ten-year period and found the same results. Given her findings, Clancy posed the question, how can we say the trauma is the cause of harm if most victims she interviewed did not report feeling the classic symptoms of being traumatized (e.g., Criterion A horror, fear, helplessness)? She brought this question to another subsequent series of interviews with survivors and found that most of them reported that at a certain point in adulthood "the cloak of innocence lifted" (p. 116) and the experience once characterized by confusion was then understood as morally wrong. At the point of realization (which was not necessarily in a moment but could occur over time), the adult survivor described feeling overwhelmed, betrayed and then focusing on self-blame; many of the classic symptoms of PTSD emerged at this point in

the victim's life. In other words, awareness of the social and cultural rejection of their experiences as being abusive and wrong was perceived as more traumatizing than the actual events.

Clancy (2009) posited that self-blame that occurs after abuse becomes more damaging upon realization because the societal narrative suggests the child should have experienced the sexual activity as non-consensual, un-pleasurable, and traumatic and that they should have reported it years earlier. Many survivors she interviewed stated they thought their abuse was "unique" or not "classic abuse" because they described letting it happen (or participating) for years without reporting. Clancy suggests that if society adopted a narrative like, "You let it happen, and it's okay. This is normal, you were too good to know bad" (p. 140) that this would recognize the child's agency and confusion without introducing guilt. She argued that because society does not recognize the normalcy of the child's active participation and unawareness that the experience is bad, the survivor believes they are an anomaly and morally corrupt for not saying no immediately; they become traumatized because they believe they have done something wrong and may be isolated from society for doing so.

Other scholars like Foster and D'Emilio (2012) have argued that recognition of children's agency in sexual experiences is also undermined when society sees and accepts children (and in particular female children and adolescents) as more vulnerable and somehow unable to say no to sex. He argues that society becomes complicit in infantilizing children regardless of their actual ability to protect themselves and make decisions because society believes their innocence extends into lack of self-control and even a willingness to be taken advantage. Viewing children as passive is especially

problematic when viewing the minority of cases who attempted to stop the abuse they incurred. While many of the children Clancy interviewed saw themselves as actively consenting it is possible that these same children may have also made decisions to not participate if there was more acceptance that children are aware of their experiences and need not blindly accept what adults tell them to do; especially if the child can sense that the adult feels what they are doing is wrong (cf. Ferenczi's introjection of adult guilt).

Clancy and others bring to light new possibilities about children's experience of agency, responsibility and guilt during sex and sexual abuse; experiences that U.S. culture refuses to acknowledge let alone discuss in therapy. An important implication of this lack of discussion, is the loss of recognition that traumatic symptoms following child sexual abuse may occur because adult survivors fear being rejected by society as being morally corrupt or wrong because they did not experience the abuse as a helpless victim. The accepted narrative for child abuse is helplessness, fear and victimhood rather than confusion or naive, but active and agentic participation.

Unlike Clancy, I would not argue that replacing victim narrative with a different form of psychoeducation (e.g., "You let it happen, and it's okay. This is normal, you were too good to know bad" [p. 140]) would resolve or prevent traumatic symptoms. The problem is that society, and in this case the TF-CBT manual, promotes one expression of trauma survival as good (i.e., helpless, fearful, victim), other expressions are either excluded from the therapy (e.g., not elicited) or are tacitly seen as deviant and bad (e.g., when a child allows or even looks forward to sexual acts). When therapies accept one particular type of traumatic expression at the price of excluding varied phenomenological

experiences, especially experiences that go against the mainstream narrative (e.g., I wasn't a victim) this practice plays a part in creating trauma symptomology.

In sum, the TF-CBT manual reflects the societal belief that trauma, and especially all child sexual experiences including abuse should be understood as a loss of agency. A taken for granted assumption that is communicated in the manual to is that patients who do not report feeling this way, or who do not accept boundary and abstinence oriented treatment (what the manual perceived as regaining agency by unequivocally saying "No!" to all forms of sexual experience) are somehow deviant, traumatized and bad. Therefore, I would argue the therapy itself can contribute to the patient's perception of feeling traumatized, helpless and like a victim.

TF-CBT Unique Theme 4: Parents as Protectors or Perpetrators

In this section, I present the fourth theme that I identified only for the TF-CBT manual and that I did not interpret for the other two manuals. While studying Cohen et al.'s (2006) manual I interpreted the cultural practices and implicit understandings about what a child and a parent are or should be in contemporary culture; one of these taken for granted assumptions was that all children have two, heterosexual parents—a mother and a father. Within this assumption, mothers were described as natural protectors of their children, and fathers, if not perpetrators of abuse, were not integral to protecting and healing the traumatized child.

Thematic findings: Parents as protectors or perpetrators. The child who has successfully completed therapy according to the TF-CBT manual should believe they could not have changed the events of the trauma, that adults had power and control over the situation, and that they were blameless. Because children are seen as innocent,

vulnerable, pure, and lacking knowledge about and agency to protect themselves from the world, the question becomes: whose responsibility is it to preserve the cultural ideal of the child?

The manual suggested that in the protection of the innocent child from trauma is the responsibility of the child's primary caregivers or parents. For example, the manual stated how confusing it can be for children exposed to ongoing interpersonal violence "typically perpetrated by parents or other adults who would ordinarily be expected to protect rather than harm children" (p. 11). After a traumatic event occurs, the parent-as-protector role is put into question and in the manual the therapist is recommended to step in as the primary protector for the dyad. The manual stated,

> Re-establishing trust often begins with a single reliable, genuine, and caring relationship. Ideally parents provide this connection for their children. However, when a child is traumatized, the parent is often also traumatized, either directly…or vicariously. In such instances, parents themselves may be in need of therapeutic assistance before they are able to provide optimal support to their child. […] Thus the therapist may play a critical role in modeling trustworthiness and providing support to both traumatized children and their parents. (p. 47)

In general, the therapist was promoted as the modal rational adult and parent who embodies the CRAFTS values (e.g., respect and self-efficacy).

It was notable that all children mentioned in the manual were assumed to have two heterosexual parents, a mother and father, as their primary caregivers. Though the manual was written within the past ten years (2006), the contemporary realities of divorce, single parenting, foster parenting, extended family caregiving, gay, lesbian or queer parents, and other caregiving relationships were not acknowledged.

Despite the ideal of mother-father dyad parenting that was represented throughout the TF-CBT manual, the manual also indicated that it was primarily the mother's

responsibility to protect and heal the child from trauma. A section on troubleshooting

included the question, "*What if the child blames the parent for the traumatic event*?"

(p. 145). The manual then gave an example in which the parent could be to blame for the

trauma, "the mother may return repeatedly to an abusive partner, placing herself and her

children at risk for ongoing abuse and exposure to violence. Helping the child understand

how the mother's personal trauma symptoms contributed to her decision making may be

quite complex" (p. 145).

In another troubleshooting example the mother again emerged:

How can I encourage parents to praise their kids more? Some parents of
traumatized children were traumatized themselves as children and never learned
to be nurturing parents. Modeling praising behavior by noticing and remarking on
parent's positive actions may be helpful in this regard (in effect, "catch them"
being good parents). Praise the smallest maternal gesture you observe on these
mothers' parts (e.g., helping the child remove a coat)." (p. 73)

In the above example the phrases "maternal gestures" and "these mothers" was

noteworthy given that the context of the troubleshooting question in the paragraph

otherwise discussed parents without a gender designation.

In yet another troubleshooting example the mother was mentioned again:

*How do you manage children who are so emotionally "blocked" that they can't
express any feelings at all?* [...] If a child was severely punished by a battering
parent for expressing negative emotions in the past, the therapist can use this
knowledge to assure the child that this will not happen in therapy, where
expression of all feelings is welcome. This child's mother could also be a
powerful influence on the child in therapy if she were able to encourage the child
to express feelings in the therapy session. (p. 105)

In the three examples mentioned above, the mother appears in the troubleshooting

sections as the solution to the child's problem and mention of fathers is absent. In a

comparative word search, the word mother appeared 91 times compared and father

appeared 26 times. The first instance of the word father in the manual occurred in a

clinical example in which the father shot a child's mother (p. 4). In the second instance,

the father had beaten a mother and child (p. 95). In the third, the father forgot to pick his

child up from school (p. 113). In the fourth a child says "my father cut my mother in the

face" (p. 121) and in the majority of the remaining examples the father attempted to kill

the child or the mother (pp. 147, 148, 155). Out of the twenty-six times the word father

appeared in the manual, there was not one single benevolent mention of a father figure. In

the one example where the father did not attempt to kill or attack the mother or child, the

father ended up dying in a drug overdose (p. 181). When guidance was given to fathers

about how to respond to child sexual abuse they were referred to only as "nonabusive

fathers" (p. 219).

       Thematic discussion: Parents as protectors or perpetrators. Research on child

maltreatment has found that 80.3% of perpetrators of child abuse and maltreatment are

parents, 3.1% of perpetrators who have an unknown relationship to the victim, and the

remainder include relatives or unmarried partners of parents (United States Department

of Health and Human Services [USDHHS], 2012). Men are perpetrators 45.3% of the

time and women are 53.5% of the time (USDHHS, 2012). Authors in the domestic

violence field have interpreted these statistics to suggest that women and men (mothers

and fathers) are equally as likely to be identified from a legal standpoint as the primary

perpetrators of abuse (Chesler, 1991). Fathers are more likely to commit violent forms of

abuse than mothers but mothers, perhaps because they are often the sole or primary

caretaker present with the child most of the time, are more likely to be convicted of

neglect (60% of maltreatment abuse cases are neglect related) (Chesler, 1991; Harris,

2010). One study has shown that the court actually favors fathers in cases of child

maltreatment and in 75% of cases when the father contests a custody or abuse case, they win, even when the fathers have documented histories of abuse (Jacobs, 1996). Similarly, when fathers do attend therapy, supervised visitation or related services post-abuse or trauma, the literature suggests that they are overly credited and praised when compared to mothers whom are expected to show-up to all services, protect and heal their children regardless (Parker, Rogers, Collins, & Edleson, 2008).

The manual reflects a cultural story of the mother as the failed protector and the father as an abusive perpetrator. Where mothers appeared central to healing and the protecting of the child, fathers, when deemed "non-abusive," were excluded from or at best treated as peripheral to the healing and protection process. The therapist was thought to symbolize and was instructed to act like the modal adult and replacement protector.

The overemphasis on mothers as protectors and healers of trauma not only reflects cultural assumptions about primary caregivers, but also is an example of what Fine (2012) called the hyper-responsibilization of women. Fine wrote that when the family is at risk, women are recruited to accept the responsibilities and guilt of family life and often do so willingly. On a local level, this may look like a natural extension from the labor of reproduction and child-care, but the acceptance of the shame and burdens of such care seemingly stretch to the "vast emotional and relational space of social responsibility voided by the State" (p. 6). Similar to Haaken's (1995) identification of sexual trauma as the accepted dialogic space for women to express suffering, Fine suggested that women are expected to and often do accept that the failings of society are due to their individual problems. Traumas that may be completely unrelated to the parents' ability to care for the child are still the responsibility of the parents, and primarily of the mother, to heal. The

lack of agency, blamelessness and passivity during trauma in childhood may add to the cultural appeal of invoking trauma narratives when as a culture we feel victimized, lack agency, and are powerless or helpless; yet in the 21st century, we locate the responsibility to heal these political problems within the family and within mothers.

TF-CBT Exemplar 1: Benevolent Restriction of Angry Responses

to Political Events via Therapy

Exemplars are stories or vignettes that capture what human being is like in a particular cultural or historical situation. In this study, I looked for exemplars that captured what human being is like in trauma culture in such a way that it could be recognized in other situations that might have very different objective circumstances, including those outside of the practice of psychotherapy. In this section I present an exemplar I identified during my interpretation of the TF-CBT manual that exemplifies how therapy can restrict patients angry responses to political events.

Exemplar findings: Benevolent restriction of angry responses to political events via therapy. In a troubleshooting section of the Cohen et al. manual, a child was described as acting out "aggressive rescue or revenge fantasies (e.g., flying to the top of the World Trade Center and carrying victims to safety, or killing the terrorists before they crashed the plane)" (p. 129). The therapist in this scenario was recommended to "point out to the child that such actions reflect what he/she wishes could have happened and then move the child toward more constructive thoughts…through which to make the world safer in the future" (p. 129).

This vignette is an exemplar from the TF-CBT manual that demonstrates how the therapy works to actively restrict the child's angry responses to political events. After the

child described their fantasy the therapist in the manual framed their response to September 11 as unhelpful and aggressive. Unsurprisingly, the manual then recommended that aggressive fantasies be immediately responded to with cognitive restructuring and though-replacement. As discussed previously there is an entire chapter in the manual devoted to cognitive restructuring and thought-replacement (pp. 107–168) and homework handouts to assist the child and parent in continuing this process outside of therapy (pp. 226–228), like the cognitive triangle homework sheet.

Exemplar discussion: Benevolent restriction of angry responses to political events via therapy. Overall the notion of fantasy as a form of understanding or catharsis was excluded from human being in the TF-CBT manual. Fantasy in the manual was discussed a few times and therapists were instructed to reframe fantasy as the child's irrational or unhelpful cognitions. In this exemplar, the child's fantasy was identified as an individual, behavioral problem, and a dysfunctional thought.

Another interpretation would be that this child was reflecting a national post-September 11 revenge fantasy that indeed turned into a reality. The U.S. government responded to the vulnerability of September 11 by capturing, torturing, and killing those who were thought to be responsible—the government tried to annihilate all sources of vulnerability (Lifton, 2002). The child's wish to kill the terrorists was not that fantastical, but by localizing societal revenge fantasies as product of an individual child's angry thoughts, the manual instructed the therapist to ignore the society in which the child is embedded. To frame the child's aggressive fantasies about September 11 as dysfunctional rather than reflective of society as a whole may reveal unexamined societal fears and rage.

The recommended treatment of this child reveals the subtle way that therapists live-out and communicate to their patients the primacy of an insular, cognitivist ideology and the narcissistic belief that we are disconnected from and yet in control of the social world through our thoughts (see previous discussion in Shared Theme 1, pp. 210-225). The result of the societal inability to face the violence that is so prevalent in society is the inevitable continuation of this violence. When therapists fail to situate their child patients' fantasies politically, in the context of the social world, these children will learn from therapy to interpret wide-spread violence in the U.S. as individual distress and turn inward rather than to create social connections or attempt to stop actual violence in the community. Attempts to stop violence will eventually seem far from the child's lived experience; engaging politically on a community level might seem almost hopeless.

This vignette stood out to me as an exemplar because I was reminded of scenarios with other populations with adults and veterans that have reflected the national response to social crises but have been interpreted as individually aggressive or pathological acts. Young's (1995) description of the group of veterans at the National Center who were placed on additional restrictive treatments after expressing anger, and Marin's (1981, 1995) discussion of the isolation of veterans who confronted U.S. society with the painful knowledge of the destructive colonial war in Southeast Asia are a few examples that I have previously mentioned. Also the treatment of Malcolm X during the Civil Rights movement demonstrated how dangerous and inacceptable it has been in the U.S. for historically marginalized persons to be angry and aggressive, despite the violence they have endured or witnessed. I say this not to suggest that the child in the TF-CBT manual is somehow similar to a mini-Malcolm X, instead my point is that the social practices of

restricting anger and reframing responses to political events as erroneous fantasies or

pathological anomalies have existed in different forms historically. Now these practices

have become an integral part of therapy in such a degree that they are viewed as benign

or even helpful rather than as restrictive, isolating, or promoting a politicized cognitivist

ideology that has a hand in silencing dissent.

Regardless of whether the child's fantasy was aggressive, in the manual all

fantasy was responded to and viewed as erroneous (if not pathological) and deserving of

thought replacement. What was excluded from human being in a traumatic world was the

notion that adults might respond to trauma in ways similar to children. Adults may

understand trauma in fantastical or what might be considered distorted or nonsensical

ways or in ways that are not easily understood, controlled, or known. The therapists' role

as the modal adult in the TF-CBT manual is to instruct the dyad of child and parent on

how to ignore and reduce fantasy and reason their way through a post-traumatic world.

The TF-CBT manual suggested that to restore innocence to children after a trauma,

rationality and control must be introduced. This example is not unique to children or

child therapy but reflects a rationalist Western cultural ideal that is central to being in a

trauma-based society.

TF-CBT Remaining Questions

In addition to the hermeneutic interpretive categories outlined by Leonard (1993)

and others, I have added the category of question generation. Some questions that were

raised through the interpretation of the TF-CBT manual were unanswered by the text, the

interpreter (myself), and our immediate context (e.g., foregrounded assumptions). The

unanswered questions may be indicative of what Donnel Stern (2010) described as an

unformulated experience, where the answer is dissociated (and thus seemingly unanswerable). Answers to such questions may be first accessible only through enactment and unconscious practice. Here I discuss the importance and context for each question following reconstruction (Stigliano, 1989).

Why were traumatized children represented as destroyed innocents lacking agency in a post-September 11 world*?* Given that children have been thought of historically in a range of different ways, the primary question I was left with after my interpretation of the Cohen et al. manual was why children were presented in this specific way at the specific time of the creation of the manual. In other words, why were traumatized children represented as destroyed innocents lacking agency in a post-September 11 world? I wondered if the frame of the destruction of naïve childhood innocence was a form of unarticulated political suffering about being American in the post-September 11th world. Did Americans feel like traumatized, abused, or sexually maimed children after the attacks? Like the children in Cohen et al. manual were described, did Americans feel they had no agency during this event and yet somehow feel that it was their fault? Was the manual an unconscious commentary or fantasy about September 11th?

Although I questioned whether the manual might have been form of commentary on September 11, alternatively I wondered if or how much the attempt to protect childhood innocence and vulnerability really had to do with September 11 and the idea of a singular, earth-shattering trauma. While it was clear that the authors were directly connected to this event and that it had an indelible impact on the U.S., and especially on those living near the sites of the attacks, the manual was published five years after the

attack. I wondered if the attacks and the fixation on terrorism had become the new vernacular, like child abuse in the 90s, for expressing daily vulnerability and social distress (cf. Cushman, 1995). In this sense, talking about protection from terrorists might have become a way we talk about the suffering, disconnection or isolation, vulnerability and insecurity of everyday life in neoliberal society (cf. Bauman, 2013).

While I cannot presume to answer these questions about the meaning of September 11 and child trauma, I believe that the daily lives of many Americans have been so insulated from recognizing everyday political suffering that only after September 11th did their lives fall out of everydayness enough to access experiences of daily isolation and vulnerability that existed during and before the attacks. The flood of interest in TF-CBT post-September 11th that the authors refer to in their introduction may be a reflection of how social vulnerability was expressed through obsession with healing the damaged child. The psychoeducation in the manual that assured the child it was not his or her fault and encouraged the child to live a happy life in spite of terrorist attacks might reflect a societal denial or even refusal of responsibility for political problems. In this light, child TF-CBT is a form of societal preservation accomplished through the medicalization of daily political suffering, but one that necessarily must avoid recognition of the causes of this suffering.

Summary of Treating Trauma and Traumatic Grief in Children and Adolescents (Cohen et al., 2006)

Questions of morality and political function did not come to light through the TF-CBT treatment as it was described in the manual, yet there were strong moral and political messages that were communicated through the manual and were taken for

granted or assumed to be natural. The TF-CBT manual included several assumptions about the traumatized self and how humans can or should be known, managed, and controlled in scientific ways. Many of these assumptions have been previously outlined by scholars who have studied managed care therapies and the scientistic trend towards therapies of technology (Cushman & Guilford, 2000; Foucault 1987, Gone 2007, Rose, N. S., 2007). Some of the taken for granted assumptions about being that were identified in the TF-CBT manual, but are not unique to this therapy, included the ideas that traumatic pathology is easily understood through scientific methods (e.g., removing bias and prejudgment while using an assessment checklist); symptoms of trauma are universal, concrete, ahistorical and acultural, trauma pathology is not located in the community or social world, but is a problem located in the individual and ultimately healed within the dyad; trauma is healed through a process of the control and monitoring of symptoms; and the patient is healed when these objective markers of symptomology have reduced and the patient has returned to an assumed natural, adaptive state of neoliberal functionality (e.g., happily returning to work and school).

The specific themes from the manual suggest that societal problems can be resolved with further rational study and knowledge. According to this manual, human being in a trauma-based society is being born into the world as innocent, asexual, and lacking agency and knowledge about the world before the trauma. Traumatic events within the manual were any events that were destructive of that innocent state and became localized within the child as a site of cultural destruction and repair. Trauma was thus represented as evil and initiated a fall from innocence. Following treatment, the healed trauma survivor child will be self-sufficient, optimally functional, happy,

emotionally regulated, and lacking awareness of knowledge bore through the trauma, and especially unaware about daily political suffering.

What it means to be good according to this manual is to respond to upsetting, confusing and violent social and political events by going to therapy and accepting or embodying uncomplicated, asocial, acultural symptoms that align with the cognitivist psychoeducational trauma narrative about PTSD. The ideal patient presents their political distress in such a way that their symptoms are amenable to the specific structure and assumptions of managed care, evidence-based therapies, which ultimately serve the needs of insurance companies and not the patient or their community.

The manual gave primacy to being in dyadic relationships generally and specifically within a tension of a child's relationship to their singular parent (either mother or father) as protector/perpetrator and later to their therapist as rescuer. The parent of the child should be able to give themselves permission to be happy, protect their child from future trauma and reinforce the tool box of skills the child learned in therapy.

Healing according to the TF-CBT manual involved returning the child to an age-appropriate state by consuming rational cognitions delivered by the modal adult-therapist; these cognitions provided security to the child after the chaos of trauma and returned him or her as much as possible to their pre-traumatic innocent state. By reconstituting the child's world as one where the child can choose to ignore horror and fantasy, the cultural concept of the innocent child could be protected. From a moral perspective, this means the child as an embodiment of the good can be protected and rebuilt through the process of therapy.

Being a child in trauma-based society can be isolating (when due to the trauma one is no longer seen as a child), confusing (when one is told to un-know or choose to forget the knowledge born through trauma), and controlled (adhering to rational guidelines for age appropriate conduct and thinking). Yet, the manual's emphasis on the choice to be positive and happy in the world suggested that these realities are mental choices that can easily be overcome through cognitive restructuring and mental fortification (i.e., mind-brain as protector). The manual emphasized retreating to an internal and mental state for protection and suggested that fortification of mental barriers was a way of "giving permission" to children and their parents to be happy, functional, and free post-trauma. The manual embodied cognitive ideology and a subjectivist reduction that recapitulated the status quo of an isolationist, politically inactive and asocial environment where persons do not act with each other or in the world in order to change it, but merely change the way they think about the world. The exclusion of society and culture from discussion in therapy (even at an age-appropriate level) reflects neoliberal values and an ignorance of the public and social sphere that the child and parent are embedded in.

After interpreting the manual I was left with a final question: Why were traumatized children represented as destroyed innocents lacking agency in a post-September 11 world? I did not attempt to answer this question but explored some possibilities, such as whether the frame of the destruction of naïve childhood innocence was a form of unarticulated political suffering about being American in the post-September 11th world if talking about protection from terrorism has become a way we talk about the disconnection or isolation, vulnerability and the insecurity of everyday life

in neoliberal society; and if child TF-CBT is a form of societal preservation accomplished through the medicalization of daily political suffering, but one that necessarily must avoid recognition of the causes of this suffering.

Manual 2: Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols, and Procedures (Shapiro, 2001)

In this chapter, I present the results and discussion of my interpretation of Shapiro's (2001) EMDR manual and supplementary texts. I will be referring to Shapiro's (2001) manual as the EMDR manual or Shapiro's (2001) manual, and Luber (2010), Shapiro (2010) and Leeds (2009) as supplementary protocol texts.

After presenting the specific context of the Shapiro (2001) manual's development, I return to the shared themes and exemplars[48] that were introduced in the previous chapter and were found in all three manuals (TF-CBT, EMDR, and Battlemind). After presenting the shared themes and exemplars, I then introduce the themes and exemplars that I identified only within the EMDR manual. Before proceeding to the next manual, I propose and briefly discuss questions that may be unanswered by the text, the interpreter (myself), and our immediate context (e.g., foregrounded assumptions) but are important to consider. Thus the structure of this chapter is as follows: shared themes (findings followed by discussion), shared exemplars (findings followed by discussion), EMDR unique themes (findings followed by discussion), EMDR unique exemplars (findings

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[48] Exemplars are stories or vignettes that capture what human being is like in trauma culture in such a way that it could be recognized in other situations that might have very different objective circumstances, including those outside of the practice of psychotherapy. In this study, I focused on identifying the therapeutic techniques and practices that trauma treatment manuals prescribed to training therapists. I noted the similarity between these techniques and practices to others in the social world.

followed by discussion), EMDR questions (questions followed by discussion), and a summary. Following the presentation of each manual, I include a final summary and discussion in which I consider all of the manuals together in light of the areas of inquiry (p. 131).

Context of the Manual's Development

EMDR was developed by Francine Shapiro in 1987 following a phenomenological observation of her own coping behaviors:

> While walking one day, I noticed that some disturbing thoughts I was having suddenly disappeared. I also noticed that when I brought these thoughts back to mind, they were not as upsetting or as valid as before. […] I noticed that when disturbing thoughts came into my mind, my eyes spontaneously started moving very rapidly back and forth in an upward diagonal. Again the thoughts disappeared, and when I brought them back to mind, their negative charge was greatly reduced. At that point I started making the eye movements deliberately while concentrating on a variety of disturbing thoughts and memories, and I found that these thoughts also disappeared and lost their charge. (Shapiro, 2001, p. 7)

Over the course of six months Shapiro (2001) began refining the eye-movement techniques she discovered with the goal of developing a therapy to reduce anxiety. Shapiro's early studies of EMDR focused specifically on the treatment of PTSD (see review in van Etten & Taylor, 1998) and were highly successful in the treatment of major trauma (see e.g., Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998; Ironson, Freund, Strauss, & Williams, 2002; Marcus, Marquis, & Sakai, 1997; Scheck, Schaeffer, & Gillette, 1998; Wilson, S. A., Becker, & Tinker, 1995). Numerous controlled studies have indicated that 77–90% of civilian PTSD can be eliminated within three 90-minute sessions (see review in Shapiro, 2001; Chapter 12).

Demographics of EMDR's treatment population. The EMDR manual was designed for treatment of adults ages 18 and older in an outpatient setting. Though EMDR was created to target PTSD symptoms it has since been found to be effective at

treating a range of disorders (e.g., personality disorders, dissociative disorders, anxiety disorders, somatoform disorders) (Shapiro, 2001, p. 360). The EMDR manual included a standard protocol (i.e., scripts with steps for the clinician to follow) for treating trauma disorders, as well as specialized treatment protocols. Shapiro's (2001) manual included specialized protocols for: a single traumatic event, anxiety, recent traumatic events, phobias, excessive grief, illness and somatic disorders, and stress reduction. The manual also mentioned special protocols for pain control, combat PTSD, chemical dependency treatment and phantom limb pain.

In Luber's (2010) supplementary protocol manual there were also specific protocols for underground mining accidents, emergency room administration, performance enhancement, increasing positive emotions, child group EMDR, and self-help or individually administered EMDR. There was also a specialized protocol called "blind to the therapist" where the patient did not describe the problem they were seeking treatment for to the therapist and did not mention the trauma or free associations to the trauma during the processing (Luber, 2010).

Context of the author. Unlike the other manuals I interpreted in this study where limited information was provided about the authors, Shapiro's manual included a comparatively extensive explanation about her life and how she developed EMDR; the supplementary manuals also included an abbreviated version of her biography (e.g., Leeds, 2009; Luber, 2010).

In 1979, Shapiro was completing a doctorate in English literature at New York University. She described a deep desire to be "one of those who shed light on our culture and literature" (Shapiro, 2001, p. 131). At the same time she began reading the work of

psychologists Salter and Wolpe and found that "the idea of a focused, predictable, cause-and-effect approach to human psychology seemed fully compatible with the concepts of literary character and plot development" (p. 121). Though psychology was a side interest of Shapiro's, she said "I held staunchly with those authors who believed in the perfectibility of humankind. I reveled in the glory of human suffering transformed into art" (p. 129).

Shortly before beginning her dissertation in English literature, Shapiro was diagnosed with cancer. This halted her education as she began a long process of treatment. She became interested in identifying psychological and physiological methods to enhance physical health:

> I believed there had to be some useful psychological and physiological approaches already developed, but why weren't they well known? Suddenly, finding these methods and disseminating information about them to others with life-threatening illnesses became more important to me. (p. 139)

During this time Shapiro enrolled at the Professional School of Psychological Studies in San Diego, California (CA)[49] in clinical psychology and made her first phenomenological observations about eye-movement and stress (mentioned above) that contributed to the first studies of EMDR. In 1987, she graduated with her PhD and since devoted her life to studying and disseminating EMDR. She is presently (2014) a senior research fellow at the Mental Research Institute, in Palo Alto, CA, the Executive Director of the EMDR Institute in Watsonville, CA and the President Emeritus of EMDR

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[49] This school should not be confused with the similarly named California School of Professional Psychology- San Diego, which is now a part of Alliant University International. Shapiro completed her PhD in clinical psychology at the Professional School of Psychological Studies, San Diego (Shapiro, 2011), which was never accredited and is now defunct (APA, 2014).

Humanitarian Assistance Programs, a non-profit organization that coordinates disaster

responses and pro-bono EMDR trainings worldwide.

Shapiro has received numerous awards for her work including the International

Sigmund Freud Award for Psychotherapy, the APA Trauma Psychology Division Award,

and the Distinguished Scientific Achievement in Psychology Award from the California

Psychological Association.

Treatment goals, structure, and principles. The overarching goal of

EMDR treatment is to reduce symptoms of any presenting psychopathology.

Shapiro's (2001) manual read:

> One of the basic premises of EMDR is that most psychopathologies are based on early life experiences. The goal of EMDR treatment is to rapidly metabolize the dysfunctional residue from the past and transform it into something useful. Essentially, with EMDR the dysfunctional information undergoes a spontaneous change in form and meaning—incorporating insights and affect that are enhancing rather than self-denigrating to the client. Clinicians should find that the information covered in this book provides the components and strategies necessary for this process, wherein the client's innate information-processing system is called into play to bring about resolution. (p. 183)

Shapiro initially called EMDR procedure Eye Movement Desensitization (EMD),

and then changed the name in 1990 to Eye Movement Desensitization and Reprocessing

(EMDR) to encompass what was referred to as the "information processing paradigm"

(916-922) or "Adaptive Information Processing model" (p. 16)—the theory at the core of

EMDR. Shapiro explained the model in the introduction to the manual:

> The Adaptive Information Processing model is consistent with Freud's (1919/1955) and Pavlov's (1927) early understanding of what is now referred to as information processing. Specifically, there appears to be a neurological balance in a distinct physiological system that allows information to be processed to an "adaptive resolution." By adaptive resolution I mean that the connections to appropriate associations are made and that the experience is used constructively by the individual and is integrated into a positive emotional and cognitive schema. (p. 30)

Entire chapters of the manual are devoted to an explanation of Adaptive

Information Processing theory and the research behind each component utilized in

EMDR (e.g., Chapters 2 and 12). The amount of theory and research behind

EMDR that is included in the manual perhaps explains the necessity for

adjunctive EMDR protocol manuals (e.g., Leeds, 2009; Luber, 2010; Shapiro,

2010) that are designed to be utilized by the therapists in the room with the

patient. Shapiro's (2001) manual also includes versions of these protocols but in a

less user-friendly format.

The eight phases of EMDR treatment and specific goals are represented in

Table 3. The standard script that is read to patients at the beginning of EMDR

treatment roughly explains the basic principles behind EMDR:

> When a disturbing event occurs, it can get locked in the brain with the original picture, sounds, thoughts, feelings and body sensations. EMDR seems to stimulate the information and allows the brain to reprocess the experience. That may be what is happening in REM or dream sleep- the eye movements (tones, tactile) may help to reprocess the unconscious material. It is your own brain that will be doing the healing and you are the one in control. (Shapiro, 2010, p. 3)

Table 3

Eight Phases of EMDR Adapted From Leeds (2009)

Phase	Goals	Tasks
Phase 1: History Taking	• Establish therapeutic alliance. • Gather psychosocial and medical history. • Develop the treatment plan and case formulation. • Rule out exclusion criteria.	• Obtain narrative or structured history. • Objective assessment of symptoms. • Identify targets for reprocessing: a) past events; b) current triggers, and c) future goals.
Phase 2: Preparation	• Obtain informed consent to treatment. • Offer psychoeducation. • Practice self-control methods. • Have patient start a weekly log. • Strengthen therapeutic alliance.	• Orient patient to issues in trauma-informed psychotherapy with EMDR. • Provide metaphors for mindful noticing during reprocessing. • Verify from log patient is helped by methods for self-control.
Phase 3: Assessment	• Access primary aspects of the target selected from the treatment plan for EMDR reprocessing. • Obtain baseline measures on SUD and VoC.	• Elicit the image, current negative belief, desired positive belief, current emotion and physical sensation. • Record baseline measures for SUD and VoC.
Phase 4: Desensitization	• Reprocess the target experience to an adaptive resolution as indicated by a 0 SUD.	• Provide discrete sets of bi-lateral stimulation and assess changes via brief patient reports. • Return to target periodically to asses gains and identify residual material. • Use additional interventions only when reprocessing is overtly blocked.
Phase 5: Installation	• Continue reprocessing target with overt inclusion of preferred belief. • Fully integrate preferred belief into memory network as indicated by 7 VoC.	• Provide discrete sets of bi-lateral stimulation while patient holds target in awareness with desired positive belief. • Continue until patient reaches 7 VoC.

Table 3 (Continued)

Eight Phases of EMDR Adapted From Leeds (2009)

Phase	Goals	Tasks
Phase 6: Body Scan	• Verify any residual disturbance associated with the target is fully reprocessed. • Allow patient to reach higher levels of synthesis.	• Provide discrete sets of bi-lateral stimulation while patient focuses on reprocessing any residual physical sensations until there are only neutral or positive sensations.
Phase 7: Closure	• Ensure client stability and current orientation at the close of each reprocessing session.	• Use self-control techniques if needed to assure stability and current orientation. • Brief patient about treatment effects. • Request patient to keep a log of self-observations between sessions.
Phase 8: Reevaluation	• Verify whether all aspects of the treatment plan are being addressed.	• Adjust treatment plan as needed based on patient report from log. • Recheck target(s) to assure stable treatment effects.

Note. SUD indicates subjective units of distress; VoC indicates validity of cognition.

A key component of EMDR is bi-lateral or dual attention stimulation; this occurs in Phases 4–6 in Table 3. Bi-lateral stimulation is performed on the patient by asking s/he to follow the clinician's fingers or a wand as they wave their hand in front of the patient's face (crossing the midline), asking the patient to track a light on a light-bar, tapping the patient on the hands or knees (back and forth from one side to the other) or by asking the patient to hold balls in each hand that vibrate alternately. Some dual attention stimulation has been conducted with sound (playing a noise in one ear and then the other) and with forms of visual tracking on a computer. Given the amount of bi-lateral stimulation needed for a typical session, many therapists find that waving their fingers in front of the patient's face can be exhausting and overtime can lead to shoulder injuries, hence the development of range of technology assisted bi-lateral stimulation tools for EMDR (see http://www.neurotekcorp.com and http://emdrelite.com).

The main activity during dual attention or bi-lateral processing is to alternately stimulate the left and right side of the body while the patient is recounting the initial traumatic memory and subsequent associations (e.g., feelings and thoughts) to that target memory. Bi-lateral stimulation is performed in what are referred to in the manual as "sets." Typically a set includes 24 to 36 eye-movements (i.e., passes from left to right and back) or other forms of bi-lateral stimulation (p. 67). The optimal amount of passes in a set and the speed at which the sets should be conducted are based on the intensity of the target (i.e., the traumatic memory or thought) that is to be desensitized, the phase of the protocol, and the specific needs of the patient. During this process subjective units of distress (SUDs) on a scale from 0-10 are monitored until the SUDs ratings of original target traumatic memory are significantly reduced (ideally to a 0 within the first session;

p. 159). During bi-lateral stimulation for cognitive reprocessing and installation of positive thoughts (Phase 5) the patient monitors their Validity of Cognitions (VoC) on a scale of 1-7, with one representing completely false and seven representing completely true. By the end of reprocessing, negative cognitions should be as experienced as completely false (1) and positive cognitions should be experienced as close to completely true (7).

Shapiro (2001) argued that dual attention stimulation is therapeutic because it contributes to "maintaining the patient's simultaneous external awareness during a period of internal distress or by activating brain functions inherent in the movements or in the attention paid to two simultaneously present stimuli" (p. 323). Shapiro acknowledged that research has yet to demonstrate the component effectiveness of bi-lateral stimulation (i.e., evaluation through a dismantling study). Shapiro also suggested that theories as to why bi-lateral stimulation works are inherently contradictory (Shapiro, 2001, p. 323). Thus it appears there is no particular theory that accounts for why dual attention processing works, except that efficacy studies of EMDR suggest that as part of the standardized full EMDR protocol it is effective at reducing symptoms of PTSD.

It is important to note that hypnotic mechanisms, which can be associated with eye movement like that used bi-lateral stimulation, were reported by Shapiro (2001) as being unrelated to EMDR. The manual cited studies that the concluded the altered brain state and brain wave patterns induced by hypnosis are not replicated in EMDR, and thus hypnosis and hypnotic phenomena cannot be central to EMDR's main treatment effects (see e.g., Barrowcliff, Gray, MacCulloch, Freeman, & MacCulloch, 2003).

Shapiro (2001) did acknowledge some utilization of hypnosis in EMDR's "cognitive interweave" technique (In Phase 5: Installation). During cognitive interweaves the therapist challenges dysfunctional thoughts, makes an interpretation or connection between different memories, or directs the patient to think about a particular aspect of the memory they are recalling. (This aspect of EMDR is somewhat similar to cognitive restructuring in TF-CBT during which dysfunctional thoughts are directly questioned, challenged, and replaced.) According to EMDR's Adaptive Information Processing theory, the clinician assists in the integration or connection between disparate neural networks that the clinician believes that the patient could not otherwise merge (Shapiro, 2001, p. 251). Shapiro (2001) noted that EMDR cognitive interweaves were derived from Milton Erikson's hypnotic command suggestion.

I have summarized the key principles and assumptions of EMDR using language drawn from the Shapiro (2001) manual on the pages indicated. The key principles include:

1. EMDR directly and non intrusively, without the use of medication, engages with human physiology to alter pathological elements that have been stored physiologically (p. 18);

2. Humans have an innate information processing system that is intrinsic and adaptive. Pathology occurs because this mechanism is blocked. If the stored traumatic memory can be access and activated the information will be taken to "an adaptive resolution" because "the system is configured to process the information and restore mental health" (p. 19);

3.   When information shifts during reprocessing, this triggers a change

in identity constructs. The patient sense of self-worth and self-

efficacy automatically shift which leads to more self-enhancing

behaviors (p. 19); and,

4.   EMDR has the ability to facilitate profound therapeutic change in

much less time than other therapies because it facilitates

"therapeutic affects through the adaptive connection of associative

neurophysiological networks in the information processing

system" which are physically proximal and thus are not bound by

time (p. 19).

The presentation of trauma in the manual. Shapiro (2001) stated:

the [EMDR] model regards most pathologies as derived from earlier life
experiences… The pathological structure is inherent within the static,
insufficiently processed information stored at the time of the disturbing
event…pathology is viewed as configured by the impact of earlier experiences
that are held in the nervous system in state-specific form. (p. 16)

In EMDR theory, the traumatic particle resides in the brain and nervous system

until triggered and desensitized through EMDR:

When someone experiences a severe psychological trauma, it appears that an
imbalance may occur in the nervous system, caused perhaps by changes in
neurotransmitters, adrenaline and so forth. Due to this imbalance, the information-
processing system is unable to function optimally and the information acquired at
the time of the event …Is maintained neurologically in its disturbing state.
Therefore the original material, which is held in this distressing, excitatory state-
specific form, can be triggered by a variety of internal and external stimuli and
may be expressed in the form of nightmares, flashbacks, and intrusive thoughts—
the so-called positive symptoms of PTSD. The hypothesis is that the procedural
elements of EMDR, including the dual attention stimuli, trigger a physiological
state that facilitates information processing. … Therefore, in EMDR when we ask
the client to bring up a memory of the trauma, we may be establishing a link
between consciousness and the site where the information is stored in the brain.
(Shapiro, 2001, p. 31)

The Shapiro (2001) manual suggested that trauma victim's negative cognitions, confusion and disturbances come from "disparate information stored in disparate neural networks" (p. 42). The Adaptive Information Processing model that EMDR supports suggests that healing comes from the integration of these two neural networks (p. 42).

Shapiro (2001) stated that the treatment follows the same essential phases (Table 3) regardless of the trauma, "most kinds of disturbing life experiences can be successfully treated, regardless of their origin" (p. 42). The manual divided traumas into "big T" Traumas, like rape and combat, and "small t" traumas, which included any event that had a lasting negative effect on the psyche (p. 43). According to Shapiro, both big T and little t traumas can be addressed following similar EMDR treatment protocols.

Key sociohistorical context mentioned by authors: Shapiro's journey. No primary historical or political event was mentioned as the impetus or context for EMDR's development in the Shapiro (2001) manual. The development of EMDR appears to have been largely instigated by Shapiro's diagnosis of cancer and interest in physical healing through psychology.

Research on EMDR was initially funded though Shapiro's dissertation work and later through the EMDR research institute she founded. Thus initial treatment development was not driven by the agendas of major funding agencies like the Department of Defense or the National Institutes of Health as the Battlemind and TF-CBT manuals were respectively. Thus EMDR was tied more heavily to Shapiro's personal beliefs about healing (e.g., the intrinsic perfectibility of humankind) than would likely have been possible had she developed the treatment solely under the auspices of a major research agency.

The original version of Shapiro's EMDR manual (1995) was developed in the time period between 1980s and 1990s when trauma was understood as being embossed in the brain (e.g., van der Kolk 1980, 1984, 1994, and Herman's 1997 work). The manual reflects veridical theories of trauma and the cognitivist ideology present in information processing models that were popular at the time.

Though direct mention of historical context is largely absent from the manual, Shapiro does briefly mention the release of the first version of the manual occurring only a few days after the Oklahoma City bombing. On April 15, 1995, Timothy McVeigh parked a rental truck filled with explosives outside the Alfred P. Murrah Federal building in Oklahoma City, Oklahoma. The explosion of the truck destroyed the front of the building and killed 168 people (Oklahoma City National Memorial & Museum [ONCMM], 1995). In response to the bombing, Oklahoma clinicians already trained in EMDR offered pro-bono treatment services and trainings to all licensed mental health professionals in the area who were interested in free EMDR training. This event marked the inauguration of the EMDR Humanitarian Assistance Program (HAP), which has since trained clinicians internationally in EMDR post-disaster in over 30 countries (Shapiro, 2010).

Some of the notable traumatic events and disasters which EMDR HAP has deployed trainers to have included conflicts in Bosnia/Croatia, Palestine and Northern Ireland, earthquakes in Haiti (2002), Marmara Turkey (2005), Gujarat (2001; treatment of 16,000 survivors), and the tsunamis in South Asia (2004; treatment of 5,000 victims), as well as response to 9/11 and Hurricane Katrina (Humanitarian Assistance Program [HAP], 2014).

Shared Theme 1: Mind-brain as Protector and the Political Use of Cognitivist Ideology

In this section, I present the first theme that was shared by the three manuals that I interpreted. All of the manuals predicated therapy on three interrelated assumptions: 1) You can change the world by changing your mind, 2) When you change your mind you change your brain; and, 3) Your brain and mind can protect you from trauma (i.e., if you have inner safety, you are safe and thus the world is safe). The main problem with these assumptions is the confusion between shifts in individual subjectivity and shifts in the social world, which can ultimately result in no change to the status quo of existing political problems and arrangements of power and domination (cf. Sampson, 1981).

Thematic findings: Mind-brain as protector and the apolitical use of cognitive ideology. This section presents quotations from Shapiro's (2001) EMDR manual and adjunctive protocol scripts (Leeds, 2009; Luber, 2010) that I found to be representative of the theme "mind-brain as protector and the political use of cognitivist ideology." I have divided the section according to the assumptions listed above. Overall in the EMDR manual there was less emphasis on the mind and more emphasis on direct manipulation and connection with the brain. Therefore, for the presentation of this manual, I collapsed the first two assumptions listed above into one theme titled "you can change the world by changing your brain."

You can change the world by changing your brain. The EMDR manual heavily emphasized the concept of healing through direct physiological access and manipulation of neuronal pathways:

> When someone experiences a severe psychological trauma, it appears that an
> imbalance may occur in the nervous system, caused perhaps by changes in

neurotransmitters, adrenaline and so forth. … The hypothesis is that the procedural elements of EMDR, including the dual attention stimuli, trigger a physiological state that facilitates information processing. … Therefore, in EMDR when we ask the client to bring up a memory of the trauma, we may be establishing a link between consciousness and the site where the information is stored in the brain. (p. 31)

The pathological structure is inherent within the static, insufficiently processed information stored at the time of the disturbing event…pathology is viewed as configured by the impact of earlier experiences that are held in the nervous system in state-specific form. (p. 16)

The primary mechanism for direct access to the brain was bi-lateral stimulation

(i.e., asking the patient to follow the clinicians fingers or tapping the patient on either

sides of their body while they free associate thoughts and memories related to their

problem). The patient need not understand the mechanisms behind why bi-lateral

stimulation works, they only need to be open to submitting their brain to re-wiring. For

example, at the start of the first reprocessing phase of therapy where bi-lateral stimulation

is used (Phase 4: Desensitization), the patient should be told:

Now remember, it is your own brain that is doing the healing and you are the one in control. I will ask you to mentally focus on the target and to follow my fingers (or any other [bi-lateral stimulation (BLS)] you are using). Just let whatever happens, happen, and we will talk at the end of the set. Just tell me what comes up, and don't discard anything as unimportant. Any new information that comes to mind is connected in some way. If you want to stop, just raise your hand. (Luber, 2010, p. 404)

While the manual initially stated that the patient is the one in control, other scripts

seem to suggest that the patients should actually be negotiating with and attempting to

direct their brain, which is actually in control and sending messages to the person. For

example:

The back of the brain talks to the front of the brain by arousal. For instance, if you walk into your home and something is not right, how long does it take for you to notice? You feel it in your body and the words we use are body feeling words such as 'I have a feeling something isn't right. What's going on?' We feel something isn't right. We ask, 'What is going on?' If the other person says

nothing, the back of the brain raps on the front harder and you feel more arousal because you can't fool the back of the brain. (Luber, 2010, p. 62)

An additional script where the patient is asked to "thank their brain" for protecting them is described later in this section (p. 313).

Shapiro's (2001) manual provided extensive theoretical and scientific background to the therapists as to why they would discuss direct brain healing with their patient. Despite the complex explanations of theories (like the Adaptive Information Processing model), Shapiro presented the idea of neural manipulation as a straight-forward and common sense concept that has existed in many psychotherapy theories:

> The invocation of a neurophysiological level is a simple recognition that this is where all change ultimately occurs. It is not assumed to be specific to EMDR; rather, any form of successful therapy will ultimately be correlated with a neurophysiological shift. Such a neurophysiological shift is explicit in models informing prolonged exposure therapies (Foa & Kozak, 1986; Marks et al., 1998) and implicit in some psychodynamic models (Horowitz, 1979). (p. 16)

The reference to other therapeutic approaches and especially to "big names" in trauma research (such as Foa and Horowitz) as well as citing numerous neurological studies created an origin myth (cf. Samelson, 1974) to legitimate the use of EMDR therapy. The point of citing these studies appeared to be to emphasize that regardless of psychological approach, all therapies ultimately change the brain in order to heal the person,

> Regardless of the psychological modality used by the clinician, it is only logical that any therapeutic change must ultimately be based on a physiological shift of information stored in the brain (see Chapter 12 for preliminary neurophysiological data regarding EMDR treatment). (Shapiro, 2001, p. 50)

Shapiro suggested that since EMDR is believed to directly access the brain, this means that the therapy can be "time-free" (see "Time-free Therapy" section in

Shapiro, 2001, pp. 48-50) and thus able to heal chronic trauma symptoms in the

course of a few one-hour sessions:

> The clinician's model must be open to the fact that rapid, profound, and
> multidimensional change in a client can take place and can be maintained over
> time. For those clinicians trained in a long-term model such as psychoanalysis,
> this may be difficult to accept. However, let me stress that clinical observations of
> EMDR sessions have revealed that no pertinent stage of healing is skipped:
> Symbols become clear, insights occur, lessons are learned, and the various stages
> of emotional resolution are experienced, albeit in a accelerated fashion […] It
> might be helpful for clinicians to recognize the comparatively short distance
> involved in crossing a synapse. (p. 50)

In this quote, Shapiro appealed to the common sense of neuroscience (i.e., the

taken for granted assumption that the brain is responsible for behavior) and suggested

that victims can quickly heal from trauma just like a neurotransmitter crossing a synapse.

This argument is problematic in a number of different ways, namely that the existence of

a small space between a synapse is in no way analogous to human change nor a logical

reason to shorten therapy; however, it appears that Shapiro provided this metaphor with

the idea that it could be helpful in convincing clinicians that length of time in brain-based

therapies is not related to change. The fact that this metaphor was presented as helpful

revealed another taken for granted assumption in the manual: therapists naturally think

about human change in terms of the brain.

Shapiro (2001) continued the application of the brain metaphor to suggest that

change in the brain need only start with the adjustment of one thought and one neuron

and that the interconnected nature of the brain (via neural networks) will ensure that these

small shifts will generalize across the brain through the course of therapy. Generalization

across the brain was then equated to generalizing across the lifespan of the person:

> For most clients, successful EMDR treatment results in the new, positive,
> cognition generalizing throughout the entire neuro network. Therefore, any
> associated memories […] that are accessed subsequent to treatment will result in

the emergence of the positive cognition ("I'm fine") along with appropriate affect. The therapeutic resolution is shown in all aspects of the target (images, physical sensations, emotion, and so on) and in past and present associated events and is also manifested in an appropriate change in behavior. (pp. 46-47)

The final sentence of this passage crystalized the connection between changing the brain and changing human lived experience. Ultimately, it suggested that the adjustment of one neuronal thought can change all past and present lived experience.

The manual often appeared to take for granted the distinction between a real world outside of the brain and described the therapy as manipulating an "internal model of the world" that is managed by "neuro networks" in the brain (Shapiro, 2001, p. 21). The manual read,

> one's natural "completion tendency" continues to rework the traumatic information in active memory until it can be reconciled with one's internal models of the world. (p. 21)

The neuro networks were described as if they were singularly responsible for determining behavior and thoughts in the world. One vignette described how a woman's self-denigrating neuro network prevented her from being functional in a business meeting:

> When the woman enters a social or business situation and desires something, the neuro network with the affect that is verbalized by "I can't get what I want; there is something wrong with me" will be stimulated, and the associated affect, level of disturbance, and self-denigrating belief will severely hamper her functional behavior in the present. (pp. 45-46)

The manual relied so heavily on the assumption that changing the neuro networks and brain changes the world because the world is represented in the brain, that at a few points the manual distinguished between the brain world and the actual world by using the phrase "real-world." For example, the phrase real world was used when discussing how to "install" (p. 94) or "resource in" (p. 94) (i.e., implant in the brain) positive visual

imagery using bi-lateral stimulation with the woman who experiences actual disturbance

the real-world office environment:

> The incorporation of a positive template is an aspect of EMDR that includes
> visualization work similar to the kind done by some Olympic athletes during
> training […] Essentially, once the client has received the appropriate education,
> she is asked to imagine the optimal behavioral responses, along with an enhancing
> positive cognition. The clinician then leads her in successive sets of [bi-lateral]
> stimulation to assist her in assimilating the information and incorporating it into a
> positive template for future action. […] The incorporation of these positive
> templates allows the client to achieve some sense of comfort and experience with
> new situations in the safety of the office. […] Once she has done this, there is a
> greater likelihood of actual positive experiences, because these internalized
> positive templates will be triggered by future external cues in the real world.
> Obviously, the clinician will need feedback about these real-world experiences to
> determine if a client needs additional assistance. (Shapiro, 2001, p. 213)

In the above quotation the clinician was directed to "obviously" check in on the

patient's actual experiences in the real world to see if the positive image and visualization

was able to take primacy over other reactions the patient had to the real world. These

directives suggested that the therapist might otherwise check in on the status of the

"internalized positive templates" in the brain world and forget that these templates were

implanted in the patient for use in real world scenarios. Though the real world is

mentioned in this segment, its purpose is to be controlled or even replaced by the positive

images that were implanted during therapy in the patient's "internal model of the world"

(Shapiro, 2001, p. 21).

In sum, the manual exemplifies what Sampson (1981) called the "subjectivist

reduction" (p. 730) where the world is understood as being processed through structures

of the knowing subject, and an individualistic reduction that grants primacy to the

individual knower. Within this view, reality is the product of individual cognitive

operations rather than of social practices lived out in historical traditions. EMDR seemed

to extend cognitivist ideology in such a way that the individualistic reduction was so

interior the brain was actually proposed as the individual knower, and not the person.

Your brain and mind can protect you from trauma (i.e., if you have inner

safety, you are safe from the world). Many of the clinical scripts described the brain as

the protector of the EMDR patient. The scripts asked the therapist to tell their patients:

> The brain is very protective and is always looking for things in the current environment that represent information stored in the back of the brain that may need attention. (Luber, 2010, p. 62)

> The brain is always protective and scanning for sensory input such as sight, sound, smell, taste, or physical sensation that reminds the brain of past things it needs to be aware of so it can fire up arousal to protect the person if need be. (Luber, 2010, p. 63)

> Perhaps the best example of brain as protector was exemplified in a script that I

named "the trauma watering hole." The EMDR manual featured an evolutionary theory

of trauma, similar to that described in the background of this study (Chapter 2, pp.16-18),

in which human response to trauma was framed as analogous to zebras fearing lions that

arrive to a watering hole in the Serengeti. The analogy of humans at the watering hole

draws from LeDoux and other evolutionary theories of neural development where a

"primitive brain" signals fear reactions without conscious thought.[50]

In the "Introducing Adaptive Information Processing and EMDR: Affect

Management and Self-Mastery of Triggers Script" (Phase 1 in Table 3), the therapist

script began by introducing the watering hole metaphor and discussing differences

between humans and zebras:

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[50] Out of the three manuals I analyzed the trauma watering hole was only mentioned in the EMDR manual; however, as noted previously in the Background and Literature Review Chapter, this metaphor is commonly used in psychoeducational scripts for anxiety therapy (see e.g., Zayfert & Becker (2006) and Robert Sapolsky's (1993) *Why Zebras Don't Get Ulcers*).

> In the thousands of years we developed this big part of our brain (point to your head); we also developed something that the zebra can't do. The zebra needs to see, hear, or smell the lion to fire up his arousal system…Isn't it interesting that people, with our great brains, only have to imagine a lion to get the same arousal response and get ready to run? (Luber, 2010, p. 63)

In this Phase 1 script, the therapist was instructed to lead the patient through a straw man rhetorical exercise of attempting to visually see lions in the office to prove the patient that no lions actually exist in the therapy room—they are all in the mind. The therapist script continued,

> So here is the secret to starting to control your arousal. If you feel arousal, and don't see a lion, it's most likely a lion living in the back of your head! THANK YOUR BRAIN for trying to take care of you, but tell your brain it doesn't need arousal right then because there is no real lion. (p. 63)

In the subsection of the script titled, "Thank your brain!" (Luber, 2010, p. 63) different example dialogues were presented to the patients for use in engaging their brain, blocking their thoughts and thanking their brain. After thanking their brain the patients are instructed to do "a body scan" (Phase 6) and ask the brain to pay attention to triggers that represent lions in the back of the brain.

In addition to activating the brain's innate protective abilities, the EMDR manual also described how the therapist could install further protection into their brain. In the second phase of therapy, "Preparation," the therapist should direct the patient to identify a safe place which can be "installed" (p. 96) or "resourced in" (p. 96) to the brain (i.e., visualized by the patient while the therapist conducts bi-lateral stimulation) for use when the patient becomes distressed.

Chapters 4 and 9 in the Shapiro (2001) manual were devoted to teaching the clinician how to work with the patient to identify an appropriate image and safe space for the patient to mentally invoke when distressed. The script read:

> Bring up the image of a place that feels safe and calm. Concentrate on where you feel the pleasant sensations in your body and allow yourself to enjoy them. Now concentrate on those sensations and follow my fingers with your eyes." At the end of the set the clinician asks the client, "How do you feel now?" If the client feels better, the clinician should do four to six more sets. If the client's positive emotions have not increased, the clinician should try alternative directions of eye movements until the client reports improvement. Sets are kept short, 6 to 12 movements apiece. (p. 126)

After installation of the safe space, the patient was then provided a "cue word" (p. 126) and the clinician and patient were then directed by the manual to practice cuing and self-cuing when thinking of distressing thoughts. The clinician script continued, "Remember, this safe place is always available to you. Just let me know if you need to return to it at any time. The clinician should occasionally use the eye movements to reinforce the safe place. This also maintains a positive association with the eye movements themselves" (p. 127).

In addition to the safe place exercise to further fortify mental barriers, the EMDR manual recommended utilization of relaxation exercises before and after trauma processing such as the "Lightstream Technique" (Shapiro, 2001, p. 71). The script for the Lightstream Technique in a supplementary manual read:

> Continue to allow the light to flow into your head, neck, and shoulders. Let it flow into your chest and down your arms and out your fingertips. Let the soothing, healing light flow through your torso into your legs and out through your feet. Let the light flow into every part of your body. Let it completely fill you up, let it work wherever it is needed inside you, to heal you and make you stronger. Then, let it spill over and surround you, encompassing you in a healing, protective layer of light. Finally, imagine saying to yourself the positive words you most need to hear right now. (Luber, 2010, p. 296)

In EMDR Phase 5, "Installation," the manual also emphasized creation of mental barriers and brain protection from the world. During installation, the patient should be asked by the therapist to recall negative thoughts and replace them with positive

cognitions during bi-lateral stimulation until the positive thought is seen as "completely true" (p. 160) on the Validity of Cognition (VoC) scale. The desired outcome of installation is that the patient has eliminated all negative thoughts or cognitions; if they do occur the patient should see the thoughts as completely untrue.

Thematic discussion: Mind-Brain as protector and the political use of cognitivist ideology. Shapiro's (2001) manual makes the subjectivist reduction that Sampson (1981) referred to, in which the world is understood as being processed through structures of the knowing subject. Within this view, reality is the product of individual cognitive operations rather than of social practices lived out in historical traditions. EMDR seemed to extend cognitivist ideology in such a way that the brain was actually proposed as the individual knower, and not the person. There was a sense of the person needing to manage, appropriately access and install things in their internal world.

The EMDR manual emphasized the brain-based nature of therapy and changes in the neuro network as being integral to healing trauma. The particular presentation of research on neuroscience and trauma suggested that re-wiring the brain was integral to any therapy. To create inner safety in a traumatizing "real-world," the manual assumed that the therapist could activate the natural healing power of the brain through EMDR and the mechanisms of bi-lateral stimulation. Through this process and the therapist's installation of a safe space, positive imagery, and cognitions, the patient could cue himself or herself to reduce distress and retreat behind the barriers of the inner world.

When explaining how to control fear using the trauma watering hole metaphor, the EMDR protocol characterized the brain as a controlling friend that the patient needs to talk with, ask questions of, and attempt to gratify or appease in order to reduce anxiety.

I again thought of the brain as Bentham's panopticon (cf. Foucault, 1995), this time where patients are standing in the prison yard of their lives asking the back of their brain if there are lions somewhere in the distance and then activating a positive image template or safe space when the alarm sounds.

I found the trauma watering hole script incredibly patronizing and simplistic; yet, something about this way of talking about trauma undoubtedly makes sense in contemporary culture. The script draws on evolutionary and neurocognitive metaphors that have become such a part of everyday thinking and vernacular (at least since the 1990s) that it's actually possible a patient would not interpret this script as patronizing but as reaffirming of how their fear responses are adaptive and normal. This response is no doubt enabled by the demand characteristics of the therapeutic situation and the desperation to escape the painful symptoms the patient experiences.

Overall, the utilization of watering hole metaphor suggested that trauma responses are natural, innate, pre-programmed, and as old as humanity. Furthermore, the psychoeducation regarding innate fear responses laid the ground work for the powerful assumption that the therapy directly manipulates or speak to the innate, ancient and primitive parts of the brain in order to treat trauma. The metaphor subtly reduced all traumatic experiences, regardless of severity, to a rote or triggered response that lacks unique qualities (every trauma is a lion or a trigger) and can be eliminated through EMDR.

When interpreting the EMDR treatment of trauma as cognitivist ideology, it became apparent how the therapist was instructed to train the patient in accepting cognitive ideology primarily through the techniques of psychoeducation, interweaves or

thought-replacement, and challenging cognitive distortions. The manual assumed that the response to both daily—as EMDR would say "little t traumas" (p. 49)—and major political suffering—Big T Traumas (p. 49)—could be dealt with by altering the way the brain functions and operates. EMDR necessarily recapitulates the status quo of an isolationist, politically inactive and asocial environment where persons do not act with each other or in the world, but merely eliminate or desensitize memories of the trauma and replace the experience of the world with positive image templates and safe spaces. In this sense EMDR treatment, while performing cognitivist ideology in the guise of healing, serves to maintain the isolationist status quo in neoliberal society: by shifting the way we perceive the world we overlook the need to change it and the need to turn to community to make meaning of and address social problems. In a world in which cognitive psychology is dominant, the necessity to change the material arrangement of the social world does not come to light.

Shared Theme 2: Neoliberalism in Trauma Therapy: The Healed Trauma Survivor as Functional Worker

In this section, I present the second theme that was shared by all of the manuals I interpreted. In all of the manuals, trauma was a major source of reducing neoliberal functionality and thus the aim of therapy was to restore functionality in this system, like getting the patient to return to work or school. There were three primary assumptions in the manuals that are a reflection of neoliberal culture: a) valorization of the enterprising self (cf. Binkley, 2011; Layton, 2010; Rose, N. S., 2007)*,* b) the acontextualized nature of trauma (Layton, 2006), and c) the privileging of modular, efficient therapy designed for managed care (Cushman & Gilford, 2000). I previously discussed these features from the

perspectives of critical scholars in the Background and Literature Review (see Chapter II, pp. 100-109), in this section I briefly relate these features to my interpretation of the EMDR manuals.

Thematic findings: Neoliberalism in trauma therapy. In this section I present quotations from the Shapiro (2010) manual and supplementary manuals (Leeds, 2009; Luber, 2010,) that are representative of the theme "Neoliberalism in trauma therapy— The healed trauma survivor as functional worker." I have divided the section according to the three assumptions listed above.

Valorization of the enterprising self. The Shapiro (2001) manual chapters on desensitization and installation (Phase 4 and 5) began with the epigraph, "The great thing in this world is not so much where we are but in which direction we are moving—Oliver Wendell Holmes Jr." (p. 144).[51] This quote typifies the primary aim of EMDR: to erase the trauma through desensitization and move forward in society. Acceptance or discussion about where the patient is in his or her life is not an acceptable or valorized way of being in the EMDR manual. Instead, the Shapiro (2001) manual promotes a version of the enterprising self that has the intrinsic capability to heal (by activating the

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[51] In addition to being a U.S. Supreme Court Justice, Holmes was also a proponent of eugenics. He decided the *Buck vs. Bell* Supreme Court Case of 1927 which stated that it was legal to forcibly sterilize intellectually disabled, unfit and female prisoners—a ruling which still stands today (Lombardo, 1985). Holmes said,

> We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the state for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind… Three generations of imbeciles are enough. (Holmes, as cited in Lombardo, 2008, p. 169)

brains natural adaptive capabilities) and be freed from the past, "The purpose of the

eight-phase EMDR treatment is to help **liberate the patient from the past** into a healthy

and productive present" (p. xiv) and to "rapidly metabolize the dysfunctional residue

from the past and transform it to something useful" (p. xiv). In these quotations, the

dysfunctional residue from the past was presented as a resource that can be processed and

made available for the enterprising self to use.

Most all skills, relationships, and processes were presented as things that could be

used to help the enterprising self move forward. For example, learning was thought to be

a resource that was described as available for use:

> A principle that is crucial to EMDR practice (but not specified in other
> information-processing theories), and which is suggested by the consistent
> application of the procedure, is that there is a system inherent in all of us that is
> physiologically geared to process information to a state of mental health. This
> adaptive resolution means that negative emotions are relieved and that learning
> takes place, is appropriately integrated, and is available for future use. (p. 15)

The acontextualized nature of trauma in neoliberal trauma therapy. Human

relationships were also presented in the EMDR manual like a resource or standing

reserve (cf. Heidegger, 1977) to help the enterprising self move forward in life. For

example, relationships were described as social resource connections, "To be with

someone you feel loved or protected with is a social resource connection (SRC)" (Luber,

2010, p. 277). Instead of focusing on helping the patient develop actual human

relationships and seek connection or help with friends, family or their community, the

manual suggested that the SRCs be installed in the brain, like the safe place, so that they

can be recalled in any circumstance:

> Take another moment to bring up the image of someone important to you, past or
> present, someone you associate with feelings such as caring, comfort, safety,
> protection, support, encouragement, acceptance, understanding, empathy, warmth,
> or compassion, or with whom you are at your best. The person you are thinking of

is your social resource. The name of the person is [blank]. Think of an event or time you shared with that person. Choose a picture that represents the best part of the event, or concentrate on your person's image, saying your person's name while you notice the feelings you have inside. Then do some tapping to deepen your connection with this resource. (Luber, 2010, p. 302)

Deeping actual social connections and political activities in the real world was replaced in EMDR therapy with bi-lateral stimulation to deepen a connection to a social-turned-mental resource—the SRC. The benefit of transforming social relationships into a mental resource is that the complexity and dependence that is involved in the real social world is eliminated. SRCs can be recalled at any place and require no relational investment; they are a resource to be used. With SRCs the enterprising self can continue to move forward without actual social connection or dependence on other people.

A modular, efficient therapy designed for managed care. I outlined the timeline of EMDR therapy delivery and cost of therapist training in Table 2. The evidence based therapy guidelines for EMDR suggest that three, one-hour individual sessions can eliminate symptoms of chronic PTSD (SAMHSA, 2013); this is extremely brief when compared against the other trauma treatments examined in this study, and also when compared to the comprehensive list of evidence-based trauma treatments (Table 1). In fact, there are only two other evidence-based treatments that have a lower recommended session limit. The brief, time-limited (or as the manual would say "time-free") nature of EMDR therapy makes it amenable to managed care settings and able to be reimbursed by insurance companies who have a set limit for therapy.

Although the therapy itself is brief, it is expensive and time-consuming to train therapists how to deliver the therapy. As seen in Table 2, the total cost for training a single clinician can cost over $3000. Shapiro has succeeded in making a highly effective, brief, and proprietary therapy for managed care; one that if accepted broadly would be

profitable on a per-clinician basis when compared to other approaches (e.g., Cohen et

al.'s (2006) TF-CBT costs approximately $35 to train). Despite the high cost that might

be prohibitive for many managed care companies, the manual also suggested that after

basic training EMDR therapy can be immediately performed and the scripts can be read

directly from the manual. The Luber (2010), EMDR HAP (2010), and Leeds (2009)

supplementary manuals also included therapist scripts with fill-in-the-blank worksheets

that the therapist could directly read from in the therapy room in order to retain fidelity to

the treatment.

Although EMDR therapy can be performed by reading from manualized

protocols, the Shapiro (2001) manual highly recommended that potential EMDR

clinicians attend the in-person trainings:

> A survey of the first 1,200 clinicians trained in EMDR showed that only 2%
> considered the supervised training unnecessary. […]. Therefore, although this
> book provides the necessary written instructions to begin using EMDR, it should
> be used in conjunction with appropriate supervision and training. (p. xiii)

Shapiro (2001) also recommended that "Generally, clinicians should work with EMDR

for approximately 30 sessions before attempting the more advanced material" (p. 198).

In sum, EMDR is structured as a one-size-fits all three-session treatment that can

be easily trained for minimum therapist proficiency in managed care settings. The

treatment is highly amenable to managed care billing and insurance coverage given that

issues like chronic PTSD can be treated in three sessions. The therapy was promoted as

so efficient that it becomes "time-free" (Shapiro, 2001, pp. 48-50). Though clinicians

can read directly from the EMDR manual during therapy and begin treatment almost

immediately, it is also recommended that they attend a series of in-person workshops and

supervision.

Thematic discussion: Neoliberalism in trauma therapy: The healed trauma survivor as functional worker. Scholars who have critically interpreted neoliberal culture in psychotherapy have identified two primary features: a) social identity is continually removed from political, local, and moral tradition and context; and, b) neoliberal culture has come to govern the lives of families, individuals and communities via technologies of therapy and the role of the expert in therapy (e.g., Binkley, 2011; Cushman & Gilford, 2000; Fine, 2012; Layton, 2010, 2013). I previously discussed these features from the perspectives of critical scholars in the Background and Literature Review (see Chapter II, pp. 100-109), in this section I briefly relate these features to my interpretation of the EMDR manuals.

The enterprising self was represented in the EMDR manual as one that can erase the past and move forward by turning traumatic events into resources for a future positive and more adaptive self. Throughout the manual all life experiences are transformed into what Heidegger (1977) has called standing reserve; friends are turned into SRCs and the real world is replaced (or rather "installed" or "resourced in") with positive images and safe places. The healed trauma survivor according to the manual should be a hyper-functional person who embodies the Oliver Wendell Holmes epigraph quoted in the manual—a person who is moving forward, independent from all persons and traditions and freed to make infinite positive choices in their world.

Shared Theme 3: Trauma Is Universal and Culture-Free (Versus Tied to a U. S., Western, White, and Middle-Class Context)

In all of the manuals, trauma was presented a universal human experience that could be treated following the same culture-free treatment manual. I divided examples of

this theme into the following categories: a) trauma symptoms are tied to universally

experienced organ malfunction (e.g., brain problems); b) flattening of all events, local

experiences, and narratives of suffering to diagnostic criteria for PTSD and the word

"trauma" or "traumatic events;" c) thought-terminating clichés (cf. Lifton, 1989) about

cultural competency; and, d) exclusion of forms of suffering from the definition of

trauma that are not from a U.S., Western, white, female, and middle-class context.

Thematic findings: Trauma is universal and culture-free. In this section, I

present quotations from the EMDR manual that are representative of the theme, "trauma

is universal and culture-free." I divided the section according to the four assumptions

listed above.

Trauma symptoms are tied to universally experienced organ malfunction (e.g.,

brain problems). EMDR's Adaptive Information Processing theory and the brain-based

approach to therapy described by the Shapiro (2001) manual were outlined in Shared

Theme 1. The Shapiro (2001) manual described trauma symptoms as the result of a brain

malfunction that is universally experienced and expressed in all humans (see quotations

presented on pp. 303 – 304 in this study). The manual used words like "human behavior"

and "genetically encoded responses in human beings" to suggest that what has been

observed by Western science about trauma must be universal to all humans. For example,

the Shapiro (2001) manual stated:

> Human behavior is not random; patterns of reaction and behavior established in
> the past are frequently triggered in the present. (p. 207)

> Some cognitive therapists might say that a child placed in a room with a tiger
> would not fear the beast unless the child was old enough to know that a tiger is
> dangerous. However, it seems clear that if the tiger turned and roared at the child,
> no matter what its age, fear and possibly traumatization would result. This
> illustrates one of the genetically encoded responses in human beings, responses
> that have developed through evolution and do not require the stimulus of

language. Thus, while a person's beliefs, stated via language, are clinically useful distillations of experience, it is the affect feeding them that is the pivotal element in the pathology. (p. 44).

These quotations exemplify the EMDR perspective that human beings ultimately experience fear, anxiety and pathology predictably and similarly across cultures on a biological level. The latter quotation suggests that language and beliefs are "useful" (i.e., a tool for therapy), but that affect and raw emotional experiences are disconnected and not shaped by cultural beliefs and language.

 Cultural, regional, or personal experiences of trauma were also assumed to be experienced similarly like a traumatic particle frozen in the brain in a disconnected neural network (see "The presentation of trauma in the manual" section, pp. 297-298 in this study). The aim of EMDR is to reintegrate the trauma through processing and desensitization (Phases 4 and 5). The manual talked about modifying the brain in therapy as if it was common-sense and that all therapies were ultimately oriented to work at the neurological level:

> The invocation of a neurophysiological level is a simple recognition that this is where all change ultimately occurs. It is not assumed to be specific to EMDR; rather, any form of successful therapy will ultimately be correlated with a neurophysiological shift (p. 16)

At one point in the manual it appeared as if there was some recognition of the social context and an acceptance different cultural interpretation and bodily reactions to traumatic events:

> In EMDR therapy each session should always be integrated into a full treatment plan. The reevaluation phase is essential because every human being is a complex individual incorporated into a complex social system. Any profound treatment effect can have significant impact on the person's associated intrapsychic factors and behaviors. These, in turn, will have an impact on the individuals with whom the client interacts, necessitating attention to interpersonal systems issues. The number of reevaluations will vary from one client to another. A client with a single trauma may require

only one to three reprocessing sessions, followed by a revaluation phase of
one or two follow-up sessions to review the treatment outcome and the
log. (p. 200)

Though this section of the manual held promise for recognition of the complexity

of human being in a social system, the manual continued by recommending to think

about this complexity by simply varying the number evaluations and reprocessing

sessions. It was assumed that EMDR in its core approach would work regardless of the

cultural and sociopolitical context of the person and the only tailoring needed was the

amount of EMDR delivered. Again, this assumption was based on the cognitivist

ideology of the Adaptive Information Processing model which essentially suggested that

that human beings function similarly and predictably; because all humans have brains,

trauma must be encoded and stored in a universal way regardless of the language, belief

system and culture of the patient.

Flattening all local experiences and narratives of suffering to diagnostic

criteria for PTSD and the words **trauma** *or* **traumatic events.** The first instance of

reduction of narrative, nuance and local stories of trauma in the EMDR manual was the

recommendation to transform the outcomes of the initial clinical interview into a modular

treatment plan. This occurred primarily in Phase 1—History Taking—in which the

manual described that creating a specific desensitization treatment plan was the primary

purpose of listening to the patient's historical narrative of the trauma:

> Overall, the clinician is attempting in planning treatment to discover parallels
> between the client's past and present in order to identify patterns of responses.
> Having delineated the present stimuli, dysfunctional cognitions, emotions, and
> behaviors, the clinician must isolate specific targets, which can range from a
> client's earliest memories to the latest disturbing experience. (pp. 107-108)

In the EMDR manual, the process of listening to the patient was overshadowed

with the objective of identifying discreet predetermined targets for desensitization. The

manual provided a transcript of a therapist performing history taking (Phase 1). The

transcript was annotated with what the therapist's parallel thought-process should be

when listening to a patient narrative. According to the manual, most of the therapist's

activity should be identifying targets (i.e., traumatic memories) for desensitization. For

example:

> CLIENT: Boy, it's difficult, because with my uncle I can more or less cut him off. My dad was the person in my family who nurtured me, probably more than anybody else. It's always been really hard for me to individuate from my dad, and—how can I say it?—there is still a lot of warmth and nurturing. A few years ago I just really set a limit on his sexual comments and told him I couldn't spend time with him if he did that, and he stopped.
>
> [Therapist]: Present relationship with father will be targeted. (p. 111)
>
> CLIENT: The memory is of me, literally on my knees, with her screaming at me and me saying, "What do you want me to do?" and she couldn't answer.
>
> [Therapist]: This memory will be targeted. (p. 112)

Other therapist activities in this transcript included, "Therapist summarizes

client's negative cognitions and seeks more information" (p. 114); "The goals the client

states may constitute behavioral measures for later assessment" (p. 116); and, "Therapist

searches for a target for the negative cognition" (p. 116). In general, the therapist was

recommended to elicit complex narratives about the experience but to hear these

narratives in such a way that each upsetting memory was reframed according to EMDR

theory (e.g., as a negative cognition or treatment target) and could be fit into phases of a

treatment plan.

The label of trauma was used throughout the Shapiro (2001) manual to refer to a

wide range of social and political suffering. In EMDR, traumas were divided grossly into

to "big T" and "little t" traumas (p. 43); these terms were used in lieu of the description

of the actual events. Big T events included: rape, sexual molestation and combat

experience. Little t traumas included "any event that has had a lasting negative effect on the self or psyche" (p. 43). EMDR was designed to treat all of these traumas following the same protocol (Table 3). Despite suggesting the same protocol could work for almost all events, the manual and supplementary texts also included many specific supplementary protocols that were tailored to the context of specific events (e.g., mining collapse, single-trauma, emergency room worker, combat veteran).

Thought-terminating clichés about cultural competency. The EMDR Humanitarian Assistance Program (HAP) institute founded by Shapiro in 1995 offers therapy to trauma survivors and pro-bono trainings in EMDR to local clinicians after disaster; the organization has conducted trainings in over 40 countries. According to the manual, HAP:

> offers trainings worldwide to teach local clinicians how to administer EMDR to those in need. Participating clinicians throughout the world have extended their help, regardless of boundaries and borders, in order to assist in the alleviation of suffering worldwide. It is hoped that through such elimination of suffering we can also help to eliminate the cycle of violence worldwide. (p. 384)

Despite spread of EMDR via HAP pro-bono trainings, the EMDR manual did not discuss the need to tailor the therapy to different cultures or for the clinicians to have cultural respect or additional training for cultural competency. According to the manual the treatment is actually "culture blind." The Shapiro (2001) manual read, "Furthermore, there are positive reports of the successful application of the standard protocols worldwide, suggesting that its effectiveness is culture blind" (p. 384). This was one of the only references to culture I found in the manual (the word culture was used only three times in the entire manual). The lack of discussing culture perhaps demonstrates how thought-terminating the "culture blind" cliché can be; no discussion of culture was perceived as needed since the therapy was promoted as culture blind. The discussion of

culture in EMDR could therefore be interpreted as a silence—something so taken for granted by the manual that it is not even mentioned. There were other thought-terminating clichés utilized in the manual that did not pertain to culture but the culture-blind reference was the only one that specifically reduced complexity and discussion about culture.

Exclusion from the definition of trauma. How a manual excludes or includes certain persons from the description of trauma is highly related to how the therapist uses the manual and the recommended screening assessments of PTSD. It is also an indication of how the manual functions politically within society. For example, to be considered as traumatized and appropriate for trauma treatment one has to meet minimum criteria on initial assessments of PTSD. As I described in Chapter II, certain populations, namely female, black, American Indian/Alaskan Native persons as well as immigrants to the U.S. are more likely to receive a diagnosis of PTSD than other groups but are also less likely to attend treatment, perhaps due to access barriers (e.g., needing child care, having a dual diagnosis such that the clinician excludes them from consideration) or lack of interest in Western psychotherapy. Despite being more likely to be given a diagnosis of PTSD these same groups are also more likely to be considered to fit under other social categories, such as criminals, rather than trauma victims after encountering a traumatizing situation (Fine, 2012).

Because I didn't include observations of the therapy or assessment in this study it was difficult to understand how the label of "trauma" and "traumatized" was being applied in such a way that would exclude certain persons from trauma therapy or the definition of trauma. The EMDR manual in fact suggested that therapists should be

overly inclusive rather than exclusionary when considering persons as traumatized (e.g.,

EMDR is culture-blind, trauma is universal, every negative life event is a little-t trauma).

To understand how people are excluded from consideration as traumatized, I looked for

examples in the manual of persons that somehow didn't fit the definition of traumatized

or didn't behave how the manual would expect a traumatized person to act.

The following forms of resisting trauma therapy and recommended therapist

responses to these problem behaviors (noted in parenthesis) were described in the EMDR

manual:

- Patient is not ready to engage in treatment (Therapist response: do not force patient to begin treatment until they are ready);

- Patient does not want to talk about trauma (Therapist response: inform patient that, "the processing is happening internally, she need not divulge the details of the memory," p. 131);

- Patient has significant abreaction and stops eye-movement such as incessant crying, dissociation (Therapist response: follow 12-step abreaction protocol to desensitize patient, pp. 174-180, then remind the patient that s/he is safe and that abreactive responses can be passed through most rapidly if the eye movements are continued]);

- Patient agrees to participate in EMDR but has blocked processing and cannot access any memories (Therapist response: change method of bi-lateral stimulation to different modality, like visual to touch); and,

- Patient fears s/he is going crazy from the therapy (Therapist response: reassure patient this fear is from old memories and fears will be lessened if s/he progresses quicker through the therapy, but also let patient know they can stop at any time).

There was also a section in the manual about patients who feared change and thus

were more likely to purse long-term therapies:

One such client, who had been involved in psychodynamic therapy for 25 years, terminated his first EMDR session, which targeted a memory of a parental abuse, by saying, "I can feel it leaving me, and I don't want it to go. I feel there might be a lot more to learn." Such clients often can be recognized by pronounced noncompliance with homework assignments, oververbalization [sic] of

experiences, and attempts to rigidly control the therapeutic process. Unless their fear of therapeutic change is addressed successfully, the clinical outcome may be negligible. (p. 196)

The manual recommended that these patients who were seemingly resistant to EMDR keep a log of their fears about changing and present these to the clinician for targeting with reprocessing and desensitization.

Overall, the manual suggested that no person would be excluded from EMDR or the definition of traumatized; any disturbance in the psyche would be targeted for desensitization as a "little t" trauma. A patient's resistance to therapy could be overcome, depending on the situation, by encouraging but not forcing the patient to participate. This encouragement often took the form of recommending the patient proceed more quickly through the therapy and eye-movement procedures. Thoughts about fear of desensitization and wanting to learn more from the trauma were reframed as fear of change and identified as targets for desensitization.

Thematic discussion: Trauma is universal and culture-free. The spread of humanitarian organizations like HAP has no doubt contributed to the international popularity and interest in PTSD. Despite EMDR's spread to over 40 countries and popularity within the U.S. across many regions, the manual did not include discussion about culture; apparently it was thought that this dialogue did not need to occur because the treatment was "culture blind." Sue et al. (2007) argued that statements about culture or color blindness are essentially what white people say when they don't want to acknowledge race and ethnicity. These statements deny a person of color's racial and ethnic experiences and their existence as a racial and cultural being. To not see culture is to essentially assume sameness in a way that presumes that others assimilate and acculturate to the dominant white culture. Many scholars have argued that culture and

color-blindness is the new form of racist ideology since the 1960s that has been less critiqued than violent racism but is just as damaging (Bonilla-Silva, 2013; Neville, Worthington, & Spanierman, 2001; Neville, Spanierman, & Doan, 2006; Richeson & Nussbaum, 2004). Although violent forms of racism can physically destroy communities and members of different racial groups, culture-blindness ignores difference to the extent that specific ethnic practices and beliefs are not recognized, respected or provided opportunities (Bonilla-Silva, 2013).

Where culture blindness may sound to some as pleasingly egalitarian, in the case of the EMDR manual it suggests that the Western, U.S. and white cultural assumptions of traumatization and healing that are embedded in the EMDR model (e.g., all of the shared themes identified in this study) are appropriate for exportation to any culture, ethnic and racial group. In other words, if the treatment works, culturally-specific assumptions about EMDR are necessarily correct and acceptable to any cultural group. It assumes cultural assimilation to the EMDR values and model simply because the symptoms (also measured via scales developed in the U.S) have been shown to be reduced in research trials with diverse participants.

The Shapiro (2001) manual did not include a discussion about how the therapy may ignore, replace or destroy cultural values, may be intrinsically structured to exclude different groups, or how suffering may not be understood expressed, and healed in the same way across cultures; there was no proposed space in the therapy for these discussions perhaps because the therapy was promoted as culture-blind and thus acceptable to all groups. This assumption suggests that therapists using EMDR can and should use the therapy regardless of national, racial, cultural, and ethnic background of

their patient in order to alleviate suffering world wide. It's striking how universalization and inclusivity was so emphasized in the manual and yet it was this very act of assumed inclusivity that became a form of assimilation and colonization.

Perhaps there was no proposed space in the therapy for a discussion of the cultural values and political practices because EMDR practitioners, like the majority of training therapists today, have not been adequately trained to engage in that type of historical and political critique or philosophical discourse. Furthermore, discussions centered on this topic might be avoided by practitioners because talking about these issues might call into question some of EMDR's foundational beliefs and justifications.

I was also disturbed by the vignette of the patient who had been in psychoanalysis for 25 years and reflected on the desensitization of his traumatic memory during EMDR. He said, "I can feel it leaving me, and I don't want it to go. I feel there might be a lot more to learn" (Shapiro, 2001, p. 196). From the limited context provided in this vignette, it seemed as if the patient was mourning the loss of his trauma, an important life experience, or perhaps participation in trauma culture within a certain light. There were also many relational possibilities that could be explored in this vignette, such as the patient telling the therapist they want to stop the therapy or don't like what the therapist is doing. Perhaps the patient was inviting the therapist to witness or mourn with them. What was disturbing about the quote provided in the vignette was the sense that the patient felt as if he were having a memory involuntarily erased and were not an active participant in the process. There was no room for discussion of the meaning of the loss, what the patient hoped to learn, and the passive sense of his participation in therapy. Instead the therapist was asked to reframe the patient's fears about losing the memory as resistance

to change and the loss of the memory as a form of liberation. The description of the vignette process was conceptualized in terms of a resistance-compliance dynamic and therefore other relational possibilities could not come to light.

Shared Exemplar: Indoctrination into a Social Void of Scientistic Managed Care

Exemplars are stories or vignettes that capture what human being is like in a particular cultural or historical situation. In this study I looked for exemplars that captured what human being is like in trauma culture in such a way that it could be recognized in other situations that might have very different objective circumstances, including those outside of the practice of psychotherapy. In particular, I focused on identifying the therapeutic techniques and practices that trauma treatment manuals prescribed to training therapists, and noted the similarity between these techniques and practices to others in the social world.

The shared exemplar, which I titled, indoctrination into a social void of scientistic managed care, has four primary features: presentation of an origin myth, locating pathology and healing within the dyad, overreliance on forms, hand-outs and PowerPoints, and directive psychoeducation and thought-replacement.

Exemplar findings: Indoctrination into a social void of scientistic managed care. This section presents quotations from the Shapiro (2001) manual and supplementary texts that are representative of this shared exemplar. I have divided the section according to the four features listed above.

Presentation of the therapy's origin myth. Samelson (1974) coined the term "origin myth" to describe the presentation of an apolitical, trans-historical narrative of incremental progress towards an objective truth and science. In an origin myth, the

subject is decontextualized and presented in the form of discoveries from individual

geniuses (typically white Euro-American men) who each contributed to the development

of the contemporary understanding of psychology. The purpose of an origin myth is to

provide legitimacy to contemporary psychological concepts by presenting them as facts

that have existed in the same form for hundreds or even thousands of years (e.g., as long

as our ancestors fought for food with lions in the Serengeti). Each of the manuals

included some version origin myth and often this myth was incorporated into

psychoeducation about why the patient should be attending the specific form of therapy

prescribed by the manual.

The origin myth of EMDR began with Shapiro's (2001) preface:

> We went from Kitty Hawk to a man on the moon in little more than 50 years. Yet despite such monumental technological advances, millions of people suffer unremitting pain and a cycle of violence continues unchecked worldwide. Surely as a society we need to redirect some of our vast resources and pay greater attention to the alleviation of global suffering. […] In 1989, 100 years after the pioneering work of Freud and Janet in the treatment of trauma, when three major orientations were compared in the treatment of posttraumatic stress disorder (PTSD), all were found to have only moderate, and equal, effects (Brom, Kleber, & Defares, 1989). A lesson may be that the psychological treatment of individuals demands a composite of knowledge from various approaches. I align myself fully with those who believe that we strengthen clinical repertoires through integration, not through displacement or exclusion (Beutler, 2000; Norcross & Goldfried, 1992; Norcross & Shapiro, in press; Stricker & Gold, 1993). In this spirit, the development of EMDR over the past 14 years has moved it from a simple technique to an integrated psychotherapy approach. (p. x)

This section of the preface aligns the development of EMDR with a history of

great scientific inventions, like landing on the moon and discovering flight, and implies

that EMDR could be a similar scientific solution to unchecked suffering worldwide.

Shapiro (2001) also suggested that EMDR has built upon a tradition of studying trauma

that began with Freud and that through integrating science and various clinical

approaches EMDR is poised to cure PTSD once and for all.

The origin myth continues in the first chapter of the EMDR manual, which

includes sub-section called "theoretical convergence" (Shapiro, 2001, pp. 20-27) that

systematically describes how psychodynamic, behavioral, and cognitive-behavioral

approaches have contributed to the creation of EMDR and its associated theory of

information-processing (the Adaptive Information Processing Theory). In addition to

Freud and Pavlov, Shapiro cited Rodgers (1951) and Maslow (1970) as providing

evidence for the naturally positive direction of the brain's information processing systems

(i.e., when activated the body will naturally heal and move toward a positive state).

Shapiro also related the idea that trauma causes an imbalance in the brain's information

processing system to Janet and Pavlov and then connected these theories to contemporary

studies that invoke neuroscience (e.g., Andrade, Kavanaugh & Baddeley, 1997; van der

Kolk, 1994; Watson, Hoffman, & Wilson, 1988; Zager & Black, 1985).

At one point, Shapiro (2001) discussed EMDR's conceptualization of information

processing as an actual paradigm shift in psychology and provided a litany of studies that

had similar ideas but were distinct from EMDR:

> Although there are a number of other information-processing theories that have
> great merit (Barnard & Teasdale, 1991; Chemtob, Roitblat, Hamada, Carlson, &
> Twentyman, 1988; Foa & Kozak, 1986; Horowitz, 1979, 1998; Litz & Keane,
> 1989; McClelland, 1995; Rachman, 1978, 1980; Teasdale, 1999), the EMDR-
> based information-processing model is both generally compatible with them and
> distinct in its elements and applications. (p. 13)

This origin myth encompasses almost all major theories in psychology

(psychoanalysis, humanistic, behavioral) and connects the work of famous psychologists

and analysts (Freud, Janet, Pavlov, Rodgers and Maslow) to rationalizing a brain-based

information processing theory that is central to EMDR. Consistent with the structure of

most origin myths, the work of these psychologists is invoked with little context and

mentioned only in so far as it contributed a developmental step towards EMRD theory.

The myth suggested that EMDR was the culmination of research that has pulled together

historical tradition of psychology with the miracles of neuroscience. I discuss the

expansive integration of EMDR's origin myth further under the section EMDR Theme 1

in this chapter (pp. 351-367).

The epigraphs before each chapter also served the purpose of an origin myth by

suggesting that the information in the chapter falls in line with a tradition of a great

master. For example, Shapiro (2001) began Chapter 2, which explains Adaptive

Information Processing therapy, with an epigraph from Albert Einstein, " As far as the

laws of mathematics refer to reality, they are not certain; as far as they are certain, they

do not refer to reality" (p. 29). This epigraph appears to have been selected to prepare the

reader for Chapter 2, in which Shapiro makes the case that much of EMDR therapy defies

common sense and understanding (e.g., lifelong PTSD can be cured in three-sessions just

like a neurotransmitter crossing a synapse, and it's unclear why bi-lateral stimulation

works but it does).

Chapter 10, which introduces cognitive interweaves (i.e., similar to hypnotic

command suggestions) for challenging patients, began with the epigraph, "As you go the

way of life, you will see a great chasm. Jump. It is not as wide as you think.—From a

Native American initiation rite" (p. 249). It is notable that the particular person or even

tribe that this quote originally came from could not be located, and instead the statement

was ascribed to a seemingly homogenous ethnic group of Native Americans. It perhaps

goes without saying that not all Native American initiation rites are similar across tribes,

contexts and history; to attribute the quote to Native Americans so broadly is similar to

saying "From a Caucasian initiation rite." If this quote was from an unnamed white person it is likely that instead the quote would instead be attributed to "anonymous" rather than to an entire race or ethnic group.

The reason I make this comparison is to point how the epigraph uses Native American traditions in order to subtly align EMDR to a stereotype of this group. It suggests that making change in EMDR requires a leap of faith that is a part of ancient Native American wisdom and rites of passage. Furthermore, the use of this epigraph is somewhat ironic because Chapter 10 (which this epigraph precedes) actually describes what would be akin to the therapist pushing the patient off the chasm by introducing cognitive interweaves to ensure that therapy proceeds as expected (see further discussion of cognitive interweaves under Promotion of Doer-Done-to Relationships in this chapter, pp. 356-358).

The Native American initiation rite was not the only example of a type of cultural tokenism to legitimate EMDR therapy in the manual. Another decontextualized cultural epigraph was presented at the beginning of Chapter 9- Protocols and Procedures for Special Situations. It read, "You can outdistance that which is running after you, but you cannot outdistance that which is running inside you—African Proverb" (p. 221). Again, there is a huge amount of cultural and ethnic variation in the continent of Africa but the epigraph reduces this variation into generic stereotype. (Now, imagine if the epigraph read "North American Proverb.") I was not sure how the African proverb epigraph particularly related to the chapter on standardized therapy protocols, but it seemed to suggest that the battle of overcoming trauma is an internal one that every culture and nationality around the world faces—such as the entire continent of Africa.

Another epigraph that was taken out of cultural context to fuel EMDR's pan-cultural origin myth was a quote from Confucius in the introduction to the chapters on preparing the patient for EMDR (Chapter 5), "It doesn't matter how slowly you go as long as you don't stop" (p. 121). This quote suggests that EMDR follows in the Confucian tradition. The epigraph aligns with a taken for granted assumption about the healed trauma survivor in EMDR as a self-actualizing, enterprising being that can forget the past by moving forward; the quote suggests that we should go forward in life no matter what, but at one's own pace. The quote in context of Confucius's writing was probably not intended to be applied in the context of an EMDR manual as a reason that humans should use therapy to become functional. D. L. Hall and Ames (1987), Confucian scholars who have written about Western appropriation of Confucian thought, wrote, "An appropriate and adequate explication of the meaning of Confucius' thought requires a language of immanence grounded in the supposition that laws, rules, principles or norms have their source in the human, social contexts which they serve" (p. 14). In the EMDR manual there is no sense of Confucian thought or self; the quote is completely out of context and only serves as a reminder of an ancient tradition and idea that EMDR is somehow tapping into transcultural and timeless conceptualizations of healing.

The remaining epigraphs include quotations from Herbert Spencer (19th century biologist who coined the term "survival of the fittest"), Henry David Thoreau (19th century transcendentalist author who wrote *Walden*), Carl Rodgers (20th century American psychologist and founder of patient-centered, humanistic approach), Oliver Wendell Holmes (20th century Associate Justice of the U.S. Supreme Court and eugenicist), Steven Levine (20th century American poet informed by Theravada

Buddhism), Alexander Solzhenitsyn (20th century Russian novelist and critic of Soviet

totalitarianism), and Gregory Bateson (20th century anthropologist). The wide range of

backgrounds and contexts of each of these authors, along with the interdisciplinary

emphasis, again is part of the weaving of an origin myth for EMDR that suggests the

therapy is a cross-disciplinary solution to human suffering and part of a long-standing

universal tradition of healing.

In sum, the EMDR weaves an origin myth throughout the text to provide

legitimacy to the practice and theory of EMDR by presenting the therapy as supported by

principles that have existed for hundreds or even thousands of years. Origin myths appeal

to the patients' common sense and reliance on expert authority because they believe the

therapist is proposing a state-of-the-art scientific discovery that is the culmination of a

pan-cultural ancient healing tradition merged with years of research on neuroscience. To

accept the origin myth is to see EMDR as ahistorical and true regardless of the

sociopolitical context of its development.

One of the dangers of presenting EMDR practices as ahistorical truths, that I

present in more detail during the discussion for this section, is that it can be more difficult

for patients to resist and question these practices and the embedded prescriptive moral

and political messages contained within the myth (e.g., to be a good trauma survivor you

need to replace angry thoughts with positive thoughts and not take action in the social

world).

Location of pathology and healing in the dyad. The primary human relationship

described in the EMDR manual was between the therapist and patient. Though the

primary human relationship discussed in the manual located healing in the dyadic

relationship of therapist-patient, at times healing was proposed to be taking place

between the patient and his or her brain almost as a self-therapy. For example, the Luber

(2010) manual included a "blind to therapist" protocol in which the patient did not need

to talk to the therapist; the therapist's relation to the patient was essentially to provide bi-

lateral stimulation and the structure of therapy. In lieu of talking about the trauma, the

patient was to pick a cue word that had neutral value for the therapist to use when

directing the patient through the phases of therapy; the manual recommended cue words

like "lamp post" that may have a vague relationship to the memory but no descriptive

quality (Luber, 2010, p. 226).

In order to assess the progress of the therapy, the therapist was instructed to ask

the patient to report SUDs, therefore the content of therapy was proposed to primarily be

comprised of the patient undergoing bi-lateral stimulation while reporting quantitative

measures of distress to the therapist. While there is clearly a dyadic structure to healing in

EMDR, protocols like "blind to the therapist" and scripts about accessing the brain

almost frame the therapy as if the therapist is another resource or tool to activate the

natural healing process in the patient, rather than as another human in relationship to the

patient.

Overall, the relationship between therapist and patient was the primary healing

relationship mentioned in the manual and was often described in utilitarian terms. A

relational disconnect in the healing dyad was also described in the clinical case

presentation of an EMDR therapist (perhaps Shapiro) working with a Vietnam veteran

(Shapiro, 2001). In the case vignette, the veteran stopped the bi-lateral stimulation

suddenly and stated, "I just realized that this is the same anger that kept me alive in

Vietnam and let me do what I had to do. I'm afraid if we continue that I will hurt you" (p.

306). After considering options, the clinician:

> instructed the client to go to a nearby area that contained no people and to allow
> himself to feel the emotion and pound the ground while verbally expressing any
> thoughts that arose. The clinician instructed him to return when he felt ready.
> Approximately ½ hour later the client emerged with a face of happy wonder. He
> had found that he had not been overwhelmed by the emotion; instead, as he
> allowed himself to express it, it had subsided. The client said that he felt he would
> no longer be the victim of his emotion but, rather, its master. These thoughts were
> used as the positive cognitions in successive sets. (p. 306)

In this vignette, the patient was directed to go somewhere that "contained no

people" and express the anger alone, without the therapist present. When the patient

presented to the therapist stating he would master the emotions (and presumably not let

the emotions affect or hurt the therapist), the therapist accepted the patient back into the

room. The therapist then responded by asking the patient to think about mastering

emotions while providing bi-lateral stimulation. The case vignette concluded with how

the Vietnam veteran was no longer angry and when he did feel angry it "was easily

handled with self-control techniques" (p. 306).

This vignette characterized another aspect of the independent, instrumental, and at

times distant nature of the dyadic healing relationship in EMDR—patients ideally should

state they are willing to be independent from the clinician (and in this case leave the

therapy room when angry) in order to proceed through the therapy and not be considered

a victim. The veteran was only accepted back in the therapy room when he had convinced

the therapist he could master his emotions and not allow his emotions to affect the

therapist or anyone else. This vignette was presented as a victorious case of EMDR but to

me it exemplified the isolating process of healing and self-mastery that is promoted

within the dyadic relationship of therapist-patient in EMDR.

Over-reliance on forms, handouts, and PowerPoint in therapy. EMDR is
extremely reliant on the therapist reading from the manual protocol and filling in the
blanks on a worksheet or form in the room with the patient during the therapy. The
Shapiro (2001) manual and supplementary manuals included in this study each contained
protocols with scripts in which the clinician should write patient responses and monitor
positive and negative thoughts, SUDs, and VoC scores at each session. The Luber (2010)
supplementary manual contained over 35 different special scenario protocols (with over
350 pages of handouts and protocols). The Leeds (2009) supplementary manual
contained ten forms that should be completed as a part of standard EMDR therapy, in
addition to fidelity monitoring checklists for ensuring training EMDR clinicians are
adhering to the appropriate model in each standard phase of the treatment. The HAP
training manual included 18 pages of forms that should be completed as part of standard
EMDR therapy (Shapiro, 2010). The main Shapiro (2001) manual included six standard
forms with reference to the supplementary material for additional forms.

Table 3 includes a tasks column that lists how the therapists should be using
forms to essentially monitor the compliance of the patient during therapy. Over the
course of therapy the standard repertoire of forms that would be completed included:

1. Treatment goals and concerns;
2. Assessing stability and readiness for reprocessing;
3. Master treatment plan list of targets;
4. Record of treatment;
5. Basic or detailed level procedural steps and script for resource development and installation;
6. Trigger log;
7. EMDR reprocessing procedural steps script; and,
8. Session summary.

The majority of these forms would be completed by the clinician as they record what the patient says and does during the therapy. The tasks listed in Table 3 included: verify from log patient is helped by methods for self-control; record baseline measures for SUD and VoC; and, adjust treatment plan based on patient report from log.

In EMDR, logs and forms take precedence over other forms of self-reporting as if verification that the patient is indeed participating and improving in therapy is not considered valid unless monitored on paper and in scientific ways.

Directive psychoeducation and cognitivist thought-replacement. The goals of the first phase of EMDR were to obtain patient history, create the treatment plan with targets, assess pre-treatment symptoms of PTSD (or other related disorders), and ensure that the patient is an appropriate fit for treatment. Phase 2 (Preparation) was primarily composed of directive psychoeducation in which the patient was informed about what problem they have by using the language of EMDR theory (neurobiological trauma and Adaptive Information Processing Model) and how EMDR was designed to alleviate the problem. The psychoeducational scripts were designed to explain to the patient that their problems are due to a trauma being frozen in their brain in disparate neural networks and then explain how the brain can be activated with EMDR to naturally heal these networks. This is summarized in the script:

> When a trauma occurs it seems to get locked in the nervous system with the original picture, sounds, thoughts, and feelings. The eye movements we use in EMDR seem to unlock the nervous system and allow the brain to process the experience. That may be what is happening in REM or dream sleep—the eye movements may help to process the unconscious material. It is important to remember that it is your own brain that will be doing the healing and that you are the one in control. (Shapiro, 2010, p. 3)

I previously quoted similar orienting scripts in detail and explained the primary psychoeducation orientation to EMDR earlier in this section (pp. 303-304; 324-236).

What is important to note about EMDR psychoeducation is how the patient's presenting problem is reframed within EMDR theory, thus making EMDR treatment seem as a natural and obvious choice for healing and solving the problem.

Thought-replacement was primarily utilized in Phase 5 of EMDR (Installation). The aim of installation was to reprocess the target trauma (i.e., have the patient talk about the problematic memory during bi-lateral stimulation) while identifying post-traumatic negative cognitions and installing new positive beliefs or resources. The primary criteria for a negative cognition was that it "represent the client's current interpretation of the self" (p. 58) (e.g., I am bad, I am useless). In situations where it's ambiguous whether the patient has negative self-attributions as a result of the trauma, the EMDR protocol required that the therapist assist the patient in identifying negative self-attribution. For example, when the therapist asks about any negative post-traumatic cognitions, if the patient describes something situational or about another person the therapist should encourage the patient to frame this as a self-oriented cognition (i.e., in an "I statement"). The manual provided the example of a patient who suffered from parental abuse who stated the primary negative cognition she had was "Mother didn't love me." The manual acknowledged that while this may have been true it could not be the primary target thought for desensitization because "an abusive parent cannot be turned into a nurturing parent" (p. 60). Instead the resulting "self-attribution" of "There is something wrong with me" (p. 60) can be desensitized by following the EMDR protocol.

If the patient does not provide any negative cognitions that can be reframed as self-attributions, the manual suggests that,

> The clinician may offer such a client a list of alternative negative cognitions to help him understand the concept. … If a client has difficulty putting a negative

cognition into words, offer some examples that, in your clinical estimation, seem to be a good fit. As a rule of thumb, most negative cognitions seem to fall into three categories: (1) responsibility/defective ("I did or am something wrong"), (2) lack of safety, and (3) lack of control. (p. 60)

Table 4 includes selections from a handout Appendix (p. 434–440) in the Shapiro (2001) manual that was designed to be provided to the patients to help them pick a negative cognition, as if the patient were picking out correct answers for a test. What is particularly concerning about the example of the patient who has a real awareness of her mother as unloving is that the therapist directs the patient to replace this interpersonal awareness with an attack on the person, perhaps because only it can be addressed within the cognitivist model. Everything about the social world here (even within a limited scope of the dyad) is transformed into intrapsychic self-talk which cognitivist practices can address.[52]

Table 4

Selections From EMDR Handout on Positive Cognitions for Installation (Shapiro, 2001)

Negative Cognitions	Positive Cognitions
Responsibility	
I am shameful	I am honorable
I am a bad person	I am a good person
I am different	I am okay as I am
I deserve to be miserable	I deserve to be happy
I did something wrong	I learned from it
I should have known better	I do the best I can

---

[52] Cushman (personal communication, April 12, 2014) has referred to this as an example of a self-sealing doctrine and circularity in research (see also Cushman, 1989).

Safety/Vulnerability

I cannot trust anyone	I can choose whom to trust
I am in danger	It's over; I am safe now
I cannot let it out	I can choose to let it out

Control/Choices

I am weak	I am strong
I am not in control	I am now in control
I am helpless	I now have choices
I am a failure	I can succeed

Once the patient identified or was directed by the therapist to pick a self-focused negative cognition, the therapist then is able to replace this cognition by installing a positive one. The installation script read:

> Do the words [repeat the positive cognition] still fit, or is there another positive statement you feel would be more suitable?" "Think about the original incident and those words [selected positive cognition]. From 1, completely false, to 7, completely true, how true to they feel?" "Hold them together." Lead the client in an eye movement set. "On a scale of 1 to 7, how true does that [positive statement] feel to you now when you think of the original incident?" VOC: Measure the VOC after each set. Even if the client reports a 6 or a 7, do eye movement again to strengthen, and continue until validity no longer strengthens. Go on to the body scan. If the client reports a 6 or less, check appropriateness and address blocking belief (if necessary) with additional reprocessing. (Shapiro 2001, p. 432)

Installation occurs until the patient believes that the new positive thought is rated as a 7 on the VoC scale meaning the thought is completely true.

In addition to installing thoughts, the Shapiro (2001) manual discussed installation of other positive "resources." According to the manual, "Resources are normally developed through appropriate modeling by caregivers and authority figures, instruction in practical and moral precepts, stories and metaphors" (p. 436). Thus the

clinician is directed to model a surrogate caregiver and rebuild the appropriate

developmental resources. The Appendix (p. 434–440) provided examples of resources

that the patient may be interested in installing, which included:

- Mastery resources: "a physical stance or movement that evokes a functional affective state" (p. 435);

- Relational resources: memories of positive role models or supportive others; this is also described as a Social Connection Resource (SCR); and,

- Symbolic resources: memories from the natural world such as "the ocean, a rock, a tree, as well as religious, archetypal, totemic and transpersonal experiences" (p. 435); The manual notes symbols from dreams can also be installed.

Overall, in the installation and thought-replacement sections of the Shapiro (2001)

EMDR manual there was notable use of utilitarian (e.g., resource) and technology-based

(e.g., installation, processing) vocabulary, which gave the impression that the therapy is

scientific and mechanistic, and healing the patient can be similar to fixing or rebooting a

brain-based computer. The therapy also necessarily required that the patient understand

their problems as a self-focused failing (e.g., it's not that mother didn't love you, it's that

you were unlovable), in order for EMDR to heal the identity crisis and self-degradation

that occurred from this self-oriented way of understanding the problem. The circular

irony of the therapy, which I discuss further in EMDR Theme 1, is that EMDR

encouraged patients and therapists that did not understand their problems as internal, self-

oriented failings to pick negative self-attributions in order for the therapy to resolve them.

Exemplar discussion: Indoctrination into scientistic managed care. This

exemplar had four primary features: presentation of an origin myth, locating pathology

and healing within the dyad, overreliance on forms, hand-outs and PowerPoints, and

directive psychoeducation and cognitivist thought-replacement. Many of these features

are therapeutic techniques that shift therapy into a form of indoctrination into a world of

scientistic managed care that ignores social relationships outside of the dyad and values

compliance and control as a good way to be human. The techniques described in this

exemplar not limited to EMDR therapy or psychotherapy in general, which is why they

have been identified as part of an exemplar.

To indoctrinate the patients into the culture of managed care, EMDR utilized

origin myths in psychoeducational scripts and epigraphs to suggest to the patient and

therapist that the values and practices of EMDR have existed for centuries and are part of

an ancient tradition. Origin myths appeal to the patients' common sense and reliance on

expert authority because they believe the therapist is proposing a state-of-the-art

scientific discovery that is the culmination of a pan-cultural ancient healing tradition

merged with years of research on neuroscience. Because the psychoeducation is designed

to present problems that the therapy will cure, it indoctrinates the patient to want the

exact type of treatment that is offered by the therapist. This is why forms of resistance to

treatment are often met with more psychoeducation; the assumption being that if the

patient were to be presented with more knowledge, science, and explanation about their

problem they will better understand their problems as rooted intrapsychically and

resolved through therapy.

The techniques (i.e., origin myths, psychoeducation, location of healing in the

dyad, and handouts) are all ways that messages about how to be a good human are

communicated by therapists serving in the role of experts in contemporary society. What

is of concern about these practices is that is that they rely on subtle assumptions about the

patient, such as that the patient does not know what s/he has experienced and need to be

educated about his or her symptoms. The practices also rely on instrumental technologies, such as worksheets and forms with quantitative monitoring systems, which are difficult to become aware of and resist via therapy given their directive content, scientific presentation, yet non-assuming delivery format. The form becomes an extension of the clinical-gaze (cf. Foucault, 1975) and self-surveillance that is promoted in the manual where one should always be aware of and control one's thoughts. Like Foucault's (1995) description of the prison shifting to the asylum and then morphing into the clinic and now into self-help books, this type of self-surveillance is completed not because the patient is pressured or is forced to absorb the doctrine but because the form is associated with healing from trauma and being a good trauma survivor. The patients want to comply and control their thoughts because they are told and have come to believe through subtle messages in therapy and in daily life (e.g., neoliberal ideals) that that is what they should do to return to society as a functional worker and a good person.

EMDR Theme 1: The Grandiosity and Mania of EMDR

In this section, I present the first theme that I identified only for the EMDR manual and that I did not interpret for the other two manuals.

Thematic findings: The grandiosity and mania of EMDR. I was struck by a sense of grandiosity, narcissism, and mania throughout my reading of the Shapiro (2001) manual. I have separated this EMDR-specific thematic finding into four sub-themes: activating the innate perfectibility of humankind via therapy; the pursuit of moral entrepreneurship; promotion of doer-done-to relationships; and, the mania of an overly integrative origin myth.

Activating the innate perfectibility of humankind via therapy. Throughout the

manual there was a reoccurring emphasis on the perfectibility of humankind. This was

first mentioned in the preface to the book where Shapiro (2001) discussed being drawn to

authors and psychologists "who believed in the perfectibility of humankind" (p. xi). First,

the brain was presented as a self-perfecting entity that innately possessed the tools for

self-healing, positivity, and adaptation; these skills could be activated through therapy

and the patient could then be rid of maladaptive and dysfunctional behavior (e.g., "The

intention in EMDR is to stimulate the dysfunctional material, activate the processing

mechanism, and allow information to flow along is natural course to adaptive resolution

[p. 147]). Thus, when appropriately activated, the brain was assumed to be able to solve

problems and improve the functional capacity of the patient in such a way that their life

could be completely positive (e.g., subjective units of distress at a 0, negative cognitions

completely un-true, and positive cognitions about self-image completely true). The

emphasis on perfecting thought processes to ensure maximum functional capabilities and

positivity occurred throughout the manual.

For example, after the primary traumatic memories and dysfunctional thoughts

were replaced or desensitized in Phase 5, the manual recommended the patient and

therapist continue to install positive cognitions to not just eliminate the patient's

problems but to maximize their functional capacities:

> Since new and more adaptive positive cognitions are possible once the memories
> are processed, more adaptive actions can be envisioned by the client. The
> clinician should use EMDR to metabolize the dysfunctional material that drives
> the maladaptive behavior and to assist the client in imagining more life-enhancing
> responses and in formulating appropriate behaviors in his mind. (p. 214)

The impatience of the therapist when assisting the patient to develop

progressively adaptive thought patterns was also discussed in the manual. The manual

advised therapists in this situation to allow the incremental thought progression to occur

unimpeded despite "when the client's statements appear to have flaws in logic or

imperfect understanding" (p. 156). The implied message here was that the patient can and

should reach perfect understanding and completely eliminate dysfunction throughout the

therapy. The therapist was portrayed as a coach that should restrain against the desire to

push the patient to be perfect too quickly.

Therapists were also encouraged throughout the manual to access their inherent

perfectibility. At the end of the manual, Shapiro (2001) discussed the ideal therapist and

noted that "training alone does not ensure competency and this is especially true for

students or researchers who have not perfected their general clinical skills through

extensive practice and clinical experience" (p. 341). The taken for granted expectation

that this quote communicates is that the aim of EMDR therapists should be to attain

perfect technique and competency. For both patients and therapists alike, the message

communicated throughout the manual was that operating in a highly functional, adaptive

and trauma-free world can be achieved in time.

In addition to reaching a state of functional perfection, the aim of thought

replacement and installation in EMDR appeared to be to maintain the patient's cohesive

and all-positive self image—every negative self-assessment that was identified during

installation was replaced by a new positive "I statement." As mentioned previously (pp.

339- 341), when the patient shared a negative cognition that was not a self-depreciating I

statement, the clinician was instructed in the manual to reframe the patient's cognition to

be self-focused (e.g., "My mother didn't love me" would be changed to "I am

unlovable;" then "I am loveable" would be installed by the clinician). Thus the therapy

demanded that the patient pick-out and submit themselves to installation of first the negative and then the positive self-assessment statements even when the patient did not initially present with a damaged self image or conceptualize their problem as self-focused.

This self-focused thought replacement could be interpreted as a type of narcissistic projection on the part of the therapy. In other words, the EMDR manual required the therapist to insist that the patient repair a damaged self-image from an early traumatic experience even when the patient may not perceive their experience in this way. The healing described in the EMDR manual took the shape of narcissistic maintenance of self-image but to do this the patient had to be set up to believe they have a damaged self image in the first place. This is another example of the subjectivist reduction in cognitive ideology (cf. Sampson, 1981) where the therapy is designed to revolve around self-image and self-talk in order to be effective. In other words, altering internalized self-talk is the only good way to reduce traumatic symptoms and change a traumatic world according to the EMDR manual because the social world is considered to exist primarily as an internal, mental map that can be controlled and manipulated via the individual.

The pursuit of moral entrepreneurship. The EMDR Humanitarian Assistance Program (HAP) institute founded by Shapiro in 1995 offers therapy to trauma survivors and pro-bono trainings in EMDR to local clinicians after disaster and the organization has conducted trainings in over 40 countries. The manual stated, "HAP therapists travel to inner-city agencies [in the U.S.], war-torn regions, disaster sites and developing nations, offering free and low-cost training to local mental health professionals" (p. 452).

Nickolas Rose (2006) has labeled the international spread of Western anxiety disorders and PTSD as partially due to a phenomenon of "moral entrepreneurship" (i.e., mental health problems are seen by American practitioners as a neglected source of misery only they can identify and conquer through the use of Western psychotherapy). He described an evangelical quality of psychiatrists who are excited by their capacity to treat or even cure disorders. To do so, the healers first must convince the public of the gravity of the problem to which their treatment is the solution; this also takes the shape of therapists marketing and selling the problem and solution to different vulnerable groups. Rose suggested that many of the technologies of anxiety prevention (that well-meaning doctors who are interested in saving the world utilize) are often created with funding from or proposed by pharmaceutical companies. Thus, what begins as a moral imperative to help and heal is transformed into an economy of healing and marketing proprietary treatments.

In the case of EMDR, even though HAP is a non-profit agency, it appeared that there was some direct profit to be made from its global dissemination. The cost of in-person trainings and continued education in EMDR treatment, beyond buying the Shapiro (2010) manual and attending the basic training provided by HAP can be upwards of $3000 per clinician (see Table 2). Thus, it could be argued that there is a proprietary benefit to spreading EMDR worldwide. Despite this potential for profit, it also appears as if HAP was also created from an evangelical interest in spreading the treatment as a particular form of eliminating trauma and suffering from the world. This is reflected in the origin myth presented in the preface of the manual, which suggested that EMDR was positioned to solve world suffering and be a great scientific discovery.

From a psychoanalytic perspective, part of the moral entrepreneurship of EMDR in reducing trauma could be interpreted as a narcissistic masochistic act to bring constancy to the therapists representation of self (for further discussion see Chapter 2, Narcissism as self-maintenance in the 20th century, pp. 109-114 in this study). It perhaps goes without saying that it is not desirable for most people to repeatedly, sometimes for 40 or more hours a week, to listen to stories of trauma, violence and suffering. People who are attracted to trauma therapies in particular (i.e., identify as a trauma therapist) may feel a great sense of reward and honor when hearing horrific accounts. It is possible that self-proclaimed trauma therapists may feel empty or lost in our contemporary culture (cf. empty self; Cushman, 1995) or perhaps have come to identify with a sense of victimhood, that the pain of repeatedly hearing traumatic stories from their patients may make the therapist actually feel more connected, real and alive. This sense of subjecting oneself to repeated pain to feel continuity has been described by Stolorow (1975) as part of a masochistic narcissistic defense that stems from a desire to be in control of and avoid possibly unpredictable pain of being in reciprocal and intimate relationships. The therapists desire to bring wide-scale humanitarian aide through mass training programs like HAP could reflect a narcissistic desire to find a mirror or sense of constant identity by responding to all suffering in a pre-formulated way (i.e., through EMDR), no matter what the culture or gravity of the trauma. Furthermore, the therapy is designed to suggest that all traumatic problems in the world can be easily fixed and that the therapist can control or even eradicate complex social and political suffering through three sessions of therapy. Thus, the therapists may also gain a sense of reassurance or, in extreme cases, a sense of omnipotent power to heal what are often complex social and political problems

by defining them as flaws in the self that can be fixed simply with EMDR and by the therapist. In these scenarios, the altruism of healing can become narcissistic and colonial when humanitarian projects are used for self-betterment.[53]

Promotion of doer-done-to relationships. Jessica Benjamin (1988, 2004) described psychic experience in psychoanalytic theories like object relations as a one-way street where one person is the subject (the doer) and the other is the object (the done to). This subject-object relationship was structured into the EMDR therapy in an instrumental and utilitarian way such that the patient was almost described as behaving like a passive vessel (cf. empty self; Cushman, 1995) that consumes, or in this case is subject to "installation" of positive objects from the therapist. In addition to the installation of positive resources, the EMDR therapist periodically engages in cognitive interweaves which Shapiro (2001) described as originating from a form of hypnotic command suggestion (p. 249). I interpreted interweaves as a prime example of the doer-done-to relationship promoted by the manual and have described them in detail here.

Cognitive interweaves were presented in Chapter 10 of Shapiro's (2001) manual as "a proactive strategy for working with challenging clients" (p. 249) that called for "the clinician to offer statements that therapeutically weave together the appropriate neuro networks and associations" (p. 249). In other words, interweaves were recommended to be used when the patient's processing is not going in the way the therapist expects or deems appropriate. The objective of interweaves, according to the manual usage, was, "to

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[53] Anecdotally, during my training in graduate school I encountered many narcissistically masochistic therapists who, to the detriment of their lives and relationships, worked overtime at their trauma focused clinic jobs. They appeared to enjoy discussing the suffering they witnessed, the amount of overtime they worked for no compensation, and seemed to look forward to solving the next big crises to come through the treatment center. See further discussion in Chapter IV: Foregrounding, in this study.

help clients (1) recognize and attribute appropriate responsibility and (2) discard the guilt

and self-blame that have undercut their sense of self-esteem and self-efficacy" (p. 253).

During an interweave, suggestions or questions are inserted during the bi-lateral

stimulation reprocessing phase to ensure the client follows the expected course of therapy

(e.g., participates openly in the installation procedures). An example of an interweave

was asking ,"Whose responsibility was it?" (p. 253) during a trauma narrative of child

abuse. Other examples of interweaves included, "Whose responsibility was it that you

learned not to be able to express anger?" (p. 254); and, "What happens if you think the

words, "It's over, I'm safe now" (p. 257). The manual noted that when a clinician

interjects an interweave during processing, "The client does not have to embrace the

statement wholeheartedly at first. Simply attending to the suggestion allows the adaptive

information already inherent in her memory system to be stimulated" (p. 257).

The manual included the following scenarios as reasons to initiate interweaves:

- Looping: "Even after successive sets the client remains at a high level of disturbance with repetitive negative thoughts, affect, and imagery" (p. 249);

- Insufficient information: "The client's educational level or life experiences have not given him the appropriate data to progress cognitively or behaviorally" (p. 250);

- Lack of generalization: "The client has achieved a more positive emotional plateau or cognition with respect to one target, but processing does not generalize to ancillary targets" (p. 249); and,

- Time pressures: The client fails to process an abreaction or negative thought sufficiently and there is not enough time left in the session for the client to do so.

Many of the situations described above suggest that the patient's intrinsic healing

capabilities were somehow faulty during the normal EMDR process and thus a more

directive intervention was necessary. While the above problems seemed to be considered

issues of patient non-compliance or resistance, they could also be understood as failures of the therapy—instances where the seemingly universal principles of Adaptive Information Processing did not work.

Overall, interweaves created a relationship between the EMDR therapist and patient where the patient was assumed to be the narcissistic object of cultural perfection. The heavy-handed interventions (literally) in response to patient resistance or non-compliance prevented alternative ways of thinking about and acting in response to trauma; they emphasized adherence and efficiency rather than contextual, creative and critical thought.

The mania of an overly integrative origin myth. The origin myth of EMDR was described earlier in this chapter (p. 255–261), where I focused on the use of this myth to naturalize and legitimate the treatment as a form of meaningful change. Here I have focused on the interpretation of the origin myth as compulsive in its over-inclusivity most approaches to psychotherapy. The mania was not only present in historical span of the inclusion (most all theories of psychology since the 1800s) but also in the massive amount of detailed text that was provided in the manual to rationalize the EMDR origin myth. One only need to peer at the table of contents to get a sense for the breadth and detail included but I estimated that at least 100 pages of the 450 page manual were devoted to expounding upon the origin myth of EMDR and its integrated nature.

For example, the first chapter of the manual includes a sub-section called "theoretical convergence" which systematically lists psychodynamic, behavioral, and cognitive-behavioral approaches and how they both contribute and culminate in the creation of EMDR (pp. 20-27). The last half of the manual (pp. 315-357) was devoted to

research on EMDR which included sections with titles such as "The Comparison of

EMDR and Other PTSD treatments;" "Hypothesis Regarding the Etiological Nature of

Memories;" "Hypothesis Regarding Orienting Response Mechanism;" "Hypothesis

Regarding Bi-lateral Stimulation Mechanism;" "Hypothesis Regarding the Distractive

Level of Stimuli;" and, "Hypothesis Regarding Free Association Summary of

Recommendations for Component" (pp. 356–377). Each of these sections connected a

wide range of diverse theories and research to support the utilization of EMDR and the

Adaptive Information Processing model that Shapiro (2001) called a "paradigm" (pp. 13;

16). The use of the word paradigm to describe this theory I found quite grandiose as it is

often associated with Thomas Kuhn's (2012) *Structure of Scientific Revolutions* and has

come to mean a revolution in science. To refer to Adaptive Information Processing as a

paradigm or initiating a paradigm shift somehow suggests that it is not only uniquely

distinct from other cognitive information processing models but that the particular theory

behind EMDR has actually revolutionized science.

    Additional manic findings in EMDR. One additional finding was the mania of

bi-lateral stimulation as a central activity of therapy. The manual instructs the therapist to

repeatedly and obsessively wave his/her fingers in front of the patients face in multiple

sets of over 20 repetitions over the course of the therapy session. The trust in the

compulsive motions of the therapist was represented in the manual's first session bi-

lateral stimulation script, which instructed the therapist to say, "I will ask you to

mentally focus on the target and to follow my fingers. Just let whatever happens, happen"

(Luber, 2010, p. 240).

The manual's description of bi-lateral stimulation seemed almost symbolic or ritualized (e.g., bi-lateral stimulation increases as the patient repeats positive thoughts). This repetitive motion constitutes such an active therapy that clinicians actually suffer from shoulder injuries if they do not supplement their therapy with technologies like light-bars and tappers (see neurotek.com). No other therapy that I am aware of involves such frantic repetitive motion on the part of the therapist. (Even the debunked rebirthing therapies, which are quite active on the part of the clinician, do not suggest a type of movement that is as compulsive and repetitive.)

One could imagine how the heightened level of activity to the therapy session would pull for different transference from patients (e.g., need to care take the clinician as they work or annoyance at the intrusive presence of the clinician).[54] Yet, this effect of the therapy is not considered. In fact, there seems to be no examination of the effect of bi-lateral stimulation on the client from a perspective of transference and demand characteristics. It is possible these influences could profoundly affect how the client complies with the therapy and interprets their treatment.

Thematic discussion: The grandiosity and mania of EMDR. Emphasis on narcissistic self-perfection permeated the Shapiro (2001) manual. There was extensive and detailed background and research provided in the manual linked detailed research and history from most psychotherapeutic theories to the evolution of EMDR and the

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[54] Though this analysis does not include interpretation of therapy sessions, I will say from my own experiences of training in EMDR, it was quite disconcerting at times to be repeating a sensitive childhood memory and look past the moving hands and over to the clinician who is sitting straight-up, watching your face, and sweating as they engage in the bi-lateral stimulation (see Chapter 4: Foregrounding). My experience was similar to the ritual described in the manual—when the clinician stopped waving her fingers, she then checked in on a set of measurements (SUDs, VoCs, new thoughts) and repeated.

Adaptive Information Processing model. The manual's psychoeducational scripts on how to activate the innate positive healing in the brain and the natural perfection of humankind did not seem to allow for patient or therapist exploration or mistakes; there was not much room in the therapy for a way-of-being that involved acceptance of negative affects, taking responsibility for traumatic participation, and perhaps redirecting or creatively engaging with trauma rather than eliminating it. Similarly, when the therapy didn't work (e.g., when the patient began looping or the positive thought didn't generalize), this was framed as an issue of non-compliance. The therapist was directed by the manual to perform interweaves (i.e., hypnotic command suggestions) to ensure the patient would be symptom free by the end of a session.

The manual required that the therapist insisted that the patient repair a damaged self-image from an early traumatic experience even when the patient did perceive their experience in this way. This was first demonstrated in the manual in the presentation of the vignette of a woman who became nervous every time she walked into a business meeting. She was seen as suffering from the negative I statement, "I can't get what I want; there is something wrong with me" (p. 45- 46). Instead discussing social or political interpretations of her experience (e.g., What are the factors in the corporate environment that do not allow for or accept women's voices and how can we talk about this?), the patient's behavior was narcissistically viewed as a product of her own dysfunctional behaviors and negative self talk. This theme reoccurred with the patient who stated that her mother didn't love her, and the therapist insisted that the patient reframe this belief into "I am not loveable." (p. 60).

In these vignettes, the patient could have understood their problems as stemming from an interpersonal, social or politically rooted source but they were directed by the therapist to reframe their conceptualization into an intrapsychic wound in the form of a negative "I statement." The vignettes present examples of the subjectivist reduction in cognitive ideology (cf. Sampson, 1981) where the therapy is designed to revolve around self-image in order to be effective. Altering internalized self-talk is the only good way to reduce traumatic symptoms and change a traumatic world according to the EMDR manual because the social world is considered to exist primarily as an internal, mental map that can be controlled and manipulated via the individual. This is a narcissistic way to understand the world because it is hyper-focused self-image management and the grandiose, if not delusional, idea that the individual can completely control and alter the world from their mind without necessarily interacting in the social world or with others.

The most concerning part of the therapy was not only its subjectivist reduction that promoted narcissistic way of being, but that the therapy encouraged the patients who did not naturally understand their world as self-focused to become narcissistically wounded and adopt beliefs that problems in the world were due to negative self-images by picking negative cognition "I statements" from a list in the manual appendix. In these scenarios, the manualized therapy has a hand in creating the pathology in order to heal it. This appears to be a narcissistic projection of the therapy—it demands the patient conform to a particular way of being (i.e., self-focused) to ensure the therapy will work appropriately; all beliefs and symptoms that do not fall within this narcissistic world view are seen as problematic, pathological and deserving of more forceful interventions like cognitive interweaves to actually "install" the negative self-talk via hypnotic suggestion.

McWilliams and Leppendorf (1990) have described the experience of being in a prolonged or enmeshed relationship with a narcissist (i.e., being the narcissistic object) as pervasive confusion, self-criticism, loneliness, and diffuse irritation. During the interpretation of the EMDR manual, I felt somewhat similar to the experience of a being in a narcissistic relationship like McWilliams and Leppendorf described; I felt largely confused and irritated while reading. I also was somewhat exhausted by the mania of the manual and extensive and dense descriptions of how the Adaptive Information Processing model was related to all other psychotherapy theories. While I am in general against increasing procedural aspects of therapy and reducing complexity in the therapeutic approach, in this case I could understand why so many authors have developed adjunctive forms and protocols to make the manual less overwhelming, grandiose and compulsive—-as well as practical and easy to apply. From my perspective, Shapiro's (2001) manual demanded a lot of the reader, the therapist, and the patient. It gave the sense to the training therapist that though one might not ever be able to fully grasp why EMDR works (given the mysteries of neuroscience and brain-based therapies), with dedicated study (and attendance of $3000 worth of therapy training) one could help patients attain perfect replacement of thoughts and eventually complete autonomy and freedom from the complexities and suffering that have become so common place in the social world.[55]

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[55] Though I didn't initially interpret the EMDR manual according to literature on cult indoctrination (see Specific Background Information Relevant to Results, pp. 116-124), Heller's (1988) triad of miracle, mystery, and authority could be applied to an analysis of the EMDR manual (e.g., the miracle of the EMDR therapy healing complex trauma across the world, the mystery of bi-lateral stimulation and necessity of advanced trainings to learn special protocols to treat disorders, and the authority of the therapist requiring I-statement thought-replacement and inserting beliefs via cognitive interweaves). I return

Though I was struck by a sense of the author's grandiosity when I studied the manual, I did not interpret the manual or its author, as uniquely emanating a form of personal pathology. Rather the manual reflects and reproduces the social world in which it was it was created. Shapiro developed EMDR in reaction to her diagnosis of cancer; this type of response to a life-threatening disease could only occur in a world in which it was seen as possible to save oneself through psychology and where it was possible for an individual to believe they could bring psychological healing to the masses via manual-based technologies. While the manual may reflect the personality dynamics of Shapiro, the popularity of EMDR and the way that it seems to speak the experience of traumatized individuals could only exist in culture that identifies with and accepts the narcissistic cultural ideals promoted in the manual.

Cushman, McWilliams and Leppendorf, and others have described the post-World War II era and especially the early 1980s, when the EMDR manual was developed, as a time of cultural narcissism (see review in Chapter II, pp. 109-114 in this study). Around the time EMDR was created, analysts had high enthusiasm for Kohut (1971, 2009, 1984) and there was an emphasis on describing narcissistic persons as being obsessed with self-image maintenance (e.g., Stolorow, 1975). Cushman (1995) suggested that the loss of tradition, religious certainty, and the effects of industrialization and spread of capitalist business post World-War II created a sense of vulnerability, alienation, and uncertainty that foreshadowed the societal embodiment of what he called the "empty self." The empty self experiences absences in the loss of community and tradition in an interior and cognitive way, as a lack of personal worth or conviction, and strives to

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to the interpretation of trauma therapies broadly contributing to the creation of a warrior cult in the Paradigmatic Objects chapter.

compensate for what has been lost politically by consuming products, goods, advertising and therapy. The social embodiment of the empty self is somewhat similar to descriptions of a narcissistic personality in the overwhelming need to maintain self-cohesion and worth through utilizing and consuming things and relationships. Thus I would argue that the EMDR manual ultimately embodies (and continues to support) the zeitgeist of the 1980s and early 1990s when the treatment was developed. EMDR was designed to thrive in a narcissistic culture and I would suggest has actually contributed to reproducing the culture and in particular, the idea that it is acceptable to respond to social problems through self-work.

Engaging in EMDR therapy might likely be experienced as aspirational where one hopes to emulate the perfection in the manual, but also as isolating and confusing when daily experiences demand continual replacement and erasure of suffering via cognitive processing. For the patients who attempt but cannot attain the image of human perfection that is taken for granted as the hope for the healed trauma patient after EMDR (i.e., the positive, entrepreneurial and functional worker), they perhaps remain traumatized in a liminal state of having implicitly failed therapy. They may be perpetually drawn to the instrumental and narcissistic therapeutic relationship promoted by manualized therapies like EMDR (i.e., searching for the right fix or someone who understands trauma). They may also feel defeated and afraid when attempting to think about the daily experience of being alone in the world with the narcissistic culture and therapeutic options with which they are provided.

Layton (2004, 2010) has described the experience of living in neoliberal culture in a similar way. She wrote:

When dependence and interdependence are repudiated and made shameful as they have been in the neoliberal U.S.–-where the attack on the poor and vulnerable continues unabated, where social politics tear away at the containment and care offered by the welfare state, and where income inequality is at or close to historic highs- you find the characteristic narcissistic defenses against trauma: retaliation and withdrawal, oscillations between grandiosity and self-depreciation, devaluation and idealization, denials of difference and the rigid drawing of boundaries between who is "in" and who is "out." (Layton, 2013, p. 77)

In sum, the EMDR manual reflects a way of being in trauma culture; it reflects an expression of cultural grandiosity or narcissism in a time of political uncertainty and social isolation in which resources and shifts in thinking are mistaken for human relationships and social engagement. The Shapiro (2001) manual not only reflects this way of being but it reproduces it by requiring patients to conceptualize their problems as intrapsychic such that the primary focus of therapy necessarily is on assisting the patient to build a positive self-image. What is particularly concerning about the narcissistic focus on self-image maintenance is that the therapy actually plays a hand in destroying the self-image first in order to repair it. The EMDR manual promotes a type of therapy that dangerously creates a false sense of self-actualization and problem resolution that is completely removed from the context of the patient's life, political action and actual problem resolution.

EMDR Remaining Questions

In addition to the hermeneutic interpretive categories outlined by Leonard (1993) and others, I have added the category of question generation. Some questions that were raised through the interpretation of the EMDR manual were unanswered by the text, the interpreter (myself), and the immediate context (e.g., foregrounded assumptions). The unanswered questions may be indicative of what Donnel Stern (2010) described as an unformulated experience, where the answer is dissociated (and thus seemingly

unanswerable). Answers to such questions may be first accessible only through enactment and unconscious practice. Here I discuss the importance and context for each question following reconstruction (Stigliano, 1989).

Why is EMDR so popular and why does it work so well right now? EMDR is extremely effective and has been shown to cure lifetime PTSD symptoms within three sessions. The fact that this therapy works so well tells us less about the timeless intrinsic healing properties of EMDR and more about contemporary society. I was left a few primary questions after this study: Why does EMDR work so well right now? What does it say about U.S. culture that brief EMDR therapy is incredibly effective at curing trauma in this historical moment? What does this say about human being in trauma culture?

EMDR's effectiveness today suggests something about the constitution of the contemporary self (cf. Cushman, 1995). After my presentation of the EMDR findings, I discussed a range of theories about the appeal of the therapy in neoliberal, narcissistic culture. I think there is something to be said about EMDR fulfilling the unarticulated desires of living in trauma-culture: to be seen as helpless and freed from the responsibilities of living in society, including the complexities of interpersonal and political relationships, but also somehow more real, authentic and unique because the trauma. The fantasy promoted by the therapy is that trauma survivors can accrue and consume mental resources to maximize their happiness via therapy *(*cf. Binkley, 2011). Any upsetting experiences or traumas do not need to be thought about or discussed, but merely erased or desensitized over three one hour sessions. Though the trauma is in effect erased or lost, it was conceptualized in EMDR as being transformed into a resource for future growth. EMDR seems to embody the ultimate trauma fantasy of the 21st century:

to quickly return to a pre-traumatic state as a functional worker within a few quick sessions while also being able to retain a form of unique positive identity and spiritual or mental fortification through trauma. Furthermore, the healed trauma survivor represents a narcissistically fulfilled life that is completely unencumbered by dependence on or attachments to the real world and social relationships; anything that impedes the healed trauma survivor from reaching their goals must only be desensitized or replaced in within the individual mind.

Summary of EMDR: Basic Principles, Protocols, and Procedures (Shapiro, 2001)

The specific themes from the manual suggest that all forms of suffering are experienced in a universal way (stored as a fixed particle in the brain) and thus can be healed through a procedural psychological treatment that directly accesses and manipulates neural networks. The utilization of the over-inclusive origin myth and watering hole metaphor suggested that contemporary responses to trauma responses are natural, innate, pre-programmed, and as old as humanity. This discourse subtly reduces all traumatic experiences to a rote or triggered response that lacks unique qualities (every trauma is a lion or a trigger) and can be eliminated through similar protocols of EMDR. Thus EMDR was discussed in manual as the universal treatment or solution to world trauma.

Human being in trauma-based society according to this manual is managing, negotiating with, and sometimes thanking your adaptive information-processing computer: your brain. The model promoted in the manual extends the Cartesian split to a space where the self and mind can manipulate the brain but the brain is primarily in control of the self. While the therapy encourages the patient to directly engage the brain,

it also acknowledges that EMDR therapy can access the brain and connect neural networks in an unconscious way that at times is not well understood (e.g., bi-lateral stimulation) given the nature of science (cf. mystery; Heller, 1988).

The self in EMDR reflects the critique of cognitivist ideology that Sampson (1981) developed, and revealed the emerging contemporary way-of-being which N. S. Rose (2007) described as managing the neurochemical self. Being in trauma-based society according to the EMDR manual can mean submitting oneself or rather one's brain to the direct control of the therapist, and the therapist (in parallel process) submits to the guidelines of the manual; sometimes both patient and therapist engage together by complying with a form or protocol. These procedures guide the patient in becoming an agentic, self-contained individual.

I also discussed how completing never-ending forms, worksheets, homework assignments, and protocols in EMDR constitute the tools of a type of self-surveillance that is complied with not because the therapist and patient are brutally pressured to watch over and reveal themselves. Instead, these forms and activities are complied with diligently because they are presented as the scientific interventions that unquestioningly heal trauma, and when followed create a successful trauma therapist and survivor. Patients want to comply and control their thoughts because they are told and have come to believe through subtle messages in therapy and in daily life (e.g., neoliberal ideals) that that is what they should do in order to return to society as a functional worker and a good person.

The fantasy promoted by the EMDR manual is that trauma survivors can accrue and consume mental resources to maximize their happiness via therapy (cf. Binkley,

2011). Throughout the manual all life experiences were transformed into what Heidegger (1977) called "standing reserve." Friends are turned into SRCs and the real world is replaced (or rather "installed" or "resourced in") with positive images and safe places. The healed trauma survivor according to the manual should be a hyper-functional person who embodies the Oliver Wendell Holmes epigraph quoted in the manual—a person who is moving forward, independent from all persons and traditions and freed to make infinite positive choices in their world. Any upsetting experiences or traumas do not need to be thought about or discussed, but merely erased or desensitized over three one hour sessions. Though the trauma is erased or desensitized via therapy, it was conceptualized as being transformed into a resource for future growth.

The popularity of EMDR and the way that it seems to speak the experience of traumatized individuals could only exist in culture that identifies with and accepts the narcissistic cultural ideals promoted in the manual. I found there to be a feeling of constant demand for perfection from both the patient and therapist in the manual. I also found there to be excessive, narcissistic focus on self-image maintenance and solving social problems through creating, manipulating and eventually erasing negative self-statements. Being a good trauma survivor in EMDR meant initially presenting to therapy as a broken or damaged self (i.e., having a narcissistic wound from childhood). If this was not how the patient presented, a good trauma survivor would be being willing to accept the therapist's help in reframing the world as a problem with self image or even assistance in destroying the self-image (e.g., picking a negative "I statement" cognition from an appendix) in order to repair the self image and heal from trauma.

Thus the EMDR manual promotes a type of therapy that dangerously creates a false sense of self-actualization and problem resolution that is completely removed from the context of the patient's life, political action and actual problem resolution. It indoctrinates the patient into particular a way of being a healed trauma survivor. In this way of being, a good trauma survivor submits to sometimes mysterious procedures in therapy (e.g., bi-lateral stimulation, cognitive interweaves) and reconstructs one's self image through the process of completing forms, and replacing thoughts. These procedures substitute for meaningful social interaction, change, or dialogue that is politically rather than self-focused.

Manual 3: Battlemind Psychological Debriefing and Training

(Adler et al., 2007).

In this chapter, I present the results and discussion for the Battlemind psychological debriefing and training series (Battlemind). After presenting the specific context of this manual's development, I introduce the shared themes and exemplars that were found in all three manuals (TF-CBT, EMDR and Battlemind). After presenting the shared themes and exemplars, I then introduce the themes and exemplars that I identified only within the Battlemind series. Before proceeding to the next manual, I propose and briefly discuss questions that may be unanswered by the text, the interpreter (myself), and the immediate context (e.g., foregrounded assumptions) but are important to consider. Thus the structure of this chapter is as follows: shared themes (findings followed by discussion), shared exemplars (findings followed by discussion), Battlemind unique themes (findings followed by discussion), Battlemind unique exemplars (findings followed by discussion), Battlemind questions (questions followed by discussion), and summary. Following the presentation of each manual, I include a final summary and discussion in which I consider all of the manuals together in light of the areas of inquiry (p. 131).

Battlemind had a complex structure and also utilized military jargon that may be unfamiliar to a psychology audience. Thus, before presenting the interpretation, it is important explain some of the terminology that will be used in this chapter and how I refer to different aspects of Battlemind.

The primary manual (Adler et al., 2007) and subsequent publications describing training efficacy (Adler, Bliese, et al., 2009; Adler, Castro, et al., 2009; Castro et al.,

2006) characterized Battlemind as an early mental health intervention for post-traumatic stress disorder and other trauma related problems; however, the Battlemind training scripts described Battlemind as a training or debriefing series and not as psychotherapy or a mental health intervention. Therefore, in this chapter, I refer to the Battlemind training and debriefing series as Battlemind, the Battlemind series, trainings, or debriefings. Throughout Battlemind, the military service members were referred to as soldiers or warriors; all of the solider trainings were referred to as warrior trainings. The Battlemind trainers for the warrior trainings were the soldiers' platoon leaders. Therefore when I refer to trainer's script for the warrior trainings this is in reference to the script that will be read to the platoon by their leader.

The phases of Battlemind are represented in Figure 4 and are explained in detail under the Treatment Goals, Structures and Principles Section in this chapter (p. 378). Adler et al. (2007) was the primary training manual for Battlemind; it described the structure of the trainings, discussed background research, and provided scripts that trainers should utilize for the debriefing phase. There were also several trainer scripts and PowerPoint presentations that were treated as the manuals for the pre- and post-deployment trainings of Battlemind. These included: the leaders pre-deployment training (WRAIR, 2008a), the warrior pre-deployment training (WRAIR, 2008b), the warriors' post-deployment training I (WRAIR, 2006a) and II (WRAIR, 2006b), and the post-deployment assessment training (WRAIR, 2006c). Some of the training scripts were published before the primary manual in 2006. All of the training scripts and presentations were interpreted in this study in addition to the primary manual.

Context of the Manual's Development

The Battlemind debriefing and training series was created as an early intervention for PTSD, depression and sleep problems in U.S. and United Kingdom (U.K.) service members returning from Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND), which are commonly referred to as the War in Afghanistan and Iraq. The Battlemind series was developed at the Walter Reed Army Institute of Research (WRAIR) in 2007 and was instituted in the U.S. Army Combat Operational Stress Control course from 2007 to 2013 as part of required pre-deployment Comprehensive Solider Fitness Training (Adler, Castro, et al., 2009). As a part of the National Defense Authorization Act, all U.S. Army service members were required to attend all phases of the Battlemind series and then complete a routine mental health assessment (DoD, 2009). In 2013, Battlemind was replaced by a resiliency training series (Reivich, Seligman, & McBride, 2011).

The content for the Battlemind training series was developed based on the Land Combat Study, which included over 5000 surveys and interviews with service members who deployed to OEF/OIF (Hoge et al., 2004; WRAIR, 2006c). Battlemind's effectiveness was assessed in a natural setting randomized study (Adler, Bliese, et al., 2009). Service members returning from Iraq were randomized by platoon to receive the complete Battlemind series (represented in Figure 4), standard post-deployment stress education, or a small or large group Battlemind skills training (without in theatre debriefing) (Adler, Bliese, et al., 2009). Groups receiving any component of Battlemind in any size group reported significantly fewer symptoms of post-traumatic stress, depression and sleep problems than those who received standard post-deployment stress

education (Adler, Bliese, et al., 2009). The symptom reduction occurred regardless of level of combat exposure.

Pre-Deployment Skills Training (Warriors, Leaders, Spouses)

- 1-2 hour workshop separate trainings for Leaders, Warriors (with platoon), Spouses; Leaders train their platoon after their training

In-Theatre Debriefing (Warriors, Leaders)

- Debriefing led by mental health staff
- Time or event-driven for Leaders and Warriors (with platoon or small group)

Immediate Post-Deployment Stress Education I (Warriors, Spouses)

- 1-2 hour workshop with platoon + small group debriefing
- Spouses have separate 1-2 hour workshop

3 to 6 months Post-Deployment Stress Education II (Warriors)

- 1-2 hour workshop for Warriors only
- Final required mental health assessment for all who deployed (DD Form 2900)

Figure 4: Battlemind training series (Adler et al., 2007; WRAIR, 2005, 2006a, 2006b, 2006c, 2008a, 2008b).

Demographics of treatment population. In 2007, when Battlemind was initiated 494,465 soldiers were deployed on active duty for the Army (Tanielian & Jaycox, 2008). Based on this rate, it can be estimated that from 2007 to 2013, when Battlemind was required for all Army forces, over 3 million recruits received Battlemind training. The average age of the trainee soldiers can be estimated from Army enrollment figures which indicate that 50.6% of active duty enlisted soldiers were under the age of 24 years old (with 6.7% under the age of 20) and 95% were under the age of 40 during the years Battlemind was implemented (Fischer, 2014). Thus half of soldiers to receive Battlemind trainings it can be assumed were between 16 and 24 years old and the other half were between 24 and 40 years old. In the first study of Battlemind effectiveness in the Army, the soldiers who received the Battlemind series (N = 1,146) were primarily male (95.8%), single (67%), junior enlisted officers (66.2%) who were in combat arms (77.6%) (Castro et al., 2006).

It is unclear what the rates of PTSD were for veterans during the years Battlemind was instituted because longitudinal studies spanning from 2007 to 2013 have not yet been published. During OEF in Afghanistan and OIF in Iraq, 21.8% of nearly 300,000 OEF/OIF veterans who first received care at a VA between 2002 and 2008 were diagnosed with PTSD (Gates et al., 2012). Other studies on OEF/OIF post-deployment have revealed rates of PTSD prevalence from 4 to 33% with the average around 15% (Gates et al., 2012). Further details regarding rates of PTSD for the population of soldiers who deployed to OEF/OIF were reported in the "PTSD Prevalence in the Military" section of this study (pp. 33-35).

Context of the authors. Although the Battlemind series was developed in 2007, the phrase "Battlemind" was coined by General Crosbie Saint when he was the Commanding General of the U.S. Army Europe in the 1980s (WRAIR, 2006c). General Saint prepared his guidelines with the help of Dr. Halim Ozkaptan from the Army Institute for Behavioral and Social Sciences and retired combat veteran, Colonel Robert Fiero. The trio has since published several books together about healing post-war injuries (e.g., Ozkaptan, Fiero, & Saint, 2007) and Dr. Ozkaptan has published a manual on faith-based healing (Ozkaptan, 2008). The authors of the new Battlemind series (Adler et al., 2007) incorporated Saint's original definition of Battlemind in their definition, "A warriors inner strength to face adversity, fear and hardship during combat with confidence and resolution. It is the will to persevere and win" (WRAIR, 2006c).

There was minimal information provided about the background of the Battlemind authors (Adler et al., 2007). During the development of Battlemind, the authors were stationed at the U.S. Army Medical Research Unit-Europe, in Heidelberg Germany where Lieutenant colonel (LTC) Carl Castro was the chief of military psychiatry and commander of the U.S. Army Medical Research Unit in Europe. Major Dennis McGurk was involved in the Mental Health Advisory Team mission in Afghanistan where he trained Leaders in Battlemind (US Army Medical Research Unit- Europe [USAMRU-E], 2008). LTC Castro appears to be primarily responsible for the drafting of scripts that were intended to be read by trainers during the skills training PowerPoint presentations; his contact information was provided at the beginning of every script. Dr. Amy Adler's research focus was brief intervention for trauma in the military and she was the first author of the primary manual for the debriefing component (Adler et al., 2007).

Treatment goals, structure, and principles. The overarching goal of the Battlemind series was to provide systematic early intervention in the military to prevent PTSD, depression, and sleep problems following deployment (Adler, Bliese, et al., 2009). The intervention was designed in three parts: a) small group psychological debriefing adapted for the military (Adler et al., 2007), b) a skills-based program called Battlemind training delivered as a PowerPoint group psychoeducational presentation and group intervention before deployment (WRAIR, 2008a, 2008b), and c) post-deployment stress education group that emphasize management strategies (also delivered as a PowerPoint group presentation) (WRAIR, 2006b, 2006c, 2007). Figure 4 shows the delivery timeline and format for each phase of Battlemind. The skills-based training program included three different versions for warriors (enlisted soldiers), leaders (officers and non-commissioned officers [NCOs]) and spouses. The training for leaders included the same content as the warrior version with additional information on how to deliver the Battlemind skills training to the warriors; it was designed as a train-the-trainers training. The spouse skills training was not interpreted in this study.

In addition the goal of preventing PTSD, depression, and sleep related problems post-deployment, each component of the Battlemind series had different specific goals that were stated to the platoon leaders. The goals of the pre-deployment skills training for warriors (Castro et al., 2006; WRAIR, 2008a, 2008b) were to:

1. To prepare warriors mentally for the rigors of combat and other military deployments;

2. To assist warriors in their transition back home;

3. To prepare warriors with the skills to assist their battle-buddy during deployment as a well as to transition back home; and,

4. To prepare warriors to possibly deploy again in support of all types of military operations including additional combat tours.

The goals of the in-theatre debriefings (Adler et al., 2007; Adler, Castro, et al., 2009) were to:

1. Support military personnel in their transition back to duty after a significant incident (in –theatre);

2. Reduce the overall mental health symptoms for the unit; and,

3. Acknowledge combat events among unit members, discuss common reactions and review actions that can be taken to facilitate transition back to duty.

The goals of the post-deployment stress training were to:

1. "Reset the soldier's Battlemind" (Castro, 2006, p. 17); and,

2. Adapting Battlemind skills so that they can be "just as effective at home as they were in combat" (WRAIR, 2006b, p. 2).

Manual's presentation of trauma. In Battlemind, the word trauma was notably absent. PTSD and other trauma related symptoms were referred to as Battlemind injuries, war stress injuries, or combat stress reactions. Reference to PTSD was limited and was only mentioned twice: once in the leaders' training in the context of debriefing (WRAIR, 2008a, p.35) and once at the end of the training in a unit on alcohol abuse and traumatic brain injury (WRAIR, 2008a, p. 51).

Overall, there was emphasis on describing all reactions to war as normal survival instincts rather than a mental disorder, "Reactions that are sometimes called PTSD can help warriors survive in combat" (WRAIR, 2008a, p. 51). The leaders were informed that they should expect these reactions:

Combat operational stress reactions are expected. Combat stress reactions are not a sign of weakness. Why look at mental health injuries as a weakness? If Soldiers deal with their combat stress reaction, they can come back to work. Treating your Soldiers who have combat stress reactions just like you would any other injured

Soldier is not just something that supports the mission, it's the right thing to do. (WRAIR, 2008a, p. 49)

Leaders were also told that the psychic impact of war needs to be understood like a physical injury, "Mental health injuries need to be treated like all other battlefield injuries" (WRAIR, 2008a, p. 57).

In Battlemind, the word trauma was not universalized to encompass all potential traumatic experiences. Events that would otherwise be considered to lead to trauma were mentioned by name and described as part of the normal day-to-day part of deployment. These events included: combat, military operations, warfare, wounding, catastrophic vehicle kill, cleaning-up of human remains, missing warriors and improvised explosive device (IED) explosions.

Key sociohistorical context mentioned by authors: OEF/OIF/OND.

Battlemind was created as an early intervention for PTSD, depression and sleep problems in U.S. and U.K. soldiers returning from Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND), which are also commonly referred to as the War in Afghanistan and Iraq respectively. OEF is associated primarily with the joint U.S., U.K., Australia and Afghan military operation in Afghanistan from 2001 to present (2014), but has also included military operations in the Philippines, Horn of Africa, Pankisi Gorge, Trans Sahara and Caribbean and Central America (Wright et al., 2010). OEF was initiated in October 2001 in response to the U.S. September 11 attacks (described previously in this study pp. 206-207) (Wright et al., 2010). The initial goal of the operation was to strike against the Taliban whom harbored al Qaeda terrorists and provide humanitarian relief to the people of Afghanistan (Johnson, 2006; Tanielian & Jaycox, 2008). The war against the Taliban ended in mid-December 2001 (Lambeth,

2001) and the U.S. turned its efforts to what the U.S. government called "stabilization"

and "nation building" in Afghanistan (Dobbins, Jones, Crane, Rathmell, & Steele, 2001;

Wright et al., 2010, p. 3). Critics since the war in Vietnam have pointed to the

paternalistic and colonial nature of the U.S. government's use of words like stabilization

and nation building to describe the violence of the war (see e.g., Connor, 1972; Mylonas,

2013). The U.S. continues to maintain approximately 20,000 ground troops in

Afghanistan today (2014).

OIF began with a surprise invasion of Iraq led by U.S. forces in March 2003

(Wright et al., 2010). Prior to the invasion, the Bush Administration (2001-2009)

garnered support for the war under the suspicion that Iraq was manufacturing weapons of

mass destruction. The invasion led to the capture of then President of Iraq, Suddam

Hussein, who was tried in an Iraqi court of law and executed by the new Iraqi

government. Although no weapons of mass destruction were ever found in Iraq, Paul

Pillar, who coordinated U.S. intelligence on the Middle East, reported that since his

tenure the Bush Administration was more interested in what Saddam Hussein "could do"

rather than the existence of weapons and The Administration would have continued to

push for war regardless of their existence (Pillar, 2013).

In May 2003, President George Bush Jr. publically declared an end to OIF

military operations by landing on the deck of the *Abraham Lincoln* aircraft carrier that

bore the infamous banner which read "Mission Accomplished" (Tanielian & Jaycox,

2008). After this time, U.S. military personnel continued to remain in Iraq ostensibly to

support the building of a new civil government, which later led the public to subsequently

critique Bush's prior declaration of mission completion (Pillar, 2013; Ricks, 2006).

After President Hussein's execution, violence rose between various groups and led to an Iraqi insurgency and the emergence of a faction of Al-Qaeda (Fisher, 2014). On August 31, 2010 President Obama announced the end of the combat mission in Iraq but forces remained until they were completely withdrawn on December 15, 2011 (Miles, 2010). Because the President declared an end to OIF but troops remained in Iraq it was necessary to give the Operation a new title; thus, the period from September 1, 2010 to December 15, 2011 was titled Operation New Dawn (Miles, 2010). There are no longer U.S. military ground troops in Iraq today (2014), however the insurgency continues between Sunni militant groups and the country's majority Shia population and Shia-led government (Fisher, 2014). There is also a question about the continued involvement of private sector militia in Iraq despite withdrawal of U.S. service troops (Avant & Sigelman, 2010; Carafano, 2008).

By 2014, it was estimated that between 120,000 to 130,000 civilians died in Iraq and Afghanistan as a result of the violence (Dardagan & Sloboda, 2014). As of January 11, 2014, 184,000 people, including both civilians and combatants, in Iraq and Afghanistan have died as result of the conflict. 6,750 U.S. service members have died to-date in Iraq or Afghanistan (Jean-Louis, Linch, Fetterhoff, & Hadar, 2014) and 447 U.K. service members (Ministry of Defence, United Kingdom, 2014). Approximately 40% of service member deaths were from improvised explosive devices (IEDs) (P. W. Singer, 2012).

The veracity and amount of evidence of the initial reasons to enter war (i.e., weapons of mass destruction) have been questioned in post-hoc analyses (Johnson, 2006; Mayer, 2009; Ricks, 2006). The primary controversies surrounding the U.S. invasion of

Iraq and Afghanistan in OEF/OIF/OED have included but are not limited to: instigation

of the war on false pretenses for U.S. economic benefit (Maddow, 2014; Ricks, 2006),

the legality of the war (British Broadcasting Corporation [BBC], 2004), human and

financial cost of war (Project, 2014), lack of transparency and government control with

use of private sector military (Avant & Sigelman, 2010; Carafano, 2008), torture and

degradation of prisoners of war (e.g., Abu Graib; Gordon, 2006; Zimbardo, 2007) and the

use of off-shore prisons (e.g., Guantanamo Bay). Within the field of U.S. psychology,

there was much controversy about the APA not taking a stance on torture in OEF/OIF

and psychologists participation in torture during the war (Allen, Keller, Reisner, &

Iacopino, 2009; Lott, 2007; Soldz, 2008). It is beyond the scope of this study to review

these controversies here but further information can be located in the citations provided

above.

       Presentation of OEF/OIF/OED in Battlemind. The experience of the

OEF/OIF/OED wars was characterized in Battlemind trainings as urban warfare with

organized terrorist groups who had limited resources (e.g., no air strikes, primarily using

IEDs)(WRAIR, 2008a, 2008b). The Battlemind pre-deployment skills training for leaders

(WRAIR, 2008a) and warriors (WRAIR, 2008b) prepared soldiers for the deployment

environment and war through a set of slides entitled "a profile of the hostile forces,"

which included a description of what soldiers may see, hear, smell, feel and think when in

combat. The training began with the trainer reading from the manual script, "What's

deployment like?" A slide of a woman in a niqab and a child both holding an AK-47 was

presented while the script directed the trainer to remind the soldiers that "the enemy is

not going to fight fair. He is going to hide behind women and children, in churches and

among civilians. Further, the enemy will not follow the laws of land warfare" (WRAIR, 2008a, p. 8). The trainer script continued, "What will you see?" A note instructing the trainer read, "Ideally the new guys should hear it from the ones that deployed before. This part of the brief should be interactive. Avoid turning this into a cultural brief… focus on the sensory overload" (WRAIR, 2008a, p. 12). The trainer then was instructed to show images of war while narrating what the soldiers will see, "extreme poverty, decay, garbage and feces, people on rooftops, gawkers "just looking," rubbled [sic] structures, incoming/outgoing fire, raging infernos- your vehicle on fire, wounded/killed friends and enemies" (WRAIR, 2008a, p. 13). The "what you will hear" slides showed women and children begging and screaming next to pictures of an explosion. The trainer was instructed to say, "You may hear: explosions, gunfire, ricochets and near misses, cries of wounded, pleas of help or mercy, wailing of mourners, shouts of rage and taunts, and multiple commands" (WRAIR, 2008a, p. 15).

The implications of these slides and the taken for granted messages about human being in trauma culture that are reflected in the training I will discuss throughout this section; however, I have presented the content of these slides here to show how a solider might first learn about the war, deployment environment, and culture they are about to enter.[56]

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[56] The Battlemind manual (Adler et al., 2007) and randomized control trial (Adler, Bliese, et al., 2009) also began with a review of debriefing literature. Although debriefing is not recommended for PTSD treatment the authors discuss numerous reasons why this literature is not relevant to the military population (Adler et al., 2007; Adler, Bliese, et al., 2009). Namely Adler et al. (2007), argued that findings from meta-analyses are irrelevant because they included studies that did not include control groups, were not focused military populations, involved individuals and not groups, and study therapists were not trained in standardized (i.e., manual-based) debriefing techniques. Adler, Bliese et al. (2009) called for military-relevant research in their studies and suggested there were

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Table 5

Battlemind Is Adapted for Combat, Not for Home

Battlemind Skill Adapted for Combat/War Zone	Battlemind Skill Not Adapted for Home Zone	Maladapted Post-deployment Thoughts	Thought-replacement to Reset Battlemind for Home Zone
Buddies (cohesion)	Withdrawal	"No one understands your experience except your buddies who were there with you."	"Provide and accept support from [your loved ones]"(WRAIR, 2006a, pp. 8-9).
Accountability	Controlling	"Nobody cares about doing things right except for you."	"Small details are no longer important" (WRAIR, 2006a, pp. 10-11).
Targeted Aggression	Inappropriate Aggression	"Kill or be killed."	"Think before you act. Wait before you respond" (WRAIR, 2006a, pp. 12-13).
Tactical Awareness	Hypervigilance	"Survival depends on being aware at all times."	"It takes time to learn to relax, monitor for revved-up reactions to minor events" (WRAIR, 2006a, pp. 14-15).
Lethally Armed	"Locked and Loaded" at Home	"You and your loved ones are not safe without [weapons]."	"Follow all laws and safety precautions regarding weapons" (WRAIR, 2006a, pp. 16-17).
Emotional Control	Anger/Detachment	"Controlling emotions is critical for mission success."	"Displaying emotions is not unmilitary and doesn't mean you are weak" (WRAIR, 2006a, pp. 18-19).
Mission Operational Security (OPSEC)	Secretiveness	"Talk about the mission only with those who need to know."	"Tell your story, but in the way you want to tell it…Be proud of your service" (WRAIR, 2006a, pp. 20-21).
Individual Responsibility	Guilt	"You have failed your buddies if they	"Your buddy would want you to drive on" (WRAIR,

Table 5 (continued)

Battlemind Is Adapted for Combat, Not for Home

Battlemind Skill Adapted for Combat/War Zone	Battlemind Skill Not Adapted for Home Zone	Maladapted Post-deployment Thoughts	Thought-replacement to Reset Battlemind for Home Zone
Non-Defensive (combat) Driving	Aggressive Driving	"Driving fast is necessary to avoid danger."	"Control your anger. Obey traffic laws. Use turn signals. Slow down" (WRAIR, 2006a, pp. 24-25).
Discipline and Ordering	Conflict	"Survival depends on discipline and obeying orders."	"A family is not a military unit" (WRAIR, 2006a, pp. 26-27).

Shared Theme 1: Mind-Brain as Protector and the Political Use of Cognitivist Ideology

In this section, I present the first theme that was shared by all of the manuals I interpreted. All of the manuals predicated therapy on three interrelated assumptions: 1) You can change the world by changing your mind, 2) When you change your mind you change your brain; and, 3) Your brain and mind can protect you from trauma (i.e., if you have inner safety, you are safe and thus the world is safe). The main problem with these assumptions is the confusion between shifts in individual subjectivity and shifts in the social world, which can ultimately result in no change to the status quo of existing political problems and arrangements of power and domination (cf. Sampson, 1981).

Thematic findings: Mind-brain as protector and the political use of cognitivist ideology. This section presents quotations from Battlemind trainings that are representative of the theme "mind-brain as protector and the political use of cognitivist ideology." I present content that supports the subthemes "your brain and mind can protect you from trauma" and "you can change the world by changing your mind;" the third subtheme, "when you change your mind you change your brain," was infrequently mentioned in the Battlemind series because the brain was not a central focus of the trainings (i.e., brain and mind were referred to interchangeably) and thus, this subtheme will not be presented.

Your brain and mind can protect you from trauma. The pre-deployment trainings (WRAIR, 2008a, 2008b) were focused on arming soldiers with mental skills to protect them during deployment. The specific skills that made up Battlemind are represented in the first column of Table 5. Interestingly, these specific skills were mostly

referred to in the post-deployment trainings. In the pre-deployment trainings, Battlemind was generally referred to as mental toughness and inner strength. The trainings defined Battlemind as, "A warriors inner strength to face adversity, fear and hardship during combat with confidence and resolution. It is the will to persevere and win" (WRAIR, 2006c). The image of the mind as a tough, impermeable barrier between the soldier and war was reiterated throughout the training from every PowerPoint slide bearing the logo "Battlemind: Armor for your mind" to quotations like, "When a soldier is at war his [or her] mind should be at Peace–Lord Moran 1943" (WRAIR, 2008a, p. 62).[57] In a slide titled "What a warrior should know and do" the first instruction was to "Steel your Battlemind" (WRAIR, 2008b, p. 26). This was defined at a later part in the training to mean, "Maintain your mental toughness, meet challenges head on, be confident, take calculated risks and maintain positive thinking during times of adversity and challenge" (WRAIR, 2008b, p. 30).

The pre-deployment training focused on what war will be like for the soldiers (see section Battlemind's Presentation of OEF/OIF/OED, p. 383) and reiterated the message that these realities should not "get in the way of Battlemind" (WRAIR, 2008a, p. 16). For example, during the "what will you think" section of the warrior pre-deployment training, the trainer tells the soldiers they will think, "There'll always be war here; always has been", "I'm wasting my life here", "They should be fighting for themselves", "They don't want us here," "There doesn't seem to be a point to this," "The sacrifices I'm making are not worth it," "No progress is being made here," and "I'm tired of this shit!"

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[57] According to the Battlemind trainer notes Lord Moran of Manton (1882-1977) was Winston Churchill's travelling medical doctor who in the 1930s lectured to army colleges on morale during war (WRAIR, 2006c, p. 62).

(WRAIR, 2008b, p. 19). The leaders were instructed to tell their soldiers after presenting

the slide:

> These are normal thoughts. And its good to recognize them now so that if you end
> up having these thoughts when you're getting through the worst days, or getting
> through the sights, sounds and smells, you can remember that these thoughts are
> just a normal part of being deployed. And these thoughts won't get in the way of
> maintain your Battlemind- of maintain your inner strength, your resilience.
> (WRAIR, 2008a, p. 16)

You can change the world by changing your mind. Where in the pre-deployment

trainings, changing the world by changing the mind was referred to as a process of

"armoring the mind" against the world as previously described, changing the mind in the

post-deployment trainings was referred to as "resetting Battlemind" in order to integrate

into life back home after deployment (Adler et al., 2007, p. 23; Castro, 2006, p. 17).

Overall, there were two primary sociopolitical experiences that the Battlemind trainings

suggested could be changed or even not experienced through armoring or resetting

Battlemind: 1) the experience of participating in war, and 2) the experience of returning

home from war feeling angry, isolated, and guilty. In this section, I focus on how

Battlemind trainings assume that soldiers can continue to avoid reckoning with the

experience of war when they return home by resetting their Battlemind.

In the post-deployment training, the leader was instructed to present the paradox

of returning home from employment:

> Let's acknowledge right up front that the combat environment is very harsh and
> demanding. You all know this better than I do because you just got back. It's hot.
> People are trying to kill you. People are shooting at you; there are IEDS; there is
> frustration with locals for supporting or knowing about ambushes/attacks; there's
> no alcohol and there's no sex, right? YET many soldiers tell us when they have
> been home for about a month and back from block leave that life was simpler
> while deployed: fewer tasking, fewer distractions, [and] Soldiers could focus on
> the mission. (WRAIR, 2006a, pp. 3-4)

The leaders presented the experience of returning home as problems or frustrations with the process of adapting from living in the "war zone" to the "home zone" (p. 5). The training proposed that the solution to the dilemma lay in adapting the soldier's Battlemind, "Battlemind is what helped you get through your deployment…You must take your Battlemind skills and adapt them so that they are just as effective at home as they were in the combat environment" (p. 5). Although Battlemind can be the solution, the leader was also instructed to warn the soldiers that without properly resetting via the post-deployment training, "Battlemind may be "hazardous" to your social and behavioral health in the *home zone*" (p. 5).

A version of Table 5 was shown at the beginning of each post-deployment training (I & II) (WRAIR, 2006a, 2006b, 2006c). The second column in Table 5 reveals what can happen to soldiers who return to the home zone without appropriate psychological resetting via the post-deployment trainings. Each of the problems listed in the second column of Table 5 were discussed in the post-deployment trainings through corresponding video vignettes (e.g., about aggressive driving, carrying weapons, and fighting with spouses). The leader was instructed to tell their warriors that,

> The key point is that if you used the same Battlemind-set you had in combat when you get home you may have experienced some problems…If you are still thinking and behaving, now that you are home, the same way you thought and behaved in combat, then these are indicators you might need some help. (WRAIR, 2008a, p. 7)

The majority of the post-deployment training proceeded through different dilemmas that can occur when the solider does not reset their Battlemind for the home zone; there was a scenario for each Battlemind skill listed in Table 5. For example, in the "targeted versus inappropriate aggression" Battlemind dilemma (line 3, Table 5), soldiers were reminded that they will "probably get very angry over the little things" (WRAIR,

2008a, p. 13) and that "in combat, everything [occurs in a] split-second. Most places where you'll be back home, you don't have to make an immediate decision" (WRAIR, 2008a, p. 13). The leader was then instructed to present a vignette of inappropriate aggression at a club where someone accidently bumps into a veteran. The trainer warns, "this is the time to turn to your buddy and get an azimuth check" (WRAIR, 2008a, p. 13). An azimuth check is a metaphor broadly used in the military for stopping and thinking about what you are doing; on deployment, an azimuth check occurs when troops stop on their journey and take out a compass to ensure they are headed in the right direction.

Another example of failure to reset Battlemind was the mission operations security (OPSEC) versus secretiveness dilemma (line 7, Table 5). In the secretiveness scenario the leader explained that the veterans will face continual questions about what happened on their deployment when the return home. The leader script read, "you need to find a way to tell something about your deployment, to the degree you are comfortable… Share with your significant other what you're doing, day to day. …The key is to be proud of your service and your accomplishments while you were deployed. Tell your story" (WRAIR, 2006a, p. 21).

The vignette for the lethally armed dilemma (line 5, Table 5) explained to the soldiers how "being lethally armed was one of Battlemind skills that kept you alive" (WRAIR, 2006c, p. 7) but being "locked and loaded" at home may mean "you or your buddy may have not transitioned that skill well" (p. 7). Another vignette focused on reducing aggressive driving, "if you are afraid to get in the car while your buddy is driving then you should get help or get your buddy help? [...] If you don't get your buddy

help, what's going to eventually happen to that buddy? [Trainer:] Listen/say: he's going to kill himself or somebody else" (WRAIR, 2006c, p. 15).

While much of the training was framed as resetting one's Battlemind internally, the dyad of the self-buddy system was also heavily emphasized. The role of the buddy in all of the vignettes was to help the veterans stop engaging their war zone Battlemind and engage the Battlemind adapted for the home zone. All of the scenarios ended with self- and buddy-checks where soldiers were instructed to assess themselves and their comrades for different symptoms of Battlemind not adapted to the home zone. The buddy's role was to help assess Battlemind and its lack of adaptation to the home zone and ultimately to assist the veteran in getting help. Thus while the training was presented as teaching soldiers how to reset their Battlemind to change their experience of the social world, the training was also about monitoring and resetting your buddy's mind. Examples of though-replacement exercises that could be initiated by the veterans or their buddy to reset Battlemind for each vignette are presented in the Directive Psychoeducation and Cognitivist Thought-Replacement section of this chapter (pp. 424-425).

Thematic discussion: Mind-brain as protector and the political use of cognitivist ideology. The Battlemind training and debriefing series manuals and training scripts suggested that the problems veterans experience in post-deployment were primarily due to a misapplication of a set of mental skills—the soldier's Battlemind. The post-deployment training turned the experience of returning from war to a series of internal mental errors or skill misapplications; skills that simply needed to be reprogrammed or reset via the post-deployment trainings.

Vignettes from the post-deployment training presented real-life problems for veterans that occur when they return from deployment (e.g., initiating fights, avoiding communication, carrying a gun and aggressive driving). Although all of these problems are located in the social world, in Battlemind the response to changing the world was to reset the mind. For example, aggression and anger that soldiers can feel returning home was presented in the training as the result of learning skills like targeted aggression and tactical awareness on deployment. Veterans' desire to avoid talking about the war upon returning home was presented as a consequence of learning to keep missions secret.

Just as the soldiers were trained to arm their mind in the pre-deployment trainings, the manuals and script suggested that they can also disarm it via post-deployment trainings. If a solider cannot disarm their mind, then their buddy was instructed to assist the solider to disarm it. The mechanistic experience of arming and disarming the mind in Battlemind suggested asocial explanations of why soldiers feel angry or isolated upon returning from deployment. This presentation of veteran's experience is quite different than the narratives described by Marin (1981), Young (1995), Lifton (1973), and Tick (2005) in their studies of veterans. These authors presented alternative views on the reactions to war. For example, they suggested that veterans may be angry at the military, government and country for a range of reasons, including participation in at times what felt like a pointless war (e.g., the "What you will think" section of WRAIR 2008a, 2008b); lack of appropriate compensation, jobs or other direction upon returning home; distance and disconnect from family; and, shame for killing or other atrocities committed. Veterans have plenty of reasons to be angry—social and political reasons to be angry— yet these possibilities do not come to light in Battlemind. Veteran's experience post-

deployment was instead framed as if the soldiers are robots that are still on duty and their software needs to be reset.

Similarly, avoidance of talking about what occurred in the war was interpreted in Battlemind as a form of highly trained operations secrecy, as if veterans don't talk about their experiences in war because they can't stop complying with the code against sharing mission operation details upon returning home. While this may be one reason veterans do not actively share war stories, it is also likely that soldiers feel isolated by the painful knowledge they have learned about war and are perhaps annoyed at the lack of awareness the general public has about the average soldier's experiences. Despite the realities of social isolation that veterans face upon returning home, the post-deployment training urged veterans to adapt their Battlemind to "be proud of your service and your accomplishments while you were deployed. Tell your story" (WRAIR, 2006a, p. 21). In a sense, Battlemind suggested that veterans almost spread a type of propaganda about their accomplishments that is perhaps unrealistic but that fits the stereotype of what war should be about—something that is at least palatable if not aspirational for the general public.

As Marin (1981) explained, veterans return from war having learned a "terrible and demanding wisdom"—the irreversibility of a type of knowledge where one's actions of killing and maiming in war irrevocably determined the destiny of victims such that there is no way to deny one's responsibility or culpability for those mistakes (p. 74). Even if a veteran did not participate in combat while deployed but was incredibly bored (e.g., waiting months for a part to arrive so they could repair a vehicle), telling a service story of horror or boredom to friends and family may not be seen as heroic—it's not exactly the story to be proud of. Furthermore, while Marin suggested that knowledge

born from war could bring veterans deeper into their community, it can be isolating for veterans to talk about their experiences because by doing so they raise questions that our society does not want to confront. They raise questions, as Marin aptly stated, "for which, as a society we have no answers" (p. 74).

In the pre-deployment training, the soldiers learned that it is expected, normal, and good to have certain individualized and interiorized expressions of stress injury upon returning. This included a tacit expectation that if soldiers were really living as a warrior on deployment they should also now be experiencing reactions listed in Table 5 like wanting to be "locked and loaded" at home. Failure to have the expression of war stress injuries presented by Battlemind may suggest to the soldiers that they did not participate on deployment as they should have by arming their Battlemind, did not have inner strength and were even cowardly because they could not appropriately "steel their mind" (WRAIR, 2008b, p. 26) against the horrors of war. Veterans who may understand their anger, isolation, or sadness in a different way than the training presented (i.e., understand their symptoms more politically) must then also face the idea that perhaps they did not absorb Battlemind like the rest of the group and were ultimately not good soldiers.

Overall, Battlemind provided soldiers with a script about what are acceptable expressions of post-traumatic injury (e.g., you are angry because you are continuing to fulfill your mission, not because you are angry at the military for broken promises). Acceptable reactions to war were framed as individual problems in which soldier's brain needs to be reset before he or she continues to misapply their Battlemind training at home. Unacceptable reactions (that were not mentioned in the Battlemind training) included those directed at the military or government for leading the country and the

soldiers to war or actions like homicide and suicide (insinuated by the locked and loaded and aggressive driving scenarios). By locating the problems of OEF/OIF within the individual solider and convincing them that they merely need to reset their Battlemind to reintegrate into society, the military is allowed to continue to the status quo of initiating and prolonging war without question. Reducing stress reactions in this way does not question or destabilize military operations because the symptoms are attributed solely to individuals.

Shared Theme 2: Neoliberalism in Trauma Therapy: The Healed Trauma Survivor as Functional Worker

In this section, I present the second theme that was shared by all of the manuals I interpreted. Economist John Williamson defined neoliberalism as moving control of the economy from the public sector and government to the private sector and corporations (Williamson, 1990). In neoliberal theory, there is emphasis on individual choices and productivity as resulting directly in success or failure; if someone is not happy, is impoverished, is starving or suffering, the theory would suggest that this is ultimately due to an individual failing in neoliberal functionality (e.g., they should get control of their life, return to work, etc.).

In all of the manuals, trauma was a major source of reducing neoliberal functionality and thus the aim of therapy was to restore functionality in this system, like getting the patient to return to work or school. There were three primary assumptions in the manuals that are a reflection of neoliberal culture: a) valorization of the enterprising self (cf. Binkley, 2011; Layton, 2010; Rose, N. S., 2007), b) the acontextualized nature of trauma (Layton, 2006), and c) the privileging of modular, efficient therapy designed for

managed care (Cushman & Gilford, 2000). I previously discussed these features from the

perspectives of critical scholars in the Background and Literature Review (see Chapter II,

pp. 100-109), in this section I relate these features to my interpretation of the Battlemind

series.

Thematic findings: Neoliberalism in trauma therapy. This section presents

quotations from the Battlemind series that are representative of the theme: neoliberalism

in trauma therapy. I have divided the section according to the three assumptions listed

above.

Valorization of the enterprising self. The Battlemind trainings mentioned

different historical figures as archetypes of the ideal solider. These included: Lord Moran

of Manton (WRAIR, 2006a), General Crosbie Saint (WRAIR, 2006c) and Audie Murphy

(WRAIR, 2006a, 2006c). All of the figures mentioned embodied a heroic solider who

witnessed atrocities but overcame his war wounds and inspired future warriors—a

militaristic version of the enterprising self. The icon perhaps most associated with the

enterprising self in the Battlemind trainings was Audie Murphy. The trainings described

Murphy as the most decorated solider in U.S. Army history. After receiving the highest

honors from the military, he was diagnosed with PTSD and spent the last years of his life

"trying to get Soldiers the help they need" (WRAIR, 2006a, p. 46). The trainers were

instructed to paint an image of Murphy to dispel the myth that "only weak soldiers have

mental health problems," and point out that "everyone is affected by combat" (WRAIR,

2006a, p. 46). Murphy's story was mentioned in both of the post-deployment trainings,

"Audie Murphy encouraged all Soldiers to get help when they wanted it or needed it. The

key is that performance in combat is not related to whether you will or won't have a Battlemind injury" (WRAIR, 2006b, p. 27).

What was not mentioned explicitly in the trainings about Audie Murphy, but perhaps would be known in military culture and amongst the soldiers attending the group, was that after World War II he became a famous Hollywood actor and icon of American heroism in movies (Graham, 1989). In Western films, Murphy was romanticized as an image of rugged individualism (e.g., *No Name on the Bullet, The Unforgiven, Night Passage, The Cimarron Kid,* and *Gunsmoke*). He also starred in several military dramas as the classic war hero (e.g., *The Quiet American, Battle at Bloody Beach*).

Murphy was perhaps most famously known for playing a version of himself in the movie *To Hell and Back* (Graham, 1989). The movie begins with Murphy as a child growing up in a large family, as the son of a poor sharecropper. His father deserts his family and his mother dies, leaving Murphy to fend for his family himself. He attempts to join the military but is rejected because he is too small and youthful; he endures jokes about being an infant sent to combat in the infantry division. (In reality Murphy did illegally enlist at age 17 when he lied about his birthdate [Graham, 1989]). Despite being small and young, Murphy fought his way up through the ranks in battle and earned the respect of his fellow soldiers and superior officers. The movie ends with a depiction of the scene for which Murphy won the U.S. Congressional Medal of Honor. In the scene, his company is forced to retreat Murphy decides to single-handedly fight off the Germany infantry by jumping on an abandon tank and using a machine gun to hold the enemy at bay.

While *To Hell and Back* parallels Murphy's life as the young poor boy turned war hero, it is undoubtedly infused with cinematic drama, war propaganda, and a larger than life American dream. The movie, like the Battlemind trainings, neglected to explain the less ideal details of Murphy's life post-war, such as the gravity of psychological suffering he endured as a veteran, and his activism in the Korean and Vietnam Wars (Hopper, 1956).[58] Instead, he is framed as purely a mentally tough solider turned war hero and movie star.

Battlemind's glorification of Audie Murphy promoted the idea that soldiers should be able to acknowledge they are suffering from mental health problems while also retaining a hyper-masculine and superhuman functionality upon returning from war (e.g., the cowboys and war heroes of Murphy's movies). The first post-deployment training concluded: "Getting help for a Battlemind injury is NOT a sign of weakness. It takes courage to ask for help and it takes leadership to help a fellow Soldier get help" (WRAIR, 2006a, p. 34). In sum, soldiers are presented with the ideal that they must somehow recognize their symptoms, reset their Battlemind, and still retain hero status after returning from war.

The acontextualized nature of trauma in neoliberal trauma therapy. In Battlemind, all trauma related psychopathology and reactions to war were referred to as war stress injuries or Battlemind injuries. Framing reactions to war as injuries suggests

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[58] Murphy's first wife described him as guilt-ridden; when he saw a newsreel of orphans in Germany he wept to think that he was the reason they had no parents (Graham, 1989). Murphy became more active in describing his post-war experiences and lobbying for veteran mental health support during the Korean and Vietnam Wars. Murphy eventually came to star in *The Quiet American* that was based on Graham Greene's anti-war novel of the same name. Murphy clarified that despite his activism and involvement in the anti-war movie, he was decidedly not anti-war or anti-American (Hopper, 1956).

that soldiers are experiencing something akin to a type of physical rather than psychic wound. I previously outlined further examples of physical injury terminology and the medicalization of trauma in the Manual's Presentation of Trauma section (p. 290). Describing traumatic events that are political and social in nature, like war, as physical injuries removes them from their social context and suggests they can be treated like a medical disease rather than a social problem.

The lack of acknowledgement of the military's role in separating soldiers from their families when discussing veteran's problems reintegrating to the home zone is another example of how Battlemind removes war trauma from its social context. The military requires that soldiers be uprooted from their homes and families for deployment overseas like in OEF/OIF. Even when not deployed, while in active service military families are asked to move frequently from base-to-base across the nation or world; this is called Permanent Change of Station (also known as PCSing) (United States Department of the Interior [USDI], 2014). A family can move any number of times during active duty, sometimes every two years.

The assumption that soldiers and their families should move for their job, and move away from their families is one expression of the neoliberal ideal that independence is seen as more acceptable than dependence. It should be expected that a veteran would have problems returning to their community after deployment to Iraq or Afghanistan because they have been separated from their family and community. Perhaps even before they deployed they were moved from base-to-base such that there was no stable community to return home to in the first place. Rather than frame the problems of veterans reintegration to family life as rooted in repeated separation from home and

community, the trainings suggest that difficulties returning home are related to the soldiers lack of ability to adapt their mind; again, the social is framed as an individual problem and dependence is seen as problematic. The ideal promoted by Battlemind is a solider who can quickly and independently adapt to any setting and a family that is able to function independently from the solider if the soldier is redeployed or moved.

The dyad of the buddy or spouse was the primary social context that was recognized in Battlemind. The post-deployment training discusses how the veterans should expect social relationships with their spouse and children to shift when returning home from a war and how the soldiers should learn how to adapt their mind to communicate as if they have left the military (e.g., Battlemind dilemmas of Discipline versus Conflict and Mission OPSEC versus secretiveness). While many of the Battlemind adjustment dilemmas focus on the dyad, there was no discussion about the larger social and political domains, such as how veterans might experience applying for a job or return to school after deployment. While a functional ideal for the solider is promoted what it means to actually return to a neoliberal society and be expected to reengage in daily life is not discussed on a community or public level. I continue discussion of how healing and pathology is located solely in the dyad in a following sub-section (pp. 420-423).

Perhaps the greatest example of decontextualizing trauma from the social world was that the Battlemind series did not actually discuss any specifics of the deployment or the reasons for going to war in any of the trainings. The trainings were so broad in their characterization of war that they could almost be used with soldiers deploying to OEF in Afghanistan, OIF in Iraq, or missions in any Middle Eastern country. Furthermore the trainings made gross generalizations about the nations the soldiers would be deploying to

as being somehow evil or disgusting. For example, the pre-deployment training reminded the warriors, "the enemy is not going to fight fair. He is going to hide behind women and children, among civilians. Further, the enemy will not follow the laws of land warfare;" (WRAIR, 2008a, p. 8). The trainer script continued, "Is the deployed environment a quiet place? Is it easy to sleep at night? Mention the call to prayer five times a day. There are often mourners;" (WRAIR, 2008a, p. 15); and "those of you [that] have been there before, what did it smell like? It's a smell a lot of third world countries have- a mix of fuel, burning trash, open or burning sewage (shit). You may recognize that same third world smell" (WRAIR, 2008a, p. 16). Then the trainer was directed to present a list of "what you may smell" to soldiers which included, "rotting garbage, burnt flesh and hair, heavy chemical and industrial smoke/fuel, open sewage.., and decaying animals" (WRAIR, 2008a, p. 17).

This presentation of the national landscape lacks actual specific cultural or national detail and paints a decontextualized picture of evil Muslim insurgents running through an uncomfortable smelly landscape. Mourners' prayers were presented as annoyance that prevented soldiers from sleeping. There was no discussion about how mourning was a direct consequence of violence and war. There was also no discussion about how what the trainer is instructed to call a "third world smell" was actually created by ongoing violence and war and would not necessarily be native to the country. The emphasis on describing the countries as "third world" also connoted a colonial image of the U.S. forces bringing civilization from the "first world" to the country in the form of war.

The decontextualized social and political context of deployment was also demonstrated in the "what will you think" series of slides in the pre-deployment training. The soldiers were presented with likely thoughts they will encounter on deployment such as, "There doesn't seem to be a point to this;" "No progress is being made here;" "I'm wasting my life here;" and, "They don't want us here" (WRAIR, 2008a, p. 19). Rather than provide information about the real sociopolitical reasons for those thoughts, what the point of the war is, why progress doesn't seem to be being made and why the locals may not want soldiers there, the trainer is directed to tell the platoon "these thoughts are just a normal part of being deployed. And these thoughts won't get in the way of maintaining your Battlemind—of maintaining your inner strength, your resilience" (WRAIR, 2008a, p. 19). Thus in the pre-deployment training, the leaders tell their platoon that they are aware of these problems, they aren't going away, they are natural automatic thoughts caused by any deployment, and instead of discussing the specific conditions of OEF/OIF, the soldiers should ensure these thoughts don't get in the way of their mission. The training suggests that nothing—not even reality—should get in the way of being a functional solider on deployment and if it does, soldiers should use their mind to persevere.

After the presentation of what soldiers are to expect upon deployment (e.g., the What you will see, hear, smell, etc. slides) the training provides what they call a few "positive reasons" for deploying:

> Deployments can strengthen your Battlemind…So you've got the Worst Day scenarios, the sensory input, the thoughts, the feelings and the hassles of deployment. But you've also got some incredibly good things that might come out of the deployment. How many of you will have a chance to move into a leadership position? None of you know if you will be the one to demonstrate courage but you'll have that opportunity. You'll get the chance to do what you've

> been trained to do…And you've got a chance to serve your country […] In everything that you do in life that matters, mental toughness and extra effort is required to be successful. (WRAIR, 2008a, p. 26)

This is where the connection between neoliberal theory and lack of social context is quite apparent in Battlemind—in lieu of providing social and political context for the war, the reasons for deployment are ultimately framed as a journey to personal self-betterment. In this quote from the training, the war was transformed into a resource (cf. standing reserve) to be used for the enterprising self, as an opportunity to increase in the ranks, increase mental toughness, demonstrate heroic characteristics and as a "chance to serve your country." Where the military may in many ways weaken social ties to family and local community through constant moves and relocation, the training presents the endeavor as one that would actually solidify personal character and strengthen social ties and connections to one's country.

In sum, the pre-deployment trainings teach the soldiers how to ignore the social circumstances of their world in order to fulfill the needs of the mission and the military as a functional solider by retaining mental toughness. The post-deployment trainings locate the political suffering and consequences of participating in war within the individual veteran, thus relieving responsibility for these problems from the military, government and public. Conversations about war are converted into conversations about preventing PTSD and war stress injuries. The solider is given a narrative about how war is actually an experience of personal growth and opportunity to become the ultimate warrior.

A modular, efficient therapy designed for managed care. Unlike the other manuals interpreted in this study, Battlemind does not have to contend with making the treatment amenable to billing private insurance. Battlemind was paid for by U.S. tax-dollars as part of national defense; it was included in the Solider Comprehensive Fitness

Program and required for all members of the military. Therefore, therapists delivering

Battlemind reported outcomes to the U.S. Department of Defense and the training was

subject to different evaluation criteria than private insurance would require. This being

said, given the massive scale of the military, outcome evaluation is also heavily

monitored, managed, and bureaucratic (albeit sometimes in non-efficient ways that halt

actual program evaluation; see review in Meredith et al., 2011). Battlemind does include

pre- and post-assessments of PTSD symptoms to demonstrate continued efficacy and is

designed to be cost-effective for widespread implementation in the military (DoD, 2009).

Thus, many of the same managed care principles, such as making a therapy efficient to

deliver in the least amount of time with the least amount of expense, have also shaped the

design of Battlemind.

The modular structure of Battlemind is outlined in Figure 4. Battlemind includes

three group trainings led by the platoon leader and in-theatre debriefings led by mental

health specialists, such as therapists, chaplains, social workers, psychiatrists or

psychologists in theatre. The design of Battlemind was cost effective because the

psychologist need only train the leaders in a single workshop how to deliver the

remaining trainings to their entire platoon (Adler, Bliese, et al., 2009; Adler et al., 2007;

Adler, Castro, et al., 2009). The PowerPoint lecture system and manual script also help to

ensure that the trainings are standardized and similarly delivered across platoons in the

military. The group treatment format also allows Battlemind to be more cost-effective

and encourages less tailoring of the treatment to individual needs and concerns. Thus, the

cost of treatment delivery is the cost of the initial training where the psychologists train

the leaders, and any ongoing involvement from the psychologists during debriefing in

theatre. The leaders are told after their initial training in Battlemind that they are

essentially responsible for delivering the warrior treatment and monitoring the mental

health of their platoon (along with the deployment buddy-system; see examples in

Creation of Altruistic Cult Leaders in this chapter, p. 331).

In addition to the modular group trainings, the soldiers were required to attend in-

theatre debriefings that are approximately one hour each. Adler et al. (2007) suggested

that while the in-theatre debriefings are designed to be event-driven (i.e., given

immediately after a traumatic event):

> there may be so many serious incidents on a combat deployment that the unit
> becomes reluctant to hold a debriefing after each one. The unit members may
> come to treat the sessions as a rote exercise. (Adler et al., 2007, p. 5)

Thus, to avoid repetition, it seems that in practice debriefings were often

scheduled on a recurrent, time-driven schedule unless something particularly

horrendous occurred. Ironically in attempt to prevent repetition, the debriefings,

while initially designed to be tailored to events and the specific situation of each

platoon, eventually become time-driven, structured, efficient, and undoubtedly

rote.

The beginning of the debriefings emphasized the time-limited nature of the

debriefing therapy and that the goal of the debriefing is to return as quickly as

possible to deployment duties in theatre. The debriefing script read:

> The reality is that your unit is going to have to return to duty and at the same time
> there needs to be time set-aside to talk about what happened. Other units that have
> gone through this kind of training have found that this kind of training can help
> units maintain focus and support each other as a team. Obviously one hour of
> training won't take away the things associated with what happened but by taking
> a moment to assess how things are going, this training can help you anticipate
> some of challenges you may face the in next few months and ways of dealing
> with those challenges. (Adler et al., 2007, p. 11).

Overall, the therapy was structured to be brief, efficiently delivered in groups or on a set time schedule, and was standardized with PowerPoints and training scripts.

Thematic discussion: Neoliberalism in trauma therapy. Scholars who have critically interpreted neoliberal culture in psychotherapy have identified two primary features: a) social identity is continually removed from political, local, and moral tradition and context, and b) neoliberal culture has come to govern the lives of families, individuals and communities via technologies of therapy and the role of the expert in therapy (e.g., Binkley, 2011; Cushman & Gilford, 2000; Fine, 2012; Layton, 2010, 2013). I previously discussed these features from the perspectives of critical scholars in the Background and Literature Review (Chapter II), here I apply them to the interpretation of the manuals for the Battlemind training series.

When traumatic events are located in the individual as an internal injury they are less likely to be considered to be a social problem. By localizing the consequences of war in the individual, as a disorder like PTSD or a mental injury, therapists do a disservice to veterans by not taking public responsibility for the consequences of war (cf. Cushman, 2013). While understanding that how to respond to war, and in particular to OEF/OIF, is complex, the lack of social context for trauma disorders presented in Battlemind helps to retain the delusion that as therapists we are preventing trauma with psychotherapy treatments, rather than by recognizing and discussing the social causes of war and thereby opposing war. The existence of the Battlemind training and debriefing series suggests to veterans they should not expect their struggles and reactions to their experience to be something that incites public engagement. Instead, the training suggests that veterans

should respond to war stress injuries in the private domain—as an internal, cognition-based wound that can be kept at bay with improved cognitions through self- and buddy-monitoring.

Limited details about the reasons for war and the social and political context of the war from a U.S. and Afghan or Iraq perspective were not provided to the soldiers. Perhaps to discuss the actual social and political context of the war or provide humanizing details about Iraq or Afghanistan would deter them from participation in war. Despite the shallow and offensive sociocultural portrait of Iraq and Afghanistan that was painted by the pre-deployment trainings, I would assume that specifics of the soldiers mission, history and purpose of the war and cultural briefings were provided in other trainings. Even if this material was covered elsewhere, the exclusion of the context and reasons for war from Battlemind suggests that these reasons are irrelevant to well-being and safety on deployment. In lieu of providing social and political context for the war, the reasons for deployment were ultimately framed as a journey to personal self-betterment. War was transformed into a resource (cf. standing reserve) to be used for the enterprising self for personal growth (e.g., war provides a developmental opportunity to increase mental toughness and personal advancement).

The goals of Battlemind and recurrent discussion of enterprising figures like Audie Murphy suggested that the Army's goal for veterans was to make them into functional and productive members of society after the war. The Audie Murphy archetype presented a tension between the ideal of the impervious Battlemind warrior that courageously drives on through any emotional or moral dilemma and the soldiers who actively monitor their mental health, attend therapy and are obedient to social norms upon

returning from war. Soldiers were presented with the ideal that they must somehow recognize their symptoms, reset their Battlemind, and still retain hero status upon returning from war. Given this tension between the ideals of the pre-deployment training and post-deployment training, it is unsurprising that the psychologists inform the leaders that 65% of soldiers don't report seeking help for fear of being perceived as weak (WRAIR, 2008a, p. 55). It seems that Battlemind and the military does such a good job of convincing soldiers that they can reason their way through war as an enterprising individual with a bulletproof mind that to admit that they are actually confused or affected by war is seen as a personal weakness rather than a social problem for which the society as a whole should all take responsibility. Overall, by framing responses to war at best as a journey to self-betterment and at worst as an individual disorder that requires self-focused mental maintenance and repair, the Battlemind training series may actually contribute to the creation of traumatic symptoms such as confusion, guilt, isolation or social avoidance, anger and associated depression or functional impairment. I explore this idea further throughout the remaining themes, exemplars and questions.

Shared Theme 3: Trauma Is Universal and Culture-Free (Versus Tied to a U. S., Western, White, and Middle-Class Context)

In this section, I present the third, theme that was shared by all of the manuals I interpreted. In all of the manuals, trauma was presented a universal human experience that could be treated following the same culture-free treatment manual. I divided examples of this theme into the following categories: a) trauma symptoms are tied to universally experienced organ malfunction (e.g., brain problems), b) there is a flattening of all events, local experiences, and narratives of suffering to diagnostic criteria for PTSD

and the word "trauma" or "traumatic events," c) the technique of thought-terminating clichés (cf. Lifton,1989) about cultural competency are often employed, and d) there is an exclusion of forms of suffering from the definition of trauma that are not from a U.S., Western, white, and middle-class context.

Thematic findings: Trauma is universal and culture free. This section presents quotations from the Battlemind manual that are representative of this theme. Because Battlemind avoided explanation of any trauma symptoms as rooted in brain malfunction, there were no examples of the Shared sub-theme of: trauma symptoms tied to a universally experience organ malfunction. I have divided the section according to the three remaining assumptions listed above.

Flattening all local experiences and narratives of suffering to diagnostic criteria for PTSD and the words **trauma** *or* **traumatic events.** Although Battlemind did not mention the word trauma, the series was designed as a mental health intervention to prevent symptoms of PTSD. After the final post-deployment training, all soldiers were required to take an assessment called the Post-Deployment Mental Health Assessment (PDHRA). All service members, including those on active duty, in reserves or in the National Guard are at some point required to complete this assessment. The PDHRA is conducted 90 to 180 days after post deployment (WRAIR, 2005); ideally, by the time of assessment, veterans will have completed all the Battlemind stages.

The PDHRA assessment begins with the solider first filling out basic information and a health questionnaire online; this is also known as the DD Form 2796. After the solider completes this questionnaire, a clinician completes the PDHRA in person using a form called the DD Form 2900. This is the assessment that determines the type of

benefits and services the veteran will receive from the VA post-combat if they indeed

meet criteria for PTSD.

There are four questions on the DD Form 2900 that pertain to trauma and PTSD,

which were selected from the PCL-C PTSD screener (Weathers et al., 1993). The four

questions are about symptoms experienced in the past month (i.e., approximately 60 days

post-deployment) including nightmares, avoiding thoughts about a horrible, frightening

or upsetting experience, hypervigilance and feelings of numbness. If the solider endorses

at least two of these symptoms they must complete the full PCL-C, which includes 17

questions rated on a scale of 1 to 5 from no symptoms to extreme symptoms (Weathers et

al., 1993). The PCL-C also includes a final question about functionality, "How difficult

have these problems made it for you to work, take care of things at home and get along

with other people?," which is to be rated from not difficult at all to extremely difficult.

After completing the assessment, the clinician is given an algorithm to understand

these symptoms and refer to care; this algorithm is publically available on the DD Form

2900 government document and has been reproduced in Figure 5. Experiencing no

symptoms at all on the PCL-C is equal to a score of 17, thus the range of 17 to 30 is

considered sub-threshold PTSD. The score of 30 to 39 is considered mild symptoms of

PTSD, a score of 40 to 49 is considered moderate, and a score of greater than 50 is

considered severe symptoms of PTSD. In the PDHRA algorithm (Figure 5) anything

above a score of 30 receives PTSD psychoeducation from the clinician. The only veterans

that necessarily must receive a referral to mental health care includes those who received

a PCL-C score equal to or above 50 for severe symptoms with severe functional

impairment (i.e. a rating of difficulty returning to work and usual function as very or

extremely difficult). It is up to the clinician to consider a referral for those soldiers who are in the severe range but do not report functional impairment or for soldiers in the mild to moderate range of symptoms that do report functional impairment.
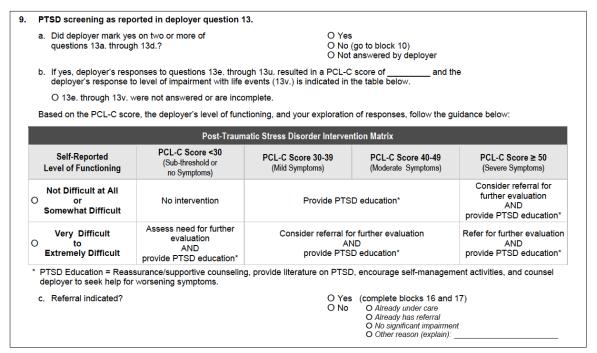
Figure 5. DD Form 2900 algorithm for military health care providers to provide PTSD intervention based on PCL-C scores.

I wondered if soldiers who are indeed referred on (the percentage that endorse above a 50 on the PCL-C and suffer severe functional impairment) would be provided an opportunity to share their story or experiences in combat in more detail after referral to psychotherapy. I examined the referral resources and the first source that PDHRA clinicians are recommended to send veterans to is a website called militaryonesource.mil which provides 12 sessions of confidential non-face to face counseling (i.e., telehealth) for mental health problems. Other resources included referrals to the VA and VetCenters.

Examination of the VA clinical triage guidelines indicated that soldiers need to go through further assessment and are more likely to be provided with

psychopharmacotherapy before counseling (DoD, 2010). When counseling was recommended, TF-CBT was the primary modality of choice followed by variations of exposure-based therapies (e.g., Foa et al., 2009) and stress inoculation training. EMDR was also suggested with caution because the guidelines noted:

> Comparable effect sizes have been achieved with or without eye movements or other forms of distraction or kinesthetic stimulation. Although the mechanisms of effectiveness in EMDR have yet to be determined, it is likely that they are similar to other trauma-focused exposure and cognitive-based therapies. (DoD, 2010, p. 118)

Both EMDR and CBT begin with yet another standardized assessment of symptoms.

Overall, it seems that before a veteran would actually be able to explain any narrative about the war, about what their problems were or what was upsetting them post-deployment, they would have gone through a minimum of three PTSD and trauma related symptom checklists and assessments (PCL-C 4 item screener in DD Form 2796; Full PCL-C 17 item screener in DD Form 2900, CAPS), one traumatic events assessment (e.g., SLES-Q) and various baseline quantitative ratings of distress and functioning (e.g., another PCL-C to begin TF-CBT in addition to ratings of baselines SUDs or in the case of EMDR SUDs and VoCs).

This process of repeated forms and quantitative measurements is an example of the scientist and procedural framework of managed mental health care. Through the completion of these forms and assessments, narrative and local experiences of suffering are reduced to check-boxes of symptoms and assessments of quantitative levels of stress that can be easily monitored, triaged, and used as data to assess patient, therapist and clinical program success. If a solider scores a 49 instead of a 50 on the PCL-C, this one point difference means they do not qualify for referral to therapy or continued services where they may actually get to explain what they experienced on deployment instead of

being subject to filling out a form that lists symptoms. Overall, idiomatic, cultural, or personal experiences of trauma that do not fit within the standard checkboxes cannot come to light through the Battlemind assessment and conceptualization of trauma.

Thought-terminating clichés about cultural competency. Cultural competency did not appear to be an aspiration of the Battlemind training, trainers or soldiers; if anything the series encouraged cultural stereotyping and creation of a feeling that those the U.S. was fighting were inhuman, evil, terrorists that could not feel or experience suffering. Thus the thought-terminating clichés about culture in Battlemind were not disguised as a form of cultural competency; discussions about culture were overtly shut down by indiscriminately labeling persons in Iraq and Afghanistan as "the enemy."

The portrayal of civilians in Iraq and Afghanistan in the training was almost a caricature (e.g., prayer five times a day disturbing solider sleep, images of women in niqabs or burqas holding machine guns (WRAIR 2008a, pg. 8), children reaching out of the rubble to touch a solider (WRAIR 2008a, p. 14); for further discussion of cultural tokenism through selected photo imagery see Lutz & Collins, 1993). Women and children were overemphasized both in the trainer script and visually, as if to remind the soldiers that devastating the country's vulnerable civilians should be expected and that this was ultimately the enemy's plan and responsibility (e.g., "Remember the enemy is not going to fight fair. He is going to hide behind women, children, in churches, among civilians;" p. 8). Already within the first slides of the pre-deployment Battlemind training there was a sense of reframing the soldier's personal responsibility for civilian death, and particularly guilt about killing women and children, as being the responsibility of a faceless enemy.

It was notable in the "what you will see, hear and smell" slide series that the impact of war on the culture was not overtly recognized and was instead presented as part of the environment of the "third world hostile forces." Cultural notes were not intended to be presented to the soldiers; anything that could possibly provide more detail or humanize the civilians or combatants was omitted from the training.

While the intent of presenting the soldiers with what to expect on deployment was to eventually argue that they must focus on fortifying their Battlemind, the presentation had moral overtones that suggested that killing the enemy (and even children, women and civilians when the enemy was hiding behind them) was somehow permissible or ethical because the enemy would not be fighting fair and following the rules. All conversation about the morality of war, let alone the culture of the persons and country that the U.S. occupied, were avoided by reframing the environment as a third-world landscape of the enemy. The involvement of the U.S. was presented as a moral mission in such a way that people of Iraq and Afghanistan were seen as somehow incapable to defend themselves or were some how amoral if they resisted the U.S. involvement.

Exclusion from the definition of trauma. From the two sub-themes of this section presented above it was clear that Iraq and Afghani civilians and combatants were excluded from being understood as experiencing trauma or suffering. U.S. forces were seen as bringing stabilization and healing to the nation that was assumed to be already undergoing civil war and filled with evil insurgents. From the PDHRA assessment, it was apparent that having a symptom threshold below a 50 on the PCL-C excluded a solider from PTSD treatment and related services. Other than these two major exclusions from trauma conceptualizations, the Battlemind trainings steered away from labels of trauma

and traumatized and instead suggested that some soldiers would have war stress injuries but all would have problems with resetting their Battlemind. Almost all soldiers were treated as if they were not traumatized per say but were experiencing the normal problems of Battlemind adaptation.

This presentation of trauma and PTSD as a normal stress injury had a paradoxical effect of excluding all soldiers from the definition of traumatized and trauma disordered, while also including everyone in the definition of potential war stress injury and Battlemind adaptation problems. The training allowed all soldiers to consider themselves wounded from war because of a courageous and not pathological form of injury.

Thematic discussion: Trauma as universal and culture-free. While the experience of a Battlemind injury was seen to be universal among soldiers, trauma was not seen as universally experienced or culture-free; Iraqi or Afghani civilians or combatants were not considered to be suffering or traumatized and the insurgents were presented as evil and amoral. There was no discussion of prolonged violence existing in Iraq and Afghanistan before or during OEF, OIF, and OND. Instead the countries were presented as having "a third world smell" as if it was intrinsic that these countries would naturally smell like fuel, burning flesh and hair, open sewage, and heavy chemical and industrial smoke. These are the smells of a landscape of war; burning flesh should not be considered to be a natural "smell that a lot of third world countries have" (WRAIR, 2008a, p. 17); these are the smells of a country that is undergoing chronic violence and war. Overall, the experience of trauma was seen as personal injury endured only by soldiers; Iraq and Afghani persons were not seen within the clearing of traumatic suffering.

In contrast to the exclusion of Iraq and Afghani persons from consideration of trauma, within the military, trauma was seen as a culture-free universal experience to all soldiers that could be easily understood and assessed as a skill malfunction (Battlemind maladaptation) or type of physical injury. The symptoms of war-stress were seen as so standard and universal that they could be identified according to symptom checklists of four questions in the PDHRA assessment. The algorithms utilized by the PDHRA clinicians were similar to those that Young (1995) witnessed being developed at the National Center for PTSD. The assessment did not elicit any narrative about what happened in the war or any of the unique qualities of soldiers' experiences. In Battlemind, the act of asking about mental health post-deployment was transformed into an efficient algorithm to adequately triage service members to the appropriate care or provide them a PTSD pamphlet. Overall, from the check-box symptom assessments to the presentation of the war itself, in Battlemind there was no room for discussion or consideration of the political and personal ramifications of war on the soldiers or civilians in the U.S., Iraq and Afghanistan.

Shared Exemplar 1: Indoctrination into a Social Void of Scientistic Managed Care

Exemplars are stories or vignettes that capture what human being is like in a particular cultural or historical situation. In this study, I looked for exemplars that captured what human being is like in trauma culture in such a way that it could be recognized in other situations that might have very different objective circumstances, including those outside of the practice of psychotherapy. In particular, I focused on identifying the therapeutic techniques and practices that trauma treatment manuals

prescribed to training therapists, and noted the similarity between these techniques and practices to others in the social world.

The shared exemplar, which I titled, indoctrination into a social void of scientistic managed care, has four primary features: presentation of an origin myth, locating pathology and healing within the dyad, overreliance on forms, hand-outs and PowerPoints, and directive psychoeducation and thought-replacement.

Exemplar findings: Indoctrination into a social void of scientistic managed care. This section presents quotations from the Battlemind series that are representative of this shared exemplar. I have divided the section according to the four features listed above.

Presentation of the therapy's origin myth. Samelson (1974) coined the term "origin myth" to describe the presentation of an apolitical, transhistorical narrative of incremental progress towards an objective truth and science. In an origin myth, the subject is decontextualized and presented in the form of discoveries from individual geniuses (typically white Euro-American men) who each contributed to the development of the contemporary understanding of psychology. The purpose of an origin myth is to provide legitimacy to contemporary psychological concepts by presenting them as facts that have existed in the same form for hundreds or even thousands of year. Each of the trauma manuals interpreted in this study included some version of an origin myth and often this myth was incorporated into psychoeducation about why the patient should be attending the specific form of therapy prescribed by the manual.

The Battlemind origin myth begins with the original Battlemind trainings by General Crosbie Saint (Saint, 1992). The term "Battlemind" was coined by Saint when he

was the Commanding General of the U.S. Army Europe in the 1980s (WRAIR, 2006c).

General Saint's *Battlemind Guidelines for Battalion Commanders* (1992) described

Battlemind as "a soldiers' fortitude, the inner strength to face adversity, fear and hardship

during combat with confidence and resolution…the will to persevere and win" (p. 1).

Saint's guidelines were developed in the post-Vietnam era when the PTSD construct rose

in popularity and the normative history of PTSD (Appendix A) and several origin myths

about the timeless quality of PTSD were popularized (Young, 1995). Saint's origin myth

locates Battlemind as a concept intrinsic to human society for thousands of years, "The

development of solider attributes underlying Battlemind is based on the principles of

human behavior and in part the practices of successful armies over a span of 4000 years

(e.g., Xenophon (Rouse, 1947) and Sun Tzu (Clavell, 1983)" (p. 15).

Adler, Castro and McGurk (2009) drew from Saint in their development of the

Battlemind training and debriefing series but slightly reworded the Battlemind definition

to be, "A warriors inner strength to face adversity, fear and hardship during combat with

confidence and resolution. It is the will to persevere and win" (WRAIR, 2006c, p. 3).

Throughout the contemporary Battlemind training and debriefing series General Crosbie

Saint was referred to periodically. For example, the final post-deployment training notes

that the term Battlemind was coined by Saint "to train his battalion commanders how to

develop the warrior ethos that they would be leading into combat" (WRAIR 2006b, p. 2).

Thus, while Saint located Battlemind as a concept intrinsic to humanity for thousands of

years, the authors of the contemporary Battlemind referred to Saint as further support for

a long tradition of training soldiers in building "armor for their mind" (WRAIR 2008a).

The Battlemind I post-deployment training (WRAIR, 2006a) also began with an origin myth about returning home from deployment:

> History has taught us that combat veterans from every war America has fought in from the Civil War to the Spanish-American War, to World War I and World War II, from the Korean War to the Vietnam War to the first Gulf War to the present, report being angry and edgy…but they're always happy to be back home. (WRAIR, 2006a, p. 2)

This myth suggests that veterans throughout time—from the Civil War to OEF—have always experienced the same reactions to the war. The utilization of this origin myth is problematic for many reasons, namely by naturalizing the state of war, existence of the current expression of PTSD symptoms throughout time, and evidence-based trauma treatments that currently reduce personal and public responsibly for killing (cf. Camus, 1946) and make it acceptable to turn inward (cf. cognitivist ideology; Sampson, 1981) rather than to the social realm to discuss the implications of war and violence; this will be discussed below.

Location of pathology and healing in the dyad. In the Battlemind training series pathology and healing in human relationships were often described in dyadic form. There was particular emphasis on the relationship between the soldier and their battle buddy. The post-deployment training framed the relationship between the solider and their buddy as one where the buddy was responsible for monitoring the well-being of their fellow solider, "You know each other. Can you recognize if you buddy is having a hard time? If no, this training will help you to recognize when it might be time to help a buddy or to get help yourself. Look around and help out those who are struggling" (WRAIR 2006c, p.4).

Buddies were particularly emphasized on the set of slides that presented a post-deployment reaction to war or readjusting home or what was framed in the training as a

Battlemind maladaptation dilemma (described in the following section, Directive

psychoeducation and thought-replacement, pp. 424-425*)*. Each dilemma included a

Battlemind check for self and buddy that listed three questions such as has your buddy,

"threatened someone with a weapon? Carried a loaded weapon in the car? Kept an

unsecured loaded weapon at home?" (WRAIR, 2006c, p. 9). After performing the self-

and buddy-checks for each Battlemind dilemma the buddy's role was to help the soldier

adapt their Battlemind and prevent the soldier from hurting themselves or another person

when adjusting to life at home.

The end of the training focused particularly on how the solider should get help

through the buddy dyad, "Here are some ways to get help. As we've already talked about

the first place Soldiers go to for help is to their buddies and to their good leaders"

(WRAIR, 2006c, p. 54). After presenting buddies as the first option the trainer suggests

the chaplain, "What's the nice thing about going to a chaplain for help? It's confidential"

(WRAIR, 2006c, p. 54). The trainer then suggests that soldiers go to the medical clinic

and to say, "If you need more help you can you go to? Behavioral Health. You can also

go off post. However, depending on where you are stationed, behavioral health specialists

may not speak English and you may have to pay out of pocket for it" (WRAIR, 2006c,

p. 54).

While inclusion of the buddy on some level may seem more relational or

community-focused than other forms of therapy that recommend complete reliance on or

calling the therapist instead of a community member when in distress, the buddy's role

was prescribed as one that was surveillance and compliance oriented. For example, the

goal of buddy-checks was ensure the buddy follows the Battlemind training principles or

is referred to behavioral health/therapy if they cannot. Thus the buddy, while supportive

and involved in the soldier's life, was prescribed by Battlemind to ideally act as an

extension of the clinical gaze (cf. Foucault) to ensure that any solider that acted out of

line could be eventually referred to or flagged for mental health treatment- even when

this behavior occurred in social settings and outside of military service.

One of the final video vignettes in Battlemind II post-training (WRAIR, 2006c)

involved such a scenario where two senior non-commissioned officers (NCO) who were

assigned as buddies were discussing a solider "SGT Jones" or "Jonesy" (p. 85) who went

from being a "go-to-guy" to now getting into "all kinds of hot water" (p. 85). The video

appeared to have been set up to invoke a sense of care-free masculinity, as both NCOs

are out of uniform, bearing their muscles in casual tee-shirts, and working out together as

they play basketball in the sunshine. The first NCO recommends to his buddy that

Jonesy be referred to counseling. The buddy, who is "not a fan of mental health" accuses

the first NCO of "going soft" (p. 87). The first NCO then reveals to his buddy that he

actually once attended counseling because upon returning home from Iraq he was so

depressed and angry that his wife threatened to leave him and take their children. The

buddy asks if the first NCO's Commander knew, and he reveals that in fact the

Commander recommended he go to counseling. The trainer script read:

> This NCO believes the myth that only weak Soldiers have MH [mental health]
> problems. He gives his buddy a hard time for suggesting that SGT Jones might
> need some assistance…and he never would have guessed that his own buddy, a
> senior NCO, would be going to counseling (p. 93).

By the end of the vignette everyone agrees that Jonesy should go to counseling

and that it is "a myth that only weak soldiers have mental health problems" (p. 94). Thus,

the training recommends that the buddy-dyads encourage referral to therapy when the buddy cannot directly assist in offering skills to reset their buddy's Battlemind (Table 5).

In sum, all of the healing relationships were presented in dyadic form: self-buddy, soldier-chaplain, solider-doctor, and solider-therapist. The other primary relationship emphasized was returning home to a significant other or spouse. The assumption appeared to be in the training that the solider would have one primary significant other who would be affected by and would be a primary support for the solider. This was true to the extent that Battlemind actually included a spouses' training, which was not analyzed as a part of this study. All of the dyads were described as supportive to the solider suffering from mental health problems, and the aim of all the dyadic interactions was to refer to mental health treatment. Thus the soldiers learn that suffering can be expressed in the social sphere of the dyad (anything larger than this might be unacceptable) and that referral to mental health is the most acceptable response to soldier's in distress.

Over-reliance on forms, handouts, and PowerPoint in therapy. Battlemind pre- and post-deployment trainings were designed as PowerPoint presentations where the trainers (the psychologists or therapists and leaders) delivered the training by reading from presenter notes on the PowerPoint. The PowerPoint format with trainer notes allowed for the trainings to be standardized across platoons in the military and for any leader to be able to deliver the exact same preparation for deployment to each platoon. The experience of Battlemind training for soldiers would be sitting in a room watching a screen and responding to prompts from the trainer.

The in-theatre debriefings did not involve a PowerPoint presentation; however, the interactions were also divided into modules and scripted (Adler et al., 2007). Each solider was given a Battlemind resource card at the end of the de-briefing that apparently contained all of the information a solider would need to respond to in-theatre distress:

> We're going to give you a card with all your local behavioral health resources on it. [To trainer]: (review the resources briefly, especially ArmyOne Source). Leaders may want extra cards. If you are a leader, or will be a leader soon, then you don't want to be fumbling around trying to find out where to get one of your service members the help he or she needs. All the information you'll need is here on the card. (Adler et al., 2007, p. 23)

The assessment of the training effectiveness and solider mental health was conducted by following the protocols outlined on several forms (e.g., PDHRA and DD Form 2900; see further discussion of the assessment in the section, Flattening of All Local Experiences and Narratives of Suffering, pp. 410-414). Overall, the solider would encounter a total of three to four PowerPoint presentations, multiple resource cards and referral handouts (depending on number of in-theatre debriefings attended) and would complete upwards of seven mental health assessments and related forms.

Directive psychoeducation and thought-replacement. The Battlemind pre-deployment training provided psychoeducation about what to expect during the war and how to respond to these thoughts by engaging Battlemind. I have presented examples of directive psychoeducation throughout this section such as the "What you will feel, think, smell" on deployment slides. There was minimal directive psychoeducation about PTSD and trauma related disorders in the pre-deployment training, except for one slide in the Leader's training which read, "Reactions that are sometimes called PTSD can help Warriors survive in combat. Most Warriors (80-90%) do not develop PTSD but some

need help […] [PTSD] is a very complex diagnosis that has several symptoms including intrusive memories, flashbacks, nightmares, being hyped up, [and] sleep problems" (WRAIR, 2008a, p. 51). This was the first mention of PTSD (out of two in the entire training) and it was presented in the pre-deployment training as being adaptive for deployment.

The post-deployment training utilized thought-replacement in each vignette of how to reset their Battlemind skills for the home zone. As the training stated, "Battlemind skills will help you survive combat and high-risk military deployments; however, these same skills will cause problems when you get home *if you fail to adapt them*" (WRAIR, 2006c, p. 4). The training included thoughts soldiers might have after returning from deployment and how to adapt Battlemind by resetting it with new thoughts (Columns 3 and 4 of Table 5). Table 5 presents how a Battlemind skill can go wrong post-deployment followed by an example of a Battlemind replacement thought that the training suggested would be adapted for the "home zone." The training did not use or mention the language of thought-replacement but the proposed interventions involved the trainer suggesting alternative actions and thoughts for the soldiers to engage in as a part of resetting their Battlemind to adapt to returning home post-deployment (Column 4, Table 5).

Exemplar discussion: Indoctrination into scientistic managed care. This exemplar had four primary features: presentation of an origin myth, locating pathology and healing within the dyad, overreliance on forms, hand-outs and PowerPoint presentations, and directive psychoeducation and thought-replacement. Many of these features are therapeutic techniques that are a form of indoctrination into a world of scientistic managed care that ignores social relationships outside of the dyad, and values

compliance and control as a good way to be human. The techniques described in this exemplar were not limited to Battlemind or psychotherapy in general.

To begin to indoctrinate the patients into the culture of compliance-oriented care management, Battlemind utilized an origin myth to suggest to the warriors that values and practices of Battlemind are static and have been accepted by soldiers for centuries. What is particularly important about this origin myth was the idea that war itself was somehow natural to humans and exists today in the same form as it did thousands of years ago. As Camus (1946) pointed out, warfare has changed immensely with the invention of modern technologies like the atomic bomb and more recently unmanned aircraft drone strikes. These technologies and abstraction of bureaucratic procedures, like attending PowerPoint trainings and filling out several DD Forms, have allowed for a social distance between those who participate in or standby while war occurs; in short, these technologies have allowed murder to become depersonalized. The war of one thousand years ago that General Saint mentioned is not the same kind of war that is fought today; and certainly the mental training to arm, reset and deprogram the modular warrior reflects and reproduces a contemporary, industrialized and depersonalized world that is not the same as it was in ancient Greece.

One danger in the origin myth of PTSD is acceptance that the current state of dissociated and distant acts of killing that involved in war are somehow historically similar and acceptable (i.e., natural, time-tested, honorable or traditional) to all wars. The second danger is that naturalization of the particular symptom expression of PTSD as it is presently represented in the *DSM-IV*. As I reviewed in the background the contemporary medicalized expression of trauma is relatively recent historically. The normative history

of PTSD (Appendix A) emerged in the 1980s after the National Center for PTSDs

development of the PTSD "knowledge product", which included a *DSM III* diagnosis,

research and treatments for the disorder. The disorders listed in Appendix A are quite

different, but their compilation into a single history or origin myth that appears to make

incremental progression to modern-day PTSD suggests that contemporary expressions of

trauma (that are cognitivist, asocial and interior) have always existed in this way. Careful

examination of the table and the definitions of trauma suggest otherwise (e.g., reactions

to war post-OEF are rarely expressed as muteness, as was common post-WWI; women's

experience of trauma was seen as categorically different to men's experience). When

comparing the traumatic sequelae and context of wars like WWII and Vietnam (See

review in Chapter II: Background and Literature Review, pp. 76-88) to the Civil War and

to OEF, there are distinct differences, such as the reasons for war, countries and cultures

involved, political climates, technologies available, and public reactions to war, to the

extent that it would be nearly impossible for these veterans to experience and express

reactions to war in the same way.

Another danger of accepting the origin myth of PTSD and those included in

Battlemind is the tacit suggestion that because distress has been expressed similarly over

centuries, the healing technologies (e.g., form, worksheet and manual-based therapies)

are the natural, common-sense response to distress. The therapies in this instance

contribute to the maintenance of the origin myth and societal acceptance that war is

natural and responses to war should be apolitical and asocial; they should occur primarily

in the mind or in the privacy of a healing dyad (e.g., therapist-patient, solider-spouse).

In Camus (1946) commentary on WWII, people were described as consumers or spectators that could be appealed to by fear, rather than by interest in social relationships; society was gripped by terror such that reflection was impossible. The Battlemind trainings are perhaps Camus' nightmare; they have been born from the continued reality of a depersonalized dystopia that Camus recognized and feared post-WWII. The Battlemind training series and the therapists who participate in this training are training soldiers through thought procedures about how to avoid thinking politically and socially about the moral consequences of murder.

Before continuing I should note that though the psychoeducation and thought-replacement exercises utilized in Battlemind provide a mental map for soldiers to follow to reprogram or reset their mind, as if they were robots, I do not intend to collude with the training in suggesting that soldiers actually are robots that simply can be programmed to accept their trainings. They are not passive vessels that have lost the capacity to think critically and morally and they are not completely subject to accepting and absorbing Battlemind trainings. It's possible soldiers have found ways to resist Battlemind and express suffering in different ways than those suggested by the training.

Although I believe that soldiers may not accept or actively can resist the training, from my interpretation of the Battlemind manuals, it was difficult to understand how soldiers might do this. The training did not appear to not make room for varied forms of suffering or resistance and certainly did not allow for reflective way of human being to come to light. I have further explored the forces of thought-reform and milieu control that make it difficult for soldiers to resist Battlemind training below.

Battlemind Exemplar 1: Battlemind Creates the Warrior Cult

Exemplars are stories or vignettes that capture what human being is like in a particular cultural or historical situation. In this study I looked for exemplars that captured what human being is like in trauma culture in such a way that it could be recognized in other situations that might have very different objective circumstances, including those outside of the practice of psychotherapy. In this section, I present an exemplar that I only interpreted for the Battlemind training and debriefing series: Battlemind creates the warrior cult (cf. Lifton, 1973). I later present the Warrior Cult as a paradigmatic object that exists as a way of being more broadly in trauma-based society; however, here I focus on the technologies and techniques of therapy that create the warrior cult. In other words, this exemplar describes how the cult is created. The cult itself I later interpret as a way of being.

Exemplar findings: Battlemind creates the warrior cult. The structure of military socialization in Battlemind resembled both a coming of age ceremony and cult indoctrination. I reviewed the broad structure of cults and indoctrination and their relationship to coming of age ceremonies in the Background and Literature Review Chapter (pp. 119-128). Here I discuss specific examples of this structure in Battlemind.

Creation of altruistic cult leaders in Battlemind. The Battlemind training was structured so that psychologists trained the leaders and the leaders trained the soldiers in their platoon in Battlemind. The psychologists primarily used the thought-reform technique of dispensing of existence (described by Lifton, 1959/1989) in the leader training to ensure that leaders followed Battlemind guidelines and created an environment of obedience and dependence amongst the soldiers. To emphasize the do-or-

die nature of the training, the first responsibility the leaders were given via the training is the responsibility of the health and well-being of the soldiers. The training stated, "As a leader, you're going to be the guy to get the bad news as it is. […] You have an obligation to take care of your Soldiers, you are the ones to deal with the news. You need a strong mind—your Battlemind—to accept those facts as they are" (WRAIR, 2008a, p. 27); "Good leadership keeps up morale and cohesion and contributes to Soldier mental health. I mean your level of leadership, not battalion or brigade leaders, you guys" (WRAIR, 2008a, p. 43), and "The only real measure of leadership in combat is mission success, valor in combat and leader performance, never personal gain. It's about you taking care of your Soldiers" (WRAIR, 2008a, p. 45).

Battlemind incentivized leaders for taking care of their soldiers by suggesting that the leaders will get better performance and obedience from their soldiers if they take responsibility for their wellbeing. For example, the leader training concluded with a slide titled "The American Warrior" that featured a quote from Dwight Eisenhower:

> The capacity of soldiers for absorbing punishment and enduring privations is almost inexhaustible so long as they believe they are getting a square deal, that their commanders are looking out for them, and that their own accomplishments are understood and appreciated. (WRAIR, 2008a, p. 72)

The training also described how indecisive and poor leadership can cost-lives, "combat is not time for a learning curve because mistakes cost lives. If you have a leader who is struggling with his or her responsibility, you need to reassign them. This can be a tough reality. But you owe it to your Soldiers" (WRAIR, 2008a, p. 44).

To gain the benefits of greater solider performance and endurance, the training instructed the leaders on how to establish credibility and trust so that soldiers will be more willing to rely on the leaders and eventually report problems, like traumatic stress

injuries, to the leaders. The training described to the leaders how they can provide

financial incentives and light duty to soldiers when they are having problems to ensure

that the leaders are trusted:

> Don't let family problems go unanswered. When we give Soldiers pre-
> deployment Battlemind training we tell them to talk to their leaders if they are
> having family problems and talk to you early. But what are you going to do with
> that information? …If you listen, if you identify actions you can take (whether
> through finance, the rear detachment, whatever) if you follow-up and check-in
> with the Solider to see how things are going, then your unit will know you're that
> kind of leader. (WRAIR, 2008a, p. 45)

The training continued that leaders should create home-like environment to

further foster trust, "It doesn't take a lot of effort to keep track of important milestones in

a Soldier's life (the birth of a child, a graduation, anniversaries). But a little attention to

those details can go a long way" (WRAIR, 2008a, p. 61). The training also directed

leaders to ensure they give out resources including water, food and rest fairly among

team members to retain credibility (WRAIR, 2008a, p. 65).

Though the platoon leaders were in many ways trained to be positioned as cult

leaders (e.g., given ultimate control over sleep, eating, job responsibilities, physical and

mental well-being and many cases life-or-death), they may not meet the classic

description of a narcissistic cult leader that self-assigns these responsibilities and believes

they have a mystical connection to a higher power (cf. M. T. Singer's (1995) definition).

Instead, the leaders were trained to foster extreme dependence of their platoon for the

purposes of the larger military goals, which on a micro-level was the early identification

of or overcoming of PTSD symptoms. On a more socio-political level, the early

identification of PTSD may also serve to identify soldiers that might seek support outside

the military, or otherwise be so outraged, violent, or depressed that they might instigate

some type of social change or rejection of the government's prolonged involvement in

war if they are not placed in therapy (cf. Young, 1995). The leaders face pressures to foster dependence on the military that they in turn place on their soldiers.

Milieu thought-reform in Battlemind. I have provided examples of Lifton's (1959/1989) milieu thought-reform techniques in Battlemind. The format of this section follows similar studies that have used Lifton's identified structure of thought reform to interpret cult phenomenon in psychology (Cushman, 1986, 1989). I did not include detailed discussion of the techniques of mystical manipulation, scared science and the cult of confession because there were few examples of these techniques in the Battlemind training. I presented examples of Lifton's thought-reform techniques here in order of those that I found most to least salient in the texts:

Milieu control. This feature of thought-reform includes taking over the entire social milieu through manipulation and control of bodies and their environment such as controlling food, rest, time structure and human communication. The military structure almost by definition involves milieu control (e.g., uniforms, set schedule, strict adherence to military procedures, rules of engagement, leaders dole out resources and set sleep and eating shifts). Prior to Battlemind it is likely the platoon already experienced milieu control in other trainings (e.g., boot camp), and thus soldiers were already primed to respond as a group rather than as individuals to the Battlemind pre-deployment training. I was interested in how thought-reform was continued in the Battlemind psychological training and debriefing over and above the general milieu structure of the military.

The first aspect of milieu control I identified was that attending Battlemind trainings and debriefing was not optional. Battlemind was designed as a preventative treatment for PTSD, sleep problems and depression for the Solider Comprehensive

Fitness Program and was required for all recruits before deployment. Similarly, the in-theatre Battlemind debriefings were required on deployment and often occurred on a set schedule (Adler, Castro, et al., 2009). Given the absence of the words treatment, trauma and PTSD in the Battlemind and the euphemisms for emotional reactions to war (e.g., Battlemind injury; see also thought-terminating clichés in Table 6), its unclear if soldiers could gain awareness that they were attending a mandatory psychological training and preventative treatment (cf. Heller's (1988) secrecy).

The second aspect of milieu control that I identified was the requirement that every person with which the solider has regular contact when deployed (i.e., leaders, fellow warriors and spouses) was required to take a Battlemind training. This is a key feature of creating in-group mentality with milieu thought-reform and distancing of outsiders. By ensuring that the recruit will only have contact with those who have undergone similar indoctrination processes they will be more likely to adhere to and encourage the principles promoted in Battlemind. For example, the adage of "Battlemind Check (Self & Buddy)" was repeated on every slide in the Warrior post-deployment training (over 30 times in the hour long training); the message was that retention of Battlemind and awareness of problems is the responsibility of first yourself, then one's assigned buddy. The buddy's job was to help remind the warrior about the principles of Battlemind. If the buddy somehow failed to address the warriors' problem and convince them to seek help, the soldiers were provided with a list of contacts, ranging from therapists to chaplains, to talk to; none of the persons on the list were outside of the military organization and culture and all had received Battlemind training.

The dispensing of existence and doctrine over person. Dispensing of existence

indoctrination involves simulating the fear of extinction such that deviating from training

or attempting to leave the training suggests a life-or-death scenario. In doctrine over

person, the organization creates situations in which it respects and values its doctrine and

objectives more than individuals of the organization. This can lead to situations where the

brutalization of the individual is condoned or even encouraged (e.g., an individual's

suffering may be attributed to misapplication or doubting of the group's doctrine). In the

Battlemind trainings these two techniques were used in tandem. Deviating from the frame

of the Battlemind trainings was defined as leading to a potential safety risk or life or

death scenario (dispensing of existence) and those who did so were seen as not absorbing

the principles appropriately and being uncourageous (doctrine over person). On the other

hand, those who did die courageously by adhering to the principles of Battlemind were

seen as sacrificing their personal goals for the goals of the military, and ultimately for the

freedom of the country (doctrine over person). Either way death was explained according

to the doctrine or as ultimately due to the acceptance or rejection of the principles in the

Battlemind training.

    In both the pre- and post-deployment training examples there was emphasis on

preventing death through engaging one's Battlemind. The following quotations from the

Battlemind training for leaders demonstrated how the psychologist trainers instruct the

leaders to create an environment of dispensing existence. The quotations are presented in

the order they appeared in the training manual texts:

> The first objective of Battlemind training is to prepare Warriors mentally for
> rigors of combat and other military deployment…The final objective is to prepare
> Warriors to possibly deploy again in support of all types of military operations
> including additional combat tours. (WRAIR 2008a, pp. 4-6)

> The worst days are going to test your Battlemind- Your inner strength to face fear and adversity in combat with courage. (WRAIR 2008a, p. 11)

> If you don't drive on, if you get stuck on decisions that you've made and feel guilty about them, what will happen the next time you need to make a decision. You're probably going to freeze. And what's the problem with freezing? What may happen? People can get killed or injured. If you end up second-guessing the decisions you made remember this training and focus on what you've learned. Watch out for each other and encourage each other to get past the second-guessing, the guilt. Trust your training, trust your leaders, trust your buddies. (WRAIR 2008a, p. 20)

These quotations demonstrate how the trainers build a progressive argument for dispensing of existence as the training progresses. The argument demonstrated in the quotations above can be summarized: 1) Battlemind is needed for protection in battle and for possible redeployment (if you don't attend you won't be protected); 2) You will have times when you will want to go home, but staying is considered courageous and your Battlemind will protect you (if you try leave you will not be considered courageous so strengthen your Battlemind now); and, 3) If you feel guilty about participating in war or killing someone this could lead to freezing and eventual death (don't think morally; don't second guess your Battlemind or you will die).

In the post-deployment training there was continued emphasis on not feeling guilt or second-guessing their training and participation in war. The following quote focused on what was referred to as "driving on" while feeling grief:

> It's 3 to 4 months since you've been back. Should you still be grieving? [Trainer: Listen for/say: yes.] But if that grief or guilt is keeping you from enjoying your life then you may need to get help. … It's easy to say in hindsight to second-guess your decision or the decisions of others. With the info you had at the time, would you make the same decision? Probably yes. It's learning from your decisions without second guessing them that's important. […] If you're feeling so much grief that you can't be happy or appreciate life then you may need to go get help (WRAIR, 2006a, p. 36-37).

The post-deployment training continued by suggesting that the soldier's "dead buddies" would not want them to obsess about their actions, "Don't allow your survival guilt to destroy you. Your buddy would want you to drive on... If you could have gone back to the day before your buddy died and [asked], 'What if you died? Would you want me to drive on?' He'd say yes... Remember the fallen and live a life worthy of their sacrifices" (WRAIR, 2006b). The emphasis in these sections was on adhering to the skills learned in pre-deployment training and "driving on." Driving on was a euphemism for not thinking morally or at all about the war. After presenting several scenarios in which the soldiers should "drive on" without thinking about consequence of their actions, the trainers were then asked to "prompt for survivor guilt" and to elicit stories from the group when they lost a comrade. The trainer then was to prompt the soldiers' to give their buddies "a head's up before [they] go on about second-guessing" (WRAIR 2008a, p. 20) because it could risk their life.

Overall, dispensing of existence was utilized in the pre-deployment trainings to ensure that the soldiers absorbed the Battlemind doctrine (lest their Battlemind became so weak, lacking courage and ambivalent that it leads to death) and that soldiers continued to retain a mentality of "driving on" and "not second guessing" when questioning the military or their participation in the war after they have returned from deployment. Those who did second-guess suggested to be weak or problematic to the military.

While it is undoubtedly true that the threat to the soldiers' life exists while deployed, the element of thought-reform that was utilized in this part of the training was the claim that the threat of death was more likely if the solider engaged in thinking, doubting or experiencing any guilt about their actions in war. The message to the soldiers

reiterated throughout the training was that they were also responsible for making sure their buddy-comrades did not think about the morality of participating in war in order to prevent the buddy's death.

A final example of doctrine over person occurred when Battlemind rationalized the suffering of the platoon and deaths of soldiers who did not second-guess and who adhered to the Battlemind principles. The idea of an honorable death by adhering to Battlemind principles and fighting for ones country was promoted in the final sentence of the last post-deployment training, "Freedom is free for most Americans. But not for you all. Everyone of you has made serving your country a personal priority and you've made the sacrifices. Most American's won't make that sacrifice. So be proud of your service" (WRAIR, 2006b, p. 30).

The demand for purity. The demand for purity involves creating an idealized or perfect model to strive for in such a way that members never feel satisfied or competent; this aspect of thought-reform increases reliance on the group leader and the official ideology to guide the members. I interpreted there to be two primary idealized models promoted in Battlemind: the mentally strong warrior solider who is unaffected by war and the solider who gets helps for his problems. I refer to these models as the Battlemind Warrior and Audie Murphy Solider respectively.

The ideal of the Battlemind Warrior was emphasized in the pre-deployment trainings as a solider who continues to exude mental toughness in the face war. Examples of the Battlemind Warrior ideal were represented in quotations like, "Deployments can strengthen your Battlemind" (WRAIR, 2008a, p. 15), "You guys are tough. There is no doubt about that. You are physically and mentally tough. You'll be able to handle what

the enemy throws at you" (WRAIR, 2008a, p. 26). In a slide titled "What a warrior should know and do" the first instruction is to, "Steel your Battlemind" (WRAIR, 2008b, p. 26) this was defined at a later part in the training to mean, "Maintain your mental toughness, meet challenges head on, be confident, take calculated risks and maintain positive thinking during times of adversity and challenge" (WRAIR, 2008b, p. 30).

The post-deployment trainings, emphasized the ideal of a solider who is mentally tough but also knows when to seek help—the Audie Murphy Solider, which I previously described in the section: Valorization of the Enterprising Self (pp. 397-399).

Both the Battlemind Warrior and the Audie Murphy Solider present masculine archetypes, similar to those that Arkin and Dobrofsky (1978) described in their analysis of military recruitment. [59] They wrote about how the military is designed to re-capitulate the lifecycle where boys enter as a skinned-head recruit, attend warrior initiation, and for some, leave the military as men—badged and rewarded in retirement. Arkin and Dobrofsky's thesis was that for soldiers between the ages of 17 and 20, a time period often seen as the transition between adolescence and adulthood, the military creates an environment for formation of a masculine military identity that is so powerful that soldiers are unable to give up this identity during the transition back to life at home. This leads to many of the problems that have now been identified as symptoms of PTSD (e.g., avoidance of relationships, anger, replaying military events).

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[59] Arkin and Dobrofsky (1978) identified three masculine coming-of-age archetypes that emerged during each phase of military socialization: the heterosexual female archetype which is to be dominated and conquered as a part of war, the team archetype in which failing is letting down your friends and compatriots, and the family archetype in which soldiers are prepared for ongoing separation from loved ones.

Attaining both the ideals of the Battlemind Warrior and Audie Murphy Solider presents an impossible bind for soldiers: the warriors should "steel their mind" (WRAIR, 2008b, p. 26), be courageous, and remain unaffected regardless of what the enemy throws at them (e.g., drive on and don't second guess); yet, after deployment, they are expected to quickly recognize every reaction that they were previously asked to ignore during war and seek help. They must somehow recognize their symptoms, alter their Battlemind, and retain hero status. As I previously discussed, given these impossible glorified models it is unsurprising that psychologists inform the leaders during their training that 65% of soldiers don't report seeking help for fear of being perceived as weak (WRAIR, 2008a, p. 55). Based on this trend, despite likely feeling the weight of confusion, guilt and suffering after war (cf. Marin, 1981), the demand for purity prevails on the veterans.

Cushman (1989) has described the demand for purity as a major step in creating what Lifton (1959/1989) identified as the "sacred science" and Heller (1988) called "miracle" where the organization develops an ideology that embodies a universal truth that is believed to be sacred, flawless and transcendent. The act of questioning, doubting or disagreeing with the sacred science is considered to be an individual personality flaw. In this case, because soldiers may perceive themselves as failing to meet the ideals of the hyper-functional and masculine Battlemind Warrior and Audie Murphy Solider they develop greater dependence on the military in hopes they will one day meet these ideals. In turn they are less likely to question the idea that these two archetypes may represent unattainable ideals or reject the notion that anger, confusion and other common reactions to participating in war are due to personal failure. The demand for purity also contributes to upholding the sacred science because soldiers may also be less likely to leave or to

seek help from sources outside the military when distressed for fear of seeming weak or not "man-enough."

 Loading the language. Speaking in thought-terminating clichés creates intellectual confusion, maintains group cohesiveness, and keeps outsiders from making meaningful contact with the group. Table 6 includes a list of clichés, jargon and euphemisms that were repeated throughout the training. Many of the clichés represented the moral doublethink (cf. Orwell's *1984*) that was promoted throughout the training: it is noble, right and good to engage in warfare but it is not good or acceptable to think critically about the morality behind decisions. The problem with thought-terminating clichés is that the therapy contributes to creating the very symptoms, such as confusion and avoidance, that it was designed to treat.

Table 6

Battlemind's Thought Terminating Clichés

Cliché	Quote of Trainer Script Surrounding One Utilization of Cliché (Citation); Meaning	Potential Thoughts the Cliché Terminates	Taken for Granted Assumption About Human being
"Steel your Battlemind" (WRAIR, 2008b, p. 26)	"Maintain your mental toughness, meet challenges head on, be confident, take calculated risks and maintain positive thinking during times of adversity and challenge" (WRAIR, 2008b, p. 30); Don't let war affect you.	• This experience can't be overcome mentally. • This will be horrific and incomprehensible. • I shouldn't or can't do this.	• Problems in the social world can be guarded against or prevented through fortifying the mental world.
"Reset your Battlemind" (Adler et al., 2007, p. 23; Castro, 2006, p. 17)	Reset the soldier's Battlemind "so they can be just as effective at home as they were in combat" (WRAIR, 2006b, p. 2); Reset your mind and you won't have problems.	• It will be difficult to adjust back home. • I don't think my problems can be fixed.	• The mind is like a computer that can be programmed and deprogrammed. • Suffering caused from war and violence can be overcome with mental skill.
"Freedom isn't free" (WRAIR, 2006b, p. 30)	"You've made the sacrifices. Most American's won't make that sacrifice. So be proud of your service" (WRAIR, 2006a, p. 34); Your suffering was for the greater good and safety of society.	All of the thoughts listed in the "What you will think during deployment" slide (WRAIR, 2008a, p. 19), such as: • No one will notice the sacrifices I have made • I've wasted my life here. • There doesn't seem to be a point to this.	• We are free because of war and the sacrifices of soldiers. • Killing is a necessary evil to ensure safety.

Table 6 (continued)

Battlemind's Thought Terminating Clichés

"Drive on" (WRAIR, 2006b; WRAIR, 2008a, p. 20)	"Don't allow your survival guilt to destroy you. Your buddy would want you to drive on. …If you could have gone back to the day before your buddy died and [asked], 'What if you died? Would you want me to drive on?' He'd say yes…Remember the fallen and live a life worthy of their sacrifices" (WRAIR, 2006b); Don't allow yourself to feel guilty.	• This was wrong. • I am devastated. • I did something wrong. • The war was wrong. • I need to mourn my friend. • I am angry.	• It is not good to think critically about the morality behind decisions. • Veterans that died in war just want you to be happy.
"Azimuth Check" or "Buddy Check"	"Most places where you'll be back home, you don't have to make an immediate decision this is the time to turn to your buddy and get an azimuth check" (WRAIR, 2008a, p. 13); Stop and check the map before you act.	• This can't be figured out with my buddy. • This problem doesn't have a map. • I don't know how to think about this.	• Problems in life have concrete answers. • Your buddy has the solution to problems.
"No second-guessing" (WRAIR, 2006a, p. 36-37).	"It's easy to say in hindsight to second-guess your decision or the decisions of others. With the info you had at the time, would you make the same decision? Probably yes. […] If you're feeling so much grief that you can't be happy or appreciate life then you may need to go get help" (WRAIR, 2006a, p. 36-37); If you aren't happy post-deployment something could be wrong.	• I don't think I made the right decision. • Something was wrong here. • I am sad about what I did/what I have participated in.	• If you could go back in time you would do the same thing again. • Thinking can lead to unhappiness. • Thinking is a form of uncertainty.

Exemplar discussion: Battlemind creates the warrior cult. Overall, the Battlemind training texts contained many elements of thought-reform that have been previously identified as part of cult or restrictive organization thought-reform techniques. The aim of the pre-deployment trainings was similar to that described by Lifton (1973): to indoctrinate the soldiers into the warrior cult and the ethic of killing without second-guessing ones actions. The indoctrination process contained in Battlemind (and also utilized in other aspects of the Army's Basic Training) breaks down the recruits old identities and commitments and reinvents them as violent soldiers—warriors, in the vernacular of the military**.** The aim of the post-deployment training was to deprogram or alter the dysfunctional Battlemind so veterans can integrate into society happily and ignore or eliminate guilt and confusion that they are likely to experience post-deployment (symptoms that are similar to those experienced after leaving a cult [West, 1993]).

Table 5 suggests that what is traumatizing about returning from war is not just the experience of war, but also the experience of having been indoctrinated into the warrior class and "arming your mind" through Battlemind. The therapy actually contributes to if not creates the trauma by preparing the soldiers to accept the skills (Column 1, Table 5), the ethics and values of what I have referred to as the warrior cult. The second training would not be necessary if not for the first training. Thus the pre-and post-training exemplify how iatrogenic traumatic illness can be created. First, the training principles are instituted as a way of being (i.e., arming the Battlemind), then the veterans' continued participation in this way of being is reinterpreted as a set of pathological symptoms (i.e., PTSD or Battlemind that is not adapted to the home zone). Once framed as symptoms,

the soldier's experience is subject to the clinical gaze (cf. Foucault) of cognitive reframing, thought-replacement, and dissociative strategies; these strategies are contained Battlemind debriefings as well as in CBT and EMDR treatments that veterans may be referred to post-deployment (after completing the DD Form 2900). The concerning consequences of extending the clinical gaze to this iatrogenic set of trauma symptoms include that the social, political and emotional depth of veteran's experience in war and the moral questions these experience pose to our society are erased, separated from the veteran's personhood, and re-conceptualized as something to be managed, contained and monitored.

We must also remember that one of the primary stated goals of the Battlemind training is to prepare soldiers for re-deployment—not just integration home, "The first objective of Battlemind training is to prepare Warriors mentally for rigors of combat and other military deployment… The final objective is to prepare Warriors to possibly deploy again in support of all types of military operations including additional combat tours" (WRAIR, 2008a, pp. 4-6). Thus, if soldiers develop dependency on their group, adhere to the training, and report problems only within their group there is higher likelihood of the solider being interested in or capable of re-deployment. In short, the post-deployment training ensures that the soldiers are interested in redeployment to retain group cohesion and do not question their responsibility or feel moral pain (cf. Marin) in such a way that they might leave the group, or worse- take action against the military or contribute to political discussions about their experience in the war.

What perhaps is telling of the U.S. military's awareness of the damage that Battlemind can cause, including the use thought-reform techniques, is the explicit need to

reset the soldier's Battlemind in the post-deployment training; the post-deployment training acknowledges that the beliefs and behaviors that the military instills under the banner of surviving war are highly dysfunctional outside of group membership and deployment. Thus, the Battlemind training itself becomes what is traumatizing about participating in war—the training that prepares soldiers to learn and accept an ethic of killing in the warrior class with no recourse for thinking or discussing this ethic. The trainings ignore the political context that causes the suffering and suggest that traumatic symptoms are an anomalous (pathogenic) occurrence or personal failure.

Previous studies that have identified cult-like features of psychological interventions have questioned the role of psychologists in these types of therapies, their responsibility to prevent harm and whether such trainings should even be considered a form of psychotherapy (e.g., Cushman, 1986, 1989). As Marin (1981) pointed out in the Vietnam War, psychiatrists' role was perversely to keep soldiers in the mood for killing. For Battlemind a similar interpretation could be suggested; the pre-deployment trainings were designed by psychologists to psychologically insulate soldiers from feeling the debilitating effects of war and questioning their role in participation. The post-deployment trainings were designed to ensure that soldiers go to therapy rather than funnel their suffering into alternative forms of coping such as self- or societal-destruction (or perhaps worse, anti-war activism.) Arkin and Dobrofsky (1978), West (1999), and others have identified symptoms of leaving a cult as similar to those represented in the *DSM-IV* and *V* PTSD diagnostic criteria.

This brings up the question: are soldiers experiencing PTSD symptoms from the acts of war, or from having undergone these treatments before entering war? In other

words, is the trauma of war made worse and more traumatizing by having been indoctrinated to accept the ethics of war, cut ties to all support and families and submit oneself to milieu control? Given the limited focus on narrative assessment of PTSD symptoms (e.g., utilization of three item PTSD screeners), it would be impossible to discern from the military's assessments of PTSD if the symptoms soldiers are experiencing are due to participation in military operations and war or also due to feeling betrayed by their government, indoctrinated into killing, and frustrated by the lack of ability or space to discuss any reactions to war outside of those provided in narrow PTSD assessments.

The role of psychologists in the military has been a point of tension and confusion for the field of psychology (for debates on torture see, e.g., Allen et al., 2009; Gordon, 2006; Lott, 2007; Soldz, 2008; Zimbardo, 2007). Though it was beyond the scope of this study to interview Battlemind trainers or interpret an in-person training, it can be assumed that those psychologists who participated in Battlemind trainings were not interested in keeping soldiers "in the mood for killing" as Marin (1981) put it, but rather they were interested in helping veterans. What is also particularly unsettling about many military-based trauma psychotherapy treatments is how the moral imperative to heal can be transformed into an exercise in repeating and prolonging the trauma of war and social denial of its consequences. How psychologists come to participate in such traumatizing treatments (and perhaps the indoctrination they also receive in training) is an important area of future study.

Battlemind Remaining Questions

How is Battlemind a good way to respond to or prevent suffering through war? We must find a place for reflection in the midst of the terror of war and ask ourselves as a field: how has healing and helping come to take this shape? How has helping others come to be expressed through a PowerPoint training that teaches thought-replacement? Is Battlemind a good way to respond to or to prevent suffering and war?

When considering the historical evolution of trauma treatments in the military since the Vietnam War one can notice how the technologies identified in the Battlemind exemplars (e.g., assessments and forms) have continued to evolve to an alarming level of efficient proceduralism from Young's (1995) description of inpatient psychoanalytic treatment with in-depth clinical interviews at the VA to the recent (2013) utilization of a three-item PTSD screener in the PDHRA. These technologies have assisted in insulating psychologists from reflection and the kind of moral questions we should be asking about the industry of trauma healing; they have distanced not just the therapists, but society as a whole from facing with what veterans actually experience and feel. The unarticulated and dissociated form of political and social suffering that we are experiencing in a climate of war is further repressed and denied when trainings like Battlemind locate this suffering in the form of an individual, internal disorder that can only be adjusted through thought-replacement in the dyad and in the confines of therapy rooms and forms. Yet this type of therapy is seen as somehow helpful and good.

From my perspective, the ultimate irony of Battlemind treatment is the fact that there is a pre-deployment training to prevent PTSD, but the training is part of the trauma. In Battlemind, the prevention of war occurs in the mind, not in reality. The strong

cognitivist ideology in Battlemind—if we arm the soldier's mind for battle we can protect them from the trauma of war—has reached a delusional level such that killing and death are somehow acceptable as long as their consequences can be mentally controlled for. This is not a unique phenomenon to Battlemind trainings. As mentioned previously, the country spends millions of dollars in funding the VA and DoD to develop PTSD preventative treatments (Basu, 2013; Baum, 2012) as if one day we can find the science to erase the experience of war by manipulating the mental life of soldiers. This is also reflected in the recent surge in research to identify biomarkers of PTSD (AFPS, 2012; Baum, 2012), psychotropic medicines like propranolol that prevent formation of memory and psychic pain during war, and thus consequently prevent PTSD symptoms post-trauma (Fletcher, Creamer, & Forbes, 2010; Pitman & Delahanty, 2007; Pitman et al., 2002), and most recently a 70 million dollar grant awarded to DARPA to study the implantation of electrodes in soldiers' brains so clinicians may monitor and stimulate the brain in combat to prevent PTSD (Hamilton, 2014).

For a field that prizes rationality so deeply, psychology's acceptance of the existence of preventative PTSD treatments in the military reflects such a skewed logic that perhaps it can best be understood as a form of dissociation or denial from the immense suffering war brings and the ways psychological techniques assist in that suffering. To retain the belief that conducting these trainings is actually preventing rather than contributing to trauma, one would have to ascribe to the ethic of the executioner (cf. Camus, 1946) and believe that war is unavoidable or necessary and can only be mitigated in the mental and not the social world.

What would make therapists and recruits alike attracted to Battlemind in this historical moment? In other words, why are we choosing the prevention of war and suffering through evidence-based trauma treatments that resemble cult indoctrination? Numerous authors believe that cults and totalitarianism emerge when traditional values and structures of a society are weakened and when there is a period of historical dislocation in which there is a breakdown in human meaning and culture (Appel, 1983; Cushman, 1986; Hochman, 1990; Lifton, 1989, 2002; M. T. Singer, 1995).

While societal concern about cults was prominent in the late 1970s and beginning of the 1980s (the Post-Vietnam era), since then interest in and discussion of cults has waned. Hence many of the articles about indoctrination and cults I previously reviewed are dated pre-1990. Importantly, as concern with cults waned, obsession with PTSD and trauma has risen. It appears as if societal focus has shifted away from trying to dismantle the authoritative structures that indoctrinate persons, to trying to cope with the consequences of those restrictive, authoritarian structures.

Several scholars have interpreted trauma symptoms as a reaction to the decline of the public realm, societal isolation and cultural degeneration (Furedi, 2004; Hillman & Ventura, 1992; Layton, 2010; Szasz, 1974). Patrick Bracken (2002) in *Trauma: Culture, meaning and philosophy* wrote that trauma is a cultural trope that expresses the concerns and fears of our time. While describing a wealth of different ways Western science has shaped trauma discourse, Bracken asked a similar question to one at the core of this study: Why have we become so focused on trauma since the 1990s? He wondered if the cultural shift away from spiritual and moral ways of understanding the self has left modern society with a no narrative to understand our lives. Perhaps the dogma of trauma

treatments have become a way that we are able to live with and encounter the coming to terms with the fragility or vulnerability of the self in the postmodern world (like Sass's, 1992, perspective on psychosis)—a way that we have come to live without having to face an explicit sociopolitical critique. Bracken asked: is trauma a culturally-specific, Western narrative that has emerged in the wake of the loss of spiritual, moral and other traditions of meaning making?

While trauma may be the way we understand what it is to be human in the contemporary world, the particular attraction to a procedural expression of life at this moment may reflect the growing uncertainty and fear of living in the world—of a helplessness and perpetual search for answers from experts and science rather than from within local community, moral traditions, social relationships and through dialogue with each other.

Summary of Battlemind Psychological Debriefing and Training (Adler et al., 2007).

The picture of human being in trauma-based society presented by Battlemind was asocial and robotic. An ethic of war, murder or killing was central to the training and the soldier's mission, yet was completely unmentioned or discussed other than in simplistic terms of fighting evil. The pre-deployment trainings taught the soldiers how to ignore the social circumstances of their world in order to fulfill the needs of the military as a functional solider. This involved retaining mental toughness and applying Battlemind skills such as thought-replacement, like the concept of "driving on" when experiencing emotional suffering. Throughout the pre-deployment trainings the solider was given a narrative about how war is actually an experience of personal growth and an opportunity to advance in the ranks and become the ultimate warrior.

The post-deployment trainings located the political suffering and consequences of participating in war within the individual veteran by suggesting that soldiers can reintegrate into life as usual post-deployment by disarming and adapting their Battlemind. The acceptable reactions to war were framed as individual problems in which a soldier's brain needs to be reset in order to avoid the misapplication of Battlemind after returning home. The Battlemind training and debriefing series suggests to veterans that they should not expect that their struggles and reactions to war to incite public engagement. Instead, the training suggests that veterans should respond to war stress injuries in the private domain- as an internal wound that can be maintained with self- and buddy- monitoring. Reactions that were considered unacceptable, and thus were not mentioned in the training, invoked the public realm, such as seeking help outside the military, critiquing the military, government, or the ways political structures are arranged. Other reactions that were not mentioned in the training but are common post-deployment include severe depression and suicide, and the less common but also devastating, homicide (e.g., Fort Hood shootings in 2009 and 2014). It's possible soldiers have found ways to resist Battlemind and express suffering in different ways, but the training does not make room for these alternatives and does not allow for reflective way of human being to come to light.

Thought-reform techniques were described in Battlemind manuals and appeared to have been used to ensure group dependency and adherence to the military's ideological guidelines. By locating the problems of OEF/OIF within the individual solider and convincing them that they merely need to reset their mind to reintegrate into society, the Battlemind training and debriefing series allows the military to continue the status quo of

prolonging war without question and leaves the veteran to take a personal and isolated responsibility for their suffering. When traumatic events are located in the individual as an internal injury they are less likely to be considered to be a social problem; conversations about war are subtly converted into conversations about preventing PTSD and war stress injuries. The technologies and bureaucratic procedures utilized in Battlemind, like attending PowerPoint trainings and filling out several DD Forms, have also allowed for a social distance between those who participate in or standby while war occurs; in short, these technologies have allowed murder to become depersonalized.

It is important to recognize that therapists participate in and are partially responsible for arranging the social world in this way. When therapists create and participate in treatments like Battlemind that localize the consequences of war in the individual, as a disorder like PTSD or a mental injury, they do a disservice to veterans by contributing to the government's and public's avoidance of responsibility for the consequences of war and the society to which they return. While understanding how to respond to war, and in particular to OEF/OIF is complex, the lack of social context for trauma disorders presented in Battlemind helps to retain the delusion that psychotherapy treatments—rather than efforts to resist war or present the social causes of war—are preventing trauma.

Battlemind reflects such strong cognitive ideology (i.e., if we arm the soldier's mind for battle we can protect them from the trauma of war) that I think it has reached an almost delusional level such that killing and death are somehow acceptable as long as their consequences can be mentally controlled for. Battlemind could only exist in a culture that ascribes to the ethic of the executioner (cf. Camus, 1946), in which war is

seen as unavoidable or necessary and can only be mitigated in the mental and not the

social world. I concluded by posing moral questions about therapists' development and

participation in PTSD preventative treatments like Battlemind.

Paradigmatic Objects

The paradigmatic object refers Heidegger's (1977) notion of an object in the clearing that focuses and gives constancy to the clearing; it re-organizes the background against which the world shows-up. Dreyfus and Wakefield (1988) explained the paradigmatic object "opens up and organizes a multidimensional world by highlighting crucial issues that then become the locus of conflicts of interpretation and the starting point of history" (p. 279). Heidegger's paradigmatic object was highly quintessential to the culture in the way it articulates the boundaries of what it is like to be human. For more detailed information on Heidegger's conceptualization of the paradigmatic object (e.g., the Athenian acropolis; see Chapter III, Method, pp. 166-168 of this study). In this study, I identified two paradigmatic objects: the trauma treatment manual and the warrior cult.

Paradigmatic Object 1: The Trauma Treatment Manual

To practice therapy according to a manual allows for a particular transformation of how therapists and patients relate to each other and how they live in a trauma-based culture. Manuals, endless forms, and the individual, managed structure of therapy can only exist in a world in which human being requires these things. In order to think of a world in which a trauma treatment manual exists I would like to encourage the reader to step back for a moment and reflect on what it was like to read the totality of the result chapters. What were the most upsetting and most comforting parts? What was the experience of reading the scripts, viewing the figures that represented the phases of treatments, seeing selections from the handouts, homework and forms? While reflecting on these questions, now imagine you are a trainee therapist in your first or second year in

a clinical psychology program and you are handed one of the three manuals that were

examined in this study. You are advised by supervisor, probably someone you admire

and trust, to read from the manual, learn and perform the therapy. This is what being a

therapist is like in contemporary trauma-based society: complex problems are responded

to with manuals, procedures, forms, and handouts. Compliance and adherence to the

manual is the starting point for most training clinicians in contemporary psychology

programs. These same messages, as I demonstrated through the interpretation of the

manuals, are communicated directly to the patient.[60]

     I came to realize that the manuals themselves are a paradigmatic object. The

trauma treatment manuals have become a contemporary response to important political

and moral questions like: What is trauma? How can I be understood by or talk to another

person about my life experiences, especially when I am not happy? How can I continue to

participate in a world that creates so much suffering without the opportunity to study and

talk about it? These are questions we ask when our life experiences have fallen out of

everydayness and they are critical to consider in therapy. But instead of seeing these

questions as an opening and laying out of what we have taken for granted, as an

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[60] I imagined an alien landing on our planet asking a group of typical therapists what they
have been doing to solve the world's problems. The therapists might hand the alien a
trauma manual or show the alien two people sitting in a room talking and exchanging
forms. They might show the alien a vignette of a boy on a playground getting bullied and
threatened with a knife, and then returning to school the next day because, the therapists
would explain to the alien, "He has changed his perception of the events in his mind".
They might show a mother in a war zone who continues to go to work and tells her child
she can resist terrorism by repeating the mantra, "This is my home, my country, and I
will not let these few evil people chase me away or frighten me into not living a full life."
The therapists might also show how they would go to the war zone and rescue this
mother and child by removing them from their community, placing them in separate
rooms with therapists, and waving a finger in front of their face.

opportunity to reflect on and think about our traumatic world, the therapist responds with a preformulated set of rules that prepetuate the neoliberal status quo—a manual. Thus, the trauma treatment manuals instantiate how to be human in contemporary society, through compliance with managed care and the embodiment of scientistic and cognitivist ideology.

Paradigmatic Object 2: The Warrior Cult

I interpreted the warrior cult previously as an exemplar in the Battlemind trainings. In the warrior cult as exemplar section, I focused on how Battlemind, in the name of preventative trauma treatment, utilized thought-reform techniques to indoctrinate Army recruits into a violent, ideologically restrictive, and rigidly structured military institution. I argued that these techniques were not unique to Battlemind or the U.S. military but have been used in other restrictive organizations and practices. In this section, I draw from my interpretation of the Battlemind manual to develop an understanding of the warrior cult as articulating a way of being—it is a pervasive dynamic and thus a paradigmatic object of contemporary U.S. society., I turn to focus less on how cult indoctrination techniques are performed (described in Chapter VIII: Battlemind Exemplar 1, pp. 423-428) and more on what it is like to live in the clearing of the warrior cult.

The way of being that I fear contemporary society creates and idealizes is one in which people easily assume the identity of trauma survivor: an enterprising, functional and fiercely individual member of a warrior cult. In the warrior cult society, to think or talk about social causes and public solutions to daily political suffering is thought of as either non-germane or dangerous. In the warrior cult, individuals are seen as free from all

dependencies and social ties, able to overcome personal and public adversity by arming

or forifying their brain and replacing thoughts in their computer-like mind. Warriors can

actualize their inherent potential by conceptualizing the world and relationships as

resources to propell the enterprising self forward (cf. Binkley, 2011). The world is seen

as structural and ulitilitarian; it can be known, studied, managed, owned, categorized and

used. Acceptance of ambiguity, social connection, reflection, feeling stuck or restful, and

thinking historically and politically are seen as impediments to actualizing the self,

embracing positivity, and achieving happiness in the warrior cult. Suffering from

complex, chronic, daily or even minor political strife is seen as a target for reduction.

Discussing suffering from a political, moral or historical angle is seen as overwhelming,

threatening, and confusing.

The language of trauma in the warrior cult serves to obscure political

understanding and flatten specific, local, cultural, and personal expressions of distress

that subvert or call into question the status quo of social arrangements that benefit those

who profit from neoliberal society. Thus when events happen that causes the world to

fall out of everdayness such that one questions participation in that type of society (e.g.,

one's responsibility in creating suffering for others and their desire to connect to others),

the members of a warrior cult society may find themselves confused or unable to discuss

this phenomenon. They are encouraged—by society at large but in particular by

therapists—to turn to the language of trauma and the manual-based procedures they have

been taught in order to reduce political and moral complexity, explain political suffering

as a medical disease, and return to life as usual as an enterprising warrior self. This is

how the warrior cult dissociates from society's violent ethics and practices and rejects

members who do not conform.

Thus, an important aspect of the warrior cult dynamic is that the political context

that causes the suffering is ignored, and thereby the suffering is then considered to be an

anomalous (pathogenic) occurrence or personal failure. In the case of family violence or

sexual attack, the larger sociopolitical causes of violence against women and children is

barely acknowledged and not treated as a realistic subject that can be understood and

successfully defeated. In the case of the suffering of soldiers returning from war zones,

the larger context that initially caused the violent behavior — that is, the indoctrination

centers on the techniques that turn civilians into soldiers and the national politics that

pursues colonial occupations and counter-insurgency tactics as part of a global strategy of

neoliberal domination — is never questioned or identified.

Membership in the warrior cult is aspirational and common sensical given the

current arrangement of the social world; however, therapists play a significant role in

retaining and promoting this way of being through their practices of healing the

traumatized self. As I came to realize in this study, therapists can contribute to

indoctrinating their patients into the warrior cult by following evidence-based manualized

trauma treatments that suggest particular ways that humans should be good trauma

survivors (e.g., the TF-CBT child-patient must erase the trauma and act age

appropriately, EMDR patients must repair their self-image until all positive cognitions

are completely true, and the Battlemind warrior must drive on and repress moral pain).

Indoctrination into the warrior cult in therapy occurs in a range of ways from promoting

psychoeducation that is imbued with cognitivist ideology (cf. Sampson, 1981) to enacting

thought-reform techniques in the therapy room (cf. Lifton 1959/1989; Cushman, 1986, 1989). I believe that it is likely therapists are also indoctrinated into the warrior cult via their education, trainings, and utilization of manuals that perscribe this way of being.

Thus both therapists and their patients may at times experience being like members of a warrior cult society, but for those who are successfully indoctrinated, membership in the cult is the solution to healing trauma and not the problem. Though there is tension to recognize the realities of daily political suffering, and perhaps give in to the malaise that has come to represent neoliberal life (cf. Layton, 2010), it is also possible that members of the warrior cult society may become so feverently devoted to regimes of thought-replacement and rejection of moral conversations (e.g., Battlemind's "driving on") that they do not sense these problems and desperately strive to be happily ignorant. Others may feel confused and traumatized by the contemporary way of being in the warrior cult, but it will be less obvious that the therapies they learn and participate in prepetuate this way of being. They may feel unable to resist or talk about why the cult is problematic, especially because the ideals of the functional trauma survivor are held so highly and the language of trauma is so widely accepted as an expression of social distress (cf. Haaken, 1995).

In a warrior cult society, patients and therapists are unable to articulate that there is a lack of social support for thinking politically and historically. Therapists may not question the role psychotherapy has played in creating an isolationist, hyper-individualized and compliant way of being—a way of being that cannot hold political and moral discussions about the causes of suffering in the world. These thoughts do not come to light in the warrior cult. Instead, the patient and therapist will feel tired, confused,

depressed, avoidant and possibly experience a range of symptoms that psychology has come to label as PTSD, secondary traumatic stress or compassion fatigue, but that other scholars have recognized as also related to cult indoctrination (Appel, 1983; Cushman, 1986; Lifton, 1989; West, 1993). Given the complusion to retain the ideals of the enterprising self in the warrior cult, this malaise only strengthens dissociation from daily political suffering, and a commitment to therapy and a cognitivist lifestyle.

Conclusion

In this study, I interpreted the concept of trauma as a way of being human and as a taken for granted way of expressing enactments of dissociated, unformulated or unarticulated political arrangements and events in contemporary U.S. culture. In a more general sense, I treated the concept of trauma through my interpretation of evidence-based trauma treatment manuals as a system of references to historical discourse and traditions that were relevant to contemporary life. The purpose of my study was to interpret the world that gives rise to and maintains distinctions like victims, survivors, perpetrators, rescuers, PTSD, trauma burden and traumatic stress—a trauma culture. Through thinking about trauma from a historical, philosophical and moral perspective, I described insights about how people think and act in trauma culture as they were reflected and reproduced in three widely used evidence-based trauma treatment manuals. I argued that it is not enough to simply realize and identify that trauma abounds in the social world, and thus an aim of my study was to describe how contemporary society identifies and understands trauma, to interpret what it means, what it stands for, what it substitutes for, and the many political meanings—especially discomforting or dangerous political meanings—it contains. One of my primary hopes in conducting this study was that through thinking about trauma from historical, philosophical and moral perspectives, alternative, perhaps previously unformulated insights, about how we think and act in this traumatized world may come to light.

In this chapter, I present the process of the hermeneutic interpretation known as reconstruction (Stigliano, 1989; see Figure 2). I first summarize the interpretations that I

previously described in the results and discussion chapters and then re-approach my

foregrounded assumptions, and discuss limitations and areas for future inquiry.

Summary of Intepretation of TF-CBT, EMDR, and Battlemind Treatment Manuals

Each of the three previous chapters were devoted to the findings and discussion

for the three evidence-based trauma treatment manuals: Cohen et al.'s (2006) child TF-

CBT manual, Shapiro's (2001) EMDR manual, and the Battlemind Debriefing and

Training series (WRAIR, 2006a, 2006b, 2006c, 2008a, 2008b), as well as their associated

supplementary texts (see Table 2). I decided to analyze treatment manuals because they

are an integral component of contemporary psychotherapy. Studying the messages

embedded in these manuals and thinking about the world that gave rise to them was

imperative given their increasing utilization and the continued cultural focus on trauma,

especially within the U.S. but increasingly internationally since the 1980s. The manuals

communicated important messages about what constitutes a good way to be human and

how people should act socially and politically within this traumatized and traumatizing

world. How therapy is being conceived, trained, practiced and exported across the world

has been increasingly determined by a manual rather than mentorship and supervision;

what constitutes good therapy and what it means to be disordered and healed was

represented in these texts.

Summary of shared themes. I identified the following shared themes across all

three manuals and provided quotations of examples of each theme that I identified.

Shared theme 1: Mind-brain as protector and the political use of cognitivist

ideology. All of the manuals predicated therapy on three interrelated assumptions: 1) you

can change the world by changing your mind, 2) when you change your mind you change

your brain; and, 3) your brain and mind can protect you from trauma (i.e., if you have inner safety, you are safe and thus the world is safe). Following Sampson (1981), I argued that the main problem with these assumptions is that they create a confusion between shifts in individual subjectivity and shifts in the social world, which can ultimately result in no change to the status quo of existing political problems and arrangements of power and domination. When a cognitivist ideology prevails in psychology, people accept—in fact strive for—changes in their subjective experience instead of changes in their material reality, thus allowing existing arrangements of power and domination to occur. In this sense evidence-based trauma treatments, while performing cognitivist ideology in the guise of healing, serve to maintain the isolationist status quo in neoliberal society: by shifting the way we perceive the world we overlook the need to change it and the need to turn to each other to make meaning of and address social problems. In a world in which cognitive psychology is dominant, the necessity to change the material arrangement of the social world does not come to light.

Shared Theme 1 highlighted various conceptualizations of what human being is like in trauma culture, and from a hermeneutic perspective, how contemporary social practices have come to constitute a particular version of the self. Cushman (2013) suggested that the reason that patients accept the practices suggested by evidence-based treatments, like TF-CBT, is not that they are mandated or are better than other practices but that they "fit hand-in-glove with the predominant self of the early 21st century. They seem to mainstream therapists and researchers to be unquestioningly correct because they speak the predominant language of our time" (p. 2). Given the cognitivist ideology presented in this theme, the contemporary self is seen as constituted through a scientific

framework. Hacking (1998) argued that the notion of soul has been replaced with memory and moral behavior that has become naturalized in the sciences (almost hardwired in the brain) rather than contingent on a relationship with the Devine. The idea of placing the brain rather than the socially embedded human in therapy has been identified by Nikolas Rose (2008) as reflective of a shift in contemporary culture that understands human beings as "neurochemical selves," in whom variations in mood, emotions, desires and thoughts are reduced to variations in brain chemicals. Rose discussed how health is a central ethical principle in contemporary society and has recently taken the shape of "somatic individuality" in which the self is understood in terms of biological health, "we understand ourselves, speak about ourselves and act upon ourselves as the kind of beings whose characteristics are shaped by our biology" (p. 480). The shift to a neurochemical self has allowed society to become amenable to economies of vitality where health care corporations and insurance companies can profit from manipulating different parts of the healthy self by marketing and selling treatments that link social ills to discreet psychological symptoms and neurochemical imbalance. When trauma treatment research describes symptoms as residing in the brain or neurons, it necessarily suggests that these symptoms can be manipulated through psychopharmaceuticals and evidence-supported psychotherapies, like TF-CBT, that target brain function.

Shared theme 2: Neoliberalism in trauma therapy: The healed trauma survivor as functional worker. In all of the manuals, trauma was understood as a major source of undermining neoliberal functionality and thus the aim of therapy was to restore functionality in this system, like encouraging the patient to return to work or school.

There were three primary assumptions in the manuals that were a reflection of neoliberal culture: a) valorization of the enterprising self (cf. Binkley, 2011; Layton, 2010; Rose, N. S., 2007), b) the acontextualized nature of trauma in neoliberal trauma therapy (Layton, 2006), and c) the privileging of modular, efficient therapy designed for managed care (Cushman & Gilford, 2000). The way of human being that was reflected and reproduced by these manuals is so amenable to management and managed care that the therapist's and patient's daily life and practices reflect decision trees and symptom monitoring technologies (e.g., SUDS, worksheets, electronic charting).

Following the interpretation of the manuals developed in this study, what it means to be a good human in trauma culture is to respond to upsetting, confusing and violent social and political events by going to therapy and accepting the interpretation that understands symptoms as uncomplicated, asocial, and acultural, symptoms that align with the cognitivist psychoeducational trauma narrative about PTSD. In this world, the patient comes to present their political distress in such a way that their symptoms are amenable to the specific structure and assumptions of managed care, evidence-based therapies, which ultimately serve the needs of insurance companies and the state, not the patient or their community. For example, the practices of restricting anger and reframing responses to political events as erroneous fantasies or pathological anomalies have existed in different forms historically (see e.g., Cushman, 1995; Foucault, 1995; Marin, 1995). Now these practices have become an integral part of therapy to such a degree that they are viewed as benign or even helpful rather than as restrictive, isolating, or promoting a politicized cognitivist ideology that has a hand in silencing dissent.

Shared theme 3: Trauma is universal and culture-free (versus tied to a U.S., Western, white, and middle-class context). In all three manuals, trauma was presented as a universal human experience that could be treated following the same culture-free treatment manual. I divided examples of this theme into the following categories: a) trauma symptoms are tied to universally experienced organ malfunction (e.g., brain problems); b) a flattening of all events, local experiences, and narratives of suffering to diagnostic criteria for PTSD and the word "trauma" or "traumatic events," c) the technique of thought-terminating clichés (cf. Lifton, 1989) about cultural competency; and d) exclusion of forms of suffering from the definition of trauma that are not from a U.S., Western, white, and middle-class context.

The manuals reduced the unique, personal and culturally-specific expressions of trauma through the process of standardized assessment (e.g., counting total traumas, symptoms checklists), applying the word "trauma" to all life experiences that involved suffering, not eliciting trauma narratives or re-writing the end of the trauma narrative as necessarily positive and happy, and the lack of acknowledgement of the specific cultural context (e.g., U.S., middle-class, white) that was embedded in and reproduced by the manuals' scripts and structure. The manuals suggested that trauma therapy functioned optimally regardless of the national, racial, cultural, and ethnic background of the patient in order to alleviate suffering world wide. When considering the exclusion of non- U.S., white, middle-class persons from the label of traumatized that Leary (2005), Fine (2012), and Gone (2007) discussed, it was striking how universalization and inclusivity was often emphasized in the manuals and yet this act's assumed inclusivity became a form of assimilation and colonization.

I argued that the developers of manualized trauma treatments benefit from universalizing trauma and seeing the treatment as culture-free because it allowed their manual and protocols to be used in a wide-range of settings and countries. On a political level, when personal narratives of trauma are disappeared or flattened (and thus amenable to a one-size fits all treatment), it makes responding to disasters and crises much easier: train therapists in a treatment manual and send affected persons to therapy. Thus it is not only the developers but also those who wish to retain the status quo of political and power arrangements who benefit from broad applications of the word trauma and manualized treatments.

Summary of shared exemplar. I also identified one shared exemplar in all three of the manuals.

Shared exemplar: Indoctrination into a social void of scientistic managed care. The shared exemplar, which I titled, "indoctrination into a social void of scientistic managed care," had four primary features: presentation of an origin myth; locating pathology and healing within the dyad; overreliance on forms, hand-outs and PowerPoints; and directive psychoeducation and thought-replacement. This exemplar described the techniques and technologies that reflect and perpetuate a particular way of being. The techniques (i.e., origin myths, location of healing in the dyad, forms and handouts, and directive psychoeducation) are all ways that messages about how to be a good human are communicated by therapists serving in the role of expert in contemporary society. These practices rely on subtle assumptions about patients, such as that they do not know what they have experienced and need to be educated about their symptoms; these assumptions have associated moral implications and political functions.

The social understandings about the causes of trauma cannot come to light within the manuals. The patient is encouraged by the therapy to present as a particular type of traumatized human whose symptoms emerge within the dyad, whose symptoms fall within a cognitivist understanding of PTSD that gives primacy to the individual and the interior self, and can easily fit within a modular, predetermined checklist. Following this way of human being, the self is compliant, easy to make sense of, and readily adaptable or even replaceable in the moment (e.g., one can change one's thoughts like switching channels on the TV). For example, in each manual the patient was prescribed a range of treatment modules. In one module, the therapy describes, elicits and accepts a type of self that is deeply emotional (e.g., trauma narrative exposure) and in another module the patient is expected to restrain and shut off emotions and thoughts as needed (e.g., thought stopping, emotional regulation). The way of human being that is reflected and reproduced by the manuals is highly compliant, performative, and modular. It is so amenable to management and managed care that the therapist and patient's daily life and practices reflect the decision trees and symptom monitoring technologies (e.g., SUDS, worksheets, electronic charting) that are used in the treatment planning (cf. N. S. Rose's (2007) economy of the neurochemical self).

What it means to be human according to the manuals is to respond to upsetting, confusing and violent social and political events by going to individual therapy and embodying uncomplicated, asocial, acultural symptoms that align with the cognitivist psychoeducational trauma narrative about PTSD. According to my interpretation of the manuals, the patient should come to present daily political distress in such a way that their symptoms are amenable to the specific structure and assumptions of managed care

(e.g., can be quantitatively monitored in therapy for both clinical and administrative purposes). Thus evidence-based therapies ultimately serve the needs of insurance corporations and not the patient or their community.

Summary of specific themes and exemplars. After presenting shared themes and exemplars, I discussed some specific themes and exemplars present in each one of the three manuals. For the Cohen et al., (2006) manual, I described the following themes: children are born with pre-traumatic innocence, children are not sexual, children have no agency during traumatic events, and parents are protectors or perpetrators. I also described the specific exemplar of the benevolent restriction of angry responses to political events via therapy. For the Shapiro (2001) manual, I described the specific theme of the grandiosity and mania of EMDR. For Battlemind, I described the specific exemplar of Battlemind creating the warrior cult. In contrast to the paradigmatic object where I described what human being is like in the warrior cult, in the specific exemplar I described the process of how the warrior cult is created through therapy.

Summary of questions. After presenting my interpretation of these specific themes and exemplars I asked questions about why trauma and human being was presented in the specific way that it was in each of these manuals at the moment of the respective manual's creation. For the TF-CBT manual, I wondered why the traumatic self was represented as a destroyed child innocent. For the EMDR manual, I wondered about the constitution of the contemporary self that would accept a therapy that can be so self-centered. For Battlemind, I wondered if the treatment was an important part in creating the trauma. Broadly, I asked questions about how has healing and helping come to take this shape (i.e., how helping others has come to be expressed through a PowerPoint

training that teaches thought-replacement). I also wondered if Battlemind was a good way to respond to or prevent suffering from war.

Summary of paradigmatic objects. Finally, I presented two paradigmatic objects: trauma treatment manuals and the warrior cult.

Paradigmatic Object 1: The trauma treatment manual. I suggested that trauma treatment manuals have become a contemporary response to important political and moral questions. Instead of seeing these questions as an opening and laying out of what we have taken for granted, as an opportunity to reflect on and think about this traumatic world, I argued that trauma treatment manuals imply that a good way to be human in contemporary society is to respond to these questions with a preformulated set of rules that prepetuate the neoliberal status quo.

Paradigmatic Object 2: The warrior cult. I presented the warrior cult as a traumatic way of being that I feared contemporary society embodies and idealizes, in which the populations aspires to be trauma survivors who are enterprising, functional, and fiercely individual members of a warrior cult. In the cult, members disavow society's violent ethics and practices. It is seen as confusing and at worst dangerous to think or talk about social causes and public solutions to daily political suffering. Membership in the warrior cult is aspirational and common sensical given the current arrangements of the social world; however, therapists play a significant role in indoctrinating and promoting this way of being through the practices of healing the traumatized self. As I came to realize in this study, therapists can contribute to indoctrinating their patients into the warrior cult by following evidence-based manualized trauma treatments that suggest particular ways that humans should be good trauma survivors (e.g., the TF-CBT child-

patient must erase the trauma and act age appropriately, the EMDR patients must repair their self-image until all positive cognitions are completely true, and the Battlemind warrior must drive on and repress moral pain).

Study Limitations and Future Directions

The primary limitation of my study was my interest in how the text engages in and shapes practice and lived experience, yet I did not actually witness or interview therapists and patients about how they engaged with the manual in therapeutic practice. Thus, this study lays the groundwork for future investigation into the practices of evidence-based training of trauma treatment manuals. I am particularly interested in the experiences of early carreer psychologists, therapists, and young trainees as they approach the field with an overwhelming desire to help and are directed to evidence-based treatment manuals. I am interested in how these trainees comply with or resist trainings and what it means to them to be a trauma-focused therapist (e.g., what does it look like to be a good trauma therapist).

The order in which I approached the interpretation of texts had a particular influence on the way I interpreted each manual. After interpreting the first manual (TF-CBT) I had refined my conceptual map and themes such that by the time I approached the second manual (EMDR) I was already identifying and expanding upon these lines of inquiry. Then by the time I analyzed Battlemind I was struck by the exemplar of the warrior cult, which I hadn't thought about when interpreting the first two manuals. If I had analyzed these manuals in a different order it is likely I would have had a slightly different intepretation, namely in that what I selected as a shared theme or exemplar may have been different. After completing the final results and discussion chapters I

contemplated returning to the interpretation again with a final conceptual map. I wanted to collapse a few of the specific themes into the warrior cult exemplar and perhaps identify specific themes in all of the manuals. Though it is likely that these revisions would have made for a more elegant study, I did not reapproach my interpretation with fewer themes because I was reminded of the cyclical and seemingly never ending nature of hermeneutic interpretation. Because hermeneutic interpretation is always incomplete, I can re-enter the circle again in another, future study. Perhaps this is not a limitation of the current study, but it is worth awknowledging when considering future investigation.

Revisitation of Foregrounding

In this section of the conclusion, I return to reflect on the foregrounding of my study (Chapter IV, pp. 167-187) and how my experience and interpretation of trauma culture has changed through the process of this study.

When I presented the proposal for this study to colleauges at my school, some of the initial feedback I received was a concern that thinking about trauma-culture and the world that produced and sustains trauma treatment manuals was too broad of a topic. Indeed, this study has spanned a wide breadth of literature—from understanding what constitutes a child to U.S. complacency with the war in Iraq. While in many ways I sacrificed depth and nuance to identify broader patterns, I approached the study of trauma culture with an awareness that thinking about trauma critically is somehow overwhelming to the field and would likely be difficult for me to conceptualize. What I found truly interesting about my colleagues' concern as I embarked on this study was the urgency with which they discouraged me from approaching this question because of its overwhelming scope; yet in everyday practice it is not overwhelming to them that trauma

treatment manuals exist in the first place. How can there be a book that perscribes a universal treatment for all forms of human suffering known as trauma? Utilizing a manual that purports to provide a solution to all human experiences of trauma was somehow less problematic for my colleagues than thinking about the world that produces that manual.

The concern that was directed at my study, should be directed at all trauma treatment manuals and the world that produces them. Psychotherapists should be wondering about how one can simply approach the topic of trauma. They should be concerned about why the field does not ask questions that are historical, political and moral and that speculate about the treatments that therapists produce and practice. In the case of evidence-based manuals, I think the field should be suspicious of treatments that are seen as formulaic, acultural or universal solutions to all types of human suffering.

Some of the other reactions I found noteworthy during the process of writing this study included those from colleagues who are engaged in what might be called mainstream, federally funded quantiative research (e.g., persons conducting randomized control trials funded by NIMH R01 grants). Many of them were perplexed by my topic. They stated things like, "Oh, so your writing kind of like a book-type of dissertation, like a philosophy one." Some of them critiqued the inclusion of only three manuals and particularly of the inclusion of Battlemind (e.g., How could I possibly compare two trauma treatments to a preventative intervention and de-briefing?) Others asked questions about what was the practical value of my study. How would I judge the quality of these treatments? Could I make a recommendation about the best treatment? In general, the majority of people I encountered in psychology had some discomfort with this topic but

couldn't seem to describe what their discomfort was, other than to talk about problems with the scope of the topic and the interpretive methodology.

Many practicing therapists I talked to about the topic seemed to understand the idea of the existence of a trauma-culture. Some of them shared their experiences of losing patients because the patients wanted to find a therapist that "got trauma" or was a "trauma specialist." Others talked about a cultural divide at conferences in which trauma therapists saw themselves as wearing a badge of unique sensitivity to patient problems. Some colleagues shared my experience of EMDR training as being cult-like and described to me their successful or unsucccesful attempts to leave training seminars and excercises. Others, who I would characterize as EMDR evangelists, seemed pleased to hear that the CBT approach was included in the study but were disappointed that I included EMDR too. They (perhaps jokingly) wondered if my inclusion of both EMDR and CBT in the same study meant that I just "hated all therapy"—as if thinking critically about EMDR was somehow problematic or destructive to the entire field but critiquing CBT was not.

With laypersons to whom I talked about the topic, the mention of the word trauma instantly invoked a sense that I was doing something important. Without hearing much at all about the study, they said things like how thankful they were that I was "looking out for veterans" or "saving abused children." I couldn't help feeling the privilege of being a psychologist in training, and the deference these people were paying to me as an expert; deference that came with the automatic assumption that as a future psychologist, all my endeavors must be ultimately helpful—especially because I was writing about trauma.

During the writing phase, my school required a dissertation course in which we are supposed to submit periodic evidence that we are actually working on our dissertation by emailng a small group of students our weekly progress. I sent my foregrounding chapter (Chapter IV, pp. 167-187) out to a group of students and received no response from them. To my surprise however, the professor for the course read this section and recounted to me her similar experiences during training in evidence-based psychotherapies, which she characterized as extensive and adversive. She reported feeling saddened by the direction of our field and was left wondering about the morality of our training practices.

When I return to the foregrounded assumptions from which I approached my study, I believe my experiences of training in evidence-based therapies were critical in order to approach this interpretation with an awareness of how texts reflect and shape lives. These manuals are not passive documents; they are both a prescriptive authority (e.g., when used in therapist fidelity monitoring) and a reflection of daily social practices that therapists and patients live out. When we engage with these texts, we are changed by them. Thus when we are assigned to read them in our training this has an impact on how we talk about the world, how we conduct our practice, how we conceptualize trauma and healing. The manual assists in constituting the boundaries of our cultural clearing as practicing psychologists.

When I compare my first encounters with these texts to my interpretation in this study, they are quite different. The experiences learning EMDR and TF-CBT that I outlined in Chapter IV: Foregrounding I believe were mainly characterized with an awareness of discomfort and isolation—a feeling of failure to resist the procedural,

hyper-individualist and cult-like elements of training. My experiences were characterized by rejection or repression of a desire to think about how therapists participate in the traumatic world we live in that often left me feeling angry or helpless to continue traumatic enactments. Writing this thesis and reinterpreting these texts was filled with somewhat similar experiences, but this time, in large part due to the support of my Chair and Committee Members, I did not feel helpless or isolated. Instead I knew that the interpretation process would be extremely challenging, but that it was important to think about the difficult political and moral questions about our field and therapeutic practices; this is one of the only ways to break the silence around how the profession might be contributing to the social world that creates trauma.

By thinking about the interpretation of the manuals with the idea that I was in dialogue with my Chair, Committee Members and other supportive members in the community, I felt more free to think in a political, exploratory and creative way about trauma that was not bound by the compliance of scientsitic proceduralism that characterized my prior training. Perhaps what I have come to experience through this study, following in the tradition of psychoanalysis, is that the process of political and social interpretation in dialogue with others may be a good way to resist and change our traumatic world.

Implications for Clinicians

In this study, I discussed several ideas about how being human in trauma-based society has come to take the shape of responding to political problems and traumatic suffering by complying with manualized treatments and colluding with the warrior cult. What should be of particular concern to therapists is the way that manual-based practice

perpetuates the social problems and traumatic symptoms that these trauma treatments purport to treat. What is unsettling about the consequences of practicing manual-based trauma therapies is how therapists' moral imperative to heal can be transformed into exercises that repeat and prolong trauma.

Beyond the specialized field of trauma therapy, the field of clinical psychology at large has largely shifted away from attempting to change our world and the social causes of suffering except in a token manner. Several clinicians and scholars have described the consequences of mainstream psychology's disinterest in political action (see, e.g., Bracken & Thomas, 1999; Fine, 2012; Hillman & Ventura, 1992; Hoffman, 2009). The profession shows little interest in resisting neoliberal demands through community development or the dismantling of authoritative structures that indoctrinate persons (Binkley, 2011; Cushman, 2011, 2014; Cushman & Gilford, 2000; Layton, 2004, 2013). Instead, the field promotes the use of manualized trauma therapies that focus on how to cope with the consequences of living in a traumatized world in an internal, asocial and isolated way—a way that ultimately benefits managed care corporations over the public welfare. Thus clinicians from all areas and specialties within psychology are in the difficult position of struggling to practice morally and with integrity, while also attempting to comply with the demands of an increasingly scientistic, apolitical and profit-driven field. Thus a final question that remains is how can clinicians resist reproducing the social world that creates traumatic suffering?

The answer to this question is not simple but it is possible to discuss. To think or talk about trauma in nuanced and complex ways takes time and responsibility on the part of clinicians and their community. Despite being embedded in a traumatized culture and

warrior cult, I argued in this study that patients and therapists are not naïve drones or

empty vessels that simply perform or absorb restrictive practices and therapeutic rules.

While we may live out many of the problematic practices described in this study, many

clinicians and patients feel uncomfortable with their participation in such practices. From

my experiences in training (Chapter IV: Foregrounding) and the review of the literature,

it is apparent that there are many clinicians and scholars who have resisted traumatic

ways of being by thinking critically and historically about trauma, by questioning our

field, (see e.g., Brave Heart, 2003; Clancy, 2009; Cushman, 1995; Farrell, 1998; Fassin &

Rechtman, 2009; Foucault, 1973; Haaken, 1995; Layton, 2010; Rose, N. S., 2006;

Tolleson, 2009; Young, 1995) and by refusing to participate in practices that they see as

amoral or colonial (see e.g., Altman, 1993; Bracken et al., 1995; Fine, 2012; Gone, 2009;

Leary, 2005; Smith, 1999; Szasz, 1974). One thing I have learned from these clinicians

is that the world cannot always be understood in instrumental ways, with problems and

solutions that are readily available and easy to come by.

Despite there being no ready answers, something I have learned from this study

that may contribute to clinicians who are struggling with these issues is to first

acknowledge that as psychologists and trainees in our increasingly procedure-focused and

apolitical field we may unavoidably enact and participate in traumatic ways of being

(Layton, 2006; Stern, 2003, 2010). One of the ways we do so is by participating in trauma

therapy as a way to express unarticulated, dissociated, or unformulated political

arrangements, events and suffering without attempting to talk about, act or change the

social world that produces this suffering. In acknowledging our participation in traumatic

ways of being, it is important that we find compassion for each other and ourselves when

attempting to think, talk about, and resist traumatic ways of being (Cushman, personal communication, May 27, 2014). Thinking about these things may require tolerating ambiguity and the time to develop interpretations that are uncomfortable or complex (i.e., interpretations that stand at the edge of the clearing). It may also require the ability to engage in therapeutic practices oppose mainstream American understandings of the good but may resist problematic aspects of trauma culture (e.g., acknowledging dependence on others, learning to live with anxiety caused by not being able to erase trauma, taking responsibility for mistakes). Beyond acknowledgement, we can strive to become politically and socially active as therapists in the therapy room and beyond (Altman, 2010; Botticelli, 2004; Cushman, 1995; Layton, 2005; Tolleson, 2009).

Finally, as I mentioned previously, my hope for this study was to break a traumatic enactment by thinking differently about trauma, but I wouldn't have been able to do so without continual dialogue about these important social and political problems with my colleagues and mentors. I would encourage clinicians, perhaps while feeling angry, unsure or afraid, to continue the process of political and social interpretation in dialogue with others as a way to resist and change our traumatic world.

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Appendix A

The Normative History of Trauma as a Mental Health Disorder

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Disorder	Originator, Profession	Year	Country, Notable Events; Historical Period	Etiology, Symptoms and Treatment	Affected Population
To be broken: *Estar Roto, el mal de Corazon*[1]	Unknown	1640-48	Spanish Army of Flanders, Thirty Years War; Age of Reason	Despair among Spanish soldiers who were forced into service to the Netherlands with no prospect of leaving; those affected were considered useless to the military and discharged to their homes.	Spanish soldiers (men)
Homesickness: *Nostalgia, Heimweh, Schweizerheimweh, Mal du Suisse*[2]	Johannes Hofer	1688	Switzerland; Age of Reason	Repeated memories of one's homeland led animal spirits to dwell in fibers of the middle-brain where traces of home clung. The spirits stopped flowing to other areas of the brain needed for human life, which resulted in excessive physical fatigue, inability to concentrate, insomnia, anorexia, feelings of isolation and frustration-eventually leading to functional impairment and possible death. Symptoms disappeared upon returning home.	Swiss soldiers (men); migrant peasants and servants (women & men); any person forced from home
Sickness for one's Country: *Maladie du pays*[3]	Dominique Jean Larrey, Military Surgeon	1789-1821	France, French Revolution, Napoleonic Wars; Enlightenment Era	Melancholic madness that included rejection of food, depression, and interest in committing suicide. Soldiers could be predisposed through a "lymphatic idiosyncrasy." Symptoms developed when soldiers were placed in foreign environments, engaged in too much sexual activity or masturbation, or faced "slavery, imprisonment or idleness" in the military. Structure, "gymnastic amusements" and "Warlike music" during hours of recreation (p. 348) prevented development. The only treatment was discharge from the military.	French soldiers (men)

Neurasthenia, Nervosism, American Nervousness, "Americanitis" [4]	George Miller Beard, Neurologist	1829/ 1869/ 1880	U.S.; Enlightenment to Victorian Era	Exhaustion of the central nervous system from the stress of "modern civilization" characterized by "steam-power, the periodic press, the telegraph, the sciences and the mental activity of women." Factors increased nervousness: the dry climate of the U.S., "the beauty of American women", "premature baldness" and "the greater intensity of animal life [in the U.S.]" (p. viii). No prescriptive treatment as "No two cases are alike in all details" (p. 177). Recommended treatment included: rest and isolation, changing employment, and "mental therapeutics."	Americans engaged in sedentary, repetitive, competitive work: women, "brain-workers" (e.g., lawyers, clergymen), "muscle-workers", students; "inebriates"
Soldier's Heart, Da Costa Syndrome[5]	Jacob Da Costa, Surgeon	1874	U.S., Civil War; Victorian Era	Cardiac condition resulting from strain and over-action during "excessive fighting and marching." Treatment included reduction in exhausting activities.	Soldiers (men)
Irritable Heart[5]	Jacob Da Costa, Surgeon	1874	U.S., Civil War; Victorian Era	Cardiac condition resulting from fear, emotional suffering and inactivity. Treatment involved maintaining schedule of activities.	Women
Railway Spine [6]	John Erichsen, Surgeon	1867/ 1882/ 1889	U.K., Industrial Revolution; Victorian Era	Spinal fractures caused by jarring from railway work; fear and terror could also create nervous shock to the spinal cord. If patient did not progress to secondary symptoms (lesions of spine) treatment included removal from railway work; otherwise prognosis was "unfavorable" (p. 98).	Working-class men: railroad
Traumatic Hysteria: *idées fixes* [7]	Jean Charcot, Neurologist	1887	France; Victorian Era	Psychic trauma in those who were hereditarily predisposed to enter hypnotic auto-suggestive states that allowed allow for a fixed idea to root in the unconscious (the seed of traumatic hysteria). In women, neuroses were often physically located in their uterus and could be released through erogenous zones.	Women; children; sickly, drunken, timid or stupid men
Traumatic Hysteria [8]	Hermann Oppenheim, Neurologist	1888	Berlin, Germany; Victorian Era	Traumatic events created tiny lesions in the brain and nervous system that were undetectable; physical trauma and psychic shock after the experience of terror led to	Working class: railroad and factory (men)

				traumatic responses: paralysis, fits, intrusion and neurosis. No successful treatment identified.	
Traumatic Hysteria [9]	Pierre Janet, Neurologist	1892	France; Victorian Era	Fixed ideas in the subconscious led to a split in consciousness that created mental weakness; those who suffered had pre-existing fissures that predisposed them to splitting. The goal of therapy was to excise the fixed traumatic memory, which can sometimes be done by converting the memory into the action of telling a story.	All persons with preexisting mental weakness (women, children, men)
Traumatic Paralyses [10]	Sigmund Freud, Neurologist	1893	Europe; Victorian Era	"Any impression in which the nervous system has difficulty in disposing of by means of associative thinking or of motor reaction becomes a psychical trauma;" this trauma as foreign body created a form of hysterical reminiscing.	All persons (women, children, men)
Hysteria: Seduction Hypothesis [10]	Sigmund Freud, Neurologist	1893	Europe; Victorian Era	Hysteria was due to mental splitting when "an incompatibility took place in…emotional life- that is to say an idea or feeling which aroused such a distressing affect that the subject decided to forget about it because he had no confidence in his power to resolve the contradiction between that incompatible idea and his ego by means of thought activity." Believed that "coitus-like acts" in childhood, perpetrated from anyone, was the root cause of hysteria. Treatment is through what is now known as Freudian psychoanalysis.	All persons (women, children, men)
Hysteria [11]	Joseph Breuer	1895	Europe; Victorian Era	Hysterical people are prone to fantastical reverie that produced a twilight state that splits consciousness; the splitting produced mental weakness because conscious activity was divided. Those prone to hysteria were "of a very lively disposition, to whom monotonous, simple and uninteresting occupation is torture." Treatment was psychoanalytic catharsis.	Persons forced to engage in boring or restricted activities (Women)
Shell Shock: Sickness [12]	Charles Meyers & William McDougall	1914-16	U.K. Army in France, World War I; High Modern Era	Heightened sensitivity and arousal manifested in sensory-motor problems called "hyperaesthesia" or dissociated numbing called "anesthesia" following exposure to shell	Soldiers with weak mental disposition and

	Neurologist, Psychologist			explosions during war; this led to a form of hysteria. Those affected were seen as predisposed to nervousness and were not entitled to a pension, unlike those classified as Shell Shock: Wound (vs. Sickness), who received greater benefits. "The essential therapeutic step is the relief of dissociation" (Leys, 2000, p. 86) or amnesia through conscious reintegration of dissociated memory into conscious thought.	nervousness prior to entering war (Men)
War Neurosis [13]	William Brown	1920	U.K., High Modern Era	Symptoms included mutism, loss of sight or hearing, spasmodic convulsions, trembling, sleeplessness, depression, and terrifying repetitive nightmares as expressions of "repressed" emotions; unable to discharge emotions through action or speech the trauma unconsciously "materialized" as physical symptoms. The traumatic events were often dissociated or unremembered. Treatment was to bring the patient back to the front-lines to abreact the emotional experience and give it verbal expression.	Soldiers, veterans (men)
Acute Stress Response [14]	Walter Cannon	1920	U.S., High Modern Era	All animals, including humans, reacted to threats and traumatic exposure with an instinctual "fight-or-flight" response located in the parasympathetic nervous system. This instinctive response could be altered, reduced through behavioral and operant conditioning (cf. Watson, Skinner).	All persons (women, children, men)
Traumatic Neurosis [15]	Sándor Ferenczi	1932	Germany, Europe, Beginning of WWII; High Modern Era	Incest, rape and violent sexual experiences as children are the root of adult traumatic neurosis. Symptoms include: identification with the perpetrator (who was often a parent or family member), introjection of adult guilt, defiance, inability to account for or describe defiance, split sense of self, seeming maturation or precocious sexual behavior as a child and caretaking of family members including abuser. Treatment involved regressive enactments in psychoanalysis to allow for a form of relational resolution in therapy; emotional distance or over-intellectualized therapy may actually reenact the neglect of the abusive	All persons (women, children, men). Middle and upper class girls and boys were emphasized

				parent.	
Reactive Attachment Disorder (RAD) [16]	John Bowlby, Mary Ainsworth, Rene Spitz	1940-1980	U.K., WWII; Postmodern era	Children who experienced extreme insufficient care became emotionally withdrawn towards adult caregivers, with social and emotional disturbances characterized by minimal social and emotional responsiveness, limited positive affect or episodes of unexplained irritability. Preventative treatment was recommended where mothers remain primary caregivers and do not separate from child for work or other responsibilities. Mothers can be referred to therapy if they are physically but not psychologically available to nurture child. Attachment-based therapies for parents and children were developed from this approach to treat RAD.	*DSM-III:* Children less than 8 months *DSM-III-R* to *DSM-V:* Children of at least 9 months of age but no older than 5 years of age. Mothers and/or primary caregivers were considered primary in treatment.
Traumatic Neurosis [17]	Abram Kardiner	1941	U.S., WWII; Postmodern era	A "physio-neurosis" in which one's "effective ego" and "body ego" become disorganized in response to a traumatic event; the instinct of self-preservation drives the neurosis, this effects "effectual adaptation" or the ability to protect oneself and control the world. Ultimately the patient experiences shock and a loss of meaning. Kardiner recommended Freudian psychoanalysis but found it ineffective in attempting to help war veterans.	Soldiers, veterans (men)
Gross Stress Reaction [18]	*DSM-I*	1952	U.S., WWII; Postmodern era	Under conditions of great or unusual stress (e.g. combat and civilian catastrophe) "a normal personality may utilize established patterns of reaction to differ from neurosis or psychosis…when promptly and adequately treated the condition may progress to one of the neurotic reactions…this diagnosis applies to previously more or less "normal" persons who have experienced intolerable stress" (Jones & Wessely, 2006, p. 688).	Normal persons (women, men)
Post-Vietnam Syndrome [19]	Robert Jay Lifton	1973	U.S., Post-Vietnam War; Postmodern era	The Vietnam War was described by Lifton as the "destroyer of psychological continuity, individual and collective" (p. 404) such that it was impossible for soldiers to "achieve the psychological status of a meaningful combat ritual" (p. 38). Effects of war	Vietnam veterans (men)

included: guilt related to the death they witnessed, survived and created, rage related to government betrayal and apathy of civilians, and self-judgment. To ward off rage and violence, symptoms of restlessness, psychosomatic freezing, numbing, recurrent nightmares, anxiety, depression, suicide and psychosis occurred (p. 157). Additional problems included: feeling of isolation from average citizens, emotional desensitization and problems with intimacy in relationships (p. 279). Soldiers' reactions to war were not conceptualized as pathological or amenable to psychological treatment.

Adjustment Disorder [20]	*DSM-III*	1980	U.S., Post-Vietnam War; Postmodern era	Previously known as Adjustment Reaction of Adult Life (*DSM II*, 1968). A maladaptive reaction to an identifiable psychosocial stressors were indicated by impairment in social or occupational functioning and symptoms in excess of normal or expectable reactions to the stressors (p. 299).	Adults (women, men)
PTSD [20, 21]	Bessel van der Kolk, *DSM-III*	1980	U.S., Post-Vietnam War; Postmodern era	van der Kolk's research established intrusive symptoms of PTSD, such as nightmares as flashbacks, as accurate replicas of the traumatic experience. PTSD emerged in *DSM-III (*1980). Criterion A was defined as an external event that was "a recognizable stressor that would invoke symptoms of distress in almost everyone" (p. 238). The diagnosis included four symptoms from three clusters: re-experiencing, numbing and detachment, and changes in personality that were not present before the trauma. Recommended treatment is psychoanalysis, group treatment and or/ psychopharmacotherapy.	Adults (women, men)
PTSD [22]	Mardi Horowitz, *DSM-III-R*	1986-1987	U.S., Post-Vietnam War; Postmodern era	Horowitz defined emotional distress as intrusive, unbidden, involuntary and unexpected. In 1987, the word "flashback" (stemming from van der Kolk's research) was added to the *DSM-III-R* diagnosis, as well as Horowitz's language of intrusive re-experiencing as well as a cluster of physiological arousal symptoms. Recommended treatment was psychoanalysis, group treatment and or/	Adults (2omen, men)

				psychopharmacotherapy.	
Complex PTSD [23]	Judith Lewis Herman	1992	U.S.; Postmodern era	Persons exposed to chronic trauma held in state of captivity, physically or emotionally experienced symptoms of PTSD and difficulties with: emotional regulation, dissociation or forgetting events, distorted perceptions of perpetrator or self, distrust or repeated search for rescuer, and loss of meaning.	Persons in captivity (women, children, men)
Developmental Trauma Disorder [24, 25]	Bessel van der Kolk and NCTSN Developmental Trauma Disorders Task Force, *DSM-5*	2013	U.S.; Postmodern era	Chronic exposure to developmentally aversive interpersonal trauma (e.g., abandonment, physical or sexual assault, emotional abuse) and subjective experience of rage, betrayal, fear, resignation, defeat or shame. Resulted in "triggered pattern" of repeated dysregulation in response to trauma cues, persistent altered attributions and expectancies, and functional impairment (p. 14). See Table 1 for suggested treatments.	Children
Disinhibited Social Engagement Disorder [25]	*DSM-5*	2013	U.S.; Postmodern era	Categorized under Trauma- and Stressor- Related disorders in the *DSM-5*. Child must demonstrated indiscriminant attachment and over familiarity with many adults, have experienced extremes of insufficient care, which is presumed to be responsible for the uninhibited attachment. Treatment is attachment-based therapy.	Children 9 months and over who demonstrate these symptoms for at least one year
PTSD [25]	*DSM-5*	2013	U.S.; Postmodern era	Clusters of intrusive, avoidance (persistent negative changes in mood and avoidance) and arousal symptoms that occur after a traumatizing or life-threatening event. See Table 1 for suggested treatments.	All persons (women, men)

Note. Page references in table correspond to the original source unless otherwise noted.

 * Indicates original source text. WWII indicates World War 2.

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Appendix B

Specific Research Questions for Hermeneutic Inquiry

Appendix B: Specific Research Questions for Hermeneutic Inquiry

1.   What is the historical context of the particular manual or document of

         interpretation? What is the setting of the document's creation and the

         context of its authors?

2.   Who is thought to be involved in the therapy and how is their relationship

         described? (e.g. dyadic relationships like: practitioner- trauma survivor,

         therapist-patient, counselor-consumer)?

3.   How is trauma described? How are human relationships described in the

         context of trauma (e.g., perpetrator, survivor, victim, rescuer)? How are

         traumatic events described (e.g., random, in the world)? What is the

         conceptualization of the etiology and location of trauma? What

         assumptions of gender, class, race, health, bodies, responsibility and

         human agency (i.e., passivity, activity) are built within these

         conceptualizations?

4.   Who or what do the authors state is responsible for causing and treating

         trauma? Who benefits (i.e., is not "guilty" of causing trauma) within

         these descriptions, and who does not benefit?

5.   What is the intended context for utilization (e.g., ideal setting, patient and

         practitioner)? What criteria are used to identify a "traumatized" patient?

         What criteria define the ideal practitioner? What is the ideal manner and

         context in which the therapists are trained in the treatment manual?

6.   What is recommended for pre-session preparation or patient engagement?

7.   What are the goals of therapy?

8. What is considered trauma treatment (vs. prevention, debriefing, assessment)?

9. How are the actors (both therapist and patient) supposed to behave while delivering treatment?

10. How are the actors prescribed to interact with the manual (e.g., does the therapist bring it into the room and read from it)?

11. How should practitioners respond to unexpected circumstances in therapy or "unsuccessful delivery" of treatments (i.e., patient avoidance, drop out, "lack of compliance")?

12. How is an individual supposed to respond to treatments and what does it look like when a patient is "healed"? How are treated individuals supposed to behave and think (i.e., what constitutes a "good" survivor or victim)?

13. What are the moral judgments around good and bad responses to trauma that are embedded in the text (e.g., problematic or adaptive symptoms and behaviors that come from being traumatized, contexts in which traumatized responses are acceptable)? What is considered to be a normative, acceptable response to trauma? What is considered to be a good or bad therapist and patient within this conceptualization?

14. What is left out of the above descriptions or taken for granted about individual and collective experiences of trauma in the text?