MEETING THE SPIRIT IN DESPAIR:

EXPLORING DISCOURSES AND PRACTICES THAT SHAPE THERAPEUTIC WORK WITH SURVIVORS OF TRAUMA

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A thesis submitted in fulfilment of the degree of Doctor of Philosophy

University of Western Sydney

30 June 2009

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Declaration

I, Linda Margaret MacKay, declare that the PhD thesis entitled Meeting the Spirit in Despair: Exploring the discourses and practices that shape therapeutic work with survivors of trauma, contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

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30 June 2009

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Abstract

Keywords: trauma, narrative, transformation, therapy, viability, subjectivity

This thesis analyses the ways in which notions of **transformation** and **viability** (Butler 2004a) can be articulated within therapy after traumatic life events or circumstances. It draws together discursive threads from psychology, therapy, neuroscience and spirituality, to examine what makes for the viability of a life after overwhelming life events. In penetrating the dialogue between what is presently understood as "the scientific truth" about traumatic experience and the embodied experience of trauma, this thesis also argues that it is not enough to simply view psychology or biology as "complicated effects of discursive processes" (Blackman, 2001, p. 230). It examines subjectivity in the interface between biological and psychological processes.

Therapeutic work with survivors of trauma is based on the act of "perfect listening". It attempts to move traumatic events into language and into autobiographical memory to make for a viable life. The notion that listening is enough suggests that what is unbearable is within the person, who, with such help, can overcome any obstacle. A traumatised person's transformation relies on neurobiological concepts to account for the positive change. However trauma work is not that simple. It is mostly challenging, exhausting, long-term and often "messy", when interventions that "should" work, don't, or the unexpected arises. Explanations and life-enhancing changes that fit at one stage of a person's life or during a course of therapy do not appear to be easily sustained over time in the lives of many trauma sufferers.

However therapy may be one domain, when understood as a "relational cure", where subjects can be recognised and called into being. Understood systemically, therapy – and research – is also domains in which to explore how it is that subjects may continue to be recognised and interpolated as viable subjects, by themselves and others.

Preface: Meeting the Spirit in Despair

When I began this project nine years ago, I had already gained some recognition in my therapeutic work with couples and individuals, and in particular, in my work with perpetrators of domestic violence. I was managing a Sydney-based counselling agency as well as training and supervising the next generation of therapists who were working or wanting to work with couples and families. In my personal life, I was managing a household and dealing with my partner's long-term unemployment whilst raising three young active daughters.

More privately, I was also still in the midst of my own psychotherapy trying to heal the wounds of years of extensive sexual, physical and emotional abuse. In many respects, I felt I was living a double life, presenting on the outside a persona of competency and commitment in my profession, whilst on the inside I felt as though I was barely functioning. I was medicated for quite severe depression which I kept hidden from my work colleagues and most of my friends because of an outwardly happy, vivacious personality that seemed to go into play the more desperate I felt on the inside. I had some sense that if the trappings of my professional life were taken away, and in spite of my love for my children, there wouldn't be anything left of me. I would somehow cease to exist altogether, and simply implode with despair. My life did not feel "life-giving", although I did believe that somehow I had been able to make a difference in other people's lives and that at times I had helped make their lives more enduring. But for myself, I existed without enjoying my own life and certainly being less than emotionally available for my daughters. I slept through most weekends, appearing to "bounce back" for my working week till exhausted, I retreated again to bed and to sleep as much as I could. When I was able to find the energy and support to clearly think and begin to articulate what I needed, I realised I was trying to find something life-enhancing in the life I was living. I knew I needed to gain something vital to bring life and a sense of the future back into my view of my self and my life. I did not really know

from what or from where this vitality could be found, but I nevertheless yearned for something life-giving to occur. And I knew I was looking for answers to questions about the nature of healing, questions that were as much personal as academic.

These questions particularly came to the forefront when clients whom I had worked with to deal with trauma issues came back to therapy saying they felt better, somehow transformed. In the midst of my own difficult efforts to get through each day, I would be curious as to what had occurred to make my clients' lives improve. How had they come to feel so different? What had changed? My private, struggling self was as much if not more interested in their answers as my professional, clinical self who needed to help them understand and consolidate this change.

Sometimes clients would tell me that something had suddenly made sense to them, or that a burden had been lifted. Other clients would tell me about a dream they had had or that the kindness of a friend or stranger had made them at last more able to make a difficult decision that they knew in the long-term would be in their best interests. Still others would say they had taken a walk in the bush that made them feel better, or that they had felt some great feeling of well-being come over them for the first time in years. And sometimes they would revisit a moment in a previous session that I too had identified as transformational in some way and talk more about that, and the meaning it had for them or the new ability it had given them to move from living a traumatised life to a more life enhancing position.

I began to informally ask therapists in corridors or in supervision sessions about these moments of transformation described to them by their clients. Some would whisper, "I know it sounds silly, but what happened in the session with my client felt really spiritual to me." Others would say, "When my client told me about the dream they had, I felt as though something miraculous had happened as well, but I couldn't really describe in words what that felt like either." Yet another told me, "All I know is that my client felt hopeful for their life for the first time in years. And I have to say, so do

I! But don't ask me for a very scientific or really coherent explanation, because I can't give you one!"

Some clients reported a lifting of depression as a result of taking anti-depressants. They appeared much more amenable to cognitive-behavioural interventions when their emotionally disabling responses were reduced. Even in these instances, some of these clients who later returned to therapy told me that they knew any improvement they had experienced rested not simply on medication or on changed belief systems, but on an encounter with something they called "the spiritual".

I heard more and more stories of this kind, recounted to me more anecdotally rather than in formal evidence-based discussions. I knew that a possible reason for little formal dialogue was because of the restraints of clinical practice, which was exceedingly time-limited when it came to discussions about the more amorphous aspects of clinical work. However, I also wondered how much the utilisation of spiritual discourses to describe experiences of transformation invited reticence within a secular clinical practice. It seemed to me that spiritual discourse, while marginalised and at times even pathologised within the predominantly secular domain of therapy, nevertheless had considerable purchase in the attempts by therapists and trauma sufferers alike to articulate experiences of "transformation".

I became increasingly curious about these transformational moments in trauma therapy. I wanted to understand what happened in such moments and by what process did they occur? In order to pursue this enquiry, I found it necessary to embark on an analysis of the possibilities and limits of trauma discourse itself.

I ask in this thesis, how transformation and viability are conceptualised and articulated within dominant theories of trauma intervention, and what the work of poststructurally oriented theorists such as Judith Butler, Lisa Blackman and Bronwyn Davies can contribute to a re-conceptualisation of

trauma, and how I, as a clinician, can best respond therapeutically to the subjects of trauma. Intellectually and clinically, my work invokes and critiques a range of discourses – including the spiritually discursive – in order to make space for those vivid relational moments within therapy that, together with a painstaking deconstruction and elaboration of the clients' narratives of selfhood and relationship, can enhance the possibility of a viable life.

Thus, this thesis has evolved into a philosophical and conceptual work in which I came to analyse how **transformation** and **viability** can be articulated and understood within and outside therapy after traumatic life events or circumstances. Beginning as an exploration of the function and experience of spirituality as articulated by clinicians working in secular therapeutic settings, I became curious as how to understand and articulate moments of transformation and healing more generally. However, this was not smooth progression as I spent many months trying to work with therapists' accounts of healing moments in therapy before I accepted that the actual accounts couched in spiritual discourses were often difficult to understand, or even incoherent. What this thesis became, then, was an attempt to grapple with how specific salient moments enable a person to transform her or himself in a way that is life-giving. What makes for a livable life when that life has been seemingly unlivable and as Judith Butler (2004a) describes a life that has been considered less than other lives, a life that has even been deemed, in the absence of any acknowledgement, "ungrievable" by others? What makes those lives enduring again or sustainable at all? How do we understand a human subject's transformation from despair to hope? How does bearing witness to stories of despair and pain assist in bringing forth transformation? What role does the therapist play in these moments of transformation? What position does the therapist take up that allows some healing to occur? How do new subject positions become available to clients so that they are able to move from locating themselves (even though others still may locate them) as living an unlivable life to now perceiving their life as sustainable in a fuller and more satisfying way?

In the midst of this earliest conceptual work, I moved from New South Wales to rural and remote North-West Tasmania where I began working in a grief and trauma agency which prided itself as being at the cutting edge of trauma research. More than ever, I began to depend on a dominant discursive technology in order to make intelligible the effects of traumatic symptoms in my clients; a language which described the functioning of the brain to explain "what had happened" to a person who suffered from pervasive trauma symptoms and what could be "restored" if the appropriate interventions were used. This language was certainly not new to mainstream psychologists, nor was it really "new" to me, only in so far as I became more articulate in utilising the language of neuroscience to "validate" and "explain" and thus locate the problem of trauma.

Still, in stark contrast to explanatory structures that utilised neurobiological and other scientific discourses, there were gaps in attempts to adequately describe moments of transformation. Some experiences seemed to evade coherent explanation, and this "thing" called "the spiritual" remained in the therapy room in much the same way as it did within my previous secular practice of therapy. Without allegiance to any particular religious tradition, spiritually discursive language could still be evoked to describe moments of transformation in therapy even as I embraced neurobiological explanations as to what had "made the difference".

In **Chapter 1** of my thesis, I provide details of the epistemological and methodological underpinnings fundamental to my work as a researcher and therapist endeavouring to examine the problematisation of trauma from the multiple perspectives that arise from specific discursive technologies. I do not come to this meeting unencumbered. I too am embedded within specific power/knowledge structures and I needed to acknowledge these and provide an account of both my own subjection within these discourses as well as my resistance to them. In this way, the first chapter mirrors a gathering together of the utilities that informed my research and practice, in particular my positioning within a feminist poststructuralist framework. In order to provide a platform for my analysis of the ways in which transformation in

therapy is articulated, I discuss Judith Butler's (1997) assertion that power constitutes the very being and direction of the subject's aspirations.

I began with interviewing therapists who were asked to describe transforming experiences in their clinical work. I then turned to and depended on alternative sources of traumatic accounts. The way these accounts have been interwoven throughout the thesis itself is an attempt to disrupt traditional techniques as they relate to writing, research and practice and as such challenge those power/knowledge systems implicit in traditional psychological and scientific texts. By writing my self into the text as I have already done at the beginning of this preface, I outline in this chapter the rationale for my endeavour to disrupt the discursive domain of traditional psychological writing and research as other poststructural writers and researchers have done before me.

Overall, Chapter 1 explores the basis upon which I have acted in the space that became available to me to disrupt consciously and earnestly traditional forms of writing, reading and theorising. This chapter has not told the reader what I expected to prove or disprove. It is not a discussion of my arrival at the beginning of my thesis at my answer first; nor is it a summary of the mechanisms that assisted me in proving why I was right. Instead this first chapter works to highlight the theories that allowed my research question to undertake new shape and form from chapter to chapter, defying the status of an entity already made in order to keep open the nature of the questions I am asking and the possible insights to which they may lead.

Having made transparent my own embeddedness within similar and competing discourses through an examination of my research methodology, **Chapter 2** is a discussion of understandings about the "nature" of traumatic responses to overwhelming life events and their impact physiologically and emotionally on individuals and wider systems. Here I discuss the social and historical beginnings of present day theories on trauma, relying strongly on the theorising of Lisa Blackman (2001) as I follow her lead in setting the stage to produce a dialogue between what is "known" about trauma and the

embodied experience of trauma itself. Through considering ideas about the practices that provide this thing called "trauma" with a specific "reality", I formulate and endeavour to respond to a number of critical questions:

1. Who or what are the major players of particular constructions of trauma?
2. How is trauma problematised by these specific members of trauma/knowledge systems?
3. For how long has trauma been problematised?
4. What changes over time have occurred in regard to its problematisation across social, biological and psychological matrices?
5. What discourses about trauma carry the most weight?
6. Which discourses are marginalised?
7. And what are the possible consequences to the traumatised subject of these specific conceptualisations of their struggles and experiences?

In exploring the problematisation of trauma as it related to Sigmund Freud and Pierre Janet's earliest work and their focus on its "presentation" in the female hysteric of the 19th Century, I go onto discuss the emergence of the phenomenon of shellshock during World War 1, and later, Posttraumatic Stress Disorder (PTSD) so as to explore within a historical framework, present day understandings of the biological and psychological processes constitutive of this "thing" called trauma. One of things I particularly noted in this chapter was that despite the attribution of unbearable physical and emotional symptoms to the impact of exposure to overwhelming and terrifying events, explorations of what makes for a "predisposition" to this form of human suffering pervade.

When I use the word "predisposition", I am not specifically referring to a predication on some form of "disorder" that produces a more vulnerable human subject, such as a person with an acquired brain injury or one who comes from a family with a history of certain neurobiological disorders that have a genetic component. Nor am I simply alluding to what was the focus of much of early 20th Century intervention into why some men developed

symptoms similar to the so-called hysterical symptoms of women, by association constituting the traumatised soldier as weak and "unmanly" and therefore "lacking". What I am referring to is how a focus on predisposition has moved to commentaries and research as to how an absence of the availability of good-enough caregivers, usually mothers, produce neurological "weaknesses", vulnerable to the development, specifically, of PTSD or other traumatic stress disorders later in life as a result of emotional misattunement in the life of the developing child. So whilst it became noticeable in my exploration that descriptors related to "hysteria" and gender based explanations for debilitating symptoms have disappeared from most traumatic stress diagnoses, at least within research literature, a concentration on early relational trauma through a form of parental (mothering) failure in childhood is fast becoming core to intervention, rather than the origins of trauma itself, such as indisputably overwhelming events such as victimisation due to ethnicity, sexual assault, war and torture.

In addition, in examining current theorising as to how the brain responds to trauma, I briefly concentrate on the utilisation of ground-breaking brain imaging techniques that highlight the effect of trauma symptoms. Here I observe how this specific technology produces "indisputable evidence" (Latour, 1987, p. 103), in order to make the workings of the brain intelligible. The technology pronounces what is "normal" and what is "pathological" in relation to the operations of the human brain, conflating these with "psychological spaces" and therefore subjectivity itself. This chapter then explores how the body (soma) and the mind (psyche) are nevertheless able to demonstrate a reflexive landscape of influence (Wilson, 2004), albeit unpredictable and interminable, which open up possibilities for human experience and subjectivity and recovery from trauma.

Recognising the challenge of bringing together the disparate discursive elements of multiple power/knowledge systems such as neurobiology, trauma theory and therapy, which I have initially identified as "players" in this project, my primary task in this chapter is to establish (alongside of the contradictions) some mutuality in the way these discourses encounter the

problem of trauma and the forms of subjectivity thus evoked. In doing so, my own epistemological positioning has needed to be acknowledged. To take a metaphor from systemic family therapy, I have needed to analyse my positioning, influence and mutual constitution as an active member of this system of trauma discourses. In a manner analogous to working with a highly conflictual family system in therapy, I have needed to find a way to reframe and articulate the problem of trauma and its potential transformation. In doing so, I have produced the possibility of deconstructing and reassembling discursive elements into a workable collaboration of which the facilitator of that enterprise - in this case myself as researcher - is an active part.

Chapter 3 immediately moves into examples of embodied narratives of trauma as I begin my elaboration of the subject positions that are produced through the language and metaphors used to describe traumatic experiences. Specifically I ask where individual "felt" experiences of trauma fit into the social, biological and cultural landscape. I examine how the use of identity language functions to capture the experience of selfhood in relation to trauma as if it is forever a fixed unchanging state, and ask what constructions may open it up as an ongoing project of re-invention. To do this, I refer to a number of stories of trauma and healing and note how the strategies survivors of trauma use to interact with their embodied experiences of trauma can transform the embodied experiences themselves. I consider how severe pain can be managed somehow in the interface between psyche and soma.

Further in this chapter, I engage with how notions of a "loss of a sense of self" emerge consistently in trauma accounts. I provide examples as to how and when the sense of a discontinuous identity arises, both trauma survivors and trauma clinicians are often compelled to identify and position themselves and others in linear narratives of selfhood. The work here becomes that of paying attention to the slippage between essentialist and poststructuralist constructions while closely investigating their usefulness in trauma work.

The notion of integration pervades clinical theory and practice, requiring a narrativisation of trauma accounts that I too deploy regularly in my work. In following this thread of narrativisation, that is, the imperative to tell and retell stories of suffering, I note that this can work both towards and against some form of recovery from trauma. Whilst this is not a new discovery (Harvey, 1996; Mitchell, 1997; Ford, Courtois, Steele, van der Hart & Nijenhuis (2005); and Kuyken, Padesky & Dudley, 2008), what did emerge in my examination was how particular forms of subjectivity are made possible dependent on the responses of the listener. In this chapter, I again demonstrate the tension I hold between a poststructuralist stance and the seductive essentialisms of psychological theorising in regard to "explaining" trauma, particularly when I comment on the role of developmental factors in predisposing a person to the experience of trauma sequelae in adult life. Thus the work of this chapter (and indeed the work of the whole thesis) is to explore this tension and the possible consequences of this in theory and practice.

What began to emerge in **Chapter 4** was that accounts of trauma that defy symbolic representation or that are unable to be articulated through another mode of communication may deem both the speaker and the speech unintelligible. If, in the act of speaking, words fail or no "sense" can be made, assumptions are frequently made about the extent of the traumatic symptoms and the subjecthood of the sufferer that may then limit the subject's opportunities for a viable life.

In examining the problem of unintelligibility, I return to neurobiological explanations in order to ask what they offer to an understanding of the unspeakability of trauma. I am attempting here to further challenge the status of narrative coherence. The imperative for the survivor of trauma to "tell the full story" as a precursor to a viable and sustainable life is called into question by the neurobiology of trauma, which suggests that much traumatic experience is physiologically unlanguagable, rather than psychologically repressed.

The examination of the efficacy of attempting to articulate traumatic experience and the consequences for subjectivity led me in this chapter to include the poetry of Paul Celan and the prose of Primo Levi. Celan and Levi provide significant contributions to Holocaust literature, both having survived the death camps. As such, their narratives allow for an examination of the makings of viability once traumatic experience has been articulated into language, given the premise that there will be a resolution to trauma if this occurs. However, from my examination I began to conclude that viability cannot be established once-and-for-all at a single point of time. It may need to be revisited again and again in response to unfolding life events. Whilst Celan and Levi successfully narrativised their accounts, this did not translate in any simple or ongoing way into a viable life, since both these men committed suicide. So, here I examine how articulation into language may in itself be an insufficient condition for recovery from trauma. Such recovery, as I argue throughout this thesis, may depend (beyond narrativisation) on forms of recognition that confer viability.

In **Chapter 5**, the focus is on attempts to bring into language details of traumatic memories and how these may resist coherent and intelligible representation. Significantly, I explore accounts of acts of genocide and atrocity that defy cultural representation and therefore elude attempts at "normal" narrative structure and "normal" autobiographical memory. I then ask what would occur if the un-narrativised voice of traumatic memory is examined for what it reveals rather than what it does not; and in so doing, explore whether this resistance to narrativisation may be productive of a greater understanding about the effects of trauma. In addition, I note how pathology may be produced through such conceptual goals in therapy as "integration", "wholeness" and "healing", and how these constructs may be implicated in the many ways survivors of overwhelming events can fail at being humanist subjects, capable of individual moral responsibility and agency. Thus this section takes into account how the lives of those who fail to achieve this form of subjectivity, albeit marginalised, can be dignified if these traumatic accounts are given the space for validation, if not

normalisation. However viability, like subjectivity, is an imperfect accomplishment that comes at a cost.

In a lateral move, this chapter also brings in visual representations of horrific events via two photographic images, in order to explore how a failure to narrativise acts of war and torture may in itself be a resistance to accommodating such forces. In this sense, I argue here that a failure to transform these events into autobiographical memory and coherent narrative reflects the indigestible character of traumatic memory – its refusal to be assimilated seamlessly into a coherent narrative account – is itself a vivid testimony to a horror in excess of understanding.

Chapter 6 focuses on a critique, although not a rejection, of the notion of therapeutic process as that which allows for the transformation of the previously inarticulable into a coherent narrative that can arguably be integrated into a person's life. As a therapist, there is something to be said for a person walking out of the therapy room with a more coherent sense of self and a narrative trajectory that tends, nevertheless, toward a viable life even as the notion of this accomplishment is problematic. It is this tension that I draw attention to here. Thus this chapter places particular emphasis on ah-ha moments in stories of transformation and discusses the "ingredients" of these healing moments. Dissociation is one traumatic symptom that is examined in this chapter in light of the transformational powers of the ah-ha moment. In so doing, I move to challenge binary notions of disintegration and integration and their privileging in psychotherapeutic and mental health discourses and instead explore the concept of "un-integration" as it relates to the experiences that exist outside of language.

In conceptualising notions of transformation, certain discursive spaces become available to the speakers or writers of such experiences. One such space that emerged, given my original agenda, was the discursive space named "spirituality", which arose within yet another discursive space of encounter named "therapy". Unspeakable spaces, spaces that may be

constituted as spiritual spaces, and spaces that may have been constituted as traumatic spaces, have surprisingly similar elements.

Finally, in examining traumatic accounts of events, such as that which took place in Cambodia, I note some similarities between these accounts of traumatic experience and attempts to language sublime transformational moments, bringing attention to the implicit in principio voice in spiritually evocative experiences as well as in traumatic ones. I suggest that the spiritual is deployed within accounts of therapeutic transformation to gesture toward a positive form of experience that, like traumatic experience, is "out of time" and challenges narrative and subjective coherence. In this way, I revisit my inaugural preoccupation with the place of spirituality in therapy, in that the most powerfully curative "mo(ve)ments" (B. Davies & Gannon, 2006, p. 6), in therapy draw on the spiritually discursive in order to express an excess that, in its bodily intensity and even its incoherence, can match and challenge the experience of trauma. With this in mind, I propose that language under exposure to extreme stress, may also be immobilised when the implicit in principio voice of spiritually evocative experiences are encountered.

The **Conclusion** to this thesis reflexively examines the intersubjectivity of the research experience and its role in the production of certain kinds of said and implied experiences for the researcher herself. It suggests that transformation and healing, as well as traumatic and overwhelming life events, may continue to elude description, unless we challenge the marginalisation of spiritual discourse within mainstream therapies, and encourage the re-emergence of the poetry of the in principio voice, in the expression of traumatic experience, and the transformation of the subject of trauma.

Similarly, challenges to limiting modes of representation and "sense-making" are viewed as productive of greater potentialities for subjectivity and viability in this chapter. I propose here that the viability of any subject,

and especially of the traumatised subject, requires continual reiteration through subjective and relational processes of recognition (Butler 2004a) that are produced in the "face of the other" (Levinas, 1985) during the therapeutic encounter.

In light of this new thinking, Deleuze asks "What is to be done now?" (Deleuze, 1988, p. 133). Through taking on the implications of a new "real" of therapeutic practice, in which even the experience of a fragmented human subjectivity is acknowledged for revealing more about being "human", therapy becomes a process that can challenge the limits to representation in order to make subjects known, recognisable and viable.

In reconceptualising trauma and its "treatment" through the research and writing of this thesis, I have expanded the possibilities for making a therapeutic response to the effects of trauma, recognised the limits of its capacity to make sense, while reaffirming that therapy is above all a "relational cure".

Chapter 1 Methodology

> The shadow of death and the pains and torments of hell are most acutely felt, and this comes from the sense of being abandoned by God... a terrible apprehension has come upon (the soul) that thus it will be forever... It sees itself in the midst of the opposite evils, miserable imperfections, dryness and emptiness of the understanding, and abandonment of the spirit in darkness
>
> **(St John of the Cross).**

My continuing work as a supervisor of other clinicians as well as a family therapist working with a very distressed client group has required that I assist individuals, couples, and families to find healing in the face of overwhelming experiences. In my clinical setting it is not uncommon for clients to present for therapy suffering from the profound psychological and physiological impact associated with, for example, the death of a child or children, child or adult sexual assault, domestic violence, the suicide of a loved one, intentional or accidental death or injury and incapacity, relationship breakdown, racial or sexual discrimination, the loss or destruction of a home by fire or natural disaster, torture and displacement due to war or persecution, debilitating or life threatening illness, chronic depression that may be associated with earlier unresolved trauma; to name but a few of the many specific "events" that may cause long-term traumatic symptoms and reduce an individual's ability to experience pleasure and a sense of personal well-being.

I have sometimes battled with my own emotional responses of helplessness and powerlessness when I have attempted to assist a client to affect a more positive view of their life. My own struggle has emerged when I have faced the reality of the damage caused them by multiple life traumas, the lack of resources available to them whether personal, social and economic, and my

own limited skills or abilities in the face of disasters, death and loss and in particular in the face of unspeakable crimes against adults and children. I know that sometimes I have needed something to hang onto that was outside my own rational world when faced with these traumatic stories. "Holding the hope," (a phrase that a supervisor gave me and I have used with my own supervisees who also struggle not to be overwhelmed by their clients' situation) for a client in deep despair often required me to reach out to other less grounded resources than those with which I had been armed in my clinical, scientific and positivist psychological training. For my own work with clients, some sense of the spiritually discursive realm had helped me bear witness to my clients' struggles, particularly throughout the arduous work of healing the pervasive effects of trauma. For instance, there have been times when I would silently reach out to a perception of something or someone outside myself or at least outside my conscious thinking processes, asking for the "right" words to say in the face of my client's despair. Sometimes, miraculously, the "right" words would appear to come, measured by my client's responsiveness, even though it felt as if these words had not emanated from the cognitive processes of my brain. I would find myself wondering what other therapists "hung on to" in situations in which they too were despairing of a client's situation. I wanted to know if other therapists sought non-rational or mystical assistance at times like these, just as I had. If they did, I wondered how they defined those experiences if they too were "given" the "right" words to say without consciously thinking them into being. Did they call this a gift of intuition or did they invest in it some spiritual quality? What else did they describe as having a spiritual element to their work? And most importantly, did these as yet undefined and amorphous elements improve the quality of the assistance they gave to clients and/or allow for other healing possibilities to emerge?

It is not surprising that researchers in the area of trauma report how exposure to stories of the human capacity to inflict cruelty on another challenges an individual's basic faith (Herman, 1992). As I have described, therapists including myself and clinicians I have supervised, can also

become unravelled in the presence of others' losses, others' suffering; and in bearing witness to stories of distress, one's own losses and grief and traumas can be touched. To quote Judith Butler (2004a) in her book, Precarious Life: The Powers of Mourning and Violence:

> One does not always stay intact. One may want to, or manage to for a while, but despite one's best efforts, one is undone, in the face of the other, by the touch, by the scent, by the feel, by the prospect of the touch, by the memory of the feel (Butler, 2004a, pp. 23-24).

Here in Australia, my experience is that clients usually present for therapy when their own resources, personal, familial or social are exhausted or inadequate. Much of the clinical work with people who suffer trauma sits in the landscape of experiences that are unnameable, grief that is not able to be mourned publicly, losses that otherwise are unacknowledged. This grief and trauma may be perceived by others to be irrelevant to the present: "That was a long time ago! Can't you just get over it?" Some injuries may not be validated by significant others in the client's life: "I can't believe for a moment your father abused you. He idealised you! Did that therapist put the idea into your head?" Some losses may be "disenfranchised" (Doka, 2002) in that significant others find it difficult to respond adequately to the grieving person owing to judgements made about the person and the mode of death, such as deaths caused by suicide, drug overdose or an AIDS-related illness. The distress or trauma may be perceived as self-inflicted: "Why didn't you just leave him if he was beating you up?" And as examined by Butler (2004a) in relating to the United States and its allies position on the "war on terror", the constitution of what is human (American citizens killed by terrorists on 9/11) and those who are not (Iraqis killed as a consequence of the war) can mean under certain conditions there is a lack of "humanness" attached to the victim: some lives and deaths and injuries are mourned and others lives or deaths or injuries go unnoticed.

Whether these traumas and losses are publicly and adequately recognised or go unnoticed, whether they are invalidated by people close to the client or

by the wider community, responses such as these constitute or undermine the possibility of a viable life for survivors of traumatic events. Yet beyond this, stories of ecstatic transformation and hope can arise from the apparent ashes of peoples' lives even in the absence of social recognition. Sometimes these stories of healing evoke language that may be described as mystical or spiritual. Sometimes these stories are perceived as emanating from the love of a higher power or God-like figure; sometimes, as in near-death experiences, clients speak of meeting and speaking to their departed relatives and return to life "a new person". In yet other instances, clients, who session after session have stated they have "nothing to live for" and that they are "overcome" with grief, tell me of suddenly being "overcome" by a profound sense of purpose and well-being. If, as according to Butler, being "overcome" implies a "mode of being dispossessed" and being "ec-static" is "… to be outside oneself… to be transported beyond oneself by a passion, but also to be beside oneself with rage or grief" (2004a, p. 24), then both overwhelming and ecstatic states evoke intense experiences that exist outside the mundane. Butler points out that many of us, she included, "are living in certain ways beside ourselves, whether in sexual passion, or emotional grief, or political rage" (p. 24). I would add to this "we," those of us, (myself included), who are in the process of healing, or seek to assist others to heal, from profound suffering. In the "ec-static" moments of transformation that punctuate the narratives of trauma therapy we too are "beside ourselves", whether these moments are described as spiritually passionate experiences, the making of illuminating cognitive connections, the experience of connecting deeply with another, or simply "moments that changed a life".

Fascinated by the discursive realm of the spiritual or divine that was evoked in many of these transformative experiences that were recounted to me by clinicians and supervisees, I became curious about the lack of mention of spirituality as a resource in mainstream secular psychological theorising. So I began to undertake research prefaced upon my perception of secular therapy's avoidance of religious and spiritual beliefs as resources for clients.

Yet on what did I base this assumption given that my own experience as a couple and family therapist and psychotherapist undertaking research in this area was generally met with interest? Indeed, most of my peers were very excited about the nature of my work and research and were almost queuing up to take part in the project itself! However, I had for some years been involved with training therapists at an undergraduate and postgraduate level and knew that generally there was an absence of teaching material, courses and publications that related to spirituality as a resource for clients and their counsellors outside the transpersonal or pastoral psychology realm, both marginalised areas of study outside of mainstream psychology training. By senior management I was told it was "interesting" that I was undertaking such research given we were not a church-based agency. And despite my parallel role as trainer and clinical supervisor, as well as a middle manager, I was often prevented from pursuing any professional development that did not relate to a focus on outcome driven tender successes and management practices capable of producing higher and higher productivity. When I attempted to discuss the possibility of spirituality as relevant to therapeutic work, I was met with raised eyebrows and an immediate change of subject. Surprisingly, in a context which prided itself on being a centre for learning, no vigorous academic discussion ensued.

I wondered if this response reflected a view that religious or spiritual beliefs are maintained outside of reason and representative of some infantile state (Freud, 1918; 1919). Ultimately, as I became more and more passionate about my research I was forced to sever my employment after nine years with the organisation that refused to grant my leave when I was awarded a short-term study scholarship. In pursuing my research, I am still left wondering how much support I may have received had my research focused on more traditional and secular areas of therapeutic intervention.

So I read with interest the experience of Froma Walsh (1999), a professor in the School of Social Administration and the Department of Psychiatry at the University of Chicago as well as the Editor of the American Journal of Marital and Family Therapy. In her edited work, Spiritual Resources in

Family Therapy, Walsh described her experience of undertaking to write a book about spirituality in therapy:

> When I became interested in working on a book on spirituality in clinical practice, one academic colleague remarked that it was a good thing that I already have tenure. Some clinicians looked appalled, and others worried that I might have gone off the deep end, possibly into some fringe group. For most psychotherapists, opening conversation on spirituality has been even more taboo than broaching such topics as sex, money or death. Spirituality and religion have been purposefully left out of clinical training, practice and research. The unspoken assumption has been that religion is not our proper domain and we should not 'intrude' into it. This has been translated into an implicit understanding between professionals and clients of 'don't ask; don't tell' (Walsh, 1999, p. 29).

Ah, I thought, someone else who knows how it feels to broach the subject of spirituality in a clinical setting! And a family therapist too! Walsh's explanation made sense to me – there's something very "fringe" or New Age about talking of spirituality and traditional therapy will have nothing to do with that sort of thing so it seems!

Subsequently I decided to interview clinicians who work with traumatised clients to glean something of the function of spirituality as a healing resource in therapy. Thus my research project began as an attempt to understand and articulate the function of spirituality in therapy. I undertook qualitative research with therapists, more specifically, counsellors, psychologists and social workers working with traumatised individuals and/or their families and who were presently employed in secular contexts. Many of the clinicians I interviewed also trained and lectured in counselling, psychotherapy, couple and family therapy and/or psychology and social work at universities or accredited post-graduate training institutions.

During the actual interviews, whilst I did not know where the work would take me with my thesis, I had at least felt able to begin to understand some "thing" about what the therapists had been describing to me. On many occasions during the interviews, I felt profoundly moved by what I was being told and how it was being told to me. The experience of interviewing the therapists was often profoundly intimate, evocative, moving, exciting and passionate. I had already hypothesised that, due to the privileging of science over religion or spirituality in mainstream clinical training, therapists were taking risks to disclose something of their work and their understanding of their work with clients outside of a traditional dry "case discussion" format of a clinical supervision. All the therapists I interviewed told me how valuable it was to "talk like this" about experiences they did not truly understand but that they had experienced with their clients and which they saw as crucial to their clients moving to a more life-enhancing future.

Yet when I began to formally examine the data I collected from the therapists I interviewed, I struggled to make sense of it. Many of the therapists' accounts of healing moments in therapy were difficult to understand. Normally extremely articulate women and men became tongue-tied as they tried to explain experiences in therapy they described as "mystical" or "spiritual" or "soulful". The data was difficult to comprehend, difficult to transcribe, difficult to analyse, so much so that when I presented an excerpt of one piece of data to my post-graduate students in psychology, I was asked whether the therapist who produced such "an incoherent rambling" was in fact mentally balanced, given the seeming unintelligibility of their account!

I persevered with analysing the data as best I could until I was forced to admit I did have an implicit agenda at the outset of my thesis that was not going to be met. I had hoped my work would help validate spirituality as a relevant if marginalised discourse in mainstream psychology that enhanced clients' healing from trauma. But how could I do that when the data I

collected was so difficult to manage and to translate into coherent evidentiary "proof" of this purpose?

Ironically, my early research interviews had performatively reconstituted the very problem I was trying to deal with. While the interviewees and I were transported by the embodied experience and emotionality of the interviews themselves, the transcribed text of the interviews seemed merely irrational and incoherent, and thus reinforced the dominant notion that spiritual explanations for therapeutic change are deeply unscientific, invalid and lacking in rigour.

Undoing an Agenda

Flipping the data on its head, by accepting what this research was not turning out to be, I was forced to ask what is nevertheless opened up for examination by this "failure" of the research process? Postmodern theories such as feminist poststructuralism eschew the notion of an objective truth, and I wondered if the disjunction between the embodied experience of the interviews and the transcribed data was testimony to this. I had to ask a couple of salient questions. What specific knowledge, albeit historically situated and produced discursively, came into view in relation to this contradiction? How are human subjects constituted through these discursive regimes? How are subjects constituted through the regime of coherence and incoherence? In particular, how is the subject of trauma constituted through what can be articulated and what can't, in relation to traumatic experience, and in the process of healing and transformation? How is the trauma therapist, as well as the trauma survivor, constituted within the regimes of therapy and of research?

Hence this thesis changed direction. I decided my data was valid in the broader sense of being "grievable" and representative of "humanness", not just despite, but because of much of it being incoherent. So I began to undertake an exploration into understanding transformation; that is, some

event or experience or series of events or experiences that are life giving, and what discursive spaces become available to the speakers or writers of such experiences. I modified and broadened my notion of the relevant "data" to include literary and biographical texts by survivors of trauma, professional literature from the dominant discourses pertaining to trauma, transcripts of conversations from therapy and supervision, and, yes, a few cogent if incoherent excerpts from the interview transcripts.

Given my original agenda, a significant portion of this work of exploration and deconstruction has been carried out within the discursive space named "spirituality" within yet another discursive space of encounter named "therapy". This turn or subversion of my original (if implicit) goal, also required I enter and stay for a while in unspeakable spaces, spaces that may be constituted as spiritual spaces and spaces that may have been constituted as traumatic spaces. It also required I make attempts to language these spaces that have otherwise been unable to be articulated – either because speaking about such spaces is taboo or forbidden or circumspect or qualified; or because the ability to articulate these spaces is extremely difficult. This research also demanded that I think about why "words fail" the speaking of some transformative experiences, at least in their raw, newly sounded, virginal form. I needed to expressly and purposefully wonder why some transformative and healing experiences sit outside language, and examine the new life-enriching subject positions that, despite this became available. And because I knew from my work with traumatised individuals that they too at the outset of treatment lacked the language to coherently articulate their experiences, I started to wonder at any possible connections that existed between the articulation of experiences individuals described as mystical or spiritual and the articulation of traumatic experiences.

Critical Psychology

Fortunately, I have been able to pursue my curiosity about these possible connections in my research as this thesis is positioned within a critical psychological framework. Situating itself within the larger discipline of

psychology, Critical Psychology (CP) aims to critique and "radically" respond to mainstream psychological theories of the subject taking into account the influence "of those from the left, feminism, ethnic and anti-racist politics, ecological movements and new forms of spirituality, and radical work more generally conceived," (Walkerdine, 2001, p. 9). The use of the term "radical" speaks to CP's emergence from the counter-culture of the 1960's, the anti-psychiatry lobby, neomarxism, the Civil Rights movement, the advent of Feminism, queer politics and the liberation psychology of Latin America. It also points to the influence of critical theory, which has challenged scientific knowledge as the site of the production of an objective truth.

Critical theory, which is sometimes called New Left theory or neomarxism, drew attention to the historicity and specificity of social science's Western rational humanist subject and challenged the notion that a liberating objective truth can be found, "that an account … is always situated. It is an account from somewhere, and some time, and some one… written for some purpose and with a particular audience in mind. It is always therefore a partial and particular account, an account that has its own power to produce new ways of seeing and should always be open to contestation" (Gannon & Davies, 2006, p. 72; B. Davies, 2000a). Harris, Carney and Fine (2001) state that critical theorists are interested in social action and therefore seek to deploy resistant strategies in order to highlight "the politics of the everyday" (2001, p. 7). Critical theorists also seek to emancipate the marginalised and least resourced human subjects who may be rendered less visible due to having unequal status with the dominant majority (think illegal immigrants, refugees in detention, welfare recipients, victims of violence or oppression, political prisoners etc). It is with this in mind that critical psychologists in Latin America are "critical of the status quo in psychology because it supports forms of domination, and critical of the status quo in society because it perpetuates forms of oppression" (Prilleltensky and Austin, 2001, pp. 39-40). In this context, critical psychologists are focusing on the evolution of a form of liberation psychology, which takes into account their specific socio-political

environment and aims to both emancipate and empower ordinary people.

Whilst critical theorists influenced by postmodern and poststructural approaches to research have yearned to embrace similar projects of emancipation (Gannon & Davies, p. 73), critical psychologists and feminist poststructuralists have moved away from these ideals given scepticism about the possibility of liberation, if agency is understood as always predicated on the positions made available through discourse and the notion of subjectivity. Therefore "possibilities for agency, resistance, 'freedom,' and emancipation [are viewed] as contingent and limited" (Gannon & Davies, p. 73). Subjectivity too, is always also a subjection to the available ways of being in which one "is both subjected to available regimes of truth and regulatory frameworks and at the same time and through the same processes becomes an active subject" (Gannon & Davies, p. 83; Butler, 1992, Foucault, 1980a). In this way, CP in Britain (and in Australia which has been largely influenced by British critical psychological thinking) converges with the epistemological underpinnings of postmodern and feminist poststructural research in which essentialist moral or ethical fundamentals are brought into question. Nevertheless critical psychologists who may or may not identify themselves as feminist poststructuralist researchers are not precluded from vehemently undertaking calls to action, although what action is possible when humanist agency is itself problematised and put "under erasure" (Derrida, [1967], 1976), is a question that will be elucidated in subsequent chapters as I work with, for example, accounts of trauma that sit outside language, and propose how these may be dealt with inside the therapy room.

Feminist Poststructuralism

Poststructuralism recognises that the subject is produced through discourse, which is its focus of analysis. Texts are examined for their historical specificity and deconstructed as to how they produce certain kinds of subjectivities; that is, certain ways of seeing ourselves as individuals, how we perceive others, our choices and desires and our world-view. In this

way, Michel Foucault theorised that discourse is thus historical, that it is always specific to a time, culture, and place, and the relational power that exists between the speaker and the listener, and "articulate[s] what we think, say and do, opening up some options for choice and decision making and foreclosing others" (Foucault, 1997, p. 315). This Foucaultian reading of discourse, which underpins poststructural theorising views the notion of objectivity as always discursively situated and contextualised at a specific time and place in history and always available for scrutiny. Hence, all forms of knowledge are "always already discursively constituted and legitimated within fields of social power relations" (Cheals et al., 2003, p. 57, citing Foucault, 1972, 1980b). Thus social power relations and knowledge are produced through discourse – how meaning is formulated, even ways of speaking because of the implicit rules which govern these processes, are productive of the power relations that underpin them that in turn function to legitimise, marginalise, oppress or exclude.

A specific example of this in my research is my discomfort with much of the data. My objective gaze constructed these texts as inarticulate, even at times, unintelligible. Yet a poststructural examination of my so-called "objectivity" led me to view this objectivity as in and of itself, already acted upon and acting through specific discursive constructions that produced this tension between my desire to legitimise the data in some way and its seeming incoherence, itself a discursive construction that marginalised the data and threatened it with total exclusion. It should be noted that the "I" as the individual orchestrating the research in fact disappears in the face of this example of the power of discourse. My "I" (if it was ever wholly mine!) is not the autonomous acting heroine, responsible in her entirety for what lays ahead. I am constituted through particular discourses. To quote Deleuze and Guattari (1987):

> You will be organised, you will be an organism, you will articulate your body... You will be signifier and signified, interpreter and interpreted. You will be a subject, nailed down as one, a subject of

> the enunciation recoiled into a subject of the statement (Deleuze & Guattari, 1987, p. 159).

Thus being both the "subject of the enunciation" and the "subject of the statement" describes the relative manufacture of any distinction between an interior and exterior life via what Butler describes as the "process of internalisation" (Butler, 1997, p. 19). Butler describes this operation thus:

> We are used to thinking of power as what presses on the subject from the outside, as what subordinates, sets underneath, and relegates to a lower order... But if, following Foucault, we understand power as forming the subject as well, as providing the very condition of its existence and the trajectory of its desire, then power is not simply what we oppose but also, in a strong sense, what we depend on for our existence and what we harbour and preserve in the beings that we are (Butler, 1997, p. 2).

B. Davies, Browne, Gannon, Hopkins and Wihlborg, M. (2006), building on Butler's understanding, describe the multiplicity of the mechanisms of power which both constitutes the subject and constructs the very terms of the subject's existence:

> Those individualising forces through which we are made into particular kinds of individuals, and the totalising forces through which populations are categorised and controlled, work on us not as power that lies outside ourselves and that we can straightforwardly resist, but they work at the level of desire, of attitudes and of values. Through the technologies of the self that we take up we shape our bodies into particular bodies, bodies that recognise and value their own specificities and category memberships. We are simultaneously governed and govern ourselves. We are individualised and totalised/categorised/governed through the same process (B. Davies et al., 2006, p.169).

And yet in noting my own appropriation by and to this discursive tyranny, I am actively employing a feminist poststructuralist approach that looks at the spaces that nevertheless become available. B. Davies (2000), referring to the former quotation from Deleuze and Guattari (1987) states:

> We are simultaneously constituted through discourse, 'nailed down,' 'recoiling' into the text, and yet we become at the same time and through those same processes a speaking subject, a 'signifier,' who can appear as separate and independent of those processes, who can even, potentially, go beyond those processes (B. Davies, 2000, pp. 14-15).

So in this sense, by refusing to foreclose on the data whilst unsure of the possibilities for subjectivity that would emerge in this process, I am following the precepts of a feminist poststructuralist approach that "insists on a particular position ... [that] seek[s] to reconfigure agency so that we still might claim it as a possibility..." (Gannon & Davies, 2007, p. 73, citing B. Davies, 2000a; B. Davies & Gannon, 2005; Weedon, 1997), even as such power is viewed as unwieldy and unstable, and possibilities for acts of resistance and liberation remain limited and contingent.

Thus power is handled differently within critical, postmodern and poststructural theories and "their different takes on power, freedom and agency act as distinguishing features between them" (Gannon & Davies, p. 73). In this regard according to Gannon and Davies, feminist poststructuralism separates from theoretical frameworks that define power as held by certain dominant groups and institutions. Given this regulatory regime, the challenge for feminist poststructuralists is to work out what actions nevertheless can take place. Butler (2004a) describes this qualified feminist agenda and the necessity:

> ... to rethink the relation between conditions and acts. Our acts are not self-generated, but conditioned. We are at once acted upon and acting, and our 'responsibility' lies in the juncture between the two. What can

> I do with the conditions that form me? What do they constrain me to do? What can I do to transform them? Being acted upon is not fully continuous with acting, and in this way the forces that act upon us are not finally responsible for what we do (2004a, p. 16).

Deconstruction

An important textual strategy which reconditions a researcher's ability to act in ways that are conducive to the creation of alternative possibilities, is to deconstruct those binary pairings within discourse that set the boundaries for ways and means of thinking and opportunities for expression. Binaries are pairings such as male/female, good/bad, rational/irrational, scientific/religious, etc, which are both limiting and hierarchical and function to promote dominant modes of thinking and behaving. One term is defined in relation to the other term that has greater status or standing. Binary pairs can be conflated, one into another. Gannon and Davies remind their readers that, "'feminist' may be conflated with 'woman' (and, conversely, 'not-feminist' with 'man')" and further " 'not feminist' can be conflated 'with misogyny or patriarchy...' " (2007, p. 73). Thus, as I described in the preface to my thesis, a therapist who specifically describes a spiritual experience in her clinical work can find her identity and her meaning-making limited by a form of categorisation that subjectifies her initially within the binary pairing of science/religion. This is then conflated to constitute her identity under the term "irrationality" which is juxtaposed against the more socially desirable construct of "rationality". But whilst I was to connect with this specific binary conflation much later, in sitting with my initial struggle with the form of the data itself, I was able to begin to identify the conflated binary pairing of legitimate/incoherent and begin to subvert its power to dictate the direction of my research.

I followed the theorising of Gannon and Davies by asking "how such binaries are constructed and maintained? What exclusions and inclusions mark such sites? How are social identities, the iterations of sex/gender, performed and concretised in the particularities of people's lives? How are they lodged in their bodies? How are the unstable borders of these sites

policed by individuals and institutions through oppositional and moralistic discourses and regimes of truth?" (p. 75). In my own research I will be examining similar questions: How are such binaries of rationality/spirituality maintained? What truth regimes produce and reduce the data to its seeming unintelligibility? What else can be said about the data if specific binaries that reduce it simply to the level of "incoherent ramblings" are disrupted? And how are human subject positions constituted through these discursive regimes, by what can and cannot be said in the process of healing and transformation? What other subject positions emerge alongside that of the "incoherent rambling therapist"?

Essentialism

It is necessary to be sceptical of essentialism, which has been defined by Diana Fuss in her 1989 book, Essentially Speaking: Feminism, Nature & Difference, "as a belief in the real, true essence of things, the invariable and fixed properties which define the 'whatness' of a given entity" (Fuss, 1989, p. xi), and to strive to understand how essentialist notions affect and mould action and subject positions that operate within the realm of the social. Whilst essentialism has been constituted as the antithesis to difference, holding a deep scepticism as to the true nature of things serves as a pointer to the multiplicity of socio-political-cultural-psychic systems that constitute the subject. Rather than articulating a binary view of essentialism and difference, in holding a both/and position, Fuss argues that:

> ... essentialism is neither good nor bad, progressive nor reactionary, beneficial nor dangerous. The question we should be asking is not 'is this text essentialist (and therefore "bad")?' but rather, 'if this text is essentialist, what motivates its deployment?' How does the sign 'essence' circulate in various contemporary critical debates? Where, how, and why is it invoked? What are its political and textual effects? (Fuss, 1989, p. xi).

Thus in acknowledging the differences embraced within essentialisms, we encounter the diversity of meanings of the term and also draw to attention the essentialism residing within any deconstructionist necessity. In this way, according to Fuss, "... there is no essence to essentialism, that (historically, philosophically, and politically) we can only speak of essentialisms. Correlatively... constructionism (the position that differences are constructed, not innate) really operates as a more sophisticated form of essentialism. The bar between essentialism and constructionism is by no means as solid and unassailable as advocates of both sides assume it to be (Fuss, 1989, p. xii).

Fuss argues that the constructionist act of using plurals such as in feminisms rather than feminism "in order to privilege heterogeneity and to highlight important cultural and social differences.... does mark a break with unitary conceptual categories (eternal woman, totalising history, monolithic feminism)" (p. 4). However Fuss states this strategy does not construct essentialism as a plural category "though conceptually signalling heterogeneity nonetheless semantically marks a collectivity; constructed or not, 'women' still occupies the space of linguistic unity... The essentialism is not countered so much as displaced" (p. 4).

Fuss counters that if there is no way to ensure a demarcation between "essentialist manoeuvres in anti-essentialist arguments" such as that which takes place when moving from the singular to the plural as a social constructionist strategy, "we must also simultaneously acknowledge that there is no essence to essentialism, that essence as irreducible has be constructed to be irreducible" (p. 4). Thus, Fuss moves to using John Locke's (1690) theory of "real" versus "nominal" essence: "real" essence is that which is fixed, unchanging and irreducible, "nominal" essence is "merely a linguistic convenience, a classificatory fiction we need to categorise and to label" (Fuss, p. 4). Thus nominal essences are produced discursively rather than "discovered by close empirical observation" (p. 4).

So what does this "essentially" mean to my thesis? At this stage of my enquiry I would imagine any discursive deconstruction, and examination of the languaging of transformation and healing sits in a "nominal" fashion as a both a truth, that is, a necessary fiction employed to distinguish between something and something else, and a construction which has been manufactured by and through discourse. If the text appears unintelligible, I must examine the construction, deployment and effects of the binary opposition of intelligibility/unintelligibility. If the language of the spiritual or profane sits outside mainstream psychological theorising, I must ask what are the conditions of possibility for that to be the case? Furthermore, in identifying new subject positions that may emerge from previously foreclosed spaces for the articulation of transformation and healing, I must then critically examine the motivation of this new deployment. In other words, even as alternative possibilities evolve, it is also necessary to insist that this new "knowledge" produced within the relations of power of which research, even poststructuralist research is a part, remains always subject to critique.

Performativity and Experience

Through the process of subjectification, gendered subjects are constituted through discourse, and it is this mechanism that underpins much of feminist poststructural theory. This premise rejects notions of the essential underlying nature of femaleness, for example, which is specific to radical feminism. Fuss' take on what constitutes the notion of a "nominal" essence produced discursively in order to relegate items to categories which can be named is expanded upon by Butler. Butler (1997), referring to her 1990 work, Gender Trouble: Feminism and the Subversion of Identity, describes the performative nature of gender:

> There I argued that gender is performative, by which I meant that no gender is 'expressed' by actions, gestures, or speech, but the performance of gender produces retroactively the illusion that there is an inner gender core. That is, the performance of gender retroactively

> produces the effect of some true or abiding feminine essence or disposition, so that one cannot use an expressive model for thinking about gender. Moreover, I argued that gender is produced as a ritualised repetition of conventions, and that this ritual is socially compelled in part by the force of a compulsory heterosexuality (Butler, 1997, p. 144).

In this way, the performance of gender both alludes to the existence of an essential gendered nature and compels the performance of mandatory heterosexual relations. Not only is there an essentialism to gender, there is a will to action to comply with heterosexual norms of relating. This will is not a "free" will in any essentialist sense, but is produced through the process of subjectification, which constitutes the subject and the desires and values that limit the boundaries of the subject's existence.

Experience and the Politics of Self-Affirmation[1]

So, just as gender is performed and produced through subjectification, the move to authenticate narratives of personal experience is motivated by the fiction of an essential truth of the subject. This perspective is particularly salient given the emphasis on my examination of personal accounts of transformation and the interplay with therapy with its emphasis on "authentic" selfhood and experience. According to Niamh Stephenson (2003):

> A politics of self-affirmation entails a transparent notion of subjectivity; at any point in time, the subject can see and know himself, and what he knows can always be represented (in language and practice). Subjectivity is reduced to conscious self-knowledge, which in turn is reduced to that which can already be articulated … [which] results in the use of a restricted, narrow notion of experience. Experience becomes what can be known and represented at any point in time. Without the space for self-doubt there can be no rereading,

[1] Stephenson, 2003, p. 136

> no interpretation…. We are at risk of becoming clichés of ourselves (Stephenson, 2003, p. 136).

This critique of the self-affirming properties of narratives of experience fits within a poststructuralist perspective, which views all knowledge as production and as historically contingent and sits in stark contrast to the "notion of the subject whose 'real' self takes the form of some kind of inner voice or space, and who also has the capacity to access this inner space and so discover his or her own truth" (Stephenson, p. 138). Thus a poststructural examination of textual accounts of personal experience, which are in and of themselves performances of discourse, demands deconstruction in much the same way as the performance of gender.

So in my analysis of accounts of transformation, I am also taking into account the "ethics of authenticity" (Taylor, 1991) in order to examine the effects of the privileging of experiences of the "true" and "soulful" self given the humanistic nature of the technologies of power/knowledge that operate within psychological discourses. By humanistic, I refer to the notion of a "true" or "natural" self that permeates much of the text I examined. In line with this, I will also examine how more traditional religious ideas, both eastern and western, have been appropriated by psychology and explore how psychology demonstrates a "form of secular humanism based on worship of the self" (Vitz, 1994, p. 7). Given this privileging, I will examine how therapy, whilst ostensibly providing liberating forms of subjecthood may forcefully draw clients and indeed therapists themselves into a therapeutic moral order that operates "at the 'deepest' levels of our sense of self" (Hodges, 2003, p. 51). This will be discussed in broader detail in subsequent chapters in relation to how transformative experiences and therapeutic "goals," are implicated in the production of the "self-determining" and self-transforming neo-liberal subject.

It is also important to note that "the deconstructive process is always,

partial, messy and incomplete" (B. Davies et al., 2006, p. 170). The original discourse does not disappear in the act of deconstruction. In this way, the "truth" of personal accounts may hide their discursive construction and they may hold within them a nominal essence which both seduces the subject into certain prescribed ways of being and may open up the possibilities of disrupting these prescriptions. Thus their examination does not bring about an annihilation of one form of "truth" of the subject for another given that "… experience isn't the basis of the subject's knowledge, it undoes his authoritative relationship to himself" (Stephenson, 2003, p. 143). Hence this thesis endeavours to sit at the site of the tension between the authenticity of experience and its production through historically contingent discursive means, in the active expectation that new forms of subject-hood and expression may emerge.

Poststructuralist Writing and Theorising

Because no objective reality exists and human subjects and their desires are constituted by and within the discourses that are available to them, "acute reflexivity – especially at the very moment of writing" (Gannon & Davies, p. 73) is what is required of the researcher/writer/subject. The research is envisaged through the "figure of the weaver, simultaneously weaving and unweaving who she is... to consider the stuff of her weaving as the discursive threads of what is possible (nameable, seeable, doable, speakable, writeable) at any particular moment in time and place, and from a particular situated position" (p. 73).

In this way, what is written, that is "the discursive threads of what is possible", is historically and contextually embedded as is the weaver or storyteller herself. The "stuff of her weaving" is the discursive material available to the subject, depending on the productions and manufacturing of that particular time. Thus the discursive threads available to me in my weaving of this research project depend on the influences on me, the subject positions I have both consciously and unconsciously taken up and those that constitute my existence, my desires, my being. How I produce this work

depends on my positioning within Critical Psychology, within mainstream psychology, within family therapy, within feminist poststructural theorising, within a white middle class western society post September 11, and within a period of time that grapples with neo-liberal structures. This production also depends on a myriad of structures and discourses that constitute spirituality, religion, feminism, and therapy and my relationship to them. How I stand, one foot inside one discourse and attempting to straddle one other, or a multiplicity of others, also constitutes the threads of my weaving. Do I feel supported? Am I alone? Can I sit comfortably? Do I dance? Do I want to waltz or would I rather rap? Are either movements in my repertoire dance steps? Am I spinning on my head and don't know it? Do I have the ability to stop the dance when I want to? Am I able to reflect on my performance of the dance of my straddling? Do I have an audience and what constitutes their watching of my performance? What do they want to see me do? Am I aware of that? Do I want to change the costume I'm wearing? What other costumes are available from the wardrobe? (I am aware that even in this writing I use the metaphor of the dance because that has been produced and iterated in the discursive production of family systems theory in which I was trained.)

In the constitution of subjectivity through discourse, something, or some mode of being that comes to be “manufactured” has in its making a number of connotations. It can be connoted to be something that is produced through a complex technology of discursive, chemical, mechanical, technical, alchemical and other technological processes, and it can also refer to something that is not “real”, something that looks authentic, and is in fact an invention, a fabrication or a fiction. How the fabrications, fictions and stories are told, what language is used, what colours are employed, what patterns emerge, and what threads are cast off or lost determine how experiences and subjects themselves are written into existence in the immediate moment of writing. Hence the immediacy of the moment of the writing and/or telling is of utmost importance, because that moment contextualises the material or discursive thread that is used.

Grappling with a Taboo

From the very outset of my research it was clear that I was grappling with a taboo. Why was the spiritual domain predominantly excluded from psychological theorising, training and discussion? I went back to theory and examined psychology's earliest premises which were born in the late 19th Century, already much aware that Sigmund Freud was most scathing about religion and by association, spirituality. Freud perceived religious or spiritual belief as evidence of society's regression into a primitive state indicative of underlying psychopathology:

> [Religion] consists in depressing the value of life and distorting the picture of the real world in a delusional manner... At this price, by forcibly fixing (religious believers) in a state of psychical infantilism and by drawing them into a mass-delusion, religion succeeds in sparing many people an individual neurosis. But hardly anything more (Freud, [1930], 1961b, pp. 31-32)

No wonder I felt so uncomfortable raising the subject of spirituality, whether with my colleagues, with research participants or in the writing of the thesis itself.

To construct a theoretical position for myself I looked to feminist writers, many of them, to quote Elspeth Probyn (1996), belonging outside in a theoretical subjectivity. These women: Luce Irigaray, Elspeth Probyn, Elizabeth Grosz, Patty Lather, Donna Haraway, Ann Game, Bronwyn Davies and Valerie Walkerdine and others had already identified the need to disrupt certain binaries to allow new notions of subjectivity. In choosing to move beyond accepted forms of binary construction, such as those I described in the last paragraph, I would also, as my feminist predecessors had done, move beyond those dualisms where one term, always in deficit, is defined only in relation to the dominant term, privileged with an embeddedness in a master discourse. I move beyond the “otherness” of the non-dominant term, always defined in lack, to create new possibilities of

understanding and theorising. To do so assists in eliciting a new "real" of freeing praxis with all its uncertainties, and moves us to psychological and sociological work that is "not a technology of regulation and surveillance" (Lather, 1991, p. 15), in this case in relation to theorising about transformation and secularity. My own desire in this regard was strong. Despite my growing familiarity with poststructural critiques of the politics of emancipation, I did nevertheless long to "emancipate" spirituality from the confines of reductionism, to imagine what would happen if spirituality were no longer perceived as an irrational way of perceiving experience, and were simply perceived as non-rational. If notions of rationality and non-rationality were valued equally in discourse, or more than this, if the binary could be dissolved, what would the consequences of this be to therapists, to therapy and to clients and patients? How would we theorise our work then? And with what effects?

Grappling with "the Data"

When I realised that most of the data drawn from the interviews lacked the general coherence and, more importantly the richness and specificity that I required for a discursive analysis, I confronted a limit in my research. I was still bound by the regime of rationality in the course of validating my theoretical work. CP and poststructuralist perspectives do not remove the discourse they critique.

So I looked for other data, other stories of spirituality and trauma from outside of my own research subjects. I went back to my literature search and gathered accounts from other therapists who had written about spirituality and therapy and from there I gathered more written accounts of trauma and survival. I both wandered and wondered through texts which talked about notions of transformation, reflecting on the way they functioned within different discursive contexts, specifically spirituality and therapy. I "discovered" the writing of Holocaust survivors, Primo Levi and Paul Celan and was immediately compelled by their stories of suffering. I became curious about the relationship between speaking and writing about

overwhelming experiences as Levi and Celan had done, given imperatives within trauma theory to narrativise accounts of trauma so as to induce healing. I became fascinated by the self-reflexive way that Susan Brison narrated her story of near death and was drawn to the richness of her analysis as to what made for a livable life after trauma. And I more actively revisited stories of survival from my own clients and my perspective on them, choosing to include these accounts in my own project.

In this way I have endeavoured to challenge my original suppositions so as position this work in alignment with Foucault who argued in his essay, What is Enlightenment? for:

> "an attitude, an ethos, a philosophical life in which the critique of what we are is at one and the same time the historical analysis of the limits that are imposed on us and an experiment with the possibility of going beyond them" (Foucault, 1994, p. 319).

We are then "always in the position of beginning again" (Foucault, 1994, p. 317) when we note how the text is "inseparable from the power relations which make them possible…" (Deleuze, 1988, p.74). I quote from Alice in Wonderland:

> 'When I use a word,' Humpty Dumpty said, in rather a scornful tone, 'it means exactly what I choose it to mean – neither more nor less.'
>
> 'The question is,' said Alice, 'whether you can make words mean so many different things.'
> 'The question is,' said Humpty Dumpty, 'which is to be master – that's all'
>
> (Lewis Carroll, 1872, Through the Looking Glass).

Rationality is a prescribed part of the disciplinary process of the thesis, just as empiricism is a dominant discourse within the theory and practice of academic research. Rationality was therefore necessary to this thesis, but so

was “beginning again”. But, in beginning again, I did not know how to mobilise the “emancipatory action” required of the feminist/poststructuralist/writer/theorist/researcher/clinician. I was aware that this action would inevitably be political, in the sense that “to politicise means not to bring politics in where there was none, but to make overt how power permeates the construction and legitimation of knowledges” (Lather, 1991, p. xvii). However I needed a direction. In text and in language, how would I consciously and deliberately articulate and position “the place from which [I] speak” (Lather, p. 8) when my intentions were challenged by traditional pedagogical practice?

Disrupting the Subject

In response to the question of “what is to done now?” I chose to include accounts of trauma, survival, transformation and suffering that had been published by other clinicians. Therapists unknown to me except through academic literature also became my research subjects, and in so doing this strategy demonstrated the deliberate emancipatory action that I was seeking. I could examine how these other therapists' notions of the therapeutic space, spirituality, subjectivity and the intersubjectivity of the clinical encounter functioned. And I could add to this mix the part my own subjectivity played in the production of this theory and this text and any evolving practice. By focusing on therapists’ constructions, I could disrupt the expert/patient binary construction that perceives the clinical psychological community as mentally “well” and “balanced” whilst their clients and patients are perceived as capable of neurosis and other forms of pathology and become the objects of research.

At the same time, I struggled to allow the traces of apparently incoherent therapist accounts from my original interviews to trouble rationality and coherence from the margins of the text. These stories had value, I believed, because they did not fit the landscape of so-called coherence. If the therapists’ accounts seem disjointed when talking about trauma and experiences they defined as spiritual, then I had to allow for the possibility that this outcome could become relevant. So I accepted these accounts had

a place in this thesis, even if that place was no longer central, so as to allow for the possibility that a relationship existed between trauma, spirituality and their faltering articulation. Further, from my theoretical base, I also wanted to hold onto the presupposition that the subject of research is someone who is discursively produced, that is, their "free will" and agency in the world are nevertheless subject to regulatory practices. With this epistemology in mind, I had at the outset hoped to construct the therapist subjects of my research as contradicting the working premise of an assumed rational and autonomous subject. The therapists I interviewed indeed provided narratives that contradicted norms of representation, so much so, that it was difficult to "account" for them "rationally". So having faced this contradiction as a literal actuality, I had at first attempted to discount these stories before allowing myself to again be challenged by alternate discursive premises. Nevertheless, these stories have a very muted presence in the final text of the thesis, and their relative absence speaks to the persistence of the drive for narrative coherence in a thesis that in many ways seeks to undo that persistence.

I also learned in my reading that I could actively participate in the dissolution of artificial borders such as those that exist between notions of academic research, text, teaching and practice. I could consciously endeavour to exercise a power that has some saliency in the disruption of the social by "undoing" the subject of sociological knowledge, what Ann Game describes as collapsing the distinction between "writing" and "text" (Game, 1991, p. 4). Similarly, traversing the borders existing between theory and practice, subverts the underbelly of postmodernist theorising still constructed within a theory/practice binary. I too must rewrite the text. To again quote Game, "[t]heory informs practice which is [my italics] in the real" (1991, p. 13). Game refers to Irigaray and Cixous when she states that rewriting such discourses "disrupts" the order and can transform it in such a way as to "jam" its "theoretical machinery" (Irigaray, 1985, p. 78), whilst Helene Cixous also says it is about "jamming sociality" (Cixous, 1986, p. 96).

> Texts [can] be thought of as embodied in practice, rather than as separate from reception or practice... reading is understood as a writing, and analysis or observation as textual activity, a practice of writing (Game, 1991, p. 18).

As a feminist researcher, it is also crucial that my work brings forth new texts both constitutive and reconstitutive of a new “double science”, using such “textual strategies… which ignite in writing and reading what are beyond the words and the rationally accessible” (Lather 1991, p. 26). In this way, a poststructural epistemology does not rely on traditional or “right” ways of doing research, taking into account that no essential reality exists outside of discourse. Thus I am endeavouring to find as many ways that are available to me to disrupt the strangle hold that binaries have on cognitions and subjectivity, on notions of transformation and rationality, and on coherence and what sits in excess of language. To do this, deconstructive writing may embrace discourses of the scientific and the rational and it may also embrace poetry, dramaturgy, music and media so to disrupt the constructions within which we are constituted. With this in mind, I have included two photographic representations of trauma in my analysis when I heard, for example, that photo journalist Tim Page had suffered posttraumatic stress symptoms after his time covering the war in Vietnam. I became interested in the way a photographic representation of a traumatic event is related to attempts to account for trauma in visual form, and in the effects of this on the person taking the photograph, or the general audience. And in letting the photograph “speak to me”, I consciously intended to disrupt usual psychological theorising, so to reduce the extent to which I participate in my own interpolation as a rational humanist subject.

Ordered Disordered Unknowing

To subvert yet another reproduction of my own oppression, I am also attempting to avoid a traditional linear exploration of research data. I have endeavoured to integrate my research findings throughout the body of this thesis in such a way as to develop a number of ideas some of which are

consistent with the poetry of the stories of spirituality and psychotherapy. In this way, this thesis builds on itself with each chapter without pre-knowledge of the understanding that will be elucidated at its conclusion.

So too, I refrain from explaining every nuance, every gap, every word, every thread, of the text I have included in this thesis in order not to limit the broader possibilities of meaning of the texts for myself and for the reader. I do raise some ambiguities, and often, sometimes, I purposefully do not. Elizabeth Grosz (1989) describes how Irigaray ably takes this postmodern reflexivity much further when she allows: "[h]er writings to perform what they announce" by "resonat[ing] with ambiguities that proliferate rather than diminish meanings" (Grosz, 1989, pp. 101-102). In this positioning my researcher's gaze can never produce incorruptible data. A research project is always subject to the subjective, that is no matter how much the scientific gaze has an intentionality of objectivity, the holder of the gaze is always and irrevocably the holder of a subjectivity or a multiplicity of subjectivities that influence and regulate consciously and unconsciously her or his view.

Further, I acknowledge Jacques Lacan (1953-4) injunction to take care not "to understand more that what is in the discourse of the subject" (Lacan, 1953-4, p. 73). Lacan's imperative becomes even more relevant to my deconstruction of the therapists' accounts when one takes into consideration that much therapeutic work has an extra discursive element. This concept of the extra discursive is easy to understand and accept as useful when one relates to notions of unconscious experience, for example, experiences which are as yet unspoken. However, what if, as I have already alluded to, some of the transformative experiences I encounter in my research cannot be articulated through language?

This text is embodied and embodies. It produces and reproduces this fledgling language as it disturbs and makes transparent the older symbolic forms of psychological and therapeutic writing and research. In embodiment, the text is disrupted and transformed; soul enters and makes flesh a transfigured inspiration of therapeutic experience. Constructing, it constructs my self, the self, soul, spirit and what is soulful in the healing intersubjective world shared with those who suffer, our clients, our friends, our loved ones, the world... Each word in relation is a synonym for the *living, breathing, embodiment, a new 'real' of experience, transporting,* joining, undoing, transforming, transcending signifier and signified, self and other, therapist and client, science and religion, forever and ever and not at all the binaries which separate, relegate and regulate.

Chapter 2: A Brief Critical History of Trauma

> Under conditions of unremitting exposure to the horrors of trench warfare, men began to break down in shocking numbers. Confined and rendered helpless, subjected to constant threat of annihilation, and forced to witness the mutilation and death of their comrades without any hope of reprieve, many soldiers began to act like hysterical women. They screamed and wept uncontrollably. They froze and could not move. They became mute and unresponsive. They lost their memory and their capacity to feel. The number of psychiatric casualties was so great that hospitals had to be hastily requisitioned to house them. According to one estimate, mental breakdowns represented 40 percent of British battle casualties… (Judith Herman, 1992, p. 20)

In this chapter I will examine the historical trajectory of thought relating to the neurobiology and psychology of traumatic experience in order to make visible the dramatic social/historical roots that are inevitably overlaid on any analysis of trauma in the present. In later chapters I will explore personal accounts of individuals' responses to traumatic experience; but in this chapter, I am setting the stage to enable me to penetrate the dialogue between what we presently understand as "the scientific truth" about traumatic experience and the embodied experience of trauma as it is recounted by individuals who have been exposed to its effects. This specific focus on the conversation between "knowledge" and embodiment is inspired by Lisa Blackman's (2001) work, Hearing Voices: Embodiment and Experience. Blackman's work, positioned within a Critical Psychology perspective, argues that it is simply not enough to talk about "psychology" or "biology" as "complicated effects of discursive processes" (Blackman, 2001, p. 230). At the same time, Blackman continues to challenge an essentialist position which sees biology as an irreducible entity. It is from this basis that my work is positioned and in subsequent chapters I will seek to "revisit biological and psychological processes as generative

potentialities rather than static entities" (p. 230). In other words, I will look at what possibilities for subjectivity in relation to traumatic experience emerge in the interface between biological and psychological processes when these processes are understood as productive rather than static entities. I will look at how these potentialities shift and transform psychological, social and biological landscapes.

Using Blackman's theorising as a guide, this chapter will examine how particular understandings of the science of trauma have emerged and mutated in the late 19th, 20th and early 21st Centuries. To start, I will provide a current overview of the various technologies and practices that give a perceived reality to the experience of trauma and begin by considering the conceptual realm of traumatic experience, examining the ways in which it is distinguished from other experiences, and how modern psychiatric and psychological or 'psy' discourses form much of the current landscape of these explanations. In discussing the theorising of Sigmund Freud, Jean-Martin Charcot, Abram Kardiner, Judith Herman and others, I will also briefly outline the emergence of the phenomenon of shell shock and its relationship to both the earlier construction of hysteria and the later formal diagnosis of posttraumatic stress disorder and other traumatic conditions. Continuing to build on Blackman's work, this chapter will draw attention to Latour's (1987) notion of "science-in-the-making", that is, the means by which theories become perceived "truths" in and of themselves and are utilised to "prove" and "explain" other theories or phenomena "exist[ing] as entities which can then be used to explain other entities… circulat[ing] across a range of theories within the 'psy' disciplines… [making them] amenable to treatment and cure" (Blackman, 2001, p. 17). These entities, along with knowledge that is perceived as unchallengeable, function to pronounce the absolute validity of certain biological and psychological conditions.

Towards the end of the chapter, I will also more specifically examine the consequences of recent scientific research into brain physiology and trauma looking at how not only the "truth" of certain traumatic symptoms is

validated, but how the kind of "truth" of what makes us human is qualified and quantified, producing, "… particular kinds of concepts and explanatory structures which make certain kinds of experiences intelligible … divid[ing] experiences up according to divisions made between the true and the false, the normal and the abnormal…" (Blackman, p. 82) to achieve the status of an essentialist "science-already-made" (Osbourne and Rose, 1999).

In a counter move, I also draw attention to the theorising of Elizabeth Wilson (2004) whose book Psychosomatic: Feminism and the Neurological Body proposes that new modes of embodiment become available when biological reductionism is tolerated and explored (Wilson, 2004, p 3). From Wilson's perspective, some feminist/ poststructuralist work on the formation of the subject may be inadvertently implicated in discounting the body. Whilst that is not the case with Blackman's work, Wilson's relevance to my thesis is her ability to expound on the relevance of examining the biological to further explore and create potentialities for psychological and embodied experience.

Shell Shock and Hysteria

Judith Herman (1992), in the opening quotation taken from her widely acclaimed book, Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror, describes many of the ghastly symptoms of "shell shock", the term coined by British psychologist, Charles Myers (1940), to explain the condition affecting soldiers resulting from their contact with the sudden jarring shells exploding around them as they fought from the trenches during World War I. Whilst there were many reports of the tremendous psychological suffering experienced by soldiers on the infamous battlefields of France from 1914 to 1918, these incapacitating symptoms of mental breakdown were nevertheless ascribed to a physical origin, despite it becoming obvious that men who had not been exposed to physical trauma also suffered from the condition. Biological explanations had long been perceived to underpin mental disturbance, despite Freud's much earlier conceptualisation of an unconscious mind. For

Freud, the unconscious was perceived:

> ... as a whole 'other realm of life', beyond the waking state, which could even break through, in the form of other 'dream-like phenomena' such as hallucinations and slips of the tongue. For Freud, the 'waking state' oriented the mind towards the operations of reason and intellect. It was through dreaming that these conventions were relaxed, and the workings of the unconscious came into play... The neuroses and psychoses were viewed as dream-like phenomena, insanity viewed as a waking dream. These symptoms had hidden meanings, the analysis of which could lead one to the origin of the disturbance. This was a psychic problem, which through a process of interpretation would relieve individuals of their symptoms (Blackman, 2001, pp. 156-157).

The construction of hysteria as “lack” in relation to the condition of being a woman, functioned to produce specific biological constructions for men suffering shell shock, not the least of which was the view that hysterical symptomatology could only be understood in terms of a certain kind of neurological disorder: “Certain types of illness appeared in unexpected forms. Of special note was the occurrence of dementia apparently without residual deterioration” (Henderson & Gillespie, 1927, p. 464). Hence the debate about shell shock and a dementia that did not worsen in the predictable way of senile dementia, still focused on whether particular sufferers were “more constitutionally predisposed” to this condition, and whether or not some individuals were more at risk of experiencing these psychological symptoms to a greater or lesser degree. Given the legacy of constructions about hysteria, unpacking the term through a gendered lens reveals how a “hysterical” man was viewed as “unmanly, womanish, or homosexual, as if the feminine component within masculinity were itself a symptom of disease” (Showalter, 1993, p. 289): “discussions of male hysteria, rather than transforming the discourse of hysteria as representing the worst aspects of femininity, actually reinforce the stereotype that it is

the disease of weak, passive, overly emotional people, whether female or male".

The term "shell shock" remained in use, even though military medics were forced to eventually attribute these traumatic symptoms to some form of psychological event, concluding that even "[t]he emotional stress of prolonged exposure to violent death was sufficient to produce a neurotic syndrome resembling hysteria in men" (Herman, p. 20). The observation that these psychological symptoms were analogous to the illness of hysteria constructed centuries before as peculiar to women, a disease "proper to women and originating in the uterus" (Herman, p. 10, citing Micale, 1989, p. 319), held long-term implications for the treatment and "truth" about shell shock and consequently other traumatic manifestations.

However it was not the first time that hysterical symptoms were attributed to suffering emanating from earlier harmful experiences. Judith Herman describes how by the mid 1890's, Janet in France, and Freud and Breuer in Vienna had concluded similarly, that "hysteria was a condition caused by psychological trauma. Unbearable emotional reactions to traumatic events produced an altered state of consciousness, which in turn induced the hysterical symptoms" (Herman, p. 12). Breuer named this changed state of consciousness, induced by traumatic events, "dissociation", a term which remains in use in psychological literature today (Breuer & Freud, [1893-95], 1955).

"Dissociation" could include a re-experiencing of some traumatic events as if they were happening in the present. Breuer and Freud noted that "hysterics suffer mainly from reminiscences" (Breuer & Freud, [1893-95], 1955, p. 7) to explain the hysterical and fragmented presentation of Breuer's and Freud's female patients. Despite initial resistance to the idea that a childhood sexual trauma is the basis of hysteria, Breuer and his patients pursued the "thread of memory" (p. 35). They uncovered major traumatic events of childhood concealed beneath more recent, often trivial events that

actually triggered the onset of hysterical symptoms. It was the memories of the trauma that intruded into and dominated patients' lives. Freud wrote in The Aetiology of Hysteria, (1896):

> I therefore put forward the thesis that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience, occurrences which belong to the earliest years of childhood, but which can be reproduced through the work of psycho-analysis in spite of the intervening decades. I believe that this is an important finding, the discovery of a caput Nili in neuropathology (Freud, [1896], 1962, p. 203).

Freud was building on the work of Jean-Martin Charcot, the great French neurologist, who managed the ancient Parisian asylum, the Salpêtrière, which had been converted into a centre of neurological and psychiatric teaching excellence. According to Herman (p. 12), Charcot's female patients were young women who had found safety in the Salpêtrière from lives of ongoing violence, victimisation and sexual assault. The asylum provided them greater safety and protection than they had ever known, and it was through Charcot's famous Tuesday Lectures that some of these women also became famous. These lectures were attended by an eager-to-be-entertained and curious elite from medical, theatrical and literary circles; within these lectures, Charcot illustrated his findings on hysteria with live demonstrations. Charcot was celebrated by Sigmund Freud for providing validity to the study of hysteria through his work with deeply disturbed hysterics:

> No credence was given to a hysteric about anything. The first thing that Charcot's work did was to restore its dignity to the topic. Little by little, people gave up the scornful smile with which the patient could at that time feel certain of being met. She was no longer necessarily a malingerer, for Charcot had thrown the whole weight of

> his authority on the side of the genuineness and objectivity of hysterical phenomenon (Freud, [1893], 1962, p. 19).

However even before the end of his life, Charcot was challenged as to whether his female patients' performances were indeed staged. And Freud was to renounce his own groundbreaking work within a year. Herman states that Freud's correspondence over that time indicated that he was troubled by the radical social implications of his hypothesis. Faced with the dilemma of acknowledging so many "perverted acts against children", Freud stopped listening to his female patients' experiences. The publication of The Aetiology of Hysteria had resulted in Freud being met with total ostracism within his profession. Within Freud's own era, there was no place for such discoveries. Freud, having knowledge that his famous patient Dora had indeed been used as a sexual toy for her father's friends, instead insisted upon exploring Dora's feelings of erotic excitement, as if this abusive and exploitative situation was the fulfilment of her desire. Nevertheless, Herman states that out of the ruins of the traumatic theory of hysteria, Freud created psychoanalysis, the powerful psychological theory founded in the denial of women's reality. Thus psychoanalysis itself became the scientific truth or entity by which the extent of Dora's "neurosis" was proved and acted upon, based on yet another perceived truth or entity, that of the Oedipal complex. When Dora broke off treatment with Freud, she was described by Freud, his students and colleagues, as "one of the most repulsive hysterics he had ever met". By 1910, Freud had concluded that his patient's accounts of childhood sexual abuse were untrue and that these accounts of abuse were fantasies. Freud's insistence on the neurotic as opposed to traumatic nature of hysterical symptoms did not sit in isolation from the earlier historical constructions. Elaine Showalter's (1993) essay, "Hysteria, feminism and gender", provides a summary of her understanding of the gendered binaries of opposition that have operated in regard to this construction:

> In the Renaissance, these gendered binary oppositions were set up as hysteria/melancholy; by the seventeenth and eighteenth centuries, they had become hysteria/hypochondria; in the late nineteenth century they were transformed into hysteria/neurasthenia; during World War I, they changed yet again to hysteria/shell shock; and within Freudian psychoanalysis, they were coded as hysteria/obsessional neurosis. But whatever the changing terms, hysteria has been constructed as a pejorative term for femininity in a duality that relegated the more honourable masculine form to another category (Showalter, 1993, p. 292).

So as with most dichotomous pairings, one term is defined as the lesser of the other and hysteria was no exception. Showalter provides us with the example of this when she points out how neurasthenia or nervous weakness, in contrast to hysteria, was perceived as a "condition of nervous exhaustion… an acceptable and even valuable illness for men… in short the neurosis of the elite" (p. 294), who were affected by the excesses of the 19th Century; for example, the demands of work, tobacco, drink, even sexual exhaustion. It is worth noting that Charcot was much more likely to ascribe the diagnosis of neurasthenia to male patients of the hospital, who were drawn from the middle and upper social classes, whilst the diagnosis of hysteria was given to his female patients. Freud too was interested in neurasthenia, which he perceived as a sexual neurosis (Freud, 1893a) with physical effects: "being somatic or bodily rather than psychic in origin and not amenable to psychoanalytic intervention… being directly somatic", the "direct somatic consequences of sexual disturbances" (Wilson, p. 18; Freud 1916, 1918). Wilson's thesis examines the consequences of this differentiating turn of Freud's in very interesting detail, but in terms of its relevance to my thesis, one of the main points of interest I describe below.

Freud's understanding of neurasthenia positioned psyche and soma as "ontologically related" because, according to Freud, a vulnerability in the body as a result of masturbation in men or a culturally prescribed sexual prohibition in women, weakens the psyche:

> What we come to know as psyche, cortex, melancholia, penis or reflex is an effect of networked influence. Neurons are libidinised; nervous systems trade pathologies; neuroses sometimes short-circuit systems of representations; sexuality circulates not just within the end-organ, but also through the ego and the external world; cultural habits become obligated to biology, and biology becomes obligated to the psyche… [Freud] suggests that neurons are 'obliged' by the psyche to give up their excitation… [However] this is not a metaphorical use of obligation… Freud's use of obligation at the level of neuropsychic interchange denatures the human- and conscious-centric sense with which obligation is used elsewhere. The effect is not to render neurological action knowable via obligation, but to make obligation curious via its association with the microbiological. Neurological obligation, then, is one way of understanding a relation between psyche and soma in which there is a mutuality of influence, a mutuality that is interminable and constitutive (Wilson, 2004, p. 22).

This mutuality of influence of the biological and psychological still begs the question, how? How is one part of the body "obliged" to rescind its usual operations? How did this theory sit alongside other neuroses which were deemed amenable to psychological intervention? And what does it mean for discussions of hysteria when the pervasive physical symptoms of the disorder remain ontologically psychic rather than somatic, as if the body, and its mutuality of influence with psychological states, do not exist? A feminist critique has tended to focus on neurasthenia from the point of view that men were more likely to be diagnosed with what is an acceptable though undesirable condition whereas women were likely to be labelled as hysterics. Wilson suggests that there is nevertheless a radical potential in Freud's (1895b) work on neurasthenia: that Freud's thinking on how psyche and soma demonstrate a reflexive sphere of mutual influence can open up rather than foreclose possibilities for human experience and subjectivity.

Hysteria and the Petromyzon

Alongside her related analysis of neurasthenia, Wilson challenges the critical focus on Freud's account of hysteria. Wilson argues that historically, psychoanalysis can or perhaps should be approached, "not just through the hysterised body of the patient", which is discussed in detail in this chapter, but through Freud's even earlier work studying the spinal ganglia of the petromyzon or lamprey, a fish with primordial characteristics (p. 1). Early in his career, Freud worked as a researcher at the University of Vienna; in his first undertaking examining the lamprey, he was able to conclude that it was the structural organisation of the cells, rather than the internal makeup of the cells of more primitive species that differentiated themselves from the nervous systems of higher order organisms. Accordingly, larger vertebrates were implicated in this study with complexity becoming regarded as the salient factor delineating lower and higher order animals. Yet Freud was to surmise that psychoanalysis began not with his work on the lamprey, but with his connection to Breuer, Charcot and his hysterical patients, coming to regard "anatomy, physiology, and chemistry as demands on – resistances to – psychoanalysis" (Wilson, 2004, p. 2). Wilson's thesis proposes that the times Freud utilised biological, even essentialist explanations "are not necessarily the moments when his accounts become static, incoherent, or critically useless. In fact, these moments of biological reduction often produce Freud's most acute formulations about the nature of the body and the character of the psyche" (2004, p. 3). Wilson continues,

> The lamprey places two demands on our current-day analyses of the body: biology and reductionism. For many feminists, these amount to the same thing; biology is reductive materiality stripped of the animating effects of culture and sociality. In a theoretical scene that is bent instinctively toward correct, reversing, or resisting the forces of biological reductionism, the body of Freud's fish has been rendered intelligible. Its biologism and its reductionism are articulate only in the capacity to signal that complexity is to be found elsewhere or later

> on. The cold, dead body of the lamprey is taken to be a benchmark against which not only Freud's theoretical progress, but also our own critical sophistication can be measured (Wilson, 2004, p.3).

What Wilson is saying here is that it is an act of reductionism to relegate the lamprey to the past, that it is as a mark of ignorance that our so-called "sophistication" makes this information irrelevant to current theorizing. She goes on to ask:

> … What new accounts of the body are possible if we are able to keep the body of the lamprey in mind? What new modes of embodiment become legible when biological reductionism is tolerated and explored? (Wilson, 2004, p. 3).

I agree with Wilson that it is reductionist to foreclose greater possibilities for embodiment on the basis of seeming static nature of biological truths: the challenge here is to explore the essentialist stance of biology in order to open it up to further eventualities. Nevertheless, this challenge was overlooked through a marking of all hysterical symptoms suffered by the patient as the effect of a conversion disorder. As such, other symptoms characteristic of a wider understanding of hysteria were discounted:

> Paralyses, facial neuralgias, loss of vision or voice, tics, bodily pains and chronic muscular contractions were common symptoms of nineteenth century conversion hysteria…. By arguing that conversion hysterics were suffering from repressed ideas and strangulated affects rather than degeneracy, Breuer and Freud gave an account of psychosomatic pathology that was immensely productive for feminist accounts of the corporeal.
>
> Nonetheless, at the same time that conversion hysteria came to stand

> in for all hysteria, there was a narrowing of the character of conversion hysteria itself (Wilson, 2004, p. 4).

In regard to the reminiscences suffered by Freud and Breuer's hysterics, Wilson argues that the way that these repressed effects are converted into bodily symptoms, or how "psyche" becomes "soma" (Wilson, 2004) is the least explored area in regard to hysteria:

> The biology of hysteria encompasses not simply the logic of spatiality (Which body part?) but also the logic of temporality (At what time? In what order?) … Hysterics do indeed suffer from reminiscences; they also suffer from bodily symptoms: they are paralysed, blinded, in physical pain, they cough incessantly, they have difficulty breathing… We may be well equipped to answer why hysterics convert, but we appear to be collectively mute in response to the question of how they convert (Wilson, 2004, p. 5).

Male Hysteria

Why hysterics convert was again the primary question posed in regard to the shell-shocked male hysterics of war. In his original 1932 paper, Abram Kardiner, the psychiatrist who comprehensively formulated a clinical understanding of neuroses that developed in individuals as a consequence of war, identified war neurosis and shell shock as consisting of a variety of traumatic symptoms including a "profound mental 'paralysis' or *inhibition"* which Freud had earlier linked to the concept of melancholia (Freud, 1917). Kardiner, who described this seeming paralysis as mirroring "a complete regression to the infantile state" (Kardiner & Spiegel [1932], 1947, pp. 92, 133-4,188, 405-413) was similarly concerned that use of this term produced a view of the shell-shocked survivor of war as mad or bad, who deserved to be given a court-martial rather than be given any treatment for their suffering:

> When the word 'hysterical'… is used, its social meaning is that the subject is a predatory individual, trying to get something for nothing. The victim of such a neurosis is, therefore, without sympathy in court, and … without sympathy from his physicians, who often take… 'hysterical' to mean that the individual is suffering from some persistent form of wickedness, perversity, or weakness of will (Kardiner & Spiegel, 1949, p. 406).

Showalter (p. 291) also translates Lucien Israël thus: “[T]he hysteria diagnosis became for a man … the real injury, a sign of weakness, a castration in a word. To say to a man 'you are hysterical' became under these conditions a form of saying to him 'You are not a man'” (Israël, 1983, p. 60).

Herman too saw the debate about the aetiology of hysteria in men who returned home traumatised from battle as focused on the “moral character of the patient”:

> …a normal soldier should glory in war and betray no sign of emotion. Certainly he should not succumb to terror. The soldier who developed a traumatic neurosis was at best a constitutionally inferior human being, at worst a malingerer and a coward. Medical writers of the period described patients as 'moral invalids' (Herman, p. 21, quoting Leri, 1919, p. 118).

What Herman calls the “traditionalist” view was put forward by Lewis Yealland (1918) who implemented interventions based on “shaming, threats, and punishments” including electric shock treatment; those men who displayed “the hideous enemy of negativism” were also threatened with court martial, (Herman, p. 21). As he was applying electric shock treatment, Yealland is reported to have said, “'remember you must behave

as the hero I expect you to be… A man who has gone through so many battles should have better control of himself" (Showalter, 1985, p.177).

At the time of Kardiner's theorisation about war trauma, psychoanalysis was continuing to make notable gains though the work of some British physicians and others. It was the only approach that had demonstrated some success in intervening and treating traumatic disorders emerging from exposure to war. The obstacle to be overcome was how to integrate what was understood by shell shock with the essential truths of psychoanalysis, that is, drive theory and the psychosexual source of hysteria.

Kardiner, himself was not to escape a labelling of his own experiences as indicative of an unconscious homosexuality. Freud's use of his theory of psychoanalysis as an entity capable of pronouncing the truth about one's perceptions or experiences is demonstrated in an essay by Ruth Leys (1996), titled "Death masks: Kardiner and Ferenczi on psychic trauma" in which Leys discusses Freud's analysis of Kardiner. Freud diagnosed Kardiner as most probably traumatised by the death of his mother when Kardiner was three years old, coming to this conclusion based on an analysis of a dream Kardiner had recounted to Freud and the possibility that his dream about an immobile, unsmiling, expressionless mask was in fact representative of his mother's "death stare" to which a very young Kardiner had been exposed, having more than likely discovered her body. What is most salient about Freud's interpretation is that Freud viewed this trauma as important only when it pointed to the problem of Kardiner's father. For Freud, the dream revealed how Kardiner had "identified with the abjected, helpless female or 'homosexual' position as a way of evading his father's aggression and rage" (Leys, 1996, p. 45, citing Kardiner, 1977, pp. 61-62), despite Kardiner's disclosure that he had been terrified of his very abusive father. Kardiner was to later reject Freud's psychoanalytic hypothesis:

> He put me on a wild goose-chase for a problem that did not exist. Namely, the use of my identification with my… mother as part of an

> unconscious homosexuality, in order to resolve the Oedipus complex… By making it into a problem of unconscious homosexuality, he turned my attention to a nonexistent problem and away from a very active one (Leys, p. 45, quoting Kardiner, 1977, pp. 98-99).

Leys' work points to the conflation that occurred when Freud and others motivated by the "truth" of psychoanalytic theory undertook to fit war neurosis within the bounds of their earlier theorising:

> Freud's initial response to the challenge had been to suggest that the war neuroses were the consequences of a conflict, not between the ego and the sexual drives, but between different parts of the ego itself – a conflict, that is, between the soldier's old peace-loving ego, or instinct for self-preservation, and his new war-loving ego, or instinct for aggression. These egos… were now defined according to Freud's new theory of narcissism as themselves sexually or libidinally charged. Such an explanation had the merit of recuperating the traumatic neuroses of the war for the libido theory and of assimilating them to the category of the ordinary transference neuroses…. (Leys, 1996, p. 49).

In addition, some of the more debilitating experiences of the battle-scarred soldier continued to be viewed through a psychoanalytic lens as regressions "to an earlier, narcissistic stage of libidinal development," (Leys, p. 49). Whether or not any of these constructions pointed to the actual "truth" of traumatic experience, what is important is that these conflations existed and underpinned the way in which certain subjects were treated and regulated even as the tenets of shell shock and traumatic symptoms were subject to perceptual shifts over many years.

Freud did however examine the physical symptoms of male hysteria prior to his later turn to his theorising on psychoanalysis. In 1886, Freud presented on hysterical hemianasthesia, that is, the loss of sensation down one side in a male patient's body. He listed the physical symptoms in minute detail, describing how he could push a needle through the skin of the man's left arm without any apparent reaction from the patient. Wilson points out how far hysteria extended through the man's body, "hystericising for example, the muscles, ligaments, and joints of the left arm and leg, the visual function of the left eye, the gag reflex of the left hand side of the throat, and the left spermatic cord" so to emphasis a "somatic compliance" (Wilson, p. 12):

> The matter of fact description reveals the compliant and complicitous character of this man's body. The capacity of the mucous membranes of the throat to convert to anaesthesia here, on the left, but not there, on the right, demonstrates that biology is more naturally eccentric, more intrinsically preternatural than we usually allow. Against the popular feminist preference for cultural or social explication of this man's condition… as Freud's needle pushes through a fold of the skin… the strange convolutions of hysteria are held within the confines of biological detail. Rather than reducing the nature of hysteria, this confinement allows the reader to perceive in biology a complexity usually attributed only to nonbiological domains (Wilson, 2004, pp. 12-13).

In this exploration, Wilson reminds us that the finding of male hysteria untied hysteria from the female subject and her uterus and drew attention to the curiosities of the human body in general:

> The medical notion of hysteria as a wandering womb has long been considered a violence against the female body. However… the question of organic wandering demands a closer examination. The notion of a roaming uterus contains within it a sense of organic matter that disseminates, strays, and deviates from its proper place. Perhaps all biology wanders. Formulated this way, hysterical diversion is not

> forced on the throat, legs, or eyes from the outside, it is already part of the natural repertoire of biological matter. A more sustained focus on the biology of hysteria would allow us to see that the proclivity to conversion (diversion, perversion) is native to biochemical, physiological, and nervous systems (Wilson, 2004, p.13).

Despite shell shock being constituted as an ailment consequent to psychologically damaging experiences, scientific literature of the time also constructed shell shock through a lens of "predisposition" be it resulting from a certain biological vulnerability, a weakness of character or lack of control, an inferior humanness, cowardice or immorality, unmanliness, excessive womanliness, perversity, wickedness or over-emotionality or unconscious homosexuality. Categorised as a neurosis, individuals suffering from shell shock were therefore amenable to psychological intervention and little attention was paid to the physical symptoms that also presented.

However individuals who suffered from psychotic presentations were not deemed to be suitable to treatment via the talking cure of psychoanalysis: "The use of suggestion and persuasion could act upon a space of suggestibility, but psychotic reactions producing a greater detachment from reality could not be 'readjusted'" (Henderson & Gillespie, p. 468). Blackman refers to Henderson and Gillespie's (1927) Textbook of Psychiatry, when she stated that psychotic presentation, that is, "madness" was perceived to be related to a "core of degeneracy localised as a pathological lesion of the brain" (Blackman 2001, pp.148-149). The concept of "reaction types" was used to account for the many and varied symptoms seeming to emanate from the same underlying cause. The "problem of mental health", according to Blackman, was positioned between the interface of the biological predisposition and certain environmental factors; hence a patient could be perceived to have inherited a certain vulnerability to mental illness. However a certain psychotic reaction "type" was perceived to be connected to "diseased biological

processes" whereas a neurotic reaction "type" was regarded, more or less, as a broad deviation from the range of normal behaviours. Nevertheless, to be diagnosed as being of a neurotic reaction "type" meant the individual could still maintain some level of relationship with their environment and self-responsibility, whereas those diagnosed as psychotic, were unable to adapt to their environment or engage in sociality. They were perceived to be dominated by their "own internal ravings and delusions" on which they eventually may act (Blackman, p. 151).

The constructions above made possible particular forms of intervention that functioned to further construct the "truth" about the experience of shell shock. These truths produced further concepts which then also functioned as truths that explained the "science" of the constitution of human nature, whether neurotic or pathological, organic or moral. Thus the extent to which a person was able "to recognise their own madness" (Blackman, 2001, p. 152), or describe their own condition as lacking or unmanly or deviant distinguished the psychotic individual from the neurotic.

The site of the treatment of the person, the subject's "psychological space" had been theorised prior to this time by Freud and his contemporaries by relating dreams to the "psychopathology" of delusions and obsessions (Freud, [1900], 1932, p. 15). Prior to Freud, dreams were either perceived to be messages from the divine or to be the body's way of releasing various biological tensions. In contrast, Freud theorised a space in which "the conventions" of wakefulness, the operations of "reason and intellect" were disrupted or relaxed and through which the unconscious came into being beyond the realm of imagination in manifestations of fantasy and uncensored speech – an autonomous psychological space independent from the brain's mechanisms (Blackman, p. 156). Freud's understanding of dreams, however, was not perceived as a return to the metaphysical paradigm: Freud saw the core element of human nature as morality and hence persisted with the production of a particular ethical human subject

whose conflicts with this morality prevailed through dreams and hallucinations in wishes and distorted memories seen to emanate from the earliest childhood states of the patient. Waking dreams and hallucinations were perceived as inextricably linked to mental illness.

Rather than evaluating the "truth" of these specific constructions, Blackman, in referring to the theorising of Foucault (1972), challenges us to ascertain in what ways certain constructions such as hysteria and shell shock have been made to operate as fixed and predictable entities of psychological phenomena which make up specific experiences. Thus our attention is drawn to the '"historicity of experience"' and the myriad of mechanisms by which specific constructions have been ordered and reordered throughout history and made to function as truth. (Blackman, p. 83). According to Foucault, truth, therefore, is "*historical and regulative"* (Blackman, p. 83, citing Foucault, 1980a, p. 131). The regulative nature of truth is further expanded upon by Nikolas Rose (1999). In the preface to the second edition of his book, Governing the Soul, Rose asserts that psychological knowledges, expertise and practices have functioned as forms of contemporary political power to construct "governable subjects" in ways fitting with liberal and democratic ideologies:

> ... Psy has helped to resolve a range of difficulties in the practical management of human beings: helping organise and administer individuals and groups within schools, reformatories, prisons, asylums, hospitals, factories, court rooms, business organisations, the military, the domesticated nuclear family... In Governing the Soul, I show that, in producing positive knowledges, plausible truth claims, and apparently dispassionate expertise, psy makes it possible to govern subjects within these practices and apparatuses in ways that appear to be based, not upon arbitrary authority, but upon the real nature of humans as psychological subjects. The human sciences have actually made it possible to exercise political, moral,

> organisational, even personal authority in ways compatible with liberal notions of freedom and autonomy of individuals and ideas about liberal limits on the scope of legitimate political intervention (Rose, 1999, pp. vii-viii).

In the attempt to understand and respond to men involved in World War I, even if it was to push them back to the trenches once they had recovered from their physical injuries, shell shock nevertheless came to be reformulated as a mental illness. The "biological processes" diseased or otherwise were centred on the cerebral cortex. The biology of the mind/brain left the body and the myriad of physical symptoms behind. Rose (1986) and Armstrong (1983) concur that the First World War provided the condition of possibility for the mind to be re-conceptualised as a "psychological apparatus" amenable to "psychoanalytic concepts and theories [which] became important techniques and practices for conceptualizing and working with particular kinds of mental processes" (Blackman, p. 155). This work is directly related to Foucault's genealogical model which follows "the lines of descent and *conditions of possibility"* of the construction through history of what constitutes the medical, the sexual, the insane and the individual (Arribas-Ayllon, 2005, p. 13, citing Foucault, 1965, 1973, 1977, 1985, 1986) and as such focuses on the "problematisation of its object of analysis" (Arribas-Ayllon, p. 13). This is what is Rose and Armstrong meant when they stated that WWI provided the condition of possibility for a refiguration of the mind. It was the event or series of events out of which a specific form of mental illness appeared and took shape. This adds another dimension to the way in which specific technologies attempted to influence and govern the behaviours of certain subjects and as such, lends to the theorisation of power as "power which acts on and through a person's actions" (Blackman, p. 86):

> This directs attention to the ways in which subjects inculcate particular relationships to themselves, such that their needs, desires

> and aspirations are aligned with wider governmental objectives and aims. This is not a form of power, which is simply constrained or repressive, but rather a form of power which works through knowledge, such that a person will come to want or desire certain norms or ways of behaving in relation to themselves. Power is not an entity but embedded in routine practices, techniques and understandings through which we act upon ourselves as subjects (Blackman, 2001, p.86).

Posttraumatic Stress Disorder: A Formal Diagnosis

It was not until 1980 that the diagnosis of post-traumatic stress disorder (PTSD) was included in the American Psychiatric Association's manual of mental disorders (Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III); [APA], 1980). This inclusion was a result, in part, of the greater social imperative of the time to explain the complex psychological issues experienced by the veterans of the Vietnam War, and was also most definitely influenced by the earlier, groundbreaking work of Kardiner ([1932], 1947).

The particular "surfaces of emergence" (Foucault, 1980b) provided by the Vietnam War can be gleaned from Wayne J. Scott's ([2000], 2001) description of the overwhelming obstacles to personal and psychological safety that Vietnam veterans faced in a war which had none of the previous rules of engagement:

> Vietnam soldiers fought an enemy that was generally indistinguishable from the village populations they were meant to protect. The enemy included women and children who might be implicated in setting lethal ambushes and maiming booby traps as well as landmines. Many soldiers had come to doubt the cause for which they had been sent to Vietnam, in a war which had never been

> declared and which ended in defeat. They remembered mates who were killed by accidents and 'friendly fire'. Their infantry war had mostly comprised tense, enervating patrols, clad in clothes and boots that were wet for days on end, with constant threats from foul water, unsafe local food, composite rations, skin eruptions, intestinal disorders, malarial infection and a well armed, elusive human enemy. Their campaign comprised an irregular sequence of skirmishes in which apparent successes were measured by ground half-secured and counts of enemy dead, which might again be innocent villagers (Scott, [2000], 2001).

Previous wars, according to Scott, had clearly defined boundaries. War was conventional with enemy soldiers and civilian populations clearly discernible. There was a “front” from which one’s battalion fought, and a “rear” to which one’s platoon could retreat and gain respite. Engagement under fire lasted approximately sixty days in WWII with soldiers aware they were fighting in distinct conflicts and operations after which they would be allowed a period of reprieve. Soldiers, whose average age at least in World War II was twenty-six years, were partisan, believing in the reasons for war. Previous wars ended in victory for the allies and returning soldiers were perceived as heroes who came home to public celebration.

In Vietnam, there was no “rear” to which soldiers could be rotated to allow them to build up their resources, as the whole of South Vietnam was under fire. Also, whilst the tour of duty was relatively short, approximately one year in Vietnam was equivalent to five years of the Second World War. Vietnam soldiers had to endure an incredible three hundred days or more in active duty in a guerrilla war that was superior militarily to any previous war, capable of the most devastating air and ground bombardment. Technological advances also increased the public’s access to media vision clearly depicting the horrors of war; the public were made aware of some of the infamous acts of barbarism committed by Vietnam soldiers, such as the

My Lai Massacre in 1968 when over five hundred women, children and elderly men were killed by American soldiers. As a result, returning veterans, who were aged on average only twenty years old whilst serving in Vietnam, were more likely to be described as other, as less than human, as baby killers, rapists and murderers. Thus public opinion had shifted to vehement discussions about the futility and immorality of war and the depravity of the soldiers who fought in such a conflict.

In a war that was lost by the allies, with little evidence of anything gained, returning veterans, disillusioned and unclear about why they had fought in this war at all, were shunned, attacked and ostracised by their own countrymen and women. Identification with childhood friends who had not fought in Vietnam was lost due to their ignorance about the war and their anti-Vietnam stance. Fathers did not "show off" their Vietnam veteran sons by taking them down to the pub for a drink with their mates as in previous wars.

In this climate of alienation and isolation, the formal diagnosis of PTSD produced a validation that a specific set of debilitating symptoms that produced psychological, behavioural and social failure, including the inability to sustain employment, could result from exposure to traumatic events irrespective of an individual's psychological and emotional processes. Descriptors which would link PTSD to hysteria and gender appeared to have disappeared in the post Vietnam War era and this new regulated constitution of PTSD as a validated category of mental illness thus functioned to allow traumatised subjects to receive psychological intervention and to be deemed amenable to such intervention within a context of a moral and political negativity to the outcome of the war.

The introduction of the DSM diagnosis implicitly suggests that to be so deeply affected by the horrors of war one must be possessed in the first instance of the desirable qualities of morality, conscience and compassion.

Perhaps this view is representative of the remorseful “conscience” of allied nations. Thus the most seriously traumatised Vietnam veterans came to be subjects for intervention, not only because they were “failed subjects” who were unable to practice specified norms of individuality and sociality, but also because they were “moral subjects” whose degree of suffering was a testament to their humanity.

Neuroscience and the Brain/Mind

In the next section I will discuss how advances in neuroscience and technology have created a further possibility for a refiguration of the mind of the trauma sufferer. Until most recent times the study of the brain has been based on the premise that it is an unchanging entity determined by genetics and by its ability to learn and grasp more complex ideas and information as it matures. What the field of neuroscience, with its focus on the study of the brain and its biology has appeared to demonstrate, is that the brain is in fact an “organ of adaptation” created and moulded, neuron by neuron through a synthesis of genetics and the impact of the environment. This notion of the “use-dependent development” of the brain (Cozolino, 2002, p. xv) has reconceptualised the brain as more than the sum of its neural activity which functions to create feelings of wellbeing, produce cognition and store memory. Neural activity has been shown to be influenced and changed in interaction with the social, that is, a person's brain activity and what the brain actually looks like changes and continues to change when, for example, the quality of an individual's interpersonal relationships change, when their beliefs change, and when a person gains a greater ability to manage their emotional states.

This new conceptualisation of the brain as plastic and renewable and open to change and development throughout the lifespan has heralded an era in which “we have the ability to integrate the clinical field of mental health with the independent field of neuroscience” (Siegal, 2002, p. x). Much of the intuitive knowing and wisdom of psychotherapeutic observation and

practice has been validated by empirically driven neuroscience. Studies of the brain have increased with technological and pharmacological advances. And arguably, pharmacological developments have also increased the availability of funding focusing on the study, growth and "improvement" of the brain. Brain-imaging not only shows us a "normal" or a diseased brain, but it allows the moving activity of the brain to be viewed and plotted. Neuro-imaging can show for example, where in the brain happiness is experienced, as it is being experienced. It can demonstrate if the language centre of the brain is inactive and what happens to the living brain under stress or when sleeping. Neuro-imaging allows a researcher or doctor to see changes over time in the brain activity, be it before and after an individual has been prescribed a specific mood-stabilising drug, or before and after the use of a psychotherapeutic intervention.

Looking at the brain of a living human being can now be achieved through new brain-imaging techniques which include:

1. Computerised tomography (CT) scans (which uses x-rays) and magnetic resonance imaging (MRI) scans (that rely on radio waves), which show cross-sectional multi-dimensional pictures of the brain;

2. Electroencephalograph (EEG) images which examine the cortex' electrical activity; and more recently

3. Positron emission tomography (PET), single photon emission tomography (SPECT), and functional magnetic resonance imaging (FMRI) which measure alterations in metabolic rates and blood flow in areas of the brain which may be turned "on" or "off" as a person performs different tasks or is asked to concentrate on certain experiences or feelings.

These neuro-technological advances, whilst nevertheless open to interpretation have functioned to produce "indisputable evidence" (Latour, 1987, p. 103) about the brain. And in so doing, scanning techniques have been able to blur the distinction between neurobiological (brain) and psychological (mind) space. As discussed earlier in this chapter, psychosis

was perceived to emanate from a biologically diminished and therefore unalterable brain whilst neurosis was perceived as amenable to cure as it existed in the psychological plane which could be altered through psychoanalysis. Freud had, however, put forward the notion that the brain is not necessarily an unchanging organ and that it is structured by and through early childhood experience and can be rebuilt through psychotherapy. At the time when the area of the brain responsible for language had just been discovered, Freud wrote his "project for a scientific psychology" (1895a) in which he depicted neurons representing feelings, cognitions and behaviours interacting with other neurons which interconnected with drives, the senses, impulses and other mechanisms. This model of the mind interacting with the brain was suppressed until Freud's death – abandoned as Freud succumbed to pressure from his colleagues to retract his earlier proposition that underpinning every instance of hysteria was repressed childhood memories of premature sexual experience.

In 1990, neuroscientist Paul MacLean put forward the proposition based on evolutionary principles that the brain was a three-part entity, a "triune brain" or as Cozolino describes it, "a brain within a brain within a brain" (Cozolino, p. 8), with each layer having lesser or more complex functions. The most primitive layer or reptilian brain is perceived as common to most species and to have been relatively unchanged through evolution. Whilst MacLean is reductionist when he assumes that the reptilian brain governs actions that are more rudimentary, he also theorised that this area was responsible for core mechanisms related to survival which include reproduction and arousal (that is, fight or flight etc.).

What MacLean called the paleomammalian brain, now more commonly known as the limbic system, is believed to be core to memory, feelings and learning and appears to enclose the reptilian brain. The most complex brain layer, the neomammalian brain, which consists of the cerebral cortex and the corpus callosum (nerves which connect the right and left hemispheres of the brain), is perceived to be responsible for self-reflection, critical thinking,

speech and consciousness itself (MacLean, 1985). Although the brain has since been further reconceptualised, this metaphor of the triune brain is helpful as it parallels Freud's initial attempts to theorise a brain/mind. For example, the unconscious mind, could be perceived to emanate from the reptilian brain; dissociation and hysteria could be perceived as emanating from flawed or failed interconnections between the three "cohabitating brains" (Cozolino, p. 9). However another usefulness of MacLean's conceptualisation was that he made the point that it is important not to confuse his triune brain as analogous to "a consecutive layering of … a strata of rock" and proposed that each evolving brain had "its own special intelligence, its own subjectivity, its own sense of time and space, and its own memory, motor and other functions" (MacLean, 1990, p. 9):

> Each part of this triune structure has its own particular disposition, and these dispositions are not arranged in functional hierarchies (in which higher parts dominate the lower). The triune model neither promulgates a rigid hierarchical structure (cognition over emotion; mammalian over reptilian), nor does it disperse these elements into a structureless association (in which we cannot tell the difference between cognitive and emotional responses) (Wilson, 2004, p. 86).

Neural Plasticity, Stress and PTSD

MacLean's model challenges the notion of a hierarchical structure whilst delineating each brain within a brain within a brain, as if there was a hierarchy of a kind. This formulation allows us to think in terms of hierarchy to understand what may be common to human primates and to, for example, an invertebrate petromyzon, whilst challenging notions of subordination and control. And the discovery of the brain's plasticity assists this conceptualisation further when it was discovered that the reptilian and paleomammalian as well as the neomammalian brain are plastic, that is, they all evolve and rebuild themselves in non-sequential, non-hierarchical ways in response to specific stimuli, thus interconnecting in vastly more complex ways than had previously been theorised. For

example, the vertical networks that interconnect the three parts of the triune brain are as important as the horizontal layers theorised by MacLean (cf. Cozolino, p. 11, Alexander, DeLong & Strick, 1986; Cummings, 1993). The cerebellum conceptualised in MacLean's model as part of the reptilian brain, is indeed a very ancient part of the brain when evolution is taken into account, but it appears to have also expanded alongside the evolution of cerebral cortex and is also involved in higher order functions such as language and rational thinking. Further, the operations of the right and left hemispheres of the brain have to be taken into account, as well as those processes of the brain's functioning which are fully activated at birth and those which do not function until much later. And psychopathology is now perceived to be the result of a dysfunctional interplay between different systems and subsystems of the brain (Mayberg, 1997).

This interplay then works to produce different kinds of subject positions given the functioning of the brain or nervous system and the moulding of this system by significant interpersonal relationships and events. This underlies the premise that the brain adapts and adjusts itself through both positive and negative experiences, creating new neural networks as it develops or using outdated or less complex neural pathways as a (seeming) method of survival. Growth of the so-called neural architecture (Cozolino, p. 22) points to the plasticity of the brain, that is, the ability of the nervous system to change, create new neurons and pathways, and alterations in the way neurons may connect with other neurons in response to new experiences and learning (Purves & Voyvodic, 1987). Given the possibility for the brain to change its structure and composition, there are further implications and imperatives to remake traumatised subjects more “human” or more “normal” in terms of working on the “plasticity of their brains” through some form of pharmacological or psychological intervention. “Proof” of any cure or amelioration of symptoms can occur by being able to compare their brains with the brains of other non-traumatised subjects.

Teachers have long known that moderate stress is necessary to encourage new learning in students and therefore stimulate the growth of neural

networks, whilst both minimal and excessive stress interferes with a student's capacity to take on board new concepts and inhibits the development of new neural circuitry (Cowan & Kondel, 2001; Pham, Soderstorm, Henriksson & Mohammed, 1997). Some significant stress is therefore necessary to trigger neural plasticity, that is, the growth of neural networks, and as such is an important tool in enhancing new learning of any kind.

Brain imaging techniques have allowed for an examination of the differences between the so-called "normal" brain and the brain of a highly stressed PTSD sufferer providing an explanation for their suffering that becomes more "intelligible" given the dominance of the scientific paradigm. Studies about trauma and its neurobiology now accept that there is long-term impact of trauma on brain function. Some of those longstanding changes in brain chemistry include excessive arousal, which brings about biochemical changes affecting learning, habituation (habits), and stimulus discrimination (Jackson, 2003; Brewin, 2003; van der Kolk, McFarlane, & Weisaeth, 1996a). In addition, the brain's response to the experience of chronic stress may permanently alter how a person deals with their environment on a daily basis and interferes with coping with subsequent acute stress. Also some cognitive processes are impaired, such as the ability for a survivor of trauma to work out that the threat is not actually apparent right now. As such, freeze responses and panic interfere with emotional memory processing in which the traumatic experience is integrated into normal memory, and the experience may be partially or more fully re-experienced, as if it is happening in the present (van der Kolk, van der Hart & Marmar, 1996b).

The amygdala (which also has a reptilian neural function) and the hippocampus are the two specific areas of the limbic system or paleomammalian brain which are integral to managing highly anxious and emotionally laden data. According to LeDoux, (1986), the amygdala makes meaning of the incoming emotionally charged data and a number of

researchers have put forward the notion that the amygdala ascribes "free-floating feelings of significance to sensory input, which the neocortex (neomammalian brain) then further elaborates and imbues with personal meaning" (van der Kolk, 1996, p. 230, citing MacLean, 1985; LeDoux, 1986; Ademac, 1991; O'Keefe & Bouma, 1969). Most importantly, the amygdala is believed to make internal representations of the external world "in the form of memory images with emotional experiences associated with those memories" (van der Kolk, 1996, Calvin, 1990). Once meaning is associated with the incoming data, the amygdala is then believed to organise emotional responses by communicating this information to the hippocampal system. Van der Kolk describes this system as the area which notes time and context in relation to specific experiences. Therefore it is integral to the way in which incoming data is stored and organised in memory. This area is also specifically necessary for the "holding in mind" of short-term memory, which is then forgotten straight away, or given a temporal quality and contextualised and stored, in permanent memory. Thus the hippocampus must function well for the proper operation of explicit or declarative memory (Squire & Zola-Morgan, 1991). And most importantly, the ability to learn from previous experience depends to some degree on the even operation of the mechanisms involved in short-term memory, (van der Kolk, 1996, p. 231). Because the hippocampus contextualises incoming data with previously organised and stored information and memory any disruption to this operation as a result of unintegrated traumatic experience, is believed to have specific effects, not the least of which is the overwhelming debilitating experience of traumatic events, without meaning or a sense of time or place and being more or less re-experienced as if they are happening now.

Research into the elevated stimulation of the amygdala in animals has shown that hippocampal functioning is compromised, (Ademac, 1991). Therefore the implication for humans is that high emotion may reduce the ability for the hippocampus to store and organise experience. Not only is the categorisation of experience impaired but experiments with animals

have demonstrated that even one incident of high-dose stimulation of the amygdala "will produce lasting changes in neuronal excitability and enduring behavioural changes in the direction of either fight or flight" (van der Kolk, 1996, p. 232, citing LeDoux, Romanski, & Xagoraris, 1991).

This change in the limbic system was also validated by the research of LeDoux and colleagues, who were able to produce "conditioned fear responses" by continual over-stimulation of the amygdala. In ascertaining that the cortical lesions thus produced stopped the cessation of these fear responses, the researchers were led to believe that, once formed, the subcortical remnants of the conditioned fear response are permanent and that "emotional memory may be forever" (van der Kolk, 1996, p. 232, citing LeDoux et al., 1991, p. 24). This conclusion validated the work of Lawrence Kolb (1987) who had hypothesised that sufferers of PTSD had severely compromised control over the subcortical areas of the brain which managed learning from experience, habituation and assisted the individual to differentiate between specific stimuli. In addition, the effects of drug and alcohol, nightmares, aging and being exposed to triggers that sent the individual back into a traumatic experience, severely compromised the ability of the individual to manage behaviour or emotional states. It is therefore possible "that traumatic sensations may then be revived, not in the distorted fashion of ordinary recall, but as affect states, somatic sensations, or visual images (nightmares or flashbacks) that are timeless and unmodified by further experience…" (van der Kolk, 1996, p. 232).

It is important to note that LeDoux has been critical of implicit and explicit assumptions that there is cognitive primacy over emotional responses and that the limbic system is "the body that mediates affect in the brain" (Wilson, p. 93). Whilst amygdala driven survival strategies of fight or flight inhibit a need to "think it over" in the immediacy of a threat, LeDoux's stand on the neurobiology of emotion as discussed in length by Wilson (2004). LeDoux positions emotions as operations of the nervous system (LeDoux, 1996) whilst iterating his "desire to protect emotion from

being consumed by the cognitive monster" (pp. 68-69).

> LeDoux is keen to position emotions as psychological events that cannot be devolved to cognitive mechanisms… that the first psychological response to a stimulus may be emotions rather than cognitive or appraising, that emotional systems are more intimately connected to bodily sensations than to cognitive systems; and that memories of emotionally significant stimuli and cognitive stimuli are processed differently. In short, he argues, there is very little neurological data to support the thesis that emotion is subordinate to cognition, and there is substantial support for the idea that different kinds of emotions are processed in different ways in the brain (Wilson, 2004, p. 93).

Whilst LeDoux is clear that cognition is not necessarily emotion's predator, the notion that different kinds of emotions are not only processed in different ways in the brain but that they also are processed in different ways in the body requires further examination. Wilson examines the case of Fraulein Elisabeth von R., a patient of Freud's who experienced gross discomfort whilst standing still and was unable to walk or even lie horizontal due to chronic pain in her legs. Freud uncovered the reason for much of Fraulein Elisabeth's pain: he learned that the woman's ill father rested his foot on one of her legs as she changed his dressings every morning. The other leg's pains came to be perceived as related to grief surrounding the death of the woman's sister and guilt about considering her dead sister's husband as a possible suitor. Whilst psychoanalysis would be able to discuss the deep emotions and conflicts which may have brought about these conversions, it is the biology of these conversions which fascinates Wilson as she asks what biological operations allow each thigh muscle to respond differently, for one to respond to Fraulein Elisabeth's father and the other her sister's husband: "What is the nature of the muscles that make them so psychologically attuned?" (p. 9). Freud too was fascinated by his patient's responses:

> As a rule the patient was free from pain when we started work. If, then, by a question or by pressure upon her head I called up a memory, a sensation of pain would make its first appearance, and this was usually so sharp that the patient would give a start and put her hand to the painful spot. The pain that was thus aroused would persist so long as she was under the influence of the memory… and with the last word of this it would disappear (Breuer & Freud, [1893-95], (1955), p. 148).

However Wilson focuses more directly on examining Fraulein Elisabeth's physiology rather than her psychology which was to remain Freud's major interest:

> The real force of Fraulein Elisabeth's condition is that the physiology of her thigh muscles (their capacity to stretch and contract; their intimacy with the peripheral nervous system) cannot be separated from the illness and death of her father or from the words of her analyst. The intersubjectivity of her analysis is facilitated not just by words, ideation, and affects but also by nerves, blood vessels, and skin. The conversation between Fraulein Elisabeth and Freud is verbal, interpersonal, and biological. The hystericisation of Fraulein Elisabeth's thighs is just one particular configuration of complicity (muscles-memories) in a field that is nothing but such intersubjective, biologically attuned complicities (… muscles-skin-legs-father-sister-hands-words-pain-analyst…). Consider the remarkable occurrence of Fraulein Elisabeth's continuing her story until the pains had been talked away. The familiar retort that such pains are all in her head seems to explain nothing; it restates rather than dissects the puzzle. Yet, taken literally (reductively), it perhaps gets us closer to the heart of the matter. If the pains are indeed all in her head, then this entails a number of reciprocal ontological contortions: that her thigh is in her head, that her mind is muscular, and that Freud's words are in the nature of her nervous system (Wilson, 2004, pp. 10-11).

Wilson asks in relation to two other patients of Freud's, how did Miss Lucy R. regain her sense of smell when she spoke the details of two forgotten traumas? How did Frau Emmy von N.'s hysterical gastric pains disappear when Freud stroked her "'a few times across the epigastrium'" (Breuer and Freud, p. 64)? For Miss Lucy R and Frau Emmy von N., Freud and Breuer could hypothesise that the abdominal pain and the sense of smell were effects of trauma and that telling or the stroking brought about some form of cure. But how both the traumas and the interventions interacted with the body is not understood at all.

Likewise, one of my own clients, Cally, flushed red down the right side of her face when she recalls being punched hard on her right cheek by her ex-lover. One day, five years into the therapy, I noticed Cally no longer blushed when remembering this violent attack. As Cally had a very extensive history of abuse, the work of therapy had not singled out this particular assault as the main focus of intervention. Consequently I could not tell at what particular point in the therapy the blush may have disappeared. All I can say is this autonomic blushing was alleviated sometime, somehow. How the trauma-memory-brain-face-blood vessels-skin-blush-word-therapist mechanisms interacted in Cally's case, to both maintain and alleviate the blush some eleven to sixteen years after the assault occurred, is still unknown. It is this curious interrelationship between psyche and soma which remain under examined despite the addition of a formal diagnosis of posttraumatic stress disorder within psychiatric literature towards the end of the last century.

Disorders of Extreme Stress

Other posttraumatic syndromes were put forward as possible entries in DSM-III prior to the formal diagnosis of PTSD. Rape trauma syndrome (Burgess & Holmstrom, 1974) and battered women's syndrome (Walker, 1984) were amongst two of the entries as the women's movement grew

stronger in 1960's and 1970's Europe, North America and Australia and New Zealand alongside anti-war protests in countries where soldiers served in Vietnam. The massive increase in reports of assault and abuse in particular of women and children and this exponential rise is no doubt linked to a greater public awareness of abuse against children given "childhood" itself is a relatively recent phenomenon. The impact of assaults on women and children as child abuse began to achieve recognition, drew attention to other posttraumatic symptoms experienced in survivors that include a loss of a coherent sense of self, ability to trust in self and others and harm to any sense of personal value or self-efficacy (van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). Eventually, the PTSD diagnosis focused on three specific set of symptoms experienced by the sufferer. The commonality of, first, the experience of reliving the traumatic event; second, the experience of numbing; and third, the symptom of hyper-arousal, substantiated the relevance of this disorder to a much wider traumatised population. This broader sample included individuals who had experienced other precipitating, unexpected and fearful events, victims of domestic violence, adult or child sexual assault, torture and trauma, physical and emotional abuse, accidents and natural disasters:

Results of these studies have contradicted many notions and popular prejudices about the effects of traumatic events and have led to the development of a new field of study, traumatic stress studies. Yet from its inception, it has been clear that the diagnosis of PTSD captures only a limited aspect of posttraumatic psychopathology. A multitude of studies suggest that complex but consistent patterns of psychological disturbances occur in traumatised children as well as in adults who have been exposed to chronic or severe interpersonal trauma at any time during the lifespan. In particular, numerous studies have demonstrated the pervasive negative impact of chronic and cumulative childhood abuse and trauma on the developing child and later on the adult (van der Kolk & Courtois, 2005, p. 385).

Trauma now encompasses a broad range of possible causes and symptomatology. Australian psychologist Colleen Jackson, whose doctoral thesis A Salutogenic Approach to the Management of Critical Incidents (2003) brought together the theorising of a number of the main trauma theorists, provides a summary of the way this knowledge has now been ordered. According to the current theorising, there are two major categories of traumatic experiences:

- firstly, a traumatic encounter with death in which the threat is real or perceived; and
- secondly, a traumatic loss which occurs when an individual or individuals are confronted with an unexpected death, in particular the death of a child, or where the loss is violent or shocking, such as the losses that occur through the events of rape, child sexual abuse, physical assault and suicide, wilful or accidental death or injury, loss of a relationship and the loss or destruction of a home by fire, a natural disaster, witnessing a tragedy, threatened loss and loss of status (Jackson, 2003, pp. 5-6, citing Raphael and Meldrum, 1994 and Everstine and Everstine, 1993).

These categories of experience have emerged from the PTSD literature of the 1970's, 80's and 90's and have functioned to allow more traumatised individuals who do not fit the narrow PTSD diagnostic criteria to access help and intervention as well as generally widen the treatment population within the psy disciplines. These broader categories also function to allow more subjects to be regulated as they fit the criteria of trauma sufferers amenable to cure. In addition, social incapacity, a large feature of many trauma sufferers' lives, becomes an object for amelioration.

What is understood about the "truth" of trauma responses given the number of journals and publications which either are now wholly or largely devoted to its study for example the Journal of Traumatic Stress, the journal of Child Abuse and Neglect, and the Journal of Interpersonal Violence, means

that clinicians and practitioners of psychotherapy look for symptoms which may indicate a response to extreme stress or threat. Trauma sufferers can also map their own experiences onto a prescribed set of symptoms that include alterations in the regulation of affect and impulse, severe anxiety, depression, restlessness, sleep disturbance, attention or consciousness, self-perception, relations with others, and systems of meaning, (Jackson, 2003, citing Raphael, 1986; Shalev, Yehuda & McFarlane, 2000; Wilson, Friedman & Lindy, 2001, van der Kolk, McFarlane & Van der Hart, 2002). The subject can then be diagnosed as suffering some form of traumatic stress.

Whilst I will discuss this in greater detail in Chapter 5, it is assumed that traumatic experience has not been integrated into what is understood as normal memory, when individuals experience a number of unmanageable symptoms including intrusive memories and flashbacks that come into focus without conscious recall, persistent nightmares, panic attacks and other anxiety provoking symptoms that mobilise the flight, fight or freeze responses as if the threat is occurring in the present. Subsequent changes in brain chemistry place an individual on high alert (hyperarousal), and a trauma sufferer may experience an exaggerated startle response when someone enters the room and may have difficulty sleeping due to a general hyper-attentiveness to the surrounding environment. The individual may then attempt to deal with these chronic symptoms by “numbing out”, by avoiding any reminder of the traumatic event or events. The person may describe dissociative symptoms such as floating above their body or appear dissociative: a colleague describes this look as that of the “dead eyes” one sees in a chronically traumatised child surviving in a war zone. The appearance of dissociation however, goes much deeper. The person may numb their feelings by self-medicating through alcohol or drugs, overwork to the extreme, engage in excessive risk-taking, even dangerous behaviour; all of which are attempts at “not-feeling” and not-re-experiencing severe traumatic symptoms, producing a subject who “requires” more governance at the individual and social level.

Relational Trauma

Studies on animals have shown that the more positive an environment during a primate's early life, the greater the push towards complexity and growth in the development of neurons and neural pathways (B. Kolb & Whishaw, 1998). If there is greater deprivation or minimal stimulation during the animal's early years, fewer, less complex neural pathways develop, learning is inhibited, and the ability to adapt to change is impaired. Similarly, research with children has shown that nurturing stimulating relationships in childhood encourage the development and interconnectedness of neural networks (Shore, 1994). Early childhood trauma and neglect, individual vulnerabilities as a result of genetic factors and trauma in adult life are perceived to interfere with the integration of neural networks and the processing of information. And those children who experienced trauma, whether physical, sexual or emotional, appear to have a greater likelihood of abnormalities in the areas of the brain responsible for higher order (cognitive, reasoning, impulse control etc) functioning (Teicher, Ito, Glod, Andersen, Dumont & Ackerman, 1997).

From a poststructural perspective, Butler (2004a) reminds us of our inherent relationality in our vulnerability as human subjects, particularly as infants and children. She states that all of us "live in a world of beings, who are, by definition, physically dependent on one another, physically vulnerable to one another" and that this is a "historical act of our formation" (p. 27). Butler goes onto say that in terms of the formation of our subjectivity, it is necessary to reflect on the place of violence in that constitution, in our very relationality, "for violence is, always, an exploitation of the primary tie, the primary way in which we are, as bodies, outside ourselves and for one another" (p.27). Butler goes on:

> We are, from the start, given over to the other … even prior to individuation itself and, by virtue of bodily requirements, given over to some set of primary others: this conception means that we are vulnerable to those we are too young to know and to judge and,

> hence, vulnerable to violence; but also vulnerable to another range of touch, a range that includes the eradication of our being at the one end, and the physical support for our lives at the other.
>
> … We cannot understand vulnerability as a deprivation, however, unless we understand the need that is thwarted. Such infants still must be apprehended as given over, as given over to no one or to some insufficient support, or to an abandonment. It would be difficult if not impossible, to understand how humans suffer from oppression without seeing how this primary condition is exploited and exploitable, thwarted and denied. The condition of primary vulnerability, of being given over to the touch of another, even if there is no other there, and no support for our lives, signifies a primary helplessness and need, one to which any society must attend (Butler, 2004a, pp. 31-32).

Butler focuses on this "primary helplessness" which constitutes our very formation as subjects . Neurobiologists and trauma theorists see responses to this helplessness as capable of different forms of violence – either an overt "eradication of our being", as Butler suggests and/or an absence of adequate care for our vulnerability, both of which are indicative of relational trauma. As a result of the absence of a caregiver to provide adequate nurture, neural networks do not develop in more integrated ways.

However this still does not fully explain the how of the interaction between environmental and biological factors that is thought to compromise some children's ability for higher order thinking. Wilson again asks some salient questions in regard to one of Peter Kramer's (1993) main case examples in Listening to Prozac. "Lucy", despite psychotherapeutic intervention, also required pharmacological intervention through the use of antidepressants in the form of selective serotonin reuptake inhibitors (SSRIs) in order to manage her extreme oversensitivity, which was perceived to be related to finding her mother murdered by a trusted house servant when Lucy was only ten years old. Kramer asks "How does psychic trauma become

translated into a functionally autonomous, biologically encoded personality trait?" (Kramer, p. 10). Wilson echoes Kramer's curiosity: "How can a mother's death become a change in serotonergic pathways?" (Wilson, p. 15).

Wilson reminds us that Kramer's question can end up in a deterministic path, that is, that the death of Lucy's mother "will be brought under the sway of synapses, neurotransmitters, and cortical pathways" (p. 16), determined by "the remarkable imperialism of the biological" (Kramer, p. 105). This deterministic position has many flaws, given that we again do not understand the how of the influential relationship between the complexity of the psychology of a response to an event with traumatic sequelae and the similar complexity of the operations of neurobiology. Nevertheless, Wilson argues that a detailed examination of neurobiology "need not be at the expense of critical innovation or political efficacy" (Wilson, p. 16). It is, therefore, problematic to make:

> … routine claims that neurological theories are always politically dangerous or imperialistic, that biology is a discursive ruse, or that the final word on any psychobiological event must always lie in the domain of social or cultural analysis. Importantly, this restaging is accomplished, not through the recitation of long familiar anti-determinist axioms, but through the iteration of reductive neurological hypotheses (Wilson, 2004, p. 16).

What Wilson is saying is that neurobiological premises can be examined with a both/and perspective, without privileging an anti-determinist position. In the case of Lucy, the mutuality of the influence of trauma and serotonin levels in fact produces more questions than answers. Whilst at the same time undoing the premise of the dominance of soma. We are left to ask how the death of her mother "obliged" certain changes in Lucy's personality and her serotonin levels. How are neurons obliged to alter a specific developmental trajectory under exposure to extreme threat, and,

likewise, how is the psyche obliged to respond to the effect of an SSRI after a pharmacological intervention?

When it comes to less obvious abuses such as the abuse of neglect or witnessing domestic violence, theorists and clinicians have noted that trauma sufferers who have experienced interpersonal violence and abuse, have great difficulty developing and maintaining secure relationships with others. Pearlman and Courtois (2005) point out that the diagnostic criteria for PTSD in the current DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. American Psychiatric Association [APA], 1994) focuses on the relational difficulties experienced by sufferers. These difficulties include avoiding people who may remind the sufferer of the traumatic event, feelings of isolation and alienation from others, a diminished ability to express a full range of emotions, a foreshortened sense of the future, and problems managing impulses and anger. As a result, the trauma sufferer may be denied the very things that may reduce some of the sufferer's feelings of isolation and symptoms, that is, social and familial support due to their inability to relate satisfactorily with others. Children too, who have witnessed abuse or suffered violence or neglect at the hands of caregivers and loved ones have been shown to have similar if not greater difficulty in managing and maintaining significant relationships with others as adults.

The question of how much trauma, neglect, abuse etc can bring about so many changes in a sufferer's personality, experience of relationships and of course, their neurobiology rests on the premise of neurological kindling (Kramer, 1993; Wurtzel, 1995; Wilson, p.24):

> Manic depression, and perhaps all depression… is a progressive, probably lifelong disorder. It can be induced in normals. The induction can take place through a series of small stimuli, none of which at first causes overt symptoms. The latency to fully expressed illness can be long, and the absence of overt symptoms is no guarantee that the underlying process is not underway. Illness, once

> expressed, can become responsive to ever smaller stimuli and, in time, independent of stimuli altogether. The expression of the disorder becomes more complex over time. Even the early stimuli are translated into anatomical, difficult-to-reverse changes in the brain… (Kramer, 1993, p. 114).

If the brains of people who are traumatised leaves them predisposed to depression, according to Wilson, then a minor incursion on their psychological wellbeing in later life leaves them with a neurological predisposition to the onset of more substantial traumatic symptoms. This fits with the current view that childhood trauma or even the relational trauma resulting from an unavailable caregiver can produce a neurological weakness which predisposes someone to perhaps PTSD or at least at a higher risk of developing post trauma symptoms in later life (Pearlman & Courtois, p. 450).

Despite Kramer's standpoint on the "inborn, biologically determined temperament" (Kramer, p. xv) of his patients as a result of his examination of the efficacy of Prozac, Wilson argues that Kramer's position doesn't simply replace socio-cultural and psychological representations of depression and subjecthood with biological determinism. Rather Kramer's detachment from these former models of depression allows for a deep "interrogation" given the "multivalent" application of antidepressant medication (Wilson, p. 26):

> … Some people feel 'better than well' when taking Prozac; some people find that a previously cherished or familiar part of their personality is attenuated by Prozac and some experience this change as a loss while other find themselves happily reoriented to a new aspect of themselves; some people become seriously agitated by certain doses of Prozac, others barely respond to it yet are immeasurably helped by another SSRI antidepressant. And all of these responses may vary over time in any given individual. Even Prozac's most notorious side effect – diminished libido and delayed

> orgasm – manifest in ways that are distressing, hardly noticeable, somewhat tolerable, intractable, readily mastered; or perhaps these side effects do not appear at all (Wilson, 2004, pp. 26-7).

Wilson is arguing that it is important not to lose sight of variants of the nervous system, itself defying notions of a fixed determinable biologism. Some people respond to SSRIs, some do not, some get better, and some have unmanageable side effects. A prescription for Prozac does not make for one defined neurological and emotional trajectory even though many feminists argue that "a serotonergic history is always a history of normalisation" (Wilson, p. 28). When feminists dispute this assumption of normalisation, the argument is still likely to be couched in terms of the discourse of women's control over their bodies and their lives. For instance, Griggers, (1997) appropriates a biological metaphor for the social body when she argues that whether or not a woman uses psycho-pharmaceuticals is not the concern: "The issue is whether the psychopharmacological machine is channelling her or whether she is in some way channelling it toward a historically informed collective notion of what would constitute a meaningful response to being subject to, and becoming woman, within postmodern culture's agitated nervous system" (Griggers, 1997, p. 133). In endeavouring to surface the "less catastrophically doctrinaire" (p. 28) possibilities of biology, Wilson challenges the binary of psyche and soma, puts radical feminist notions of controlling one's body "under erasure", and exposes the limits of political perspectives that challenge biological essentialism at the cost of reproducing a mind/body split.

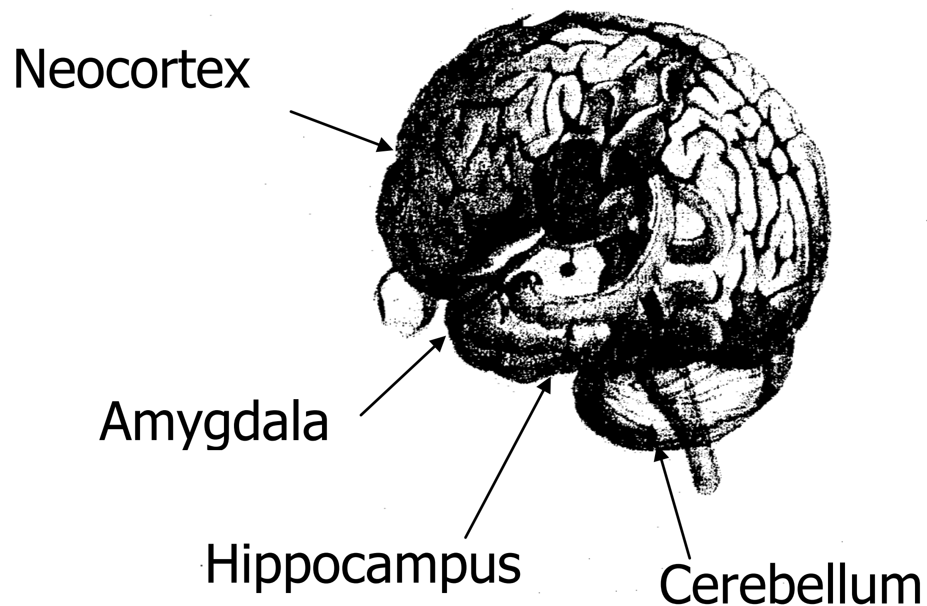
Implications for Therapists and Clients

The relevance of this broader categorisation allows more subjects to be treated and hence a greater population of sufferers to be regulated. In addition, the prevalence of information regarding brain functioning invites therapist and client subjects to **map** their own experiences or observations

accordingly seduced by the positivist knowledge and "dispassionate expertise" (Rose, 1999) of the neuro-imaging neuroscientist. As such, the trauma subject comes to desire not only the amelioration of any distressing symptoms but also accepts the regulatory practices as part of their own autonomous choice, having been discursively if less consciously trained into so doing (Blackman, p. 86).

A very simple example of a subtle form of the above can be seen when the following graphic appears below:

Memory Systems in the Brain



I have found that the unsolicited and unexplained deployment of the above brain diagram, in teaching or setting the stage for discussions about brain functioning, even as it may appear on a single slide in a power point presentation when I am explaining "something about trauma" in my own work, blurs the boundaries between biological and psychological space in relation to trauma. This diagram seduces listeners and readers into believing that my explanations of trauma are empirically valid, simply by deploying the image of the brain in any presentation. This is where science begins to take over as fact, and the picture of the brain, whether or not explained, implicitly **stands as a sign for science**. The brain represents concrete "evidence" that what is about to be explained is "truthful". This is an example of Latour's (1987) "science already made" and it doesn't matter that the picture of the brain is not detailed or more explicit. It is nevertheless easily perceived as a "truth" in and of itself and has been utilised to "prove" and "explain" other theories about trauma. In this way, the picture of the brain presents as an entity which then "explains other entities" (Blackman, p. 17). Yet as Blackman states, "[t]hese are not 'truths' in an essential way (i.e. reflections of our essential human nature), but particular kinds of concepts and explanatory structures which make certain kinds of experiences intelligible and divide experiences up according to divisions made between the true and the false, the normal and the abnormal…" (Blackman, p. 82). It is the absence, in such a representation, of the history of successive explanations for trauma, and of descriptors such as gender, hysteria and even the term "repression", which I think makes this version of truth more possible. Thus the deployment of scientific diagrams to illustrate the "truth" about trauma and its impact on the brain, functions to allow a biological premise for the problematisation of traumatic experience. It provides both the trauma clinician and the trauma sufferer a map for reading the possibility of a traumatic "disorder" and seduces the subject to map their experience onto the brain, so to speak, and onto the theory of the brain that is being presented in order to reconstruct the past.

When I or another clinician tell a client that they need to understand "something about brain functioning" and "traumatic responses" through the language of science, there is already an implicit premise that the descriptor functions as fact, as science already made. This may serve to objectify traumatic experience by focusing on "the brain" rather than the experience of the individual subject and in so doing provides a vehicle for a subjectivity which is both more validating to the sufferer, that is, "It's not just me!" and produces an object (the brain) to be worked on which "proves" its amenability to treatment at a time when pharmacological technologies are active proponents and sponsors of research into depression, anxiety and other mental disorders. For example, when I explained to my client, Kara, what I understood about her "over-active amygdala" and the impaired functioning of her hippocampus to explain the flashbacks she experienced, her predisposition to avoidance behaviours such as drug abuse and her reduced ability to concentrate, or to think logically and at times her inability to recognise that this trauma actually occurred in the past, Kara exclaimed, excitedly:

> I knew there was something wrong with my hippopotamus (laughing)… well, that's what I'm going to call it, anyway! So I'm not mad, my brain is just not working right! That's why I'm not and probably won't ever be like other people!

Quite simply, neurobiological "facts" appear to allow an individual to embrace a subjectivity that can both limit their view of their experience, "I won't ever be [better]!", creates a subject who feels somehow "special": "I won't ever be like other people!" and also functions to biologically validate their own experience, "My brain is not working right" and escape a subjecthood of pathology, "I'm not mad!" It also places me, in the position of therapist, as an expert on brain functioning, no matter how primitive my explanation may have been. I am more likely to be trusted and validated by both my client and my psychological colleagues who place less store on anecdotal therapeutic information than on "hard facts".

Furthermore, neurobiological explanations such as the above, which then colonise human subjects, function to evade discussion and intervention as to the more obvious causes of severe trauma: that is severe and pervasive violence, both sexual and physical, war and torture. A focus on relational trauma more often does the same and works to produce human subjects who will come to desire a moral and ethical responsibility to heal themselves and their relationships in order to reduce the "risk" of "producing" traumatic symptoms in their children. In addition, whilst the descriptor, for example of "hysteria", appears to have moved away from the gaze of theorists, this focus on early relational trauma diffuses more obvious explanations relating to overwhelming and terrifying events, and moves parents, specifically mothers, from subjects to objects amenable to intervention and regulation.

In summary, I have attempted in this chapter to outline some of the matrix of scientific explanations and constructions which relate to traumatic responses to overwhelming experiences that have functioned as the truth of these experiences over the last 120 years. In doing so, I have established a basis from which to explore the continuities and tensions between what we presently understand as "the truth" about traumatic experience and the embodied experience of trauma. Given the predominance of neuroscientific explanations, it will require a purposeful reflexivity in order to avoid foreclosure of discussion of the relational elements of trauma and recovery.

In attempting to open up new potentialities in the interface between the biological and psychological processes that give a perceived reality to the experience of trauma, I may have outlined the history of trauma as if it is a static entity which has slowly been uncovered and discovered in more and more detail, making it ever more amenable to intervention or cure. The danger here is that my research is pulled by the discourses that exert the most authority, those that are empirically and scientifically measurable – that I too am seduced to perceive brain functioning to be the "constant

category used to explain the aetiology of certain experiences" (Blackman, p. 227).

Blackman states:

> If one views the object, hallucination, [or in my thesis, trauma] as historically constituted within an adjacent field of discourse, historical investigation should be oriented towards describing the field of discourse, and its conditions of possibility, rather than the description of the gradual development of medical understanding and progress. This frees the writing to become something 'other'. It is not one of knowing the answers and using history to chart the progress of that certainty, but to disrupt the certainty of present understandings, in order to think about the [...] experience differently (Blackman, 2001, p. 97).

A both/and position in my work requires me to interrogate neurobiological explanations for trauma in order to open up more potentialities for human subjectivity. Given the ground-breaking work of Wilson (2004), I need to consider psyche and soma as equally influential aspects of the landscape of trauma intervention. Neither can be subordinated in favour of the other. Both psychological and neurobiological approaches to trauma can have positive and negative consequences for subjectivity. I need to examine approaches to trauma for any inherent reductionism and also for their potentialities.

In the next chapter I will consider current therapeutic explanations and interventions that also have a voice in the complicated system responding to the problematisation of trauma whilst attempting to maintain a critical psychological perspective. I will also begin to include personal accounts of traumatisation in order, as Foucault (1989, p. 121) proposed, to "produce something that doesn't yet exist and about which we cannot know how it will be." Taking into account the various truths about traumatic experience that influence my own work and the work with traumatised populations

within the related psy disciplines, I wish at least to begin to explore new ways of transforming understandings about the experience of traumatisation. I want to do this in a way that thoughtfully and ethically acknowledges the role of therapeutic intervention in the regulation of subjects and also in facilitating healing and transformation in the lives of traumatised individuals.

Chapter 3: Therapy and Traumatised Subjects

> That was the first day I looked in the mirror after the attack. My hair washed, my face clean, perfumed, powder on my chest and pretty underwear – I felt ready for the world. I looked in the mirror without a thought, expecting to see me. Instead I saw a face I could hardly recognize. The girl looking back at me had thin, sunken cheeks. Her skin was not a healthy colour. She was very pale and she had a very large bandage and blood on her neck. But it was her eyes that really shocked me. Her eyes were staring back at me, glazed and distant. I will never forget that moment. My eyes were the eyes of a person who has seen hell …
>
> (Shari Davies in S. Davies & Holden, 1997, p. 63).

> Unlike Descartes, who had 'to demolish everything completely and start again from the foundations in order to find any knowledge 'that was stable and likely to last', I had my world demolished for me …
>
> (Susan Brison, 2002, p. 25).

> People ask me if I'm recovered now, and I reply that it depends on what that means. If they mean 'am I back to where I was before the attack?' I have to say, no, and I never will be. I am not the same person who set off, singing, that sunny Fourth of July in the French countryside. I left her in a rocky creek bed at the bottom of a ravine. I had to in order to survive. I understand the appropriateness of what a friend described to me as a Jewish custom of giving those who have outlived a brush with death new names. The trauma has changed me forever, and if I insist too often that my friends and family acknowledge it, that's because I'm afraid they don't know who I am …
>
> (Susan Brison, 2002, p. 21).

In the following section I will begin an exploration of various subject positions produced through and in relation to traumatic experience and chart the difficulty for traumatised subjects and the clinicians who work with them to move from the notion of a traumatised identity. There are many implications for this given the essentialist bias of identity language, which evades the possibility of subjectivity as an ongoing project of multiplicity and re-creation. Much of the language of trauma and thus the experience of trauma itself is articulated and therefore experienced in terms of identity rather than subjectivity. My understanding of the way identity language is used in relation to trauma is that it functions to evoke metaphors which may suggest, for example, that an essential self is killed or permanently damaged by trauma, or alternatively that something essential about the self survives trauma. So, interwoven throughout this chapter are a number of accounts of traumatic experience that I will examine; first, to outline my theoretical position when it comes to the production of the subject of traumatic experience; and second, to examine what I mean by "experience" in the light of these various accounts; and third, to look at the potential for the generation of a multiplicity of subjectivities in regard to narratives[2] of trauma such as these.

Also examined in this section is one of the dominant theories of therapeutic intervention, that is, the relational cure of therapy, which is perceived to create a space in which therapist and clients undertake reparative interpersonal work so that healing and transformation occur. Other dominant techniques of change employed in trauma work with clients include cognitive behavioural therapy (CBT), which challenges beliefs about self and others in order to elicit change in behaviour, and exposure therapy, which is designed to desensitise traumatic triggers (see Briere & Scott, 2006; van der Kolk, McFarlane, & van der Hart, 2002; Kuyken, Padesky, & Dudley, 2008; van der Kolk, McFarlane & Weisaeth, 1996).

[2] I am grateful to those who have provided personal accounts of traumatic experience and in particular the work of Susan Brison (2002). Brison has attempted to subvert the dichotomy between the personal and the political by refusing to maintain the "abstract, universal voice [which labels] … first-person narratives as biased and inappropriate for academic discourse" (Brison, 2000, pp. 5-6).

Although I do not examine these techniques in much detail in this thesis, I acknowledge that my work challenges the belief systems of my clients, and I specifically consider how exposure therapy can work to desensitise triggers in the context of a relational approach to therapy with trauma survivors. My background as a family therapist and recent trauma literature that focuses on early relational trauma as a pre-cursor to the development of posttraumatic symptoms later in life, predispose me to focus on the relational aspects of trauma therapy. From this perspective, successful therapeutic work with survivors includes increasing a person's ability to maintain safe attachments with significant others including the therapist as well as being able to develop feelings of trust, safety, and enduring connection in significant relationships (Harvey, 1996). It is within the context of a trusting therapeutic relationship that many distressing cognitions, feelings and behaviours can safely be validated and/or challenged as the case may be, utilising, for example, CBT or exposure work, The therapeutic relationship is perceived as integral to this process (Herman, 1992), whatever the specific technique employed.

I hope in this section to find ways of negotiating the tension between the poststructuralist critical psychological perspective that underpins my analysis and the essentialist theoretical "truths" that inform my thinking and work as a therapist. When I focus on the relational aspect of this work, opening it to examination, I do not do so simply because I am charged with disrupting its premises. I do so because I also believe in many of its precepts and consider these essential to my own work and to the work of therapists in general. Evading the lure of fixed notions such as "identity" and "science" and even "the relational cure" is difficult, but my challenge here is to step both inside and outside my undoubted embeddedness in the dominant discourses and practices surrounding trauma work.

The Subject

According to P. Smith (1988) "the subject" consists of "the series or conglomerate of positions, subject-positions, provisional and not necessarily indefeasible, in which a person is momentarily called by the discourses and the world he/she inhabits" (P. Smith, 1988, p. xxxv). B. Davies (2000a), drawing on the work of Walkerdine and Lucey (1989) expands on this concept:

> … [O]ur existence as persons has no fundamental essence; we can only ever be spoken into existence within the terms of available discourses. We are thus multiple rather than unitary beings, and our patterns of desire that we took to be fundamental indicators of our essential selves (such as the desire for freedom or autonomy or moral rightness) signify both the discourses and the subject positions made available within them, through which we have been constituted and constitute ourselves (B. Davies, 2000a, p. 55).

Similarly trauma survivors are hailed by discourses which both constitute their subjectivity and their actual experience of trauma. However as discussed in the previous chapter, the "truth" about traumatic experience and any subjectivity invoked not only involves a penetration of the discursive processes that inform "what is known" about trauma – it also involves penetration of what is understood as the neurobiological changes that occur under prolonged exposure to threat. From the premise that traumatic experiences both influence and are influenced by neurobiological and embodied processes, these processes can not be said to be static, irreducible, finite entities. Neurobiological effects of trauma act on the construction of traumatic experience and traumatic experience and the subjectivities evoked act on or produce neurobiological changes. Thus subsequent to exposure to prolonged stress, "one must experience some kind of biochemical or neurological transformation," which works to brings forth the "potentiality of the experiences" (Blackman, 2001, p. 216). In other words, biology should not be perceived as a fixed, unchanging entity. The

embodied experience of traumatisation can itself transform this biological entity and create a myriad of possibilities of the experience itself. In this way, both the neurobiological and embodied experience of trauma are "inseparable from the ways in which [they are] made intelligible and acted upon" (p. 216).

Experience

As discussed, one of the major difficulties for the problematisation of trauma is the constant pull towards a biological essentialism that functions to explain the "truth'" of traumatic experience. In this regard, the challenge facing this thesis is to conceptualise both knowledge and experience from a critical psychological position. Thus Blackman's specific theorising of experience is central to my thesis. This positioning requires a reflexive diligence as to how to give merit to accounts of embodied experiences of trauma without reverting to an essentialist stance which privileges, as Blackman describes, "aspects of the body as universal substrates of experience" (Blackman, p. 214):

> In conventional psychological theory, the emotions are presented as a set of variants, a universal set of characteristics, usually reducible to biology, which we all feel, but may simply interpret in different ways. This kind of body/cognition dualism allows for "culture" to enter the equation as a set of narratives or discourses which we may use to interpret the bodily experience differently. This body/cognition dualism is often overlaid by other dualisms, such as innate/learned, nature/nurture, individual/environment and natural/social. These are the very dualisms that studies of embodiment are attempting to displace and overturn (Blackman, p. 214).

Writing in The International Journal of Traumatic Stress Studies, Van der Hart, Nijenhuis and Steele (2005) conceptualise trauma not as an event but

as the subjective reaction by a person to that event. They state that they judge “only those who have developed at least substantial symptoms of trauma-related disorders over the course of their lives to be traumatised” (Van der Hart et al., 2005, p. 414). At the same time as making an important distinction, this conceptualisation of traumatisation shifts the emphasis away from violent and traumatising actions to the psychology of the traumatised subject. However, I think that it is important to focus on how potentially traumatic events are experienced even while they may be differently experienced by different subjects.

My understanding is that an experience of an event is made up of a number of factors. The first factor relates to the activity of experiencing, and I will use the example of a car accident to explain. In a vehicle accident there are a number of things that “happen” and there are a number of things that people “do”. There may be damage to a vehicle or property; there may be differing perceptions of “what happened” for each car accident victim and any witnesses at the scene; a person involved may have fled from the accident, another person with no thought to their own safety, may have pulled people out of the car; a multiplicity of thoughts and feelings may have been evoked by the sense of the experience such as fear, confusion, anger, relief etc; physical changes may have taken place in the event of injury to the body and medical attention may be required; there may be also psychological (and neurobiological) changes in the case of a traumatised response - “I thought I was going to die and I can't stop reliving that moment” or alternatively there may be an enhanced sense of well-being - “I am so lucky I survived!” All in all, an event or experience of an event consists of participants who do certain things, think certain thoughts, whose psychological and biological spaces respond in certain ways such that an experience is not a static entity that someone “has”, rather it is something that someone “does” (cf. Rom Harre's (1986) work on emotions and the theorising of Hochschild (1983), which is also discussed by Blackman, 2001).

Second, alongside the need to theorise experience as something someone does, is that an individual's experience should not be perceived as authentic and therefore “true” as if this account of an experience emanates from a thoroughly autonomous, objective rational individual who can completely and accurately describe a past event. Experiences or “these thing that happened to me”, like knowledge, “cannot be anointed as ‘authentic’ or 'true'” in that they cannot be “legitimately deployed or construed as larger or longer than the moments of the lives they speak from” (Brown, 1995, pp. 40-41). In other words, the notion of a subject without the history within which they are situated, has vanished. Experience therefore remains contextually and discursively constructed. Carinne Mardorossian (2002) argues further that in bringing to light the dangers of viewing experience as an entity that reveals a specific essentialist truth about some thing or event requires that “[r]ather than asking what 'truths' experience reveals” the challenge from a poststructuralist perspective is to ask “what blindness its invocation hides” (Mardorossian, 2002, p. 769). Thus maintaining a curiosity about what is not said in the recounting of experience can be as interesting and cogent as what is elucidated. Within the unsaid moments of experiences, within the chasms and silences and pauses of what cannot be told, truths may be produced that point to the power relationships that an overt examination would obscure (cf. Mardorossian, p. 756).

The third factor to be taken into account in regard to experience is what Niamh Stephenson (2003) describes as its “malleability” (Stephenson, 2003). This malleability is produced by the both “reflected and reflecting” (Butler, 2004, p. 148) experiencing subject. Experience “ossifies” (Stephenson, p.143) in the face of a subject who ponders as they write or speak as to their concurrent positioning as witness, participant and observer from within the experience and also outside of it. In the ongoing relationship between talking, responding and reflecting about experience in the presence of another, the experience changes and is transformed as it is told and retold. Like the subject, experience itself is always in the throes of becoming a new and evolving account.

The Body

As briefly discussed in Mardorossian's work in relation to power, the example of the car accident above and in the previous chapter, which focuses on the neurobiology of trauma, malleability extends not only to experience but to the physicality of experience in which the body "can be sculpted, moulded, altered and transformed" (Blackman, 2001, p. 212). Again central to this thesis is Blackman's understanding of the body, which is formulated as a generative, rather than fixed entity. Blackman sees this conceptualisation as sitting in stark contrast to Foucault's conceptualisation of the body as simply an effect of discourse: "except as an effect of discourse [t]he body is passive, 'always–already' waiting to be written upon by cultural discourses. The body simply becomes an effect of discourse" (Blackman, 2001, p. 212). Blackman argues that Foucault's conceptualisation forecloses rather than generates potentialities of the body. In contrast, however, Butler (1997) argues as a result of her understanding of Foucault that there is some aspect of the body that remains outside of its subjugation by discourse. Butler goes on to frame the body "as that which not only constitutes the subject in its dissociated and sublimated state, but also exceeds or resists any effort at sublimation" (Butler, 1997, p. 93):

> … in Foucault the possibility of subversion or resistance appears (a) in the course of a subjectivation that exceed the normalising aims by which it is mobilised, for example, in 'reverse-discourse,' or (b) through convergence with other discursive regimes, whereby inadvertently produced discursive complexity undermines the teleological aims of normalisation. Thus resistance appears as the effect of power, as a part of power, its self-subversion (Butler, 1997, pp. 92-93).

So if, as both Blackman and Butler argue (if not Foucault himself), that the body needs to be understood as a generative entity, then a both/and position can be adopted. In this way, the substance of the body, "the beating of the

heart, the pulsing of arteries... the vital signs of the living body" (Shildrick and Price, 1998, p. 1) is understood as inseparable from the discourses and practices centred upon it and it is this interconnectedness that should not be ignored. It is with the view that the tension needs to be explored between the body, its biological substrate which experiences pain or other somatic influences and the discourse and the power relations which are inscribed upon it, that I explore in the following example.

The following two excerpts serve to open up this discussion to such considerations. The first is an ABC radio interview conducted by Australian journalist, George Negus on 22 March, 2004 with author and world class ballet dancer, Li Cunxin, who spoke of the abject poverty of his early life; the second extract is taken from Li's (2003) widely acclaimed book, *Mao's Last Dancer*, in which he described the physical pain he endured for his audition at eleven years of age for Madame Mao's Beijing Dance Company:

> That's right. I was destined to be a peasant for the rest of my life. The minute I was born….. Oh, it was...it was terrible, really. Certain years, the tree barks were eaten by desperate people. And nearly every meal when my mother served on the table - there were seven boys in my family - the seven of us would look at the food that was served, then look at our mother, in her eyes, desperate. We knew then just by looking at the food, there is not enough food for all of us. We knew we'd go to sleep starving that night (Negus, 2004).
>
> I watched a few of the students being tested before me, and they cried out and winced. One of the officials come over to me and bent both of my legs outwards. Another official held my shoulders to stabilise me and a third pushed his knee against my lower back, at the same time pulling both of my knees backwards with great force to test the turnout of my hip joints. It was so painful it felt like everything would break at once. I wanted to scream as well, but for some reason I

> didn't. I had a stubborn thought: I didn't want to lose my dignity, I didn't want to lose my pride. And I clenched my teeth….
>
> Th[e next] audition was much harder. The girl with the big eyes from my class didn't pass this round: she screamed when they bent her body backwards and was disqualified for inadequate flexibility of her back. Then it was my turn. One teacher lifted one of my legs upwards, two others held my other leg steady and straight. They kept asking me if it hurt. Of course it hurt: it was excruciating! But I was determined to be chosen, so I kept smiling and replied, 'No it doesn't hurt,' as they lifted my leg higher and higher. Be strong! You can bear the pain! I kept telling myself. I did bear the pain, but the hardest thing was pretending to walk normally afterwards. They had torn both my hamstrings (Li, 2003, pp. 106-7).

Li's ability to hide his pain was fuelled by his desire not to lose his "pride" and "dignity". This technology of self, borne out of incredible determination to resist a specific prescribed and impoverished future, functioned to allow Li to bear extreme physical pain. He resisted the seemingly inescapable narrative trajectory of his birth into a poor peasant family: "We knew we'd go to sleep starving" and "kept smiling" to make the selectors believe he was flexible enough to be chosen for the most prestigious ballet school in China. For Li, his "cultural meaning [was] intrinsic to embodied experience on the level of being in the world" (Csordas, 1994, p. 270). Csordas is saying that it is this interface which is the salient variable, that is, it is vital to examine what is produced in the interface between the man's dialogue with his biological experience and the biological experience itself. The pain Li's body suffered was mediated through the dialogue between his perception of the continuing hardship he faced and his desire to resist any foreclosure of a different possibility. No doubt the despair of his own "mother, in her eyes, desperate" had informed his inner dialogue, so clear was his recollection today. But did it make the pain he felt any less painful than the pain experienced by "[t]he girl with the big eyes"?

> Surely all human beings, whatever their culture or time, have felt pain. The more interesting question is how they have interpreted the experience of pain. And maybe, the experience of pain is so conditioned by the cultural-historical interpretations of it that there is little more that can be said about it other than it is generally aversive (Weiss and Haber, 1999, p. 6).

Again Blackman, drawing on the theorising of Weiss and Haber, sees any lived experience which is usually considered to have some form of "invariant biological status" as relatively fluid and malleable. So-called irreducible categories of experience such as pain or affect are never independent of social, cultural and political processes. Blackman continues, "… to what extent is 'biology' a stable, invariant category, when through the embodiment of biological processes the experience itself is transformed?" (Blackman, p. 216). In Li's example, the mediation of this physical and discursive encounter did not stop the tearing of hamstrings. However this tension functioned to produce a human subject whose desire for change transformed the perceived limits of physical experience. This transformative potentiality is what is absent from most examinations of the interface between biology and the social, and Blackman, further elucidating Csordas' work, states that it is in "the space 'in-between' where both become transformed" (Blackman, p. 227):

> … [T]he strategies and understandings that people use to engage with bodily experiences transform the bodily experience itself. Neither one, nor the other can be disentangled, rather there is a synthesis of bodily experiences with a deep sociality. Csordas is arguing that biological processes are an important part of embodiment, but that they are not reducible to biology. Going beyond the preoccupation with causality, he argues that the body is an agent, not a resource, and that biology is always situated, a dynamic process. This is not simply an 'interaction' between biology and the social, but that we carry the

> social in our bodies; it is an inseparable process (Blackman, 2001, pp. 228-229).

In the following section I will endeavour to illustrate how experiences of trauma remain malleable to flux and reinvention even when they fall into discourses which portray them as fixed unchangeable entities. Similarly I will examine how these experiences and their perception of them may function to evoke the psychological metaphor of the stuck traumatised individual or a subject capable of a multiplicity of ever moving and changing subject positions, positions which may or may not invoke viability.

A Loss of Self

> Traumatisation involves a loss of the pre-traumatic personality structure in adults, and interferes with the development of a cohesive and coherent personality structure in children. In other words, traumatisation consists of some degree of division of the personality (van der Hart, Nijenhuis & Steele, 2005, p. 414).

Trauma theorists van der Hart et al., hold that there is some 'split' in the make-up of the personality that occurs when traumatisation takes place. Drawing on the theorising of Allport (1961) who defines personality as "[t]he dynamic organisation within the individual of those psychophysiological systems that determine his characteristic behaviour and thought" (Allport, 1961, p. 28), van der Hart et al., (2005), propose that a structural dissociation of the personality takes place when adults or children are unable either in part or whole, to integrate potentially traumatising experiences "within the confines of a relatively coherent personality" (p. 415). This notion of "integration" will be explored further in more detail, but as a common starting premise for therapists working with clients who have suffered trauma, it is important to draw out this particular investment

in identity language which may both bind and blind the therapist to other potential subjectivities for their clients.

Herman, whilst not tying herself to this idea of a division of the personality, states, “[w]hile the victim of a single acute trauma may feel after the event that she is 'not herself,' the victim of chronic trauma may feel herself to be changed irrevocably, or she may lose the sense that she has any self at all” (Herman, 1992, p. 86). Herman, S. Davies and Brison, the first, a renowned writer, researcher and clinician in the field of psychological trauma, and the second and third, two women, both survivors of terrifying assaults, the impact of which they explore in their autobiographies, identify the dilemma of this loss of self.

In the quote from When Worlds Collide (1997) made at the start of this chapter, S. Davies, an Australian woman who survived a horrific sexual assault and attempted murder, dialogues with herself as she confronts the sight of some of her physical injuries as reflected to her in the mirror. This dialogue includes a description of her sense of seeing a different self from the one she had washed and dressed that morning. This almost disembodied perception of herself is reflected to her through her eyes as she encounters a self that she was not before facing her in the mirror. It is as though S. Davies is asking, “Who is this person with these ‘gazed and distant’, and possibly dead eyes? It is not the me I thought I was when I washed and dressed this morning… It is a different me, a me that is strange to my previous sense of self.”

In the quote from S. Davies she reads what she sees as another self. She invokes the concept of different selves to read the eyes that have “seen hell”. It would be different had S. Davies read the eyes as continuous with her own eyes, as having the light gone out of them, or the window to her soul being temporarily closed. If this was so, S. Davies might also have wondered how long that window would need to be closed before she could bear to open it again. In this reading she would have performed a

narratively coherent self without needing the idea of two selves, the technology of multiple selves to account for her subjectivity.

In the subsequent quote taken from her book, Aftermath: Violence and the Remaking of a Self, (2002), Brison, a philosophy professor who was also left for dead after a vicious rape and attempted murder, describes something similar when she says she left the self she was before at the bottom of a ravine. And she adds something more to this when she states she had to leave her old sense of self behind "in order to survive". I want to know at this point what it is about the old self that would stop her surviving this attack? Is it that Brison's previous self contained a sense of innocence or a magical belief in her own omnipotence and invulnerability that can come with having lived a less difficult life? Yet according to Brison, the issue is not just about a sense of loss of previously held values or beliefs, it is much more a sense of being unable to identify with the person she was before:

> In the traditional philosophical literature on personal identity, one is considered to be the same person over time if one can (now) identify with that person in the past or future. One typically identifies with a person in the past if one can remember having that person's experiences and one identifies with a person in the future if one cares in a unique way about that person's future experiences (Brison, 2002, pp. 62-63).

It is easy for me as therapist to hold in mind a perception that both Brison and S. Davies will wish, as other survivors of trauma also wish, to regain a sense of their former selves – the selves that hold the innocence of a before time. This deployment into which I have unwittingly fallen, is that of a specific technology of a "lost self", based on a linear notion of time and an idealised and stable image of the past as a fixed state to which one has lost the possibility of return. It would be equally viable to see the present trauma, for example, as proof that one can survive anything, that all one's past fears were irrelevant, because when the worst happens, one survives

unimaginable life-threatening events. Yet in Brison's example, the need to be connected to this old self is driven by a need to identify and position oneself in some form of linear narrative of self (p. 62). Brison makes the point that this need speaks to the notion of subjectivity as "narrative, as embodied, and as autonomous" (p. 62) a discursive positioning at least temporarily undone by her traumatic experiences.

So a question arises. How does it help, or not help in the accomplishment of a viable life to think of an old self as dead? How does the belief that recognition of the new self, make the new self real? Does thinking of herself as dead produce for Brison a technology of self which marks out a necessity for a transformation into "aliveness"? One more literal understanding of what makes for a "viable" life is breath, air, oxygen in order to be enlivened, an inspiration of energy. Yet the materiality of Brison's experience, being "left for dead" has to be read in the interface between her actual physical experience and what may be deemed necessary in order to bring about a transformation of her subjecthood. Just as Brison was operated on after the attack in order to deal with her severe physical injuries so that she would not die, must she be operated upon in a psychic sense to also have a future viable life? With this in mind, Brison's near death experience can not be read as simply irreducible to the biological implications. But the biologism of Brison's experience may have been acted with and through her understanding of the psychic trauma she experienced in order to hold the hope that some form of operation on her psyche would also save and give her a more inspired (oxygenated) life. This construction of her subjectivity would be therefore life-enhancing rather than life-reducing, that is, rather than "I am nearly dead", her sense of her subjectivity is transformed into "I am (in fact) nearly alive."

It is important to also note that in the extract above, Brison refers to two selves, one pre trauma, and one who survived the trauma. Yet, as she writes, she deploys another self, her "I", or observer self, capable of commenting on these other dichotomous selves. William James (1892)

conceptualised this phenomena of the “I” and the “me”, (and two "me’s" could be said to exist in Brison’s text) in this way:

> Whatever I may be thinking of, I am always at the same time more or less aware of myself, of my personal existence. At the same time, it is I who am aware; so that the total self of me, being as it were duplex, partly known and partly knower, partly object and partly subject, must have two aspects discriminated in it, of which for shortness we may call the Me and the other the I (W. James, 1892, p. 176).

In this sense, W. James points to his “double” self as Russell Meares describes it in his book, Intimacy & Alienation: Memory, Trauma and Personal Being (Meares, 2000, p. 9). But Meares elaborates this concept further when he points out that W. James points to another word which is deployed to describe W. James’ selfhood:

> It is ‘myself’. Where does it fit? Is it synonymous with ‘me’, as James implies, or is it something else. Since it is a different word, it may, like ‘I’ and ‘me’, involve a subtle but significant difference in meaning…
>
> We can come to some kind of answer to this question if we reconsider the expression, ‘I was not myself when you saw me last’. This person is saying something which, in logical terms, does not make sense. Nevertheless in a general way, we know what he means. The speaker is referring to a state his hearers know. The expression implies a certain stability for ‘I’ and ‘me’ but a potential variability for ‘myself’. In this case, ‘myself’ is not equivalent to ‘I’ and ‘me’. Rather, it is a third term (Meares, 2000, pp. 9-10).

In Brison's example, her sense of identity, from a humanist perspective, is perceived as discontinuous and therefore problematic and I argue that this discontinuity is represented through the variability of how she is not “herself”, the third term of Meares’ theorising. This specific

problematisation emanates from the push within humanistic concepts for individuals to be constituted as having identities that are "continuous, unified, rational, and coherent" (B. Davies, 2000a, p. 57). From a humanistic perspective, this strange sense or absence "undoes" the survivors' sense of who they are now, and their selfhood is problematised as something to be restored, reworked or transformed, in order for the individual survivor to again "be normal". In contrast, a poststructuralist view of subjectivity as discontinuous and fragmentary allows space for different forms of subjectivity "post trauma". At the same time, this view "does not undo" the construction of a survivor's subjectivity in terms of the original discourse that shaped it and which in turn is shaped by the survivor's responses to it.

I notice that within this examination I wonder about Brison and S. Davies' "personality coherence". Despite seeing both women as able to embrace multiplicity in terms of their own subjectivities, I still have to monitor myself as I see their experiences as "unintegrated" within their "whole" personality, as if I know what that would like look, if a "whole" personality existed as an essential construct. As a therapist, I have slipped into identity language that identifies their struggles as "lack" or their personalities as fragmented, a notion that sends me sliding into the notion of structural dissociation as hypothesised by van der Hart et al., (2005). This slippage is not good, nor is it bad; however it has particular consequences for therapeutic work with clients such as S. Davies and Brison if I view their subjectivities through a binary of integration/disintegration.

According to Brison, these retold narratives of the traumatic experience are attempts at re-authoring the experience so that some form of autonomous mastery can be achieved. Perhaps the re-telling is deployed as a form of resistance to the passive, submissive discourse of the victim, so as to embrace the subjectivity of a survivor. In this way, the re-telling of the trauma also functions to actively re-experience the trauma in such a way that different things may occur. The narrativisation of trauma is an active

movement of the experience of trauma and in this way, the experience is not a static entity.

Yet the construction that it is "essential to talk about it, again and again" as a way of achieving mastery over the trauma reflects again the push towards the notion of the self-responsible autonomous subject who will one day, be able to renounce their victim-hood, to be agent (fully-functioning, regulated and self-regulating) of their own lives. It also promotes the premise that talking about the horrible event that has occurred will not heighten unmanageable symptoms of traumatisation. Yet there is a telling and a re-telling here which can both work and work against itself, both reactivating the trauma, and also opening up the possibility that it will look different in the next telling, and so enable it to be let go, but there appear to be a number of factors necessary for the "letting go" to occur.

Exposure Work

In treating traumatic symptoms which involve flashbacks and intrusive thoughts or images, "exposure therapy" has come to the forefront of intervention, particularly for single event traumatic memory (Keane & Kaloupek, 1982; Foa, Steketee & Rothbaum, 1989; van der Hart & Spiegel, 1993). Its focus is to expose a trauma sufferer to aspects of the traumatic experience, a specific intrusive memory of a distressing event for example, by asking the client to talk about it in detail in the session. The prescription for work of this kind involves a first phase of treatment that consists of the all important focus on safety (Herman, 1992). This entails, according to also Ford, Courtois, Steele, van der Hart and Nijenhuis (2005) and Kuyken et al. (2008):

1. soundly building a therapeutic alliance by using empathy and modelling, through my responses, a "containing" environment, so that I can hear very difficult revelations without becoming overwhelmed by them

myself, thus modelling the capacity to manage the seemingly unmanageable;

2. reducing the risk of suicide, self-harming and impulsive behaviours including substance abuse, eating disorders or aggressions towards self and others, by replacing them with skills and strategies which enable the client to manage these overwhelming states (Linehan, Tutek, Heard, & Armstrong, 1994);

3. increasing the client's ability to manage her emotional states;

4. improving the client's access to nurturing beliefs and strengths;

5. working with attachment issues in regard to early caregiver and subsequent significant relationships in order to strengthen the client's experience via the therapeutic relationship.

This phase also involves psycho-education which "demystifies" (Ford et al. 2005, p. 438) the process of treatment for the client so that she can become aware of how her suffering is understood clinically, that is "the biological, psychosocial, and traumatic aspects of symptoms and disorders" (p. 438). It is also part of this treatment to assist the client to increase her ability to access support networks which would help her manage any subsequent crisis which may ensue (Pearlman & Courtois, 2005) and to challenge any negative beliefs. If for a moment I were to imagine myself working individually as a therapist with either Brison or S. Davies, I would endeavour to avoid the phrase "how you were before", which is based on identity language that draws on notions of a permanently lost self. I would cautiously invite them to consider a notion of selfhood which can survive what they otherwise thought was impossible, by asking them details of the resources they drew upon to survive, and in so doing improve each survivor's access to their own internal and external resources. Asking a question that assumes each woman had the resources not to be overcome by their terrible experiences is an intervention that can function to open up the possibility of a construction of each survivors' subjectivity consequent to the trauma as viable and livable.

The second stage of exposure therapy involves working with memories of trauma with the intent of gaining what Harvey (1996) describes as “mastery over memory”, in which traumatic or implicit memory is moved into autobiographical memory. The conceptualisation of memory as implicit or explicit, traumatic or autobiographical is explained in subsequent chapters in greater detail, however once first phase coping strategies and significant affect management have been established, the focus of exposure work with clients shifts to encouraging the client to voluntarily and safely process memories of trauma. Through increased self-regulation, the secondary goal is to resolve the physical, emotional and cognitive sequelae of symptoms that have resulted. As Ford et al. point out, there continues to be much controversy as to when and how these memories of trauma should be focused on whether it is necessary for therapy to focus on the memories at all (p. 439). The shift in focus from establishing safety to memory processing can either be initiated by the client, initiated by the therapist or is done in a transparent collaborative approach in which the therapist and client continually assess the readiness to continue this process in the light of the client's ability to manage their emotional states; the specific plan for memory work depends on the therapist's preferred treatment plan and the presenting symptoms which the client brings to the session.

The third phase of exposure work is focused on “enhancing meaningful ongoing involvement in viable interpersonal, vocational, recreational, and spiritual relationships and pursuits” (Ford et al., p. 438). This phase involves assisting the trauma sufferer to build relationships with significant others that are sustainable and enriching, engage in activities that enhance sense of meaning and purpose through working in paid or unpaid employment, make a contribution to some community enterprise, and/or to simply find pleasure in the activities of everyday life. However all three phases are dependent on the quality of the client/therapist relationship in regard to the experiences of safety and empathy.

The Therapeutic Relationship

In Chapter 2, I noted that in the first part of the 20th Century neuroses were perceived to emanate from unresolved biological imperatives that Freud conceptualized in his famous drive theory until a paradigm shift occurred when the emphasis in therapy moved to early childhood experiences of mothering. These experiences, or lack of, were implicated in the failure to satiate drive experiences and eventually, drive theory was de-emphasised with the advent of object relations theory in which the libido was re-conceptualised by Douglas Fairbairn (1952) to be object seeking (for the (m)other) as opposed to pleasure seeking. Harry Stack Sullivan (1953), Donald Winnicott, (1971), and Heinz Kohut (1977) and other leading psychoanalysts moved to privilege the notion that the healthy development of a child takes place in the relationship between caregiver and infant. Psychological models focused on the mother-infant relationship emerged in post World War II Britain, Europe, North America, Australia and New Zealand. This privileging of the importance of the mother and child relationship occurred at a time when men had returned from battlefields and women were required to return to primary house-keeping and care-taking roles after having worked in munition factories and office jobs in what were previously male-occupied domains prior to the war (Coleman, 1995). In the 1950's, even greater emphasis was placed on a woman's role as housewife and mother as evidenced by the literature and media of this period (Hartman, 1982), and it is of note that the child's psychological well-being, which had previously been constructed on libidinal drives that privileged the role of the father (for example, Freud's Oedipal complex), now emphasised the quality of her or his relationship with the mother (Bowlby, 1940; 1960).

Bion (1970) first conceptualised the experience of empathic engagement by the therapist with the client through the metaphors of maternal reverie and the therapeutic container. The "contained" is perceived to be the baby or patient/client whilst the "container" is the mother or therapist. Bion's theorisation forms a basis to notions of wellness which are perceived to

emanate from an individual's "integration" and sense of "coherence" – concepts which I began to discuss in the previous chapter in relation to the narrativisation of experience. His conceptualisation attempts to explain the relationship between the somatic experiences of both therapist and client and the nature and function of the empathic connection experienced in the therapist/client encounter:

> The 'contained' evacuates unpleasure in order to get rid of it, whilst the 'container' accepts and modifies these primitive emotions and transforms them into a coherent and meaningful pattern. In maternal reverie, the infant's own feelings are similarly too powerful to be contained within his personality and he therefore arouses in his mother feelings of which he wishes to be rid. She accepts these unwanted feelings and modifies them so that they can be taken back by the infant in a more tolerable form… Mental health is therefore based on the responses of the parents to the needs of the infant – their capacity to intuitively contain the unthinkable, unknowable and indescribable experiences of the infant and survive (Stein, 1999, p. 184).

Bion named the above experience as "O", theorising that it worked as a model for the client's adult relationship experience with significant others. Thus "O" emerged conceptually as the container that safely held experiences of un-integration, incoherence and unknowing long enough for the process of integration and developing coherence to take place. According to this perspective, it is in the interaction with nurturing caretakers that a coherence of self is believed to emerge: such as when a baby smiles and the parent smiles back, or when a child falls over and the parent responds by attempting to soothe the child and recognising that some injury has taken place. These mirroring responses serve to shore up the child's sense of entitlement to express their feelings and needs around significant others. When a caregiver indicates to a crying child that the adult is sad because the child is sad, a mutuality is conferred which provides

a legitimacy to the child's experience that can be brought forward into adulthood.

Problems of Containment

Sue Austin (2002), importantly, I believe, critiques the aforementioned models of mother/infant observation and the notion of containment, reminding theorists of the origins of this accepted surveillance practice for trainee clinicians/observers post Second World War at the Tavistock Clinic in London, in order to draw attention to the power relations inherent in these models. Her discussion focuses on the infant observation discourse, adopted by Child Guidance Clinics as a result of this earlier work and theorising of Winnicott, Bowlby and Bion, which still operates within psychoanalytic training. Austin challenges us from a critical psychology perspective:

> ... to move away from the clinical focus of the task, which is to think about the baby and infantile states of mind. This is necessary in order to question [... the] image of a third party who has never met the parents and baby in question having a moment of Proustian clarity about their relationships. Shifting the focus in this way invites the Foucaultian question: who does this fantasy of insight or knowledge serve? ...
>
> Object relations, as a parent discourse of infant observation, assumes that a phenomenon called containment exists and that it is universally experienced as 'good'
>
> (Austin, 2002, p. 113).

Austin also notes that containment which insists on an "ultimate (maternal) presence" has been made to be "'the' legitimate object of desire" (p. 121) and points to Samuels (1993) earlier work:

> Object relations theories unwittingly perpetuate the political status quo... Object relations theories focus on intrapsychic and

> interpersonal explanations for personality development and dysfunction. They tend to rule out sociopolitical or other collective aspects of psychological suffering. The version of personality that object relations presents, with its accent on the decisive part played by early experiences [and] maternal containment ... is, in many senses, little more than a reproduction of the kind of personality that the culture which surrounds object relations already valorises (Samuels, 1993, pp. 275-276).

What Samuels and Austin are saying is that any emphasis on changing a patient or client's experience of self via a relationship modelled on the earliest relationship of all, that of the mother and the child, was built on constructions of the perceived make-up of the individual's internal world, (Ghent, 1992), without attention being made to the pervasive embeddedness of the subject within the social. This focus on "objectively" examining the experience of self of the psychoanalytic patient as mediated between self-object and child-parent experiences then works to produce the desire for this entity called "containment". Yet "containment" theorised on the basis of primary maternal care may not be possible or appropriate within many contexts due to sociocultural differences in work practices, the availability of resources, social and familial understandings that may or may not focus on dyadic rather than broader family and/or community interaction with an infant, and overall economic and political stability.

My thesis, then could slip into belying the struggle of navigating a both/and trajectory when accounting for theories which inform my work and simultaneously allowing for their subversion. I act as the panopticon when I pronounce "good enough" attachment (containment) in my observations of parents and families; to counter this, I must then turn the gaze on myself and recognise that I can never be an objective observer, even though I am produced within relations of power to sometimes be the objective expert on the constitution of "good-enough" parenting.

By conflation, the "good-enough" therapist has become central to facilitating more positive re-enactments of the patient's early child-caregiver relationship which functions to mould the patient's experience of self. Well known trauma expert John Briere & Scott (2006) write accordingly that a patient's experience of self requires a safe external environment. An environment which requires hyper-vigilance because of potential emotional or physical threat, does not allow for a child to experience the introspection necessary for development when all survival cues are turned to the external world. Meares (2000) similarly refers to the development of autobiographical memory and the ability to reflect when he talks about the "doubleness of consciousness" (Meares, 2000, p. 39), which is dependent on the ability to notice, for example, "I am thinking", or "I have thoughts", cognisant that an observing self is aware of a thinking or feeling self. So in providing a safe space in therapy for a remodelling of a poor child-parent experience, it is necessary for there to be a "good-enough" therapist available to the client. She or he then becomes more able to "explore his or her internal thoughts, feelings, and experiences and... form a more positive attachment to the therapist..." (Briere & Scott, 2006, p. 151).

A consequence of attention being focused on the ability of a therapist to recreate a more nurturing and containing environment for their client also broadened the range of traumatised clients for whom the talking cure had been a viable option for treatment. Therapists emanating from the school of self-psychology, which is based on Kohut's (1977) central notion of the self-object, would now work with clients who suffered psychological conditions usually excluded from intervention. For example, narcissism could now be treated: this condition is described in DSM-IV as an enduring pattern of self-importance and grandiosity which demands constant admiration and attention from others because of a pervasive sense of entitlement. A narcissistic person is perceived to be devoid of empathy for any other person because for the narcissist, "the other" doesn't exist. All others are merely reflections of the narcissist's self. Self-psychology allowed psychopathology such as narcissism, previously described quite negatively, to be viewed as a condition perceived to emanate from "parental

failures in empathy" (Aron, 1996, p. 7). Thus a person perceived to have a narcissistic presentation became amenable to cure through the operations of the therapeutic relationship. Briere & Scott (2006) similarly focus on those clients deemed to suffer the most disastrous relational disruption through their lives, that is, those people diagnosed with borderline personality disorder. Amongst other symptoms, people diagnosed as "borderline" suffer intense emotional outbursts in reaction to what others would perceive as unimportant interpersonal encounters and may engage in impulsive self-destructive behaviours in an effort to reduce or self-medicate reminders of abandonment or rejection or loss:

> A fair portion of such behaviour and symptomatology can be seen as arising from triggered relational memories and conditioned emotional responses associated with early abuse and abandonment, rejection, or lack of parental responsiveness, generally in the context of reduced affect regulation capacities. The 'borderline' individual may attempt to avoid the associated distress by engaging in activities such as substance abuse, inappropriate proximity seeking (for example, neediness or attempts to forestall abandonment), or involvement in distracting, tension-reducing behaviours (Briere & Scott, 2006, p. 155).

When the focus of therapy first shifted to the mother/child relationship, its basis nevertheless rested on individualistic notions of the self. It was not until the term "intersubjectivity" entered this field of intervention that a further paradigm shift occurred. Winnicott (1971) and particularly Atwood and Stolorow (1984) used this term to describe the meeting of two subjectivities rather than the meeting of only one subjectivity, the self of the baby and of an object, the mother. This particular shift required a re-alignment, from the meaning-making of the mind of the individual patient or client, to which most psychotherapeutic discourses are committed, to an engagement with the process of meaning-making as produced through relational processes. This in turn led to the proposition that meaning cannot ever emerge from an unadulterated individual origin. Seeing individuals as

"autonomous agents" and relationships as "secondary and as derivative by-products of individual units" (Aron, 1996, p. 138) became a limited proposition. The "impoverished language of relatedness" did not do sufficient justice to the way relationships are active in "wishing, hoping, or fearing" (Gergen, 1991, p. 160). Gergen states,

> … To appreciate the possibility [of selfhood], two preliminary steps are useful: first to bid final adieu to the concrete entity of self, and then to trace the reconstruction of self as relationship
>
> Kenneth Gergen, 1991, p. 140.

Auerbach & Blatt (2001) provide a recent, more comprehensive account of intersubjectivity theory. They, along with Kenneth Gergen (1994), describe a third paradigm shift which occurred in psychoanalytic thinking. This fundamental alteration occurred with the advent of postmodernist, constructionist, constructivist and poststructuralist theories that understand knowledge and truth as generated within the social, thus pointing to the multiplicity of what may stand for "truth" which itself sits within multiple socio-cultural-political regimes of power/knowledge systems. Following upon the foundational work of Gregory Bateson (1972), in therapeutic terms, the therapist no longer could be perceived as an objective observer of the intra-psychic world of the client; rather they are implicated and implicate the construction of the world of the client producing what family therapist, Lyn Hoffman (1991) describes as "a world of mutual influence and constructed meaning" (Hoffman, 1991, p. 78).

Characteristics of the client's personality and their construction of self via the ways they negotiate relationships with others can be gleaned from observing the developing relationship between therapist and client. However, in making observations about the quality of this relationship, the therapist must also, "see how they themselves are embedded as participants in the very field that they are simultaneously observing" (Aron, 1996, p.

140). Opinions and diagnoses made by the therapist are always made from within this field of intersubjectivity, not from a neutral outside position. As such, analyses made by the therapist mirror the therapist's own subjectivity as well emanate from any personality traits of the client. Therapists glean information about this relational system through their own observations and subjective experience and from the information the client has gleaned about them and the client's opinion of the therapeutic dyad. It is limited, then, to see individuals as autonomous agents "determining relationships". In a recursive fashion, relationships also construct individuals. Relationships themselves, therefore, are not only implicated, they are intrinsic to the production of individuals. Thus, relationships decide individuals and individuals decide relationships. In embracing these kinds of ideas to greater or lesser degrees, many analytic theories of mind have now made the transition from positivist to constructivist ideas and also from individual to relational notions of meaning-making in the production of subjectivity. In particular, the notion of intersubjectivity has allowed subjects previously perceived as unamenable to cure to enter the landscape of psychological intervention.

A Systems Approach

In 2005, when watching a video of therapeutic work with a Vietnam Veteran at the Australian Society of Traumatic Stress Conference in Adelaide in 2005, I remember being struck by his answer to a question right at the end of the interview. Most of the tape focused on the veteran's experience of exposure therapy, but after revealing details of the many traumatic images and sensations which had haunted him, the man's answer to the question of what was "the worst thing?" about his experience of traumatisation was exceedingly salient when he stated, "The worst thing? The worst thing was when my wife left me." Despite seeing mates die in battle and the deaths of women and children, the most difficult and painful issue for this Vet to overcome was the loss of relationship with his wife

which was brought about, he assumed, by his violent temper and irrational outbursts that appeared to have arisen as a result of his experience of traumatisation. Similarly, other survivors of trauma also report having difficulty sustaining meaningful relationships with others and this, as well as management of disturbing symptoms, has become one of the powerful motivating forces for attendance in therapy.

Butler (2004a), similarly refers to our relational “beingness” (my word), in the way that we are both constituted by our relations but also dispossessed by them” (p. 24), when she states that at “our most intimate levels, we are social; we are comported toward a ‘you’…. ” (p. 45) and it is this comportment which propel us as dispossessed through grief and loss and trauma and violence to be “beside oneself with rage or grief” (p. 24). Whilst this also fits with an object relations focus, I take Butler’s meaning in regard to our constitution as relational beings in the world to have greater implications for the work of systemic therapy. Systemic therapy focuses on interventions that are deployed in the recursive processes of our interactions with significant others.

As a consequence, a **systemic** perspective is an alternative lens for conceptualising and practicing a relational cure in therapy. The traditional psychodynamic view, described in the previous section, focuses on the therapeutic relationship, that is, the relationship between therapist and client. In this perspective, client and therapist relational experiences are perceived to replicate the client's early child-caregiver relationship and this replication and the intrapsychic “self” that emerges, is the focus of intervention. The systemic perspective, on the other hand, which emerged prior to and developed alongside post modernist and social constructionist lenses, largely omitted to consider individualistic constructions of self. Social worker and family therapist, Carmel Flaskas (1999), notes that the notion of the family system was and still is dichotomous to the notion of the individual self and in this way mirrors the juxtaposition of systemic versus individualistic or psychoanalytic therapies (Flaskas, 1999). From this stance, the therapist is viewed as the facilitator of improved

communications, attachments and meaning making between members of a system, usually a family but where possible, wider systems including educational, health and legal power/knowledge institutions. Negative experiences between family members (and wider systems where possible) are reworked in session so that negative interactions between significant others change. The quality of the relationships is thus improved and sustained over time, even trans-generationally. For example, a woman who perceives her partner has been unavailable to her emotionally may, through therapy, experience her partner differently once the partner resolves some issue which may have blocked the extent to which the partner could be intimate. Whilst this work may be intrapsychic for the partner, the behavioural interactions and beliefs about their spouse are challenged at the same time, hence the systemic underpinning to the work. In so doing, conflict may de-escalate between the couple, and the children of the relationship may experience greater attentiveness to needs that were otherwise overshadowed by the stress in the family. When a parent is perceived to be able to show greater attentiveness to their child, attachment theory (which has now been deployed within both psychodynamic and systemic therapeutic modalities) suggests that the child may also have an improved experience of selfhood as the attachment to the care-giver has become more secure (cf. Fairbairn, 1952; Winnicott, 1971; Bowlby, 1971; and Kohut, 1977). In addition, the child who now experiences a parent as more available to them, also experiences themselves as more loveable or less the "cause" of the conflict if arguments have arisen about how either parent responds to the child. This in turn operates, it is assumed, to produce an adult child who is also more available to attend to the needs of their subsequent children.

This meaning making not only extends to the quality of present and future relationships. It is both mediated by and challenging to the social narratives that are encompassing but not limited to, gender, culture and class. For example, the social narrative about what makes a "good" parent can be deployed by the therapist to evoke different behaviours in the client, based on discourses about parenting that are available. The therapist punctuates a

particular narrative, when, as in the earlier example, availability to one's child is put forward as a positive result of changed behaviour. The desired "change" or "healing" occurs when meaning about the behaviour changes, thus the narrative which is deployed to account for relational experiences is inextricably linked to the production and reproduction of narratives of selfhood, and in a systemic approach, the examination of the relational system is the experience of self (Flaskas, p. 23). What Flaskas is saying is that the experience of relationship is unequivocally linked with the experience of self: "You love me therefore I am loveable," or "I am a good parent because I am (now) more attentive to my child".

In my own work with clients, I regularly invite more than one member of the same family to join in the therapeutic work. My personal view is that facilitating transformation in the nature of the relationships between people in families and wider systems is far more healing and effective in the treatment of trauma than working with one person alone. Specifically this approach works to create an active recognition (a concept on which I will elaborate further in this chapter) by members of the person's family system of the other's experience of suffering – a recognition that is sustainable outside the therapy room. Thus, I work from a systemic basis even when I only see one member of a family system. I look with the person at how the person's sense of self was reinforced or undermined within their significant relationships. I may invite their "significant others" into therapy and examine the recursive behavioural patterns that reinforce certain perceptions of selfhood, others and the world. Depending on my level of engagement with them, that is, the safety of our shared inter-subjective space and therapeutic relationship, I would challenge behaviours and beliefs which were not working for their "self in relationship". Hence as a general rule I focus on the perceptions of the individual's interactions with significant others and work to facilitate sustainable change even if other members of the system never attend, particularly a parent's children.

It is significant that much of my early training was conducted in an Australian version of the British Child Guidance Clinic, which was, and

arguably still is, despite the resistance of many leading family therapists, one of the institutions still operating within "a hub of a programmatic movement for mental hygiene; drawing together the powers of the courts over children who had done wrong, and parents who had wronged them, the universal obligatory scrutiny of conduct in the school, and the private anxieties of family members about the behaviour of their children, into a powerful network linked by the activities and judgments of doctors, psychologists, probation officers, and social workers" (Rose, 1989, p. 131).

Given this, I want now to demonstrate what a reflexive attention to my embeddedness within "a programmatic movement for mental hygiene" can produce when responding to a family that has suffered domestic violence. Whilst my intention when working with this family was to open up more possibilities for viable subjectivity after trauma, it became obvious that there remained a discursive imperative to continue to produce certain kind of governable subjects when I found myself focusing on the dyadic relationship between a mother and her son.

Katrina brings her son, Daniel, aged 9 years, to therapy. He is, Katrina says, uncontrollable and he is hurting his younger sister Chelsea, who is aged 4 years, by being too rough. In the first interview, which was taped with th*e family's permission for training and teaching purposes, these three* members of the family are present. Katrina tells me her relationship ended with the children's father three years ago after an incident in which he threatened to kill Katrina and the children. Both Daniel and Chelsea are medicated for Attention Deficit Disorder (ADD).

Daniel: (sitting on a chair, leaning it towards his mother, interrupts), "Yep! That's what he said!"

Chelsea: (drawing on the whiteboard with markers, nods emphatically towards LM) "Yes he did!"

LM: "So your dad was very violent?"

Katrina: "Yes. He still threatens me even..."

Daniel: (interrupting) "My dad has an uncontrollable temper, just like me."

LM: "It's uncontrollable?"

Katrina: "Well you could try to control your temper, Daniel or you will be just like your daddy."

Daniel: "My dad's a bad man, that's what he is (moving out of his chair to show me a scar on the back of his hand). Look what he did to my hand!"

Katrina: (to LM) "He thought he was teaching Daniel a lesson."

Daniel: "It still hurt though."

Katrina: "He dropped hot oil on Daniel's hand when Daniel was too close to the stove."

Daniel: (holding out his hand for LM to inspect) "It was to teach me a lesson because I was in the way."

LM: "That must have been very sore, Daniel."

Daniel: (turning back towards his mother, rubbing his hand as if it was still hurting now) "It hurt, didn't it Mum?"

Katrina: (without looking towards her son) "You're alright."

LM: "Katrina, you said he still threatens you?"

Katrina: "Yeah, because he's only allowed supervised access with the kids."

Daniel: (swinging his legs on the chair, interrupts) At Macca's, but Grandma Tracey has to come."

LM: "Grandma Tracey? That's your dad's mum?"

Daniel: "Yeah. She bought me a cricket bat last week for my birthday."

LM: (nods and smiles at Daniel) "Daniel, you said your dad was a 'bad man'?"

Daniel: (again leaning forward in his chair towards his mother) "He's bad alright! And he's crazy in the head! He has a gun, hasn't he, Mum? And he isn't allowed to have one!"

Katrina: "That was ages ago Daniel. It was unlicensed but it was reported to the police. Anyway he's been away at the mines in WA for six weeks now and he's got another girlfriend."

Daniel: "Well if Daddy comes back with his gun, I'm going to wait behind the door and hit him with my new cricket bat, that's what I'm going to do!"

(Daniel stands up from his chair, starts to pick it up to raise it over his head as if it was the cricket bat and starts to swing it as if swinging at an assailant).

Katrina: (stays seated without moving towards Daniel and speaks in an exasperated tone) "Don't do that Daniel."

Chelsea: (runs to Daniel, grabs a leg of the chair, tries to pull it away from him, and then echoes her mother's tone of voice) "Stop it, Daniel!"

Daniel: (pulling the chair hard away from Chelsea so that she loses her balance and falls over, says indignantly) "I'm just showing you what I'll do if Daddy...."

Chelsea: (crying loudly, punches Daniel, then runs to stand behind her mother).

Katrina: (pulls Chelsea towards her and placing her on her knee) "See what you've done Daniel! You hurt Chelsea!"

Daniel: (standing as close to his mother as possible whilst attempting to avoid Chelsea's attempts to kick him whilst she sits on her mother's lap)

“She just punched me! And Mum! She's trying to kick me too!”

Katrina: (ignoring Daniel, turns towards LM) “See what I mean?”

As with any clinical work, my first priority is the family's safety and this appears to be established, at least temporarily, by the information that the children's father is working away in Western Australia and that he is distracted, I assume, by a new girlfriend. At the same time as I am taking in the content, I am assessing for possible trauma responses as well as noting information about the quality of the attachments in this family. I am thinking a number of things, some of them contradictory as I try to hypothesise about the family’s strengths and difficulties:

- Daniel appears eager to talk about what he's been through.
- The children appear to be included in open discussions about their father.
- The children may be privy to many adult discussions.
- The children, or at least Daniel, have witnessed their father's violent behaviour.
- Daniel may be quite traumatised depending on how he has processed what he has witnessed.
- Daniel is still scared his father will come back and try to hurt the family.
- Daniel says his father is “bad”.
- Daniel is struggling to be different to his father by embracing a hero narrative as a protector of his mother and sister. This calls Daniel into a more viable subjectivity.
- Daniel also holds a similar subjectivity to the one designated to his father as that of an angry person with an “uncontrollable” temper.
- Daniel is quite articulate for a child who is described as uncontrollable.
- Katrina maintains an almost casual attitude to the past violence.

- Katrina may maintain this attitude in order to nonverbally stress that the violence is a thing of the past and the family is safe now.
- Katrina minimises the severity of the violence with the effect that the violence is normalised.
- Katrina, even now may be numb, even dissociative to cope with the feelings of terror her ex-partner's violence may have invoked.
- Daniel appears to be attempting to reach out to his mother.
- Katrina appears to be ignoring these attempts.
- Katrina has not as yet shown empathy towards Daniel.
- Katrina is concerned about her son's capacity for violence whilst at the same time suggesting that Daniel can be different to his father. The subjectivity in which Katrina views Daniel is therefore very ambivalent. This appears to create ambivalence in Daniel's perceptions of his own subject position.
- Katrina does not appear to acknowledge the part Chelsea plays in interactions with her brother.
- Katrina demonstrates appropriate attachment with Chelsea.
- Chelsea appears to have an appropriate attachment towards her mother.
- When ignored by his mother, Daniel will reach out to others, such as the therapist.
- Katrina and the family doctor believe that both Daniel and Chelsea are ADD. This produces a subjectivity in which the violence that the children have witnessed, disappears.

My expert position with the family endows me with the power to pronounce what is "normal" and what is not. I am invested socially and politically with positional power that produces me as the auditor of relationships in that I can make judgements about the members of this family and the quality of their relationships with the consequences that these opinions are considered superior to those that the family may hold. When these opinions are communicated, either verbally or non-verbally, this in turn makes available to each member certain subject positions which they can accept or resist,

taking into account that certain subject positions have already been taken up by each person given the responses and interactions of other members of the family and the larger systems in which they are embedded.

The family has certainly suffered events which are considered overwhelming. I, as the therapist, am not looking only for signs of distress reactions to these events, I am also looking for signs that a family member is not having enough of a reaction to these events. In so doing, I invoke certain possibilities for Daniel in the way I may respond to him which can include that of (a) traumatised child, (b) potential abuser like his father, (c) a child with attachment difficulties, (d) a child with a conduct disorder, (e) a child with attention deficit disorder, (f) the family scapegoat, (g) bullied older brother, (h) parentified child (that is, a child who has knowledge or responsibility which is inappropriate to his age), (i) abused child, and (j) child-at-risk of harm, (k), the protector and heroic child, etc.

Katrina, alternatively, may be called into taking up some of the following subjectivities in her work with me: (a) caring mother, (b) neglectful and uncaring mother, (c) battered wife, (d) bad mother, (e) woman with a dissociative disorder, (f) "good-enough" mother, (g) mother who has not provided a secure attachment for her son, (h) woman with dependent personality disorder, (i) mother who favours one child over the other, (j) "co-dependent", and so on.

The particular subjectivities that are called into discursive existence in my work with the family can be productive of viable lives and relationships or work against those possibilities. In my subsequent work with this family, I proceed to work to enhance the attachment bonds between Daniel and his mother, because I assess that Katrina is not as attentive to Daniel "as she should be". I have noted that Daniel consistently looks towards his mother for acknowledgment – he moves his chair towards his mother's chair in session but Katrina is generally unresponsive to this movement and he seeks her out for comments and validation – "It hurt, didn't it Mum?" Daniel appears to want his mother to recognise him as a subject, rather reduce him

to a ‘bad person’ like his father, who needs to be sorted out through the intervention of family therapy.

A strength of family therapy work is that the behaviour of a family member can be reframed in a positive systemic way, for example, Daniel reaches out to his mother in order to bring her closer to him rather than to just “get attention”. Katrina’s ignoring behaviour could be reframed as necessary in order to protect him from her anger should she show it, with the effect a more positive relationship is maintained between mother and son. But whilst I find these very good working hypotheses, the pervasive discourse around attachment still pronounces the relationship between Katrina and Daniel “as not secure enough”, so in subsequent sessions I work to assist Katrina to respond more actively to Daniel, indeed to initiate responses to him which are not predicated on only reacting to his “bad” behaviour.

Pushing me in this direction is research knowledge (K. James, 1999) that suggests that boys who witness violence towards their mothers by their fathers are more likely to become violent towards their partners. I feel a moral responsibility to intervene effectively so that this does not occur, believing that a repair in the attachment bonds with his mother will pre-empt this, as will a focus on structural interventions which allow Katrina to exert her authority and to respond appropriately. Nevertheless, a moral responsibility has been discursively inscribed upon me and I discursively emphasise this already discursively produced inscription on Katrina. This does not mean this is wrong, but it does produce my own subjectivity as that of moral regulator and agent. I perform this subjectivity as if this agency is wholly mine, rather than that which has already been discursively produced. This means that I too am implicated if these interventions fail. This mirrors the discursive imperative for mothers to continue to produce children who then themselves become moral ethical subjects, despite the role that has been played by the abuse of other significant others, in this case, Daniel’s father. Both I and Katrina have to be “good-enough” – Katrina in order to produce a moral and ethical subjectivity in Daniel, and myself in order to produce the same in Katrina.

As I reflect on my above discussion, I notice that Daniel's father has disappeared from scrutiny. This does not mean that I don't see his behaviour as having been severely abusive; I do. This does not mean I refrain from naming and validating Katrina and Daniel's experiences of fear and even terror. But the intervention remains the responsibility of myself and Katrina and, to a lesser extent, Daniel. And in this sense, I reproduce a gendering that sees women as responsible for relationships, rather than focus on the original abusive behaviour which most likely hijacked Katrina's ability to parent Daniel differently.

Further discussions with Katrina in a later session elicit information which explains Katrina's reticence to respond more actively to Daniel. She is afraid that Daniel will turn out like his father because she is scared of Daniel's growing strength and capacity for physical (male) violence. It is not just because Daniel is his father's son that Katrina is afraid of Daniel's capacity for violence. It is Daniel's very maleness, a gendered category of subjectivity that scares Katrina and this produces in her debilitating fear and ineffectiveness when dealing with Daniel even though she is still physically stronger than Daniel is now.

Katrina and Daniel's individual and collective responses to these events have become available to scrutiny through their attendance at therapy, which operates to produce them as subjects amenable to regulation. I do not escape implication as a member of this network that works to regulate the way families behave and thus reconstitute particular forms of human subjectivity. As a therapist, I am working to produce certain kinds of subjects, as I name them and call them into being in the Althusserian sense (Althusser, 1971; Butler, 1997). When I focus on improving the quality of Katrina and Daniel's attachment, they are produced as subjects who are implicated in a failure of parental empathy during early childhood development rather than subjects who have experienced domestic violence.

In the next example, I provide an extract of work I undertook with a woman whose experience of parental attachment produces more obvious traumatic symptoms. I provide this example to show that whilst I am mindful of the effects of violence, particularly violence perpetrated by males against women and children, I cannot help but move back into more of attachment focus and concentrate on the quality of therapeutic "container" to bring about change.

Thirty-eight year old Donna[3], who has a history of self-harming behaviour, was sexually abused by her elder brother who was ten years her senior, from the age of three years until she left home when she was twenty-two years old. Donna was diagnosed with borderline-personality disorder, when she was hospitalised after a suicide attempt at the age of sixteen years. *Note how this interaction below requires a focus on "minute particulars" (Hobson, 1985; Meares, 2004, p. 51):*

Donna comes into LM's office. Her manner which is characteristically shy is unusually absent. She tells LM she has been able to get her learner's permit. LM smiles and congratulates her.

LM: "Well done!"

Donna grins. Then quickly wipes her hand over her mouth and looks away embarrassed. She looks back at me anxiously and wipes her mouth again.

LM: "You smiled. Then you moved you hand across your mouth."

Donna becomes more agitated, is looking around the room, looking everywhere else but towards LM.

LM: "You shouldn't smile?"

Donna, looking more desperate, continues to rub her face.

LM: "You looked like you wiped your smile away?"

[3] Significant identifying details have been changed.

Donna: “Yes.”

LM also notices tears are welling in Donna's eyes.

LM: (Gently, leaning forward towards her) “Why?”

Donna: (Leaning back in the chair) “I can’t smile.”

Donna suddenly looks stricken. She stands up, faces the window, rubs her face and mouth anxiously and sits down again. She rubs her face as if scrubbing it with a flannel.

LM: (With dawning realisation) “When you were growing up were you told to 'wipe that smile off your face?’ Just like you did then?”

Donna doesn't answer. She quickly dabs her eyes but there is no noticeable pause. I notice her expression is bland, sightless and dissociative. She starts to tell me about going shopping the day before with her mother and sister. I think that is the most she can stand in terms of showing her vulnerability today and I follow her digression for now.

The day after this meeting, I am told by Donna’s GP that Donna came for her medical appointment in a very dissociative state. The GP is surprised because these episodes have been less frequen*t, at least during Donna’s* most recent medical appointments. I reflect on my session with Donna and my verbal response to her smile.

This reactivation of her trauma system seemed to occur when Donna let herself smile, and it is obvious to me, as someone trained in the technology of transference, that the experience has brought up terrible feelings of dread, perhaps terror as though I have become the mother who might demand that Donna “wipe the smile off her face”. Meares (2000) describing moments such as the above, writes that “memories of a state in which one’s feeling of personal existence are overthrown are registered implicitly as a stunted narrative; a ‘script’ which tells the individual he or she is bad, inferior, useless, and so on, confronting a traumatising other, who is critical,

alienating, controlling, and so on" (Meares, 2000, p. 3). As in the previous example, my training again leads me away from an emphasis on the effects of an identified crime of violence (in this case childhood sexual assault) and into the territory of attachment theory and the failure of maternal care.

The absence of a caregiver's attunement to a child's developing sense of self is regarded neurobiologically to be implicated in "reducing the orbitofrontal cortex's capacity to regulate cortical and autonomic processes" (Briere & Scott, p. 150; Siegal, 1999). This reduction in turn is believed to motivate negative defence mechanisms which impede the developing child in relationship. This recursively is seen by theorists to impede the development of a coherence of self. Significant to this specific development is the role of mirror neurons. In a child's development, mirror neurons are believed to play a significant part in enabling an individual to assess another person's mood, copying certain actions, experiencing empathy with another person. Stern writes,

> Mirror neurons sit adjacent to motor neurons. They fire in an observer who is doing nothing but watching another person behave (e.g. reaching for a glass). And the pattern of firing in the observer mimics the exact pattern that the observer would use if he were reaching for the glass himself. In brief, the visual information we receive when we watch another act gets mapped onto the equivalent motor representation in our own brain by the activity of these mirror neurons. It permits us to directly participate in another's actions without having to imitate them. We experience the other as if we were executing the same action, feeling the same emotion, making the same vocalisation, or being touched as they are being touched… Clearly, the mirror neuron system may take us far into understanding (at the neural level) contagion, resonance, empathy, sympathy, identification, and intersubjectivity (Stern, 2004, p. 79).

Without actually having to imitate or copy another's actions, our mirror neurons fire as if we had performed the action ourselves, suggesting that we

literally “go through the motions” in our head. As such, mirror neurons are part of what is believed to assist “implicit knowing” which is “nonsymbolic, nonverbal, procedural, and unconscious in the sense of not being reflectively conscious” developing in the non-verbal register of a child’s experience (Stern, p. 112). With Daniel in the earlier clinical example, I also hypothesised that he would have identified with both his mother (and his father) through this process. Seeing his mother threatened and physically hurt many times as it came out in further sessions, created a resonance with Daniel as if it had happened to him, so that his mother’s trauma became his trauma. With Donna, I think she would have learned at a very early age that she had to smother her smile. Whether she learned this from being sexually assaulted by a much older brother from age three, from implicit and explicit maternal messages, or from both, it seems that she had come to embody an early prohibition on showing this particular sign of pleasure, amusement or recognition. Ainsworth, Blehar, Waters & Wall’s (1978) attachment research, demonstrated that a baby at 12 months knew at an implicit level how to hold their face and body, what feelings to show, what expectations to have and what expressions to hold back when the baby’s mother returned after a short absence from the child. The baby knew whether to move towards his mother, to appear to ignore her, to protest or to demand her attention by crying loudly. Without language, this implicit knowing appeared to operate outside conscious awareness, yet it nevertheless motivated the baby’s reactions to their mother. Donna, as an adult, had some conscious awareness of the need not to smile, but it is doubtful that she would have needed a sense of this in the realm of the explicit “known” till she first registered her mother telling her “to wipe the smile off” her face, maybe at the age of four years. Prior to this, Donna would have been avoiding smiling through her gleaned implicit knowing and the resonance of her mirror neurons:

> The implicit includes a vast array of knowing that everyday social life is based upon. For instance, what do you do with the direction of your gaze when you are listening to another; when you are talking? What do you do with your body and tone of voice when speaking to

> an authority figure or to a therapist for the first time? How do you let someone know you are about to terminate a discussion without saying so, or that you disagree with the person but do not want to go into it? How do you know when someone likes you? How do you know that the person knows you like him or her? (Stern, 2004, p. 117).

Donna and I can as yet not share a smile; we cannot actively share pleasure in Donna's success and as such, this traumatic trigger repeatedly disrupts Donna's everyday experiences in conversation and in relationships. Donna's coerced acquiescence to the imperative "not to smile" demonstrates the other-directedness she has learned in the context of the abuse she suffered. Her difficulty is not necessarily solely related to the ongoing sexual abuse she experienced from her brother, although being-for-others is a common consequence of childhood sexual assault, and moreover, at least in my experience as a family therapist, developmental, sexual, physical and emotional abuse can too often occur in the same families. Perhaps, in the context of hidden sexual abuse, her mother's reality became Donna's reality; Donna's own natural states and expressions of emotion came under such scrutiny that they were stunted. Until this moment in therapy, none of her struggle has even been partially articulated. I wonder if she has even thought consciously of her need not to smile before. Nevertheless, over the course of her therapy, I may never directly refer to the injunction, but I know that when Donna smiles with minimal censure, her sense of her selfhood has begun to flourish in much the way a different more nurturing parental experience would have provided for her.

> By facilitating self-exploration and self-reference (as opposed to defining self primarily in terms of others' – including the therapist's – expectations or reactions), therapy can allow the survivor to gain a greater sense of his or her internal topography. Increased self-awareness may be fostered particularly when the client is repeatedly asked about his or her ongoing internal experience throughout the course of treatment. This may include... multiple, gentle inquiries about the client's early perceptions and experiences, his or her feelings

> and reactions during and after victimisation experiences, and what his or her thoughts and conclusions are regarding the ongoing process of treatment. Equally important, however, is the need for the client to discover, quite literally, what he or she thinks and feels about current things, both trauma related and otherwise. Because the external directedness necessary to survive victimisation generally works against self-understanding and identity, the survivor should be encouraged to explore his or her own likes and dislikes, views regarding self and others, entitlements and obligations, and related phenomena in the context of therapeutic support and acceptance ... 'identity training'... (Briere & Scott, 2006, pp. 152-3).

Briere and other theorists believe early implicit beliefs about self and others are encoded implicitly from the start of infancy and that these become internal working models (Bowlby, 1982) or relational schemas (Baldwin, Fehr, Keedian, Seidel & Thompson, 1993). "As a result, most people have 'infantile amnesia' for these early relational memories – although such memories can trigger cognition and conditional emotional responses [...], they cannot be consciously recalled as part of the past" (Briere & Scott, p. 154).

Whatever the intervention, the effect on Donna's subjectivity of her early relational experiences are such to "divide the subject against itself":

> The other's consistent or intermittent abuse of our vulnerability, mild or major, the other's consistent or intermittent misrecognition – these are the events that fragment the subject and divide the subject tragically against itself... [These] are at the heart of the neurotic misery of the divided subject... For I believe that we weave our subjectivity – in complex and non-linear ways, to be sure – from our conscious and unconscious responses to the two kinds of relational experience that most of us have; one in which we are treated as objects by significant figures in our lives and one in which we are treated as subjects (Layton, 2008, p. 64).

The “divided” subject then, if that is how such fragmentation and distress can be understood, is a product of varying forms of recognition, both viable and unviable if viability too can be understood as emanating from our treatment as subjects rather than objects. Levinas (1985; 1986) most cogently describes this difference in terms of whether the “other” constitutes the subject as human.

With Donna, I cast her into a particular subject position, that of a severely traumatised woman, who has experienced such severe abuse and relational trauma that I can not help but see her as “damaged” even as I consciously try to stop thinking of her as such. This does not mean I see the potential for her to embrace a viable subjectivity as permanently foreclosed, but there is an element of this in my work with her. This may colour my work with her so that I may challenge her less, expect less, and affirm her more for a lot less than I would other clients. Perhaps this means I will display more compassion and empathy for her which allows something unexpected to happen, such as Donna taking a bigger leap forward and embracing more opportunities than I thought possible. Perhaps she will perform only to the extent of my and others’ perceptions of her abilities because of the persuasive nature of these conscious and unconscious inscriptions. I have to admit that at times I don’t think she will ever live as full a life as many other people, and I feel sad. And then I am surprised when she manages to save for a car, get her full driver’s license, and obtain two days per week paid work for the first time in her life.

When I cast a client into a particular subject position, I perform a recognition. I hope that it is a recognition that involves treating the person as a subject not an object. But more often than not, therapeutic work can objectify clients when a perception of them as “damaged” forecloses opportunities for their subjectivity and experience. However whilst I remind myself they are not passive receptors of others’ perceptions, my own attempts as a therapist to be “good enough” can cast me into the perceived role as the most important person in the client’s life, similar to that of

mother to child. In this way, I again have been unwittingly reproduced as the source of my client's well-being which in and of itself is always problematic, that is, I am not that powerful but this discourse reaches into the myth of the individual autonomous agent who can exact change in another as if they were an object to be worked on. Yet Donna would not have come to therapy if she did not want to resist the subject position into which she was cast as a child. Conversely, Donna does not always do what I suggest – she does resist those interventions that don't work for her, despite me seeming to be able to pronounce through my positional power, "what's best".

Recognition

Brison (2002) also insists on a recognition when she asks others close to her to acknowledge and recognise this other dislocated, dis-embodied and deadened subjectivity she is facing, in order to know her, the new person she perceives herself to be after her traumatic experience:

> … [N]ot to be seen is not to exist, to be annihilated. Not to be heard means that the self the survivor has become does not exist for these others. Since the earlier self died, the surviving self needs to be known and acknowledged in order to exist (Brison, 2002, p. 62).

For Brison, the need for a specific form of recognition emerged as an issue of selfhood. Therapists too, commonly identify this issue of selfhood by intentionally recognising the person's suffering and in so doing open up the space for the transformative power of the operation of that recognition. Family therapists have long since been aware that recognition in family systems and in wider communities or society opens up far more potentialities for the transformation of human experience than can ever be realised. Yet recognition can only be mobilised as a technology of healing. It is not in itself healing. For Nazis who engaged in war crimes and who

then took up another persona, "recognition" for them is death. For Brison, her pain and vulnerability and her shifting subjectivity from competent professional and academic, to victim of a horrendous assault was unable to be recognised by others because this would require some acknowledgment of how she was treated as object that paradoxically allows her to embrace a viable subjectivity in the act of that recognition.

Butler (2004a) theorises that this recognition is constituted through normative notions of what is human when she comments on the violence perpetrated against transgender, gay and lesbian lives, specifically the violence done to their bodies. In terms of marginalised populations such as these, and I would place other victims of crime in this category, specifically crimes of sexual violence, when Butler asks:

> What is real? Whose lives are real? How might reality be remade? Those who are unreal have already suffered the violence of derealisation. What, then is the relation between violence and those lives considered as "unreal"? Does violence affect that unreality? Does violence take place on the condition of that unreality?
>
> If violence is done against those who are unreal, then, from the perspective of violence, it fails to injure or negate those lives since those lives are already negated. But they have a strange way of remaining animated and so must be negated again (and again)... (Butler, 2004a, p. 33).

Brison felt (and believed) that recognition could not be deployed as a mechanism of healing without telling and retelling the traumatic narrative. I argue here that in the negation of her recognition of a person who suffered violence through a lack of acknowledgment, Brison is being constituted as "unreal", even as this lack of acknowledgment may speak to the society's deficiencies in responding to sexual violence. Butler (2004a) goes on to extend these ideas through her reading of Levinas. Butler states that others

hail us in order to make moral demands to us, “ones we do not ask for, ones that we are not free to refuse” (p. 131), yet these demands can both produce viability or negate it depending on the form of recognition that takes place even in its absence.

> Because the trauma is, to most people, inconceivable, it is also unspeakable. Even when I managed to find the words and the strength to describe my ordeal, it was hard for others to hear about it. They would have preferred me to just 'buck up,' as one friend urged me to do. But it’s essential to talk about it, again and again. It’s a way of remastering the trauma, although it can be retraumatising when people refuse to listen. In my case, each time someone failed to respond I felt as though I were alone again in the ravine, dying, screaming. And still no one could hear me. Or, worse, they heard me, but refused to help (Brison, 2002, pp. 15-16).

The form of recognition that Brison is saying she needs in order to achieve some sense of healing is one in which she is recognised as a subject, not an object and therefore abject. In this sense, recognition of one's subjectivity promotes humanness and viability. Failing to notice or respond in a viable way produces not just an absence of recognition but a misrecognition. For Donna, the misrecognition by her mother, when Donna had to wipe her smile off her face, functioned to deny her viability and subjecthood.

Implications for Therapy

Feminists have deployed “trauma” in validation of the occurrence and profoundly negative effects of events such as childhood sexual assault. At the same time, we have inevitably been involved in producing the subject position of a pathological trauma sufferer or victim. (cf. Herman, 1992). More recently, there seems to have been a huge shift of attention, from the

social injustice of sexual assault, to its biological and psychological effects. A parallel shift is that the feminist therapist becomes less a facilitator of understandings of gender power relations who assists with the unravelling of dominant stories of abuse, and the effects of gender discourses such as women being responsible for relationship, or to blame for staying in a relationship where their partner is violent. The therapist becomes more of an expert responsible for managing risks to the "safety" of a "survivor" (a neoliberal discourse of risk management in therapy, as noted by Rose, 2005), for explaining the neurobiological consequences of trauma, and for assisting a staged developmental recovery process. This remains a move away from a community, social and relational response to sexual assault and domestic violence, and from understandings of gender power relations, toward an individualising and pathologising model.

In this chapter I began an examination of the way "trauma" and the subject of trauma is spoken through discourse into being and in particular the way identity language evades the possibility of subjectivity as an ongoing project of multiplicity and reinvention. This exploration required cutting through any perception of biology as a fixed unchangeable entity and embodiment as simply reducible to discursive strategies. A "potentiality of experience" emerges in the interface between the biological or neurobiological and embodied experiences of trauma. Similarly, this thing called "experience" is not a static entity – it is an ongoing activity which involves movement and change. Just like the human subject, experience is historically contextualised and constructed and has a malleability which changes and is transformed whenever and however it is articulated and the techniques with which subjects engage with experience transform the experience itself given biological and sociality processes are inseparably located within the body.

In this transformative engagement between biology and discourse, experiences of trauma evoke subject positions which may or may not invoke viability: the perception of a fragmentary, discontinuous sense of identity may undo a sense of viability in the humanist sense; from a poststructuralist

position, the original subjectivity does not necessarily stay undone, but it holds the potential for new subjectivities to emerge. Specific therapeutic technologies are deployed to produce certain subjectivities, but the danger is that some revert to individualistic notions of the self without vigilant reflection on the part of the therapist.

The speaking of trauma can operate for and against itself, reactivating the trauma, and/or also opening up the possibility of a retelling that restores the viability of the subject. This narrativisation is an active movement. In therapy, recognition can be mobilised to transform experience and enhance viability, or it can do the opposite, depending on the meaning of this recognition or the subjectivities that may be invoked. This moves me into the next chapter, in which I delve into the landscape of an unspeakable remainder in many traumatic experiences, whether or not they are spoken or written about in great detail or articulated prematurely or carefully in a therapy setting, and what that means for both neurobiological and psychological understandings about trauma, subjectivity and viability.

Chapter 4: Languaging the Unlanguagable

Today I held the suicide note of a twenty year old man in my hands. He had gassed himself in his car and the note was splattered with his haemorrhaged blood.

'This is what happens when you are poisoned by carbon monoxide,' his mother, Tina, tells me.

I am speechless. I start to stutter.

'Oh, oh, GGod....'

After five sessions of what I'm sure had been empathic work with this woman, for the first time my body registered the violence of her son's death.

'Don't read it if *you're finding it too upsetting'* Tina says.

My face had obviously given away its dispassionate facade.

'No its fine,' I said.

But it wasn't fine. The nature of this young man's death had chilled me. I hadn't been this close to the gory reality of a death like this in all the years I had worked with grief and trauma. There is nothing fine about pain like this – a mother's torment and evidence of her son's physical and emotional anguish.

Wor*ds on a bloody notepaper said,* 'Don't blame yourself ... I am weak ... I *can't go on,'* words painted in lethal hues.

What do I say, now my body knows so much more about this terrible moment? I feel a terrible weight in my chest and I babble, 'H*e's, he's ... terrible pain here…'*

I struggle to find something comforting to say, but no such words come.

'I'm so glad I have this,' his mother smiles, 'Other people have nothing when people die suddenly. The coroner held it back after the police found it. But *Reece left me this so I would be able to understand. But I couldn't* even tell my husband I had it at first. I would try to tell him and no words *came out.'*

I feel disoriented. I try to remember what I'm supposed to be doing, my role as therapist.

'His love shines through for you *and his brother, sisters, dad…'*

Tina nods.

I continue, 'Reece sa*ys there's nothing to forgive ...* He says this isn't your *fault. He left you this note wanting you to go on without him ... So what* does it take to forgive yourself fo*r not being able to stop this?'*

We are both crying.

'Maybe I can begin to forgive myself now. I can't tell you how important it was for you to see this. At first I thought no one could ever see it. Now you've read it, I don't feel so alo*ne.'*

I w*on't tell her it's been a privilege and a horror at the same time. Tina hugs me as she leaves, saying, 'Thank you. Thank you so much.'*

(LM: Taken from case notes, 2005)

I begin this chapter on the unspeakability of trauma with these case notes, because for each of us, the son, the mother, and me as therapist, there was both trauma and a certain unspeakability. For each of us, something has been unlanguagable. The mother, Tina was unable to speak about the note to her husband when "no words came out". Giving the note to the therapist who could touch it and read it creates a space in which Tina can speak. For the son, Reece, something was so terrible that his life was no longer viable. He had some language available to him with which he could write a rational note to his mother in order to tell her that even at this point of non-viability he is concerned for her and the family and does not want them to take on a burden of guilt. That is, he has language to write that message, but the something else that led to his death was apparently unspeakable and unresolvable. As for me, the therapist, I stutter and babble when faced with the visual reality of the bloody note itself and experience at a physical level some of the unspeakability, which seems to register as heaviness in my chest. My words are forced and limited in the face of the blood-stained note. The blood works as a signifier of great power in enabling me to recognise the son's and mother's suffering in ways that telling his death did not.

This chapter examines the aspect of trauma that is experienced as unspeakability from the perspective of those closest to it. There are individuals who find life so painful that they give up on the struggle to go on, like Reece, who could put into language something of his hopes for his family to continue living without him, but could not speak or resolve his pain in a way that enabled him to continue living, if it is assumed that the speaking of his pain would enable him to regain a viable life. I have also included accounts of others, like Tina, who have suffered traumatic loss. These people attempt to speak and make meaning in a way that reduces their pain or which helps them develop a narrative that makes their own viability secure. In this way, I begin a more detailed exploration of what makes for a viable life, if viability is understood in my reading as recognisable, grievable, livable and human. This definition of viability encompasses an ethical scope that sits outside humanist concepts such as "life sustaining",

"meaningful" and "worthwhile", all of which are invested in and constitute aspects of the notion of an individual autonomous self. Instead, this viability is relationally constructed[4], in the way in which mutual recognition is conferred between people and groups of people through normative socio-political regimes which decide recognisability (Butler, 2001).

In the next chapter, I will focus on the unspeakability of trauma from the position of the therapist listener, removed from the immediate impact but nevertheless implicated in the traumatic fallout, but for now I turn my attention to those who suffered the unintelligibility of trauma more immediately.

The Problem of Unintelligibility

Psychoanalyst, Juliet Mitchell (1997) describes how Freud (1891), building on the work of Charcot, first linked the unintelligibility of some traumatised clients with the symptom of aphasia, that is, the "loss or impairment of the faculty of symbolic formulation and of speech due to a lesion of the central nervous system"[5]. Aphasia, which normally results from brain injury or disease rather than psychological trauma, is also linked to the term "aphonia", which is defined as a "loss of voice, due to an organic or functional disturbance of the vocal organs"[6]. Mitchell reminds us, that in 1900, it was Dora's great difficulty in speaking which brought Freud's most famous patient to psychoanalysis and that this condition also recurred after she left treatment although it received "neither attention or explanation" (Mitchell, 1997, p. 126). Nevertheless, Freud had theorised that in curing the psychologically induced aphasia, the trauma itself would be ameliorated by language. More than twenty-five years later, it was believed that the mutism and "unspeakable nightmares" (Mitchell, p. 126), above all other

[4] See also Johnella Bird (2004) who uses "relationally constructed" language with clients to create in turn a "relationally conscious" position in therapy that works to challenge normative assumptions about selfhood. (Bird, 2004, p. 11).

[5] The Macquarie Dictionary (1981). McMahon's Point, NSW: Macquarie Library.
[6] Ibid.

psychiatric symptoms suffered by traumatised soldiers from World War I, needed to be spoken about by the one traumatised in order for traumatic symptoms to reduce.

Freud's premise, that memories that are spoken can resolve the trauma and bring the patient into a state of well-being, is still held as a therapeutic truth today. However this notion may blind therapy to some kinds of irresolution that speaking cannot cure and that resist attempts to be spoken into words or sit outside language itself. It also leads to binary conflations which ally terms such as "meaning" and "language" with the term "rational", which then are placed in superior opposition to the term "feeling", which is very commonly conflated with the 'irrational'. Similarly, Mitchell extrapolates "the visual dimension of dreams" to mean "regressive", which is juxtaposed against that which is perceived as "legitimate", language:

> Traumatic language is a verbal version of the visual language of dreams; words are metaphors, similes, and symbolic equations… they become expressions of feeling rather than of meaning (Mitchell, 1997, p. 132).
>
> In asking a patient to put their dreams into words we are making an apparently progressive move – words make sense only in relation to each other, as a chain of signifiers. It is from such a perspective that [simply] the visual dimension of dreams is regressive… (Mitchell, 1997, p. 127).

Brison, continuing in the same binary mode, perceives traumatic memory as malleable even though this is not a conscious process. She describes traumatic memories as "bodily, fragmented, sensory, intrusive, recurrent, uncontrollable" and narrative memories, that is memories which are coherently structured and put into acceptable language, as "linguistic, more coherent, more under control" (Brison, 2002, p. 31). That which is "under control" in the case of the boy who gassed himself in his car, was his ability to express concern for his family, if we were to say that his ability to speak

of this care was logical, coherent, legitimate and therefore rational, whilst the despair that led him to take his own life, whether emanating from traumatic memory or not, could certainly be socially and psychologically constructed as "uncontrollable" and irrational.

Even as I map this landscape of viability I am aware that I am assuming that the subject who suicides has reached a point at which they consider their life to be non-viable. In this way I am taking up a notion of viability that emanates from a number of competing discourses. Suicide is often a matter of acting on a discourse of unviability that is dominant at that point of the subject's life. The finitude of our lives as embodied subjects is in considerable tension with the postmodern idea of the fluidity of subjectivity, in that we may have multiple narratives of selfhood, some of which may be in favour of continuing to live. However if we act on a narrative that insists our lives are not viable then we will be dead whether or not this was the only story available to us. For Reece, there could have been times when something was so terrible that his life was not viable and other times when this was not so, times for instance when his relationships with his family were enough to sustain him. This tension marks the terrible character of suicide - its finality and totality, even while narratives of self are rarely total or final.

If, as Mitchell theorises, speech or the absence of it in this instance, reflects emotion rather than cognition, there has been a subtle movement into binaries which privilege that which is utterable over that which is difficult or is impossible to be spoken. In spite of this, Mitchell draws attention to the absence of curiosity in regard to the impact of trauma on speech when she states, "That hysteria should be produced by a trauma and cured by language is not the same as asking what might be the effect of a trauma on language" (1997, p. 126). In so doing, Mitchell draws attention to the possibility that the problem of unintelligibility is a possible product of trauma[7].

[7] Conversely, the reverse could be equally said, trauma is deployed to "make sense" of the otherwise unintelligible. See Chapter 5 for further discussion.

In the months preceding the incident of the note, I recalled that Tina had attempted to find words that could explain why her son had taken his own life and why she had not been able to prevent his death. She had sought counselling, hoping that in talking about her terrible sorrow, her pain might somehow reduce so that she could go on living, still parent her remaining two children and be a “good wife” to her husband. She had told me that some days she still pretended Reece was alive, and that his death had not even occurred. These days, she said, were “ok days”, days when she did not need to fight her own suicidal thoughts because they did not need to arise. After all, Reece was “alive” on those days. At other times, when she was struck by the reality of her son’s desperation, going over and over in her mind her perception of the last hours and minutes of life, Tina told me of her despair, although I knew that the word, “despair” was inadequate to describe this experience. Tina also told me of her “guilt” that she “should have known” that her son, who had struggled with depression, was uncharacteristically “happy” the week before he died. Reece had made cheerful contact with all members of his immediate family hugging his mother more than once the last time she saw him alive, before smiling and waving and yelling from his car as he drove off, “See ya later!”

The jovial character of Reece’s last interactions with his family suggest that, in making the decision to end his life, he was relieved of the burden of his sense of its non-viability, but this makes sense only in hindsight. This decision was not a decision Reece could discuss with his family, nor could the reasons for his life’s unviability be spoken to them. What was made intelligible, Reece’s joking demeanour, and his love for his family, did not however make for viability.

This said, my focus here is to explore the dilemmas in speaking about trauma and to what extent a narrative of viability can become available. In the next extract, I examine my work with another client, Julie, and look at the consequences of my understanding of having initiated premature “exposure” work with her in attempting to bring a recurrent nightmare into

speech. I draw attention to how, after each twist and turn in therapy, "what happens", changes for Julie in terms of her subjectivity, both in her own perception and mine. So I use this example to point to the potential for an undoing of subjectivity in therapy and the challenge for me and for Julie to take up new potentialities of experience and subjecthood, when Julie's "undoing" appears final and complete. In this account, a static, unchanging sense of hopelessness is reflected and fed through my slippage into identity language and essentialisms about experience. It is this tension between a traumatic and a facilitative "undoing", in the context of my attempts to assist Julie to speak the unspeakable, that I hope to begin to address in the next section.

Julie, a 42 year old chef, comes to me telling me that she has taken sick leave because over the past few weeks she began suffering nightmares, is not sleeping and is experiencing terrifying panic attacks. In the initial assessment I learn that Julie had suffered domestic abuse some years ago and that she had also suffered nightmares and panic attacks when she had been separating from her husband as he had been particularly verbally threatening. Her only recent concern had been for her 16 year-old son who had been hospitalised for injuries he suffered in a skateboard accident. I encourage Julie to see her GP for an assessment for medication given the degree of hyper-arousal I see in her presentation and because Julie has also told me that she is contemplating suicide.

By our next meeting she has been prescribed anti-depressants. We work on cognitive-*behavioural strategies to reduce Julie's symptomatology. Over* the next few weeks, her symptoms reduce, she tells me she does not feel suicidal and she is pleased that she has also been able to successfully implement some of the strategies she has gained from therapy. For example, when she feels panic she takes herself outside into her garden, *pulls out a weed or two, and* 'grounds herself with the e*arth'.*

Julie's nightmares persist but with guidance she is attempting to consciously change the ending of the nightmare by imagining herself safe before she attempts to go back to sleep. She tells me she is feeling much better about talking t*o a 'shrink'* and, as I continue to provide her with support and psycho-education, she tells me how she tried to survive her ex-*husband's abuse.*

She returns to therapy after a particularly difficulty encounter with her ex-husband about her concerns about their son. J*ulie's nightmares and panic* attacks increase. The nightmares are filled with terrifying images of her trying to run away from someone trying to kill her.

Again I focus on symptom management, but with no improvement this time. Unless she gets a psychiatric assessment her medication cannot be increased. My client is not able to see a psychiatrist for some weeks due to the shortage of qualified medical practitioners in the North West of Tasmania. After consultation with my colleagues, I make a decision that I need to go into the nightmares with her and look at them symbolically or metonymically (i.e. examine the chains of signifying words she uses in the dream as well as the symbols) to see if I can assist her to gain some *'mastery' over the nightmares.*

Julie agrees since she is desperate to try anything to reduce the intensity and frequency of the nightmares. The dream follows this usual pattern: she is being chased by something or someone who wants to kill her and ends up running towards a door down the end of a white corridor. When asked what the corridor means to her, she tells me the corridor symbolises death or insanity. It also reminds her of a hospital. [I think to myself, her son has just got out of hospital and I know Julie has been very concerned for his well-being.] I ask her how the association with the hospital may be significant. She tells me it may have something to do with being worried for her son. With this realisation, I notice she there is some lifting of her mood, and that she appears quite relieved.

'So that's probably what that dream is about. It's about my fear for my son because he was injured.*'* She leaves the session less anxious with an instruction from me to remind herself that her son is now safe and that she needs to remind herself of this when she has nightmares or begins to panic.

Julie returns for her next session. She appears distraught and dishevelled. There are enormous bags under her eyes. The nightmares have not abated. In fact they have got worse. Again in the dream, she is running down a white corridor terrified for her life. No amount of reasoning with herself has made any significant difference.

I encourage her to revisit her dr*eam but this time I ask her to 'be'* the white *corridor". She is surpris*ed when her perception of this prop in her dream *changes. She says* 'I am the white corridor and I am telling the woman to keep safe and NOT to go tow*ards the door at the end of me.'* I ask Julie to stay in role as the corridor and to look back at the woman in the dream and to tell me what she sees. Julie appears startled as she tells me that she sees a 4 or 5 year old female child. I ask her what that means. She discloses that she has been told she was grabbed by a man when she was walking home from school with her brother and that she was missing for some hours. She says she has no conscious memory of this incident but she had been told by her family that they *believed she had been rescued 'before anything happened.'* I ask her what she makes of this. *She says,* 'This is not just about my son, or my violent ex-husband, is it? Something really bad happened to me when I was little but n*o one has ever talked about it.'*

I ring Julie next day and she tells me she had the best night's sleep she has had for months. I am very relieved as I am going away interstate for a few days to a conference. Next morning I get a crisis call from Julie as I am *about to board my plane. Her message says that she doesn't think she can* go on. Her speech is fractured and she *says she has taken some drugs 'to take the edge off'*. Her voice sounds very young. I encourage her to access any supports she can and that I will ring her back in 2 hours when I land at my destination.

When I finally call, a friend of Julie's answers and tells me she is caring for *Julie's son. Julie was taken to hospital having been found curled up in the* foetal position, crying hysterically. Julie, whilst having a history of substance abuse but as far as I knew, no other self-harming behaviours, had *carved her son's name on her arm because, as she told her friend,* 'I need to remind mys*elf why I must not kill myself'*.

My immediate response to Julie's fragile state is to assume that I had processed Julie's dream in such a way as to have re-traumatised her. I remind myself of Briere & Spinazzola's (2005) words in relation to Julie's "self-capacities" (Briere & Spinazzola, 2005, p. 402), which include the trauma sufferer's inability to self-regulate her internal responses:

> Problems in the self-domain, in turn have been implicated in the development of dysfunctional behaviours often seen in complex posttraumatic outcomes, including suicidality, impulse control, substance abuse and the 'tension reduction' behaviours (e.g. self-mutilation) (Briere & Spinazzola, 2005, p. 402).

In my anxiety to reduce Julie's symptoms I believe I have rushed prematurely into exposure work, although it is indicative of work with trauma survivors in that my therapy with Julie shows the extreme difficulty a clinician can have in trying to reduce symptoms of trauma whilst not being able to predict how the psychological and biological spaces that are the "sites" of intervention are going to respond. The movement from what could be perceived as the experience of a non-viable subjectivity for Julie to a viable technology of self and back again to a non-viable and perilous subjectivity is just one example of the messiness and unpredictability of the work of a trauma therapist, armed with the current "knowledge" of trauma intervention but unable to control the myriad potentialities of the inseparable interconnections of biological, psychological and social spaces that are nevertheless acted upon as if they are static entities rather than alchemical fluid domains.

My first thoughts when I hear what I perceive to be a “regressed” Julie on the phone is that I have “undone” her severely and that I have made her remember something that is too painful to be remembered from her childhood. I perceive her subjectivity in essentialist identity terms. She is regressed, damaged and possibly “can’t be fixed”. My attempts to help Julie gain some mastery over her symptoms, that is, move her towards the notion of autonomous, self-regulating selfhood, are overturned. Her unpacking of her dream and its metaphors in the light of a returning memory had no known trajectory, just a potentiality of producing a myriad of subjectivities, some of which are viable and some of which are not. I judge her attempts to “remind” herself to stay alive as “borderline” even as I am aware her own subjectivity is one that is attempting to metaphorically claim viability for herself.

This telling of the trauma appears to have reactivated it, but mastery of the trauma as the goal of the telling seems at once necessary and impossible, at this point in time, when I sit with an essentialist perspective. I believe Julie’s telling has functioned to create both awareness and an overwhelming response to this awareness that puts her viability into question. For Julie herself, who may be sitting outside therapeutic essentialist discourses that see self-harming behaviours as pathological, her action is an attempt to make her life livable in the presence of overwhelming trauma. The malleability of her embodied traumatic experiences and the subjectivity invoked also invokes a subjectivity in me that moves me into identity language. I am a helpless, traumatising therapist who had done irrevocable harm; I am a therapist who has facilitated new possibilities for healing even if in the moment this potential appears regressive; and I am a therapist intent on using the subjectivity that Julie has invoked for herself to call on her to create new subjectivities which can make for viability (whilst not damaging her body). And I am a therapist who did not provide the conditions for safety that were necessary for this processing to take place, nor had I processed the trauma enough. According to Ford, Courtois, Steele, van der Hart and Nijenhuis (2005) and Kuyken et al., (2008), the preconditions for

processing traumatic material had not been established with Julie.

I berate myself:

1. I should have paid more attention to the first phase of exposure work which would have given Julie skills and provided her more psycho-education to help her make sense of her experience.
2. I should have assisted Julie to more fully collaborate in the process of achieving some self-regulation for herself and ensured she was more connected to support networks in case of a such a crisis as this. (Pearlman and Courtois, 2005)
3. *A "good" therapist does not move* to exposure work prematurely.
4. I overestimated Julie's control of her substance abuse, which escalated subject to the processing of her account.
5. The exposure work, whilst not focusing initially on a traumatic memory induced a remembering of such an event, which was not further processed as the escalation in traumatic symptom, affect dys-regulation and self-harming behaviours intensified.
6. This pre-emptive move produced complex and dangerous results.
7. Julie is now **more** damaged than when she began the work.

When I take a moment to stand back from the above damning thoughts, I am reminded that a move such as this into identity language forecloses a vision for me of Julie as potentially more than this and functions to have my own subjectivity foreclosed as well. I have "done harm", not good, and I am terrified Julie's potential for viability has been shut down irrevocably in my "misrecognition" of her readiness to resolve her nightmares. And I reflect as I write that I have not "undone" the original discourse of the autonomous subject who is "continuous, unified, rational, and coherent" or at least should be, within regulatory practises that decide what and how a "normal" individual is and should behave. Julie's distress is categorised by me as "abnormal", even psychotic.

Second, I have slipped into believing that with all the right ingredients in place, Julie would have responded in a specific prescribed way as if she was simply a combination of specific elements, nor more no less, a chemical to be made. This construction of Julie's subjectivity treats her as malleable in a prescribed modernist way, and denies the potentiality of her subjectivity, which may or may not have responded in the anticipated way to produce the specific human subject who has had a “successful” trauma treatment. The possibility of Julie accessing a potentiality of experience is foreclosed when I treat Julie as an object to be acted upon. Yet my own thoughts denounced me as I went over what I should or shouldn’t have done.

It was not until much later that I reminded myself of my own nightmarish years of depression and complex post traumatic symptoms and my own “failed” therapies when I left sessions more “undone” than when I arrived. Now, post the worst of my own personal symptoms of traumatisation, I am lured into the fiction of a constantly attentive self-reflecting and reflexive therapy practitioner who must at all times maintain this competent performance of herself, transparent about and learning from her mistakes. My own positioning within neo-liberal times as responsible for the regulation of others evades my awareness. I have not “followed the rules” therefore I have failed in my role as therapist and I have earned failure for my client. As I confess and therefore make transparent my professional “errors” with Julie, I move into a performance of my own subjectivity which requires intervention and regulation, just as Julie in her distress requires assistance to move towards more “self-mastery”. My own stance produces a gaze that functions to question my ethics and professionalism. It serves to obscure that which cannot be regulated, that potentiality of Julie’s subjectivity and my intervention. This governmentality in action in my performance as therapist/clinician will be explored in greater detail later; nevertheless, I draw attention to this phenomenon as I struggle to manage both the “ethics” of good therapeutic work with clients and the ethics of self-responsibility produced through practices of surveillance and self-surveillance.

Unintelligible Speech

I move now to an example of unintelligibility in which the difficulties in actually producing speech are clearly audible. Attempts may be made for memories and dreams to be spoken into language to make them intelligible to others and to resolve the underlying trauma itself, I return now to brain functioning and trauma and the effect of trauma on language. Wald, Taylor and Scamvougeras (2004), describe the treatment of a woman suffering some form of traumatically induced speech problems. "Ms A", who had worked in emergency services prior to her retirement, suffered from an embarrassing speech disruption which meant she frequently could not speak, or if she did so, her speech was unintelligible. Sometimes she was only able to verbalise the sound, "'mmmmmmmmm'". These episodes took place more often when Ms A was tired or stressed but they could also occur spontaneously (Wald et al., 2004, p. 14). It had been observed that when Ms A remembered traumatic events that she had attended in the course of her work, speech difficulties were triggered, although her speech had not been impaired until she had been exposed to a specific reminder of a very distressing event.

> Such events included attending the scenes of industrial and vehicular accidents, and homicides in which the victims had been severely mutilated. When Ms A recalled these events during the assessment interviews, she wept deeply, trembled and became intensely distressed. She recalled feeling upset, but not greatly so, at the time of the actual events… (Wald et al., 2004, p. 14).

Having undergone thorough medical testing and even ear surgery in an attempt to improve her condition, which proved impervious to usual treatment, Ms A was found to have no neurological or physiological basis for the speech problems. She was therefore diagnosed as suffering from some posttraumatic symptoms including debilitating flashbacks and

profound distress when exposed to traumatic reminders. These symptoms were subsequently treated with cognitive behavioural strategies which allowed her to become desensitised to traumatic stimuli. For example, she was encouraged to "observe" her speech difficulties without judgment and was also provided with alternative and less disturbing perceptions of the traumatic events she had witnessed. One case in point was Ms A's belief that maiming and disfigurement are always associated with terrible suffering. This perception was replaced by an alternative, more emotionally manageable cognition that people terribly mutilated in accidents were more than likely to have died instantly. Therefore they would have been unlikely to have felt very much pain at all (p. 17).

Whilst Ms A's speech difficulties largely disappeared and her traumatic symptomatology reduced, it is not clear whether Ms A remained symptom free in the long-term. What was observably true is that the treatment led to a reduction in the speech difficulties. What is not yet known is whether the speech difficulties will recur. Why the speech difficulties occurred some time after the actual traumatic events, disappeared, and why they return if return they do, as they did for Dora a hundred years previously, requires further examination.

Broca's Area

Hilkka Huopainen, (2002, p. 103) provides an example in which "the intensity of the [traumatic] experience" leads to the failure of normal speech mechanisms when he quotes novelist Milan Kundera's (1987) novel, The Unbearable Lightness of Being, to provide an account of the events of 1968. In this extract, Czech leader, Alexander Dubček attempts to address the people on the radio after the Soviets had arrested him and forced him to sign a compromise treaty for Czechoslovakia:

> He returned, humiliated, to address his humiliated nation. He was so humiliated he could not speak. Tereza[8] would never forget those awful pauses in the middle of his sentences. Was he that exhausted? Ill? Had they drugged him? Or was it only despair? If nothing was to remain of Dubček, then at least those awful long pauses, when he seemed unable to breathe, when he gasped for air before a whole nation glued to its radios, at least those pauses would remain. These pauses contained all the horror that had befallen their country (Kundera, 1987, p. 72).

> Any man confronted with superior strength is weak, even if he has an athletic body like Dubček's (Kundera, 1987, p. 73).

Huopainen discusses throughout his paper what to date is currently understood of brain functioning and trauma. The author tells us that the above example demonstrates LeDoux' (1992, 1996) work as to how "the intensity of the [traumatic] experience leads to the failure of hippocampal functioning... The state of mute agitation, 'speechless terror,' evoked by the traumatic situation resembles an infantile state ('infans' in Latin means one 'who cannot speak') which, on the level of brain physiology, is governed by the functioning of the amygdala and the immature development of hippocampal-neocortical neural connections" (LeDoux, 1996).

For myself and my colleagues, it was very exciting to find out that Rauch, van der Kolk, Fisler, Alpert, Orr, Savage, Fischman, Jenike & Pitman, (1996) and Rauch and Shin (1997) had conducted studies in positron emission tomography of patients with PTSD, thereby establishing a scientific basis for the difficulties faced by individuals attempting to manage their highly charged and anxiety ridden emotional states and making sense of their limited ability to articulate their traumatic experiences. Van der Kolk, referring to his work with Rauch et al. (1994a) writes:

[8] Tereza is a character in Kundera's novel, The Unbearable Lightness of Being (1987).

> … [These patients] were exposed to vivid, detailed narratives of their own traumatic experiences... We collected narratives from these subjects with PTSD then read these accounts back to them; when this precipitated marked autonomic responses and triggered flashbacks, a scan was made. For comparison, the subjects also wrote and were exposed to narratives that invoked a neutral scene. During exposure to the scripts of their traumatic experiences, these subjects demonstrated heightened activity only in the right hemisphere – in the paralimbic belt, part of the limbic system connected with the amygdala. Most active were the amygdala itself… Activation of these structures was accompanied by heightened activity in the right visual cortex, reflecting the visual re-experiencing of their traumas that these patients reported. Perhaps, most significantly, Broca's area 'turned off'. We believe that this reflects the tendency in PTSD to experience our emotions as physical states rather than as verbally encoded experiences. Our findings suggest that PTSD patients' difficulties with putting feelings into words are mirrored in actual changes in brain activity (van der Kolk, 1996, p. 233).

This information on the inactivity of Broca's area (the part of the brain specifically concerned with speech) under exposure to extreme stress provided a "valid" explanation for the inability to articulate some experiences and the basis for the re-experiencing of traumatic material as if it is happening now. When PTSD victims are having their traumatic recall, they may suffer from speechless terror in which they may be literally "out of touch with their feelings" (van der Kolk, 1996, p. 234), and any ability to articulate them. This information functioned to re-conceptualise the "hysterical" ramblings of the trauma sufferer. They were no longer "mad"; they were simply subject to a reduction in brain activity.

The question of whether the amelioration of traumatic symptoms, in particular improving the coherence of a trauma survivor's speech or personal narrative, addresses what makes for long-lasting personal viability in a world that can be chaotic, violent, uncontrollable and distressing, draws

me to the writings of poet, Paul Celan. Celan, whose parents died in the death camps of World War II, was awarded the Bremen Prize for Literature in 1958. He described his own efforts to write about and speak of his experiences of loss in his famous "Bremen Speech":

Reachable, near and not lost, there remained in the midst of the losses this one thing: language.

It, the language, remained, not lost, yes in spite of everything. But it had to pass through its own answerlessness, pass through frightful muting, pass through the thousand darknesses of death-bringing speech. It passed through and gave back now words for that which happened; yet it passed through this happening. Passed through and could come to light again, enriched by all this.

In this language I have sought, during those years and the years since then, to write poems: so as to speak, to orient myself, to find out where I was and where I was meant to go, to sketch out reality for myself.

It was, as you see, event, movement, a being underway, it was an attempt to gain direction. And if I inquire into its meaning, I believe I must tell myself that this question also involves the question of the clock hand's direction.

For a poem is not timeless. Certainly it lays claim to infinity, it seeks to reach through time—through it, not above and beyond it.

A poem, as a manifestation of language and thus essentially dialogue, can be a message in a bottle, sent out in the—not always greatly hopeful—belief that somewhere and sometime it could wash up on land, on heartland perhaps. Poems in this sense too are underway: they are making toward something.

Toward what? Toward something standing open, occupiable, perhaps toward an addressable Thou, toward an addressable reality.

Such realities, I think, are at stake in a poem.

And I also believe that ways of thought like these attend not only my own efforts, but those of other lyric poets in the younger generation. They are

the efforts of someone who, overarched by stars that are human handiwork, and who, shelterless in this till now undreamt–of sense and thus most uncannily in the open, goes with his very being to language, stricken by and seeking reality.

(Paul Celan, Bremen Speech, 1958, translated by John Felstiner, 2001).

Celan eloquently describes the journey of language which bears the mark of traumatic experience, and which had to “pass through muting” and “the thousand darknesses of deathbringing speech”. Celan’s writing articulates his own survival of 19 months forced labour under the Nazis. Felman (1992) argues that Paul Celan’s efforts to seek reality through and with language produces a testimony. Testimony that shows the “relation *between language and events”* involves a movement into and out of the suffering that was experienced in order to overcome "overwhelmedness" - a process that Felman constitutes as “moving on” (Felman and Laub, 1992, pp 28-29). Celan’s incredible talent survived his experiences of profound loss and despair and he was able in his poetry to articulate this journey: “so as to speak” [my italics]. Celan suggests that without language he was adrift in the past, present and future, and he talks about his attempts at articulation as enabling the production of “a being underway”. I wondered if this “being underway” represents for Celan a movement towards recognition, viability and humanness after the torture and murder of his parents and millions of others, and this curiosity led me to Christine Ivanovic’s (1997) discussion on Celan, ‘“All poets are Jews” – Paul Celan’s Readings of Marina Tsvetayeva’.

Ivanovic writes that in 1963, Paul Celan succumbed to his first hospitalisation after becoming seriously depressed after he was publicly accused of plagiarism by Claire Goll, widow of poet, Yvan Goll. Goll, just before his death, had asked Celan to translate his poems from French, which Celan had done, but Claire Goll had denied that Celan had a right to do this. Whilst there was never any substantiation to the claim, Celan’s alleged culpability became a topic of discussion in literary circles for years, and

culminated with a formal investigation of the charges. Ivanovic writes this crisis caused Celan much anguish and led to a deepening of Celan's understanding of his positioning in history as a Jew. This positioning was not a personal one, based on his own sense of his Jewish identity or faith, rather this positioning was perceived at a socio-political level and was expressed through Celan's poetry. Celan according to Ivanovic, equated his denigration and exclusion as a poet to the suffering throughout history of the Jews. The accusations made towards Celan were the vehicle through which Celan could be banished from literary society and Celan perceived this action as analogous to anti-Semitism, a similar dangerous, xenophobic force, which would ultimately lead to annihilation. It is notable that at this time, as Ivanovic points out, Celan employed particular words and phrases in his poetry, words such as "totschweigen" which means to "pass over in silence" and other phrases which translated mean, "I do not exist," and "I am nobody" (Ivanovic, 1997).

In his collection of works, "*Die Niemandsrose"* (1962), Celan asserted "All poets are Jews", an association of one group of the reviled and tortured with another, with the word "Jew" understood, as Celan did throughout his life, as a wounding anti-Semitic slur. However this association was opaque to most readers of his poetry as Celan inserted the words using the Russian Cyrillic alphabet in an epigraph in the poem "Und mit dem Buch aus Tarussa". Ivanovic draws attention to the fact that the German reader would have great difficulty making sense of these words and that these words would never have been articulated in the Russian language in this form.

> On the contrary, it seems that this indecipherable epigraph was put there to create a meaning of its own, a meaning which relates to all those themes alluded to in the poem itself… All of this points to the written form of the pronouncement, it indicates the otherness through its format, through the form in which it appears. Since it cannot easily make a claim to comprehensibility, it corresponds to that principle of revealing and concealing, of exposing and hiding, which has generally

been recognised as constitutive for the poems of 'Die Niemandsrose' (Ivanovic, 1997).

Whilst Ivanovic's culminating point in her examination of Celan's work in this context was in establishing a link with Celan's formulation of this specific epigraph with the influence on his work of Russian poet Marina Tsvetayeva, in the above extract, she points briefly to the opacity of Celan's work. This lack of transparency suggests a subject which is "opaque to itself" (Butler, 2001, p. 22). Celan deploys a strategy which is neither utterly transparent to self or to others, in order to open up the wider possibility of accepting the opacity of others (poets, Jews), rather than rejecting them for their unknowability. Furthermore, if Celan is similarly making this implicit point when he constructed the epigraph, he is challenging others to accept the unknowable in him as a poet, his "otherness", his humanness in his otherness.

If so, this position sits in contrast to Celan's words in his "Bremen Speech" some four years earlier which inferred language provided a transparency with which he was able "to orient myself, to find out where I was and where I was meant to go, to sketch out reality for myself". Language in this reading would function to make visible a "woundedness" from which one can re-enter the world as a viable life, but when I subsequently read that Celan drowned himself in the Seine in 1970 I became painfully aware that language, even the language of poetry, may not be enough to undo an unlivable reality. The "relation between language and events" in this instance was inadequate to the task of "*moving on*" (Felman and Laub, pp. 28-29). Prior to his vilification as a poet, Celan is uncertain how to become visible to himself. He is ambivalent about becoming grounded in a sense of linear time, about moving from "becoming" into a being that is recognisable and thus viable. When he sends out his message in a bottle, he is not very hopeful. Then in the next paragraph he asks "Toward what?" does he send this message, it is only "perhaps toward an addressable Thou". So the speech holds both the hope of communication and recognition, and the awareness that this is unbelievably difficult. And in this way, the language

is asked to bear more perhaps than it can bear, and the one he addresses may or may not find the message afloat on the sea. So perhaps it is not such a contradiction when he kills himself, since the ambivalence was already there.

After his slanderous treatment, this “death-bringing speech”, Celan moved into a profound sense of “un-being”, a recognition which meant death rather than life, although Celan resisted the “frightful muting” of these attacks through his work. When Celan’s integrity as a poet came under public scrutiny, his viability as a human being came into question even when his ability to write of his experiences did not.

The point that is beginning to emerge here in this brief example of Celan’s life and work is that communication of traumatic events through language can only be partial and incomplete, because that recognition by others can be withdrawn or changed in such a way as to inhibit its communication. In other words, recognition by others of another’s viability is never accomplished once and for all as the viability of life lies in the ongoing reciprocity and relationality that cannot be established at one singular point in time. Freud’s premise that moving trauma into language, cured the trauma does not take into account the impermanence of existence, this movement in “the clock hand’s direction”. Viability is therefore not a static entity, nor is language or poetry “timeless”, a finite punctuation of what makes for viability. Recognition is a fluid “event” that is relationally constructed again and again which makes and unmakes viability, turns beingness into “un-being”. Celan’s search for “reality” through the words of his poems can be perceived as a deployment by which meaning, itself particular to the production of subjectivity struggles to be expressed in language, which in turn acts recursively to produce specific and changing forms of subjectivity and viability in relation to self and others.

Felman and Laub, using Celan’s poetry as an example, hold that the role of bearing witness to a personal testimony will make for a livable, bearable life. In this way too, therapy holds that the act of perfect listening will be

enough to make for viability. The notion that listening is enough suggests that what is unbearable is positioned simply within the person and refers to the notion of the individual autonomous self, agent of their own destiny, whom, with a little help, can overcome any obstacle. But what if it is a horror that also lies outside the person and exists in the world, a horror which is neither in an individual's personal control nor likely with all the best intentions, to disappear? It appears then that amelioration of such trauma through language can never be a cure, and nor may it be enough to ensure psychological, emotional and finally physical survival. Abraham Lewin (1942) writes:

> Perhaps because the disaster is so great there is nothing to be gained by expressing in words everything that we feel. Only if we were capable of tearing out by the force of our pent-up anguish the greatest of all mountains, a Mount Everest, and with all our hatred and strength hurling it down on the heads of the German murderers of our young and old – this would be the only fitting reaction on our part. Words are beyond us now. Our hearts are empty and made of stone (Lewin, [1942] (1989), p. 46).

Here Lewin clearly speaks of the profound limits of language. In the presence of that which is barbarous and inhumane, words that do not receive recognition of human viability are made futile by the deafness of aggressors. Recognition and viability involve action, humane acts that recognise the viability or humanness of the other. Lewin is saying here that in their absence, all that is left for the oppressed and tortured are similar acts of aggression. Was suicide the action of aggression for Celan and even Reece, when words were beyond them, when Celan threw himself into the Seine, when the boy gassed himself in his car? Were the only words available to Reece that were adequate to express his feelings, those words that conveyed his care for his family? Was his heart "empty and made of stone" when it came to his perception of the viability of his own life? Was Julie's self-harming an expression of the limits of language in providing her with a sense of safe-keeping? Did her body have to be inscribed with her son's

name to more adequately speak of her desperation than any words could do justice? Was this because of premature trauma work or was her self-harming behaviour a consequence of her trauma irrespective of the therapeutic process, given the unspeakable "nature" of the events of Julie's childhood? Was it not necessarily a "poverty of language" or loss of speech that the boy battled with when it came to describing his sense of his despair, but rather was the issue its uselessness against his depressive illness, "as a weapon against the current enemy bent on destroying him" (Langer, 1995, p. 3). Just as for Lewin, were the only actions available to Reece and Celan to express the non-viability of their lives, destructive acts, but in their singularity, destructive acts against their own lives?

Second Languages

I now move to the work of British psychoanalyst and family therapist, Charlotte Burck in her 2004 paper, "Living in several languages", to look at trauma and language from a different perspective. Burck undertook qualitative research into the differing experiences of subjectivity produced for people who were bi- or multi-lingual. Regarding language as "culture soaked", Burck chose to research language as it provides the means "to consider the interconnections between individual subjectivity and the social and cultural context" (2004, p. 315). Referring to Bakhtin, (1981), Burck writes:

> Languages are intrinsically sites of ideological and social struggle, between languages, and within any one language … due to unequal power and status. Questions of how individuals manage a positioning in several languages include the meanings language speaking is given in the wider context, [and are] related to the power relationships and institutionalised practices within which individuals are embedded (Burck, 2004, p. 315).

Burck built on earlier research that discovered that individuals presented different values and even different personality traits depending on the specific language they were speaking (Ervin, 1964; Ervin-Tripp, 1973). She suggests that details of events were even recounted very differently depending on the language spoken, and most surprisingly, "individuals could be simultaneously psychotic in one language and coherent in another" (Burck, 2004, p. 316, referring to de Zulueta, 1984). Whilst this is not by any means a complete summary of her work, Burck did find that certain experiences can best be elicited in an individual's first language; that depending on the language the person utilised, a person may have a quite different sense of identity (p. 320); and that individuals may move differently, and exhibit contrasting behaviours and that overall the person's sense of subjectivity and embodiment depending on the language spoken was quite different.

Burck's study provided many examples showing how language is not neutral and that different languages have different effects and meanings (p. 322). In addition, only being able to speak or be understood in one language for a bi-lingual or multi-lingual speaker may dangerously silence aspects of self and the individual's relationship to self and others. And most importantly for the purposes of my research, Burck found that the distance of a second language may be protective and enable speaking about traumatic experiences impossible in a first[9].

This understanding of the different subject positions evoked and the ease with which traumatic material can be spoken in different languages for multi-lingual speakers, raises the question of whether Celan wrote in his first language. Without having any specifics about Celan's first, second or subsequent languages, what is known is that he was born Paul Antschel to German speaking Jewish parents and grew up in Czernowitz in Bukovina,

[9] It's interesting to note here that according to Mitchell, in aphasia caused by physical injury or disease, the first language to disappear is a second or subsequent language. With "hysterical" aphasia, "Breuer's patient Anna O spoke English when she had lost her native German…" (Mitchell, 1997, p. 127).

which, prior to World War I, bordered on Romania and Russia at the far eastern edge of the Austro-Hungarian Empire. Celan gained proficiency in several languages, which is not surprising as Ukranian, Romanian, Yiddish, Polish and German were widely spoken in the province, with German being the language of choice for most Jews living in Bukovina. Everyday language for Jewish children was Yiddish, but this was largely overtaken by German as the children grew, with all things German being privileged by most Jews living in Bukovina. It is interesting that Celan's epigram "All poets are Jews" was written in Russian, a language with which Celan was extremely comfortable and proficient to the point of translating works of Russian authors. But this begs the question as to what subjectivity did that evoke for Celan that writing in German did not? Was the language of his German oppressors expressive of his personal torture but also the means by which he was vilified? Was German the language of his oppressors, Yiddish the mother-tongue of the oppressed and Russian the language which provided distance, further a distance from mainstream Russian language, being Cyrillic in composition?

In the next section, I turn to another Holocaust survivor, Primo Levi, rather than the other celebrated author from these terrible times, Viktor Frankl[10]. Levi's work has been described by a number of authors as demonstrating how language can both function to reduce and increase psychological survival. The language that is examined below comes from English translations of Levi's native Italian prose and describes the effects on humanness when camp life is mediated through the dialect of Levi's oppressors, which was not, in fact, an exact German. The language used in the concentration camp was a "Lagerjargon", a bullying camp slang, consisting of a coarse amalgam of a number of different languages and

[10] Viktor Frankl and his highly regarded work, "Man's Search for Meaning" are often cited as proof of some transcendent viability after terrible trauma. Frankl, a German psychiatrist who is considered a founder of humanistic psychology developed "as a result of his experiences" a mode of therapy called logotherapy. It has recently come to light that in fact he participated in experiments on prisoners for the Nazis and that he only spent three days in a concentration camp despite implicit claims to the contrary (Pytell et al. 2006). However I do cite aspects of Frankl's work in Chapter 6 in relation to his view of transformative processes after trauma as his ideas are interesting and relevant to this later section.

underlined by constant physical punishment (Volpato & Contarello, 1999, p. 251). With this in mind, and building on the work of other theorists, I examine how language functions to establish viability or non-viability in circumstances which continue to defy efforts to be imagined except by those who lived through them.

In the brutal nights we used to dream
Dense violent dreams,
Dreamed with soul and body:
To return; to eat; to tell the story.
Until the dawn command
Sounded brief, low:
'Wstawàch *' (get up):*
And the heart cracked in the breast.

(Primo Levi, [1958], 1987, in Se questo è un uomo, "If this is a Man").

When the phrase "l'univers concentrationnaire" was first coined by David Rousset (1947), he enabled survivors of the Holocaust wanting to write about their experiences and who also needed to have these stories authenticated to refer to a place which had "a common physical and psychological locus" (Gunzberg, 1986, p. 10). Rousset's univers concentrationnaire, translated by Ramon Guthrie as "The Other Kingdom" is a universe completely separated from other universes, a place of death that can never be adequately portrayed. Gunzberg writes:

In attempting to describe it, while bearing witness to the sufferings of countless others, one can relate only one's own reality; yet to leave even a seemingly small element out of the document is, in a sense, to fall short of one's duty as a survivor, for that detail might symbolize the reality of a thousand dead (Gunzberg, 1986, p. 10).

Whilst at the same time recognising that the terrible experiences of the Shoah can never be adequately described by language (Rosenfeld, 1997) the phrase, univers concentrationnaire has been used to make sense of the Holocaust experience by another Shoah survivor, Bruno Bettelheim (1952). Bettelheim describes this experience as an "extreme situation", a state in which a person is deprived of all previous defence systems and values such that she/he is required to reconstruct a new set of behaviours and principles in order to survive. In an "extreme situation", the preservation of values and behaviour that were once a prescription for an individual's usual being-in-the-world, may incur great danger to self or others, hence the need for an undoing of what previously constituted subject-hood. Volpato and Contarello (1999), referring to the work of Kijak and Funtowicz (1982), describe the following set of criteria constitutive of an extreme situation as "(1) finding oneself in a completely unknown situation without any precedent in one's previous history; (2) when other human beings are responsible for the suffering; (3) undergoing aggression which, being legally justified, creates guilt feelings in the victim; (4) undergoing almost unbearable physical and psychological pain; (5) being a constant eyewitness to fatal torture and deliberate killing; (6) being left in complete isolation, separated from one's family without any knowledge of their fate; (7) undergoing a complete change of environment; (8) perceiving no temporal limit to the existing situation; (9) undergoing a total loss of human and legal rights; (10) having no chance to react against the aggressors;" and "(11) being obliged, in order to survive, to behave in ways which would be unthinkable in normal times" (Volpato & Contarello,1999, pp. 241-242).

Primo Levi, an Italian chemist who, like Celan, was incarcerated by the Nazis during the Holocaust, began writing about his experience of his univers concentrationnaire[11] shortly after his release. With 650 other Italian

[11] It should be noted that Levi himself deplored interpretations such as those made by Bettelheim, cited above. Whilst Bettleheim also survived a concentration camp, Levi was critical of any simple interpretations, any point by point guide to explaining (away) the experience of the Lager. Levi discussed Bettelheim in an interview in 1983, saying how much he disliked him and disliked the way Bettleheim appears to say, with certainty, "Now I'll explain how things really worked" (Smith, 2004, p. 68 citing Levi, 1983).

Jews, he had been transported to Auschwitz and remained there for nearly a year until the Russians liberated the camp in January 1945. In 1947, and being one of only three survivors of the original 650 Italian contingent, Levi originally published his memoir, Se questo è un uomo, "If this is a Man".

Levi first writes about being transported into the neverland of "otherness" during the infrequent breaks in the progress of the train carrying the internees towards incarceration from Italy to Auschwitz. The journey is suffocating and Levi describes something of the sense of the alienation he and his fellow companions were forced to experience:

> During the halts no one tried any more to communicate with the outside world: we felt ourselves by now 'on the other side' (Levi, [1958], 1987, p. 24).

One of the first encounters with the process of dehumanisation comes with many imperatives, including the imperative not to question. Levi recounts such an instance when he reaches for a piece of ice in order to drink from it and quench his four day thirst; during the train journey to the camp, all requests for water had been ignored by the SS. The Nazi guard pushes the precious icicle out of reach. Levi asks, "Warum?" "Why?" to which the guard replies with an aggressive shove towards Levi, "Hier is kein Warum". This is translated to mean, "You may not ask 'why?' here" ([1958], 1987, p. 35). For Levi and the other Holocaust victims, the "why?" which would in usual circumstances, elicit an answer, instead functions to deny the viability of the one who asks the question. When this recognition is removed, the message that remains is loud and clear, "Your call is not worthy of an answer. You do not exist". Butler (2001, p. 24), referring to Cavarero (2000), writes that we are all, necessarily, "exposed to one another", and that this visibility underlies any belief that we can be certain we exist - the Cartesian, "I think therefore I am". It is not possible to simply put questions to myself, to "pos[e] questions of myself alone. I exist in an important sense for you, and by virtue of you. If I have lost the conditions of address, if I have no 'you' to address, then I have lost 'myself'" (Butler, p. 24).

Without the listener, the respondent to one's hails, one's own testimony, one's own existence becomes unviable:

> …if we speak, they will not listen to us, and if they listen, they will not understand (Levi, [1958], 1987, p. 33).

Levi's realisation that the work of the Lager, the camp, is that of a "great machine [designed] to reduce us to beasts" (Levi, p. 47) must have engendered despair. Yet that despair was indescribable in words, an awareness of the "grand design" of the camp could in no way be adequately expressed:

> Then for the first time we became aware that our language lacks words to express this offence, the demolition of a man. In a moment, with almost prophetic intuition, the reality was revealed to us: we had reached the bottom. It is not possible to sink lower than this; no human condition is more miserable than this, nor could it conceivably be so. Nothing belongs to us anymore; they have taken away our clothes, our shoes, even our hair; if we speak, they will not listen to us, and if they listen, they will not understand. They will even take away our name: and if we want to keep it, we will have to find in ourselves the strength to do so, to manage somehow so that behind the name something of us, of us as we were, still remains (Levi [1958], 1987, pp. 32-33).

In this way, Levi in his writing is pointing to two deaths for each person in the camp: their death as a viable human being and their actual physical death. Levi describes his fellow internees as:

> non-men… whom one hesitates to call […] living: one hesitates to call their death death, in the face of which they have no fear, as they are too tired to understand... on whose face and in whose eyes not a trace of a thought is to be seen … (Levi, [1958], 1987, p. 96).

Valerio Ferme's (2001) treatise points us to the title of Levi's testimony and draws attention to this author's understanding that there are two possible meanings, both which point to the heart of my discussion. The first is that "If this is a Man", that which makes for humanness must be put under scrutiny, be it that of the oppressed or the oppressor. The second interpretation that Ferme makes is that "If this is a man", that which cannot be spoken, points to the failure of language to account for the atrocities of the camps, whether it is to describe them or to provide them with a rational explanation. What Ferme does is to describe how language nevertheless "remained present in its absence" (Ferme, 2001, p. 57), and therefore operated as a mechanism which could be subverted in order to rebel against the Nazi captors. Hence Ferme describes Levi as testifying to a conflict between two modes of signification.

> The one, based on the perverse semiotics of Nazi annihilation policies, is bent on creating a disjunction between words and their referents. This becomes especially obvious in the torturers' attempt to remove any 'human' connotation from the signifier 'Jew.' The other, that of the resisting camp prisoner [Häftling], attempts to mis-appropriate and then re-appropriate language both inside the camp and, eventually, in the testimonial memoirs that follow liberation. In the camps, understanding the signifying structure means learning how language functions (i.e., how to obey and disobey orders, knowing one's number…) in order to survive; but also maintaining one's 'being-ness,' one's coherence as human beings, one's consciousness (Ferme, 2001, p.57).

An example that is specific to the reclaiming of language as a means of restoring viability in the face of the ever present dehumanising effect of language in the camp is what occurs when Levi encounters another internee, Steinlauf, in the camp's bathroom. The "rules" that the Nazis will enforce about "cleanliness" are written on the toilet walls. Whilst there is no soap with which to wash, Steinlauf is nevertheless observed thoroughly washing his hands and face, using the dirty water sitting in the troughs. Levi is

bemused, but his companion explains that although they are enslaved, the prisoners:

> … still possess one power, and we must defend it with all our strength for it is the last – the power to refuse our consent. So we must certainly wash our faces without soap in dirty water and dry ourselves on our jackets. We must polish our shoes not because the regulation states it, but for dignity and propriety. We must walk erect, without dragging our feet, not in homage to Prussian discipline but to remain alive, not to begin to die (Levi, [1958], 1987, p. 47).

Steinlauf contends that in boldly complying with the orders, the prisoners, "die Häftlinge", will be enlivened by what is obviously designed to shame and demean them. Whilst Levi is initially sceptical, Steinlauf has been able to demonstrate to Levi that it is possible to resist their captors and their dehumanising imperatives by implicitly following the orders. The prisoners continue to embody and perform the everyday actions that signify a basic human dignity even while they are denied the resources to do so. In this way, they continue to perform, for themselves and each other, a humanity that their tormentors would deny to them. Some sense of viability is regained for Levi as he takes back what has been colonised to restore some semblance of recognition, to make life more livable and thus bearable in the camp. In following orders made to "beasts", non-viability can be transformed into recognition and beingness.

Somehow through the terrible months ahead before liberation, Levi manages to survive. But Nancy Smith (2004) reminds us here that for Levi "liberation" was an even more shocking state to encounter, "in the aftermath of trauma" (N. Smith, 2004, p. 66). Levi tells us:

> What we saw resembled nothing I had ever seen or heard described. The Lager, hardly dead, had already begun to decompose. No more water, or electricity, broken windows and doors slamming to in the wind. Loose iron sheets from the roofs screeching, ashes from the fire

> drifting high, afar. The work of the bombs had been completed by the work of man: ragged, decrepit, skeleton-like patients at all able to move dragged themselves everywhere on the frozen soil, like an invasion of worms. They (the remaining ill prisoners) had ransacked all of the empty huts in search of food and wood, they had violated with senseless fury the grotesquely adorned rooms of the hated Blockaltestre (prisoner in charge of block) ... no longer in control of their own bowels, they had fouled everywhere, polluting the precious snow, the only source of water remaining in the whole camp around the smoking ruins of the burnt huts, groups of patients lay stretched out on the ground, soaking up its last warmth ... Other starving spectres like ourselves wandered around searching, unshaven, with hollow eyes, greyish skeleton bones in rags, shaky on their legs, they entered and left the empty huts carrying the most varied of objects, axes, buckets, ladles, nails; anything might be of use (Levi, Survival in Auschwitz, 1993, pp. 158-172).

N. Smith reprimands us for reading into the above the humanist assumption of "the precious resilience of the human spirit" (Smith, 2004, p. 67). What she sees is the continuing "demolition of a man":

> Do not be deceived. These Nazi camps were masterfully designed to be resiliency-killing factories, which systematically shattered every ounce of the human psyche so there would be no bouncing back (N. Smith, 2004, p. 67).

N. Smith tells us that "to return, to eat, and to tell the story" is fraught with pain and with what can't be borne. Levi wrote:

> I believe that it was precisely this turning to look back at this 'perilous water' that gave rise to so many suicides ... after Liberation. It was ... a critical moment that coincided with a flood of rethinking and depression (Levi, [1986], 1989, pp. 75-76).

Levi prompts us to note that suicide was a very unusual event during incarceration. Prisoners did appear to allow themselves to die but they did not make an overt act of suicide:

> There were 'other things to think about' as the saying goes. The day was dense; one had to think about satisfying hunger, in some way elude fatigue and cold, and avoid the blows. Precisely because of the constant imminence of death there was no time to concentrate on the idea of death. All of one's organism is devoted to breathing... (Levi, [1986], 1989, p. 76).
>
> ... the feeling of shame and guilt… [emerges] ... with the reacquired freedom ... Coming out of darkness, one suffered because of the reacquired consciousness of having been diminished. Not by our will, cowardice, or fault, yet nevertheless we had lived for months and years at an animal level: our days had been encumbered from dawn to dusk by hunger, fatigue, cold, and fear, and any space for reflection, reasoning, experiencing of emotions was wiped out. We endured filth, promiscuity, and destitution, suffering much less than we would have suffered from such things in normal life, because our moral yardstick had changed. Furthermore all of us had stolen: in the kitchen, the factory, the camp, in short from the others, from the opposing side ... Some had fallen so low as to steal bread from their own companions. We had not only forgotten our country, and our culture, but also our families, our past, the future we imagined for ourselves, because, like animals, we were confined to the present moment (Levi, [1986], 1989, p. 75).

Viability

Levi's account points to the transitory nature of survival and viability. What makes a non-man in the camp is performed once liberation has arrived. The

shackles of the absence of recognition are internalised, individually and collectively and even in the freedom, continues to function as a tool of death and the unbearable. N. Smith further reminds us that the lesson learnt from Levi's book, The Truce, "a 'Truce' is possible which allows brief emotional sojourns to what used to be 'home'" (N. Smith, p. 68). Levi could return to Turin, get married and have children and run a business but a truce is by its definition, impermanent:

> I reached Turin on 19 October… my house was still standing, all my family was alive… I found my friends full of life, the warmth of secure meals… the liberating joy of recounting my story… and a dream full of horror has still not ceased to visit me….
> … And in fact, as the dream proceeds, slowly or brutally… everything has changed to chaos… I am in the Lager once more, and nothing is true outside the Lager. All the rest was a brief pause, a deception of the senses, a dream... Now this inner dream, this dream of peace, is over, and in the outer dream, which continues, gelid, a well-know voice resounds: a single word, not imperious, but brief and subdued. It the dawn command of Auschwitz, a foreign word, feared and expected: get up, 'Wstawàch' (Levi, [1963], 1987, pp. 379-380).

Levi's testimony speaks to what makes for livable life. Language was deployed by his Nazi captors to remove individual and collective dignity and human value from the incarcerated. Yet language, conversely, was the tool of Levi's resistance in the way it was reappropriated to regain something of that human beingness. Nevertheless, Levi, like Celan, also committed suicide some years after the Holocaust. Both of these amazing talented men were ultimately "demolished" by the trauma they suffered, their ability to language their experiences proving inadequate in any quest they may have undertaken for long-term viable lives, for viable lives until natural deaths. For Celan, his recognition as a poet suffered enormously under the strain of a particular vilifying audience. Did the same happen for Dora, which is why when she ended therapy with Freud, her aphasia returned? Do both the mechanisms of language, from brain to tongue to

voice box, and the substance of language, depend only on the relationship with the listener? But if so, how does one explain Reece whose relationship with his family was good, but his sense of his own viability was not? How does one explain the consequences for Julie – was self-harming and suicidal ideation an expression of the unviability of her life that (in)adequate language could not repair? For Levi, the strain of the memory of his treatment, once he was relatively safe, did not allow for a full life of viability. The strain of recounting his story in language may at times have been too much and certainly the overwhelming memories intruded into his everyday life. Levi wrote that the suffering that came from such an experience of extreme horror continued interminably. He quoted Amery, an Austrian philosopher tortured by the Gestapo, who suicided in 1978:

> Anyone who has been tortured remains tortured… Anyone who has suffered torture never again will be able to be at ease in the world, the abomination of the annihilation is never extinguished. Faith in humanity, already cracked by the first slap in the face, then demolished by torture, is never acquired again (Levi, 1989, p.25).

If I am making any "truth claim" at this point of my thesis, I believe that, based on these tortured accounts, viability is not a fixed entity that is established once and for all at a singular moment in time. It may need to be revisited again and again when despair re-emerges in the psyche of the human subject. The narrativisation of trauma may work to provide both the amelioration of symptoms and a recognition that provides viability. But this viability may not be infinite.

Perhaps the most profound idea that has emerged in this chapter is that language is not only "written" or inscribed on the body; it is indelibly and violently carved into the body to function as central to embodied processes. This idea developed in recognising how people with second languages can embrace very diverse subjectivities in response to the language they use in the story they need to tell. Yet despite this indelibility, this inscription at the deepest level of embodied sociality, language is not enough to adequately

represent terrible overwhelming experiences of trauma, nor can it with any certainty, create all the necessary conditions of possibility for recovery from trauma.

The next chapter focuses further on the relationship between unspeakable events and memory in regard to the sustainability of a viable life. It will discuss this alongside the problematisation of memory and unintelligibility in the narrativisation of traumatic accounts.

Chapter 5: Memory and Narrative

Death at Dong Long Lach, near Bin Hoa - 2nd January '69.
A nun from the destroyed church and seminary, just beyond the perimeter of the air base, 20 km north of Saigon, passes the body of an NVA soldier killed while attempting to spring his comrades from a nearby POW camp. After the aborted attack a battalion of Bo Doi made a last ditch stand in the refugee commune's church: upon sunrise, they were annihilated by helicopter gun ships and ground troops
(Tim Page's "Nam" Box, Lot 182).

> Philip Williams: Amongst War Correspondents, photographer Tim Page is legendary. For four years he photographed the Vietnam War for Time Life, Paris Match and Associated Press. But as I am about to discover, he's paid a high price.
>
> Tim Page - Photo Journalist: I was 20 when I got to Vietnam. I think that [my] youth was [my] saving grace because with youth comes innocence, naivety.
>
> Philip Williams: Vietnam was a war without censorship. Tim Page went everywhere, covered everything and saw too much.

Tim Page - Photo Journalist: There were bullets, there was stuff happening, but I wasn't the target, and the younger you are the more invincible, I think you like to imagine you are.

Philip Williams: Tim Page was the role model for Dennis Hopper's crazed photojournalist in Apocalypse Now. But in real life, Tim was far from immune to the horrors of war.

Tim Page - Photo Journalist: The first time I saw torture, a Vietcong suspect was being interrogated. And here's a guy standing there with a bayonet off his carbine to put it in the guy's gut and he's drawing it up. I turned away. The shock of seeing somebody deliberately… [killing someone]. I didn't grow up in the Bronx, I grew up in a nice English suburb. [To see someone] deliberately inflicting harm, torturing somebody, is inconceivable until you actually witness it.

Philip Williams: Did you switch off? Was there an emotional switch that you had to use?

Tim Page - Photo Journalist: Not an emotional switch. I mean I have to be honest, I used a lot of dope, opium and alcohol. I don't think these were criminal acts. It was a method of survival. You self medicated. I sound like an old druggie or something. You tried to bury it. I mean you didn't, I suppose. In a certain sense you buried it under vast heaps of drugs and alcohol. You like to think that the camera was some sort of magic filter, which enables you to become invisible. The effect of what was in front of you was filtered out by the camera, and the translation that you put on that moment in making the photograph, making the image, somehow absorbed the shock of it. You start to see shapes and forms almost in abstract. I like to call it 'art in body parts'.

Philip Williams: But Tim's camera was not enough to protect him. He was wounded three times. Then in 1969 he took the full force of a landmine.

Philip Williams (looking at a photo): So this is you, almost dead?

Tim Page - Photo Journalist: Officially dead.

Philip Williams: You were dead at that point?

Tim Page - Photo Journalist: I was DOA at that moment, declared DOA. And in the chopper according to the nurse she restarted my heart three times.

Philip Williams: Tim had lost 25 percent of his brain and, semi-paralysed, spent a year in hospital. But it was the hidden impact of the horrors he'd witnessed that would live with him forever.

Tim Page - Photo Journalist: I tried to commit suicide three times. I mean to find yourself sitting in your [own shit], so far down and out, whether it's alcohol induced, drug induced, it's not important. And to take a 38 pistol, take out one round and play deer hunter, put it into your mouth and it comes up empty. Is there a message in that? I suppose there must be

(ABC TV: COMPASS: BEARING WITNESS. Aired June 17 2007).

Someone a long time ago wrote that books too, like human beings, have their destiny: unpredictable, different from what is desired and expected. The first of these two books also has a strange destiny. Its birth certificate is distant: it can be found where one reads that 'I write what I would never dare tell anyone'. My need to tell the story was so strong in the Camp that I had begun describing my experiences there, on the spot, in that German laboratory laden with freezing cold, the

war, and vigilant eyes; and yet I knew that I would not be able under any circumstances to hold on to those haphazardly scribbled notes, and that I must throw them away immediately because if they were found they would be considered an act of espionage and cost me my life… (Levi, 1987, p. 381).

If I had not lived the Auschwitz experience, I probably would never have written anything. I would not have had the motivation, the incentive, to write. I had been a mediocre student in Italian and had had bad grades in history. Physics and chemistry interested me most, and I had chosen a profession, that of chemist, which had nothing in common with the world of the written word…

Now, many years have passed. The two books, [“If this is a Man” and “The Truce”] above all the first, have had many adventures and have interposed themselves, in a curious way, like an artificial memory, but also like a defensive barrier, between my very normal present, and the dramatic past. I say this with some hesitation, because I would not want to pass as a cynic: when I remember the Camp today, I no longer feel any violent or dolorous emotions. On the contrary, onto my brief and tragic experience as a deportee has been overlaid that much longer and complex experience of writer-witness, and the sum total is clearly positive: in its totality, this past has made me richer and surer. A friend of mine, who was deported to the women’s camp of Ravensbrück, says that the camp was her university. I think I can say the same thing, that is, by living and then writing about and pondering those events I have learned many things about man and about the world.

I must hasten to say, however, that this positive outcome was a kind of good fortune granted to very few. Of the Italian deportees, for example, only about 5 percent returned, and many of these lost families, friends, property, health, equilibrium, youth. The fact that I survived and returned unharmed is due, in my opinion, chiefly to good

> luck. Pre-existing factors played only a small part: for instance, my training as a mountaineer and my profession of chemist, which won me some privileges in the last months of imprisonment. Perhaps I was helped too by my interest, which has never flagged, in the human spirit and by the will not only to survive (which was common to many) but to survive with the precise purpose of recounting the things we had witnessed and endured. And, finally, I was helped by the determination, which I stubbornly preserved, to recognise always, even in the darkest days, in my companions and in myself, men, not things, and thus to avoid that total humiliation and demoralization which led so many to spiritual shipwreck (Levi, 1987, pp. 397-398).

In previous chapters, I began an examination of current constructions of the "normal" brain and the brain of a traumatised person in the current context of a blurring of perceived boundaries between neurobiological and psychological spaces which has taken place over the past two decades. In the following section, I will discuss in more detail the problematisation of traumatic memory in relation to two main themes. One concerns the construction of "wholeness", that is the therapeutic and linguistic discussions of what constitutes a "healed" human subject after traumatic experience and the function of that constitution. The other theme that will be examined in this chapter concerns speaking and silence and managing the wound created by trauma even though the "nature" of the wound may appear to have been transformed into language. In this chapter I will also revisit Page's and Levi's accounts to examine them in the light of theories of memory, language and narrative and notions of integration. I will also grapple with something of their opacity when I try to find what are the consequences of the unsaid or unnarrativised experiences to which these extracts allude.

Memory, Language and Narrative Voices

Autobiographical, explicit or "normal" memory, as it is called within the human sciences, is believed to join events, locations, others and self at a particular point in time. Autobiographical memory, which has access to

language, is thus understood to establish the context of an event, including its emotional significance, perceptions about self and others and behaviour integral to the event. All of these factors are knitted together through a written or spoken narrative that manages an individual's perceptions about her or his internal and external worlds. This spoken narrative is the in medias res[12] voice of memory (Langer, 1991). That is, it portrays the voice of explicit memory in which a person is able to locate themselves within " 'normal' moral and cultural contexts", engendering a sense of a linear continuity of self and personal meaning making" (Uehara, Farris, Morelli & Ishisaka, 2001, p. 37). Thus an autobiographical narrative voice has a rhetorical style that enables the narrator to reflect and comment upon certain experiences, so as to ascribe specific meanings to those experiences within culturally available repertoires, including meanings that confirm the selfhood of the narrator. In contrast, Janet theorised that flashbacks or traumatic memories were not actual memories, capable of representation, retrieval and control in the way of autobiographical memory as it is understood today. Traumatic or implicit memory has what Langer described as an in principio[13] quality (Langer, 1991) that may be quite unstructured and incoherent. This traumatic voice brings events to life in a more immediate way but does not produce a sense of linear continuity of selfhood or meaning. The above texts which commence this chapter give examples of the in medias res and in principio representations.

Drawn by an overwhelming desire for narrativisation, Levi's "need to tell the story" was so pervasive that he even began capturing his experiences in words penned in "haphazardly scribbled notes". He sought this written autobiographical account despite being under constant surveillance, despite the fact that he could not risk these notes being found. If this writing was motivated by a need for recognition, it was a recognition that only Levi could give himself at the time. Levi writes that his two books, "have

[12] The phrase in medias res is Latin for "into the middle of things" such as into the middle of an action or a sequence of events, as in a literary narrative. Websters New World College Dictionary.
[13] In principio is Latin for "in the beginning". In the Latin Vulgate Bible, John 1: 1 begins with the phrase, "In principio… ": "In the beginning was the Word, and the Word was with God, and God was the Word." Available from http://www.dictionary. babylon.com.

interposed themselves, in a curious way, like an artificial memory, but also like a defensive barrier, between my very normal present, and the dramatic past". He points to the performative and constructed qualities of autobiographical memory, although there is a dissonance with the construction of the work of the narrative as also the work of healing, when Levi admits this memory is "also like an artificial barrier". This dissonance sits uncomfortably alongside theorising that deems language as the core component of integration, that is, the process by which a number of perceived aspects of self (e.g. emotional, cognitive, behavioural, historical, etc.) come together to form a "balanced" human-being, compatible with their environment. According to this construction, the developing human-being composes a sense of selfhood over time through employing personal narratives such as these:

> Children are told by others, and gradually begin to tell others, who they are, what is important to them, and what they are capable of. These self-stories are shaped by the children's interactions with parents, peers, and available cultural models. In this process, stories serve to perpetuate both healthy and unhealthy forms of self-identity (Cozolino, 2002, pp. 34-35).

Theorists such as Cozolino might assume that Levi's "defensive barrier" is characteristic of a still incomplete integrative process, despite the detailed accounts of his experiences during the Holocaust. And/or this dissonance might point to the vividness of the experiences Levi had during the Holocaust, a vividness that is paradoxically more available to him through traumatic memory or the traumatic voice of the graphic implicit impressions of his experiences that defy or are outside language. Conversely, there appears to be a supposition by Cozolino that all children live in a relatively safe and predictable world, despite the fact that most of the world's population live in conditions of abject poverty and deprivation.

Similarly, a protective boundary was created by the camera when photo-journalist Page described how, in photographing pictures of war and

atrocity, “making the image, somehow absorbed the shock of it”. Yet Page also says that he began “to see shapes and forms almost in abstract. I like to call it 'art in body parts'”, an observation that can be analysed as consistent with fragmentary traumatic memories. Page points to the persistence of the traumatic images and memories he experienced, despite his use of alcohol and drugs, when he says “You tried to bury it. I mean you didn’t, I suppose”. Page can be understood as unable to reduce the disabling effects of these haunting images, which became “snapshots” of traumatic events caught on camera – an irony given that the metaphor of the snapshot has been used in trauma literature to describe flashbacks or fragments of memory as if they are single frames or images disconnected from any mediating narrative. Page’s trauma can be considered (and was experienced as) fragmentary and unable to be integrated into Page’s life story or autobiographical memory. Unlike narrative or declarative memories, which are seen to be stored in normal memory and deemed to be under the control of the muser, who is able to retrieve them or put them away again at will, Page’s images of body parts may be full or partial re-experiences of the very traumatic events that he witnessed and which intruded into his everyday life. In this sense, this “traumatic” memory is not considered to be memory at all, but a disorganised and unfiled image or sense of an event, disconnected to other factors relating to the trauma until it can be spoken into memory.

At the same time, it is interesting to note that the composition and play of light in the “Death at Dong Long Lach” photo works strongly to create a kind of transcendent beauty that restores a kind of humanity to the scene in viewing the nun’s shock and grief as she moves around the body of the soldier. The light catches the nun’s habit; this everyday ordinariness of wind and light and shadow sits alongside the horror of the scene and the grace of the woman, her clothing and the landscape. This may be some kind of equivalent in visual discourse to in medias res, but being wordless perhaps it does not so seamlessly reconstitute the humanist narrative as Levi's writing does. Certainly it does not save Page from the powerfully destructive effects of what he has both witnessed and experienced. It is not my intention to set up the image in opposition to notions of autobiographical

narrative: Page is fluent in a visual language and ironically conscious of his art, to the extent of being concerned that in abstracting his subjects he may have dehumanised them. However much he might hope for the mediation of the camera to protect him from the horror, it doesn't, either emotionally or entirely. Page's interview has a kind of burning honesty, and his story and images place him in the position of bearing witness as well as literally in the line of fire - his images make for “direct hits”. Yet he has “failed” at the humanist task of reconstituting himself as “whole”, recovered, and/or made greater by his experiences, given his ongoing struggles.

Perhaps this so-called “failure” has occurred because these iconic representations stay in traumatic memory such that they reinforce for Page a sense of overwhelming powerlessness in their defiance of articulated and therefore manageable meaning making. Page comments that the filtering effect of the camera allowed him “to become invisible”. Was it some premise based on the notion of the neutral observer/witnesser/recorder of events that led him to desire to see himself or his journalist persona in this way? But if so, this fiction was not helpful in removing Page from the immediacy of the events. Or was the desire for invisibility more from a sense of having to disappear to survive? If one is not visible, one is not truly in situ, meeting the horror face on. And if one is not directly present, the full impact of the horror may be reduced. Yet this possibility of invisibility did not protect Page from being physically and psychologically wounded himself, from becoming a casualty of war. Ironically, he was wounded three times before his most life-threatening injury as a result of a landmine, only to attempt suicide much later, the desire to live being strong in the immediacy of his presence in the war, but weak within the gap of dealing with the experience of it once he is out of the war zone. The phrase “three times” punctuates the interview, three times, like a deadly refrain; Page is wounded “three times”, the nurse restarts his heart “three times”, he attempts suicide “three times”. The interview itself has a rhythm almost as surreal as the composition of the photographic images.

Further, it is worth contemplating here what the consequences would be if Page could have seen the events head on, if he could have witnessed them without the protection of the camera, and been fully present to a violence that he could later make speakable and intelligible through a seamless narrative. Had Page demonstrated an ability to accommodate these events in some lucid and coherent way, would this have been productive of a subjectivity that was more human, or less so? What if forgetting, incoherence, abstraction and invisibility are appropriate strategies to resist a dehumanised subjectivity?

Girl running from Napalm Attack, Vietnam – 1972.

In contrast, Kim Phuc Phan Thi, the little nine-year-old girl burnt by napalm in the famous photo taken in 1972 by Associated Press photographer, (Nick) Ut Cong Huynh, makes the comment "I cannot change the history of what happened to me," she said. "But I can change the meaning of it" (Phuc, 2008). Ut won the Pulitzer Prize for his photograph of Phuc which helped turn the tide of opinion against the Vietnam War. Phuc suffered burns from napalm all over her body and fortunately survived to start in the late 1990's, the Kim Foundation International which is focused on providing free medical assistance to children who are victims of war and terrorism. In

running this Foundation and providing inspiration as a motivational speaker, Phuc has what has been described in various articles in the press, as an attitude of loving forgiveness. Within discourses which promote transcending human suffering, Phuc appears to have reconstituted herself (or at least has been publicly reconstituted) as "whole" despite or because of her terrible experiences.

However, for the purpose of this specific examination, I want to turn to Ut's image and examine it in relation to Page's photo which begins this chapter. Ut's photo of 9 year old Phuc and other fleeing, distressed children, may also equate in visual discourse to the in medias res, but again does not flawlessly reconstitute the humanist narrative in the way that written narratives often do. In not protecting the viewer from the terrible effects of war and depicting a similar searing honesty, many more people were incited to move to end the Vietnam War. If photographs such as these do the work of autobiographical memory by reconstituting the humanist narrative and also create the intensity and immediacy of traumatic memory, they may allow more space for the production of an ethical response to trauma. Butler comments that the sheer force of this visual image, images that people "won't supposed to see" due to the US government's support for the war, "disrupted the hegemonic field of representation itself" (Butler, 2004a, p. 150):

> Despite their graphic effectivity, the images pointed somewhere else, beyond themselves, to a life, to a precariousness they could not show. It was from the apprehension of the precariousness of those lives we destroyed that many US citizens came to develop an important and vital consensus against the war (Butler, p. 150).

What Butler is saying is that the unavoidable gap between the experience of an event and "remembering it in representation" (Huyssen, 1995, p. 3) is in fact crucial to the development of alternative potentialities for experience and subjectivity which otherwise would have been foreclosed by a hegemonic tyranny. The very gap, the sense "the images pointed

somewhere else, beyond themselves, to a life, to a precariousness they could not show", allowed trauma's dehumanising effects, which otherwise are avoided in order to meet a particular political trajectory, to open up possibilities for subjectivity, broadening the scope of perceptions about who is human and whose lives are worth grieving.

Narrative and the in principio Voice

However, trauma theory states that only when an event is contextualised through narrative are links made between the multi-layered sensory, emotional and cognitive elements of any happening so that it can be "resolved", made sense of, processed, or "filed" away in "normal" or declarative memory. According to this theorising, when Levi remembers Auschwitz in the present, he says he "no longer feels any violent or dolorous emotions", as though the rage and distress emanating from his experiences are no more. The act of writing would appear to have mediated the in principio vividness of the horrifying events. Not only does he have relief from these emotions, Levi describes a subjectivity of the "writer-witness" as if it contains all the hopeful (and desired) aspects of an autonomous, self-regulating, integrated selfhood. Levi's narrative encompasses aspects of viability also - "this past has made me richer and surer". This act of speaking and writing by which Levi produces a remembrance for self and others is an example of what makes for autobiographical memory:

> [Normal memory] like all psychological phenomena, is an action; essentially it is the action of telling a story… A situation has not been satisfactorily liquidated… until we have achieved, not merely an outward reaction through our movements, but also an inward reaction through the words we address to ourselves, through the organisation of the recital of the event to others and to ourselves, and through the putting of this recital in its place as one of the chapters in our personal

> history… Strictly speaking, then, one who retains a fixed idea of a happening cannot be said to have a 'memory' … it is only for convenience that we speak of it as a 'traumatic memory' (Herman, 1992, citing Janet, [1919], 1925, pp. 661-63).

Maurice Halbwachs states, "it is in society that people acquire their memories" and even when a person is alone at the time of the event, "it is also in society that they recall, recognise, and localise their memories" (Halbwachs, 1992, p. 38). Brison comments that what is necessary is "not only the words with which to tell our stories, but also an audience able and willing to hear us and to understand our words as we intend them" (Brison, p. 50). Levi had an audience to whom his writing could be read, to whom his accounts would resonate. His work was applauded during his life as well as posthumously, and this recognition of his narrativisation would have been, I imagine, as he intended it to be, assisting him to reconstitute himself as "whole" human being, at least for a time. But what if this reconstitution is invaded at times by the traumatic elements of his experience?

Babette Rothschild (2000) holds that one's senses hold the memory, that is, an individual's visual, auditory, smell, taste and tactile senses are the implicit strongholds of traumatic events. Michaesu and Baettig (1996) created the term, "iconic symbolisation" to explain the process by which a traumatic experience is imbued with visual character. Without a context in which to place it (the role of narrative) the visual identity continues to exist as a symbolic representation situated outside language. This traumatic representation, constitutive of a yet unnarrativised "history of the present" is nevertheless mediated through culture, so even flashbacks or snapshots of these recollections are viewed through the lens of socio/cultural representations. When Page talks about "art in body parts" I think of this as an iconic representation of what the camera captured but Page's psyche was unable to process:

> … [t]here is, in addition, a gap between the event (which may be described in countless ways) and the experience of it. I am here

> simply rejecting a naïve realist view of perception and of experience generally, a view that may be unwittingly evoked by those trauma theorists who emphasize the 'snapshot' character of traumatic memory. (Not even snapshots capture 'the given' as it is, without distortion and selection.) Events are experienced by means of representations – sensory perceptions, bodily sensations, and linguistic classification (even if only a 'something terrifying'), and these are all influenced by perceived cultural meanings of the events (Brison, 2002, p. 31).

Page's "art in body parts" reflects this cultural representation providing both opaqueness and an entry into cubist imagery. Levi's dissonance reflects the gap between his descriptions of the Holocaust and his experience of it. At a time when war was publicly sanctioned, Ut's photo reflects what could not be said about the Vietnamese – that they too were also suffering terrible trauma as a result of US involvement. In these instances I propose that the traumatic element is necessary precisely because it sits outside humanist narratives which make moral and cultural "sense" of the world.

Challenges to Representation

In the next section, I will examine attempts at moving unspeakable events into language, making particular reference to the theorising of Uehara et al. (2001), who explored the process of narrativisation undertaken by survivors of the "killing fields", the period of time between 1975 and 1979 when the Khmer Rouge committed unimaginable atrocities against millions of Cambodians. This examination is based on the premise that some events, (which also include the Holocaust), defy representation because cultural signifiers and metaphors disappear in the face of extreme brutality and acts of genocide.

If it is assumed that experience is a communal vehicle that "joins norms to sentiments, social meanings to cognition, social relationships to

psychobiological responses" (Kleinman & Kleinman, 1994, p. 712), then systematic ethnic "cleansing" produces a communal experience on an unimaginable scale. Experience can be constructed as comprising a collection of interactive and conciliatory social mechanisms that move recursively between the socio/cultural and what Uehara et al. describe as the "'body-self'" (p. 30). Thus patterned communications between the social, psychological, biological and relational interact with the physiological, the "body-self" to produce mental or physical distress in the face of disaster (Uehara et al, p. 31.) As outlined in Chapter 3, experience is not a static entity that someone has, rather it is something someone does, and it is contextually and discursively constructed. Furthermore, the body-self is inseparable from social, biological, psychological and relational discourses centred upon it:

> … [T]he imprint of experience upon bodies-selves is social and semiotic as well as psychobiological. The incorporation of experience into the body-self involves a semiotic attempt to endow events with meaning, to incorporate them into a coherent life narrative (Uehara et al., 2001, p. 31).

This semiotic attempt to ascribe events with meaning is particularly relevant to the notion of integration and how, or if, it functions in severe abuse and atrocity. The bio/psycho/social/relational interaction with the body-self is never more heightened than under the extreme stress generated by ongoing acts of barbarism. As discussed in Chapter 3, the perception that healing and "wholeness" occurs once trauma events are transformed into coherent narratives, sits in partnership with the notion that narrativisation then transforms traumatic events into manageable elements of normal memory. They can be filed away and retrieved as required rather than come into play spontaneously, holding the trauma sufferer captive. Resolution of trauma is inextricably linked to the making of an autobiographical memory according to many theorists such as Harvey (1996): when one gains "mastery over memory", one gains mastery over the trauma.

We saw in the previous chapter how Paul Celan storied his memories through his poetry. Therapeutic interpretations of Celan's ambivalence in regard to his sense of the future or the frightening flashbacks of Julie's childhood kidnapping can be construed as unresolved symptoms of trauma and/or as inadequately "narrativised" accounts. However another question or understanding emerges if we do not automatically assume a failure of the autobiographical process. What if the continuing presence of in principio accounts reflect the unspeakable nature of acts of atrocity against individuals and whole communities?

Theory related to trauma treatment states that a significant goal of therapy with traumatised individuals is that of "integrating" traumatic experience into the life narrative of the trauma sufferer. This pull towards a specific semiotic construction of coherent selfhood is supported by present day discourses about the constitution of "healing" and "recovery" from trauma. Psychological discourses suggest that recovery from trauma occurs when we are able to regain the sense of integrity that we had prior to the traumatic events that seemingly demolished us. As such, the mechanism through which this integrity of self returns is semiotic, because new discourses are constructed to explain fragmented and paradoxical life events. Hence when previous events appear to gain some sense of moral significance, they do so because they are now able to connect to other events in a person's life. The person has "recovered" from trauma through a process of "re-integration", "… through the process of self (re)constitution, we feel 'returned to wholeness'" (Uehara et al., 2001, p. 31). This process draws on our ability to make new stories about our life using the culturally mediated metaphors and discourses that are available to us in relationship with others, in particular the listeners to our narratives living in community with us. Thus language is the vehicle through which the individual understands and describes the self and the world. And it is language that is used to create the allusion of a domination of those irrational processes that might otherwise challenge the notion of a coherent and autonomous humanist subjectivity. According to Riessman (1991) individuals "create who they are, and the definitions of their situation that

they want listeners to adopt in their biographical accounts" (Riessman, 1991, p 44), binding together contradictory and fragmentary components of specific events to make an account which is coherent to the listener.

Whether or not the memory of a trauma is implicit, the trauma sufferer still endeavours to make a coherent account of what they have experienced and this is in spite of the memory being fragmentary in nature. As Ricoeur (1984) points out, the narrator attempts to create a narrative which is culturally acceptable in that the tense is uniform in delineating when events occurred, and the progress of the story is rational and linear. In the following extract, Sithan, a survivor of the Killing Fields of Cambodia, entreats his researcher to make a coherent account of his story so that it relates to his other life experiences in the face of fragmented memory that is "just *there"*:

> I just hope that you could put a story together somehow. That's why I try to keep, you know, in a chronological order. Hopefully it stays that way. But in terms of dramatic experience, you know, it's kind of just there. You have to put it together yourself, time-wise (Sithan in Uehara et al., 2001, p. 37).

Uehara et al., utilising Lawrence Langer's (1991) conceptualisation of different ways of speaking used in narrative accounts, delineates the two competing narrative states that are employed by Sithan above. The explicit or "in between time" voice (Uehara et al., p. 37) belongs to autobiographical memory. Here Sithan moves to understand and speak of the traumatised events of the Pol Pot years as a happening which occurred in a coherent linear way after his earlier life and before the present day: "That's why I try to keep, you know, in a chronological order". This attempt sits in contrast to the implicit memory of trauma, which is "kind of just there".

The voice of autobiographical memory allows the traumatised sufferer to "to heal the historical breach created by atrocity, and to relocate himself within 'normal' moral and cultural contexts" (Uehara et al., p. 37) where,

for example, meaning is made. This is illustrated when Sithan goes on to say that he can achieve anything having survived the killing fields due to his own strength and determination. And Primo Levi employed a similar hero or survivor narrative when he stated:

> Perhaps I was helped too by my interest, which has never flagged, in the human spirit and by the will not only to survive (which was common to many) but to survive with the precise purpose of recounting the things we had witnessed and endured. And, finally, I was helped by the determination, which I stubbornly preserved, to recognise always, even in the darkest days, in my companions and in myself, men, not things, and thus to avoid that total humiliation and demoralisation which led so many to spiritual shipwreck (Levi, 1987, pp. 397-398).

This "capacity to make meaning" is a function and consequence of a linear narrative of autobiographical memory. Levi engages with a narrative of transcendence when he suggests that it is through his role as an observer and narrator of the human spirit that he could "avoid the total humiliation and demoralisation which led so many to spiritual shipwreck". Uehara et al. punctuate the request that Sithan makes above, to connect his account [my italics], to "put it together" in some way so as to make sense (meaning) of it. They point out that his entreaty as to this difficulty is testimony to the fact he cannot at all times produce a complete narrative of his experience. Again, this voice is indicative of what has previously been described as that which emanates from traumatic memory, the "art in body parts", that which is "kind of just there", defying "the banal reassurances of common memory" (Kleinman & Kleinman, 1994, p. 717; Langer, 1991; van der Kolk and Fisler 1995; van der Kolk and van der Hart, 1991). In this way, attempts at a coherent narrative often fail, despite the traumatised person's own personal commitment and/or outside psychological intervention focused on coherently communicating their experiences (Uehara et al., 2001, p. 32). The traumatic voice cannot engage with a

specific narrative to make meaning, to locate a subjectivity within a specific historical context.

According to Langer, rather than reconstituting selfhood and the pre-existing life narrative, traumatic memory "assaults and finally divides the self" (Langer, p. 47). In this way, the movement of autobiographical memory to narrativisation is opposed by the pull of traumatic memory to experience the unspeakable, such as that which occurs with atrocity, as an unrelenting re-experiencing of the event or events as if they are happening now. In this theorisation, traumatic memory defies attempts to be integrated into constructions of a linear narrative of a healed, re-constituted, whole self.

Narrativisation and Atrocity

> The gaping, vertiginous black hole of the unmentionable years. The silence formed like a heavy pall that weighed down on everyone. Parents explained nothing, children asked nothing. The forbidden memory of death manifested itself only in the form of incomprehensible attacks of pain… The silence was all the more implacable in that it was often concealed behind a screen of words, again, always the same words, and unchanging story, a tale repeated over and over again, made up of selections from the war.
>
> It was a silence that swallowed up the past, all the past, the past before death, before destruction. To speak up and thus to realise the grip of death, which was the grip of silence seems to have represented for these parents too grave a danger for such an action to seem possible (Fresco, 1984, quoted in Laub, 1992, p. 64).

The "selections from the war" that were told and retold in the above extract arguably existed in autobiographical memory, situating the events in a linear, meaningful (and therefore meaning-making) sequence. What was

not spoken, that which remained in the "silence", was the voice of traumatic memory. This implicit memory again portrays its timeless quality. In fact, it "swallowed up the past, all the past, the past before death, before destruction". It evaded narrativisation and sense making. Uehara et al. propose that survivors of some trauma undergo these overwhelming obstacles in integrating their experiences into an autobiographical narrative because they have experienced or witnessed the most unspeakable form of trauma which can occur, such as that which takes place in atrocity (Uehara et al., p. 32). This trauma is inarticulable and creates a "silence" which resists narrativisation because atrocity is an occurrence which annihilates the ability of moral, legal and socio/cultural norms to direct the conduct of individuals or groups (Langer 1991). Barbarous treatment of human beings such as torture, starvation and mass murder and the humiliation of a person or large groups of people in order to make them collude or take part in the degradation of themselves or others (Uehara et al., pp. 32-33) violently tears apart so-called norms of sociality and culture. Survivors of atrocity not only witness the unbearable and the unspeakable, they may too be complicit in some of the acts of atrocity themselves or be so shamed by what they could not do or what they witnessed that attempts at narrativisation within known acceptable socio/cultural metaphors are resisted. Langer (1991) argues that the survivor is therefore caught in the void between the impossibility of forgiving him or herself for past actions and an autobiographical memory which cannot be wholly produced through the act of speaking. The atrocity survivor experiences continual emotional anguish, "[r]eliving the choiceless choices of the killing fields days … suspended between the struggles of common [autobiographical] memory [which condemns the terrible actions of the past], and deep [traumatic] memory" (Uehara et al., p. 38).

The total inability of someone who has suffered atrocity to narrativise these experiences can therefore be understood as "the failure of morally decent people to come to grips with profoundly immoral events" (p. 33) and the failure of self-reflective capacities in the face of the morally reprehensible. Langer used the following example:

> ... One can say, 'When I get married,' or 'If I die,' or 'If someone I love dies,' or 'If I have a child,' or 'When I get a job,' or 'If I have some money,' creating certain theoretical probabilities and then imagining oneself into those situations because we know how to think about them – they have precedents in our own or other people's experience. But no one before has ever said, 'When I get to Auschwitz, I…'; therefore, the mind remains blank. There is no way ... of imagining it in advance or of thinking about it when you're in the midst of it, because mental process functions not in a vacuum but in relation to something that happened previously, that you had felt, thought, read, seen or heard about (Langer, 1991, pp 103–104).

The suggestion of being "out of time", the way the "mind remains blank" and the impossibility of imagining a before, middle and end to a traumatic account again speaks to the traumatic voice. Atrocity, in this reading, denies language its narrative trajectory, "ruining" memory, producing what Langer describes as a severe divide between autobiographical (Langer uses the term "common" memory) and traumatic memory, (what Langer describes as "deep" memory). Langer perceives common memory to be neutral, and atrocity resists transformation into a neutral domain. This produces what Frank (1995) describes as "chaos" in survivor stories, or "anti-*narratives"* (his term) made up "of time without sequence, telling without mediation, and speaking about oneself without being fully able to reflect on oneself" (Uehara et al., p. 34, quoting Frank, 1995, p 98). Whilst I don't agree that the autobiographical voice always moves in opposition to the traumatic voice in the way suggested by Frank's "anti-narrative" term, I view the notions of the anti-narrative and the traumatic voice as similar in their resistance to narrativisation. I conceptualise the persistent re-emergence of the traumatic voice within autobiographical narratives, not only as evidence of the disturbance of the traumatised subject, but as an insistent witness to the unspeakability of trauma and the unacceptability of atrocity.

Whilst neuroscience may explain that this is because the language centre of the brain, Broca's area is not functioning, this is nevertheless a reductionist position if other factors interfering with survivors' attempts to story their traumatic experiences are in fact mediated by the kind of trauma they suffered, as in those who have experienced atrocity.

> The survivor cannot consistently place the killing fields in 'the past,' cannot view it as an event sandwiched in between her previous and current life trajectories. She cannot maintain the emotional or temporal distance from atrocity necessary to turn raw into reflected experience. Analogies cannot be drawn nor metaphors created. As a result, the survivor's discourse is at some points characterised by an absence of structural coherence – confusion of contexts, tenses and time frames; unreflected enumeration of experience fragments; and disrupted theme progression. Viewed from this perspective, a survivor's inability to create personal narratives that coalesce past and present is an expected outcome of experiencing atrocity (Uehara et al., 2001, p. 34).

The difficulty a survivor has in compartmentalising the killing fields into the past emanates from this seeming stuckness in the present moment. There is no before, or after, no temporal quality with which the events are situated because the subject is caught in the spectre as if they are happening now. Whilst this is characteristic of flashbacks of other traumatic material which have been discussed in the previous chapter, atrocity produces paradoxically an absence of metaphors or chains of signification with which to represent its effects.

"Eloquent Chaos"

> One of the cruxes of war… is the collision between events and the language available – thought appropriate – to describe them… Logically, there is no reason why the English language could not

> perfectly well render the actuality of… warfare: it is rich in terms like blood, terror, agony, madness, shit, cruelty, murder, sell-out and hoax, as well as phrases like legs blown off, intestines gushing out over his hands, screaming all night, bleeding to death from the rectum, and the like… The problem was less one of 'language' than of gentility and optimism… What listener wants to be torn and shaken when he doesn't have to be. We have made unspeakable mean indescribable: it really means nasty. (Brison, 2002, pp. 50-51, quoting Fussell, 1975, pp. 169-170).

This "collision between events and the language available", according to Fussell, points to the absence of a listener willing to hear words and phrases that evoke horrible images. However, the notion of the traumatic voice goes further, (paradoxically) representing that which sits outside language and the "more common" representations of horror even as described above. The traumatic voice points to the absence of signifiers with which atrocity can be described. It is in this absence that the inapprehension of atrocity reveals itself.

Uehara et al., have coined the term eloquence in chaos to encourage witnesses to trauma to not only pay attention to the coherence of a survivor's testimony but to the eloquence in chaos, that is "the ways in which anti-narrative content and pattern vividly express and reveal a survivor's particular and complex experience of atrocity" (Uehara et al., p. 34). The atrocity discourses whether in autobiographical or traumatic representation, speak eloquently of the incomprehensibility of atrocity, (which is again paradoxical) and are profoundly significant examples of how atrocity traverses the discursive metaphors that constitute selfhood to further traumatise inner psychic space and travel back again (Kleinman & Kleinman, 1994). Uehara et al., argue that specifically spoken discourse mirrors and maintains anti-narratives, that is, traumatic voices (see also Ewing, 1991; Langer, 1991; Lewin, 1993) as written discourse, are refined and edited in order to remove semblances of the incoherent and chaotic.

Page's photo is an example of how atrocity crosses metaphoric barriers that constitute or de-constitute selfhood, if both the in principio and in medias res qualities of the image are assumed. Pictures not only paint a thousand words, they can also signify in ways that mirror the processes by which trauma is embodied and re-experienced. Spoken and written discourse constituted as eloquence in chaos also "crosses over" (Kleinman & Kleinman, 1994) to embodied experiences of trauma felt as unrelenting bodily pain as in the "Chaotic Body" (Frank, 1995).

However atrocity goes further to compromise notions of selfhood as in Langer's "Divided Self" (1991):

> For the Chaotic Body, the primary narrative struggle appears to be to 'give voice' to bodily pain which is beyond speech; for the Divided Self, it is to reconcile irreconcilable narrative voices. In both cases, however, narrative chaos reflects the refusal of atrocity to be 'put in its place' and the perduring struggle of the survivor to apprehend the inapprehensible (Uehara et al., 2001, p. 35).

Page's and Ut's photos defy attempts at putting atrocity into "its place". Similarly, in the following extract, the notion of Langer's "Divided Self" is used to describe disjunctions in Sithan's narrative, that is, the way the survivor of atrocity alternates between autobiographical and traumatic representation:

> Here in this country there isn't much germs because it's cold sometimes, but in the old country it's hot all the time, so there are germs. Fly - - - oh - - - flies swarming the rice wok. They never washed or anything, they brushed the flies off and cooked again. Very - - - very bizarre. I think you guys are lucky you know - - - [laughs] - - - I think you guys - - - should appreciate what you have - - - [laughs] - - - That's why - - - I see kids nowadays - - - it's crazy. My kid, I will send him off to live in Cambodia for several months. It's hard, you know. During - - - I watched the herds and stepped on - - -

> the corpses, well. Those corpses, well - - - they buried them, lightly covered them with dirt and so lots of grass grew. When there was lots of grass, the herds wanted to eat there, right, because of the plentiful fertilizer. I went looking for the herds, trying to bring [them] back, I stepped on it and penetrated through - - - Oh my God - - - I looked down and there it was - - - all the skeletons - - - maggots, yea big. They swamped my feet and I ran in panic. When it was corpses like that sometimes you lose - - - you lost your consciousness - - - [laughs] - - - When I was so scared, I was no longer afraid - - - no longer afraid (Uehara et al., 2001, p. 38).

Beginning his narrative in medias res voice, Sithan compares the weather between the United States and Cambodia. Sithan's traumatic voice suddenly emerges when he shifts to the Killing Field's era and says, as if it was occurring now, "Fly --- oh --- flies swarming the rice wok…" Then Sithan shifts back to his autobiographical voice when he comments on the positive aspects of living in America and that he will send his child to live in Cambodia some time in the future. Then again, Sithan's traumatic voice emerges in contrast when he describes the horrible images he saw as a child (Uehara et al., p. 39).

Page, earlier in this chapter, likewise moves between both autobiographical and traumatic memory:

> The first time I saw torture, a Vietcong suspect was being interrogated. And here's a guy standing there with a bayonet off his carbine to put it in the guy's gut and he's drawing it up. I turned away. The shock of seeing somebody deliberately…. [killing someone]. I didn't grow up in the Bronx I grew up in a nice English suburb. [To see someone] deliberately inflicting harm, torturing somebody, is inconceivable until you actually witness it.

Page's narrative voice starts by setting the scene when he first sees someone being tortured. He then moves to his traumatic voice as he

describes the terrible cruelty as if it was happening in the present. Words evade him and I interpret his unsaid thoughts. His autobiographical voice counters as he reflects on how difficult it was to see such violence when he didn't grow up in a violent neighbourhood. His voice disappears with the assumed image of a traumatic memory, the "see[ing] someone" [again, my interpretation].

Similarly, Felman (1992) describes the experience of a student, who along with his classmates, was exposed to two videotaped Holocaust testimonies, the poetry of Mallarmé and Celan, the historical testimonies of Camus and Dostoevsky and the clinical theoretical work of Freud. In examination of the crisis that had taken place to his class of students, who appeared to suffer traumatic symptoms as a result of their exposure, Felman believed that the class "felt actively addressed not only by the videotape but by the intensity and intimacy of the testimonial encounter throughout the course" (Felman & Laub, 1992, p. 48) and that the students responses seemed to convey "an anxiety of fragmentation" (p. 49). One student wrote:

> Viewing the Holocaust testimony was not for me initially catastrophic – so much of the historical coverage of it functions to empty it from its horror. Yet, in the week that followed the first screening, and throughout the remainder of the class, I felt increasingly implicated in the pain of the testimony, which found a particular reverberation in my own life… Literature has become for me the site of my own stammering. Literature, as that which can sensitively bear witness to the Holocaust, gives me a voice, a right, and a necessity to survive. Yet I cannot discount the literature which in the dark awakens the screams, which opens the wounds, and which makes me want to fall silent. Caught by two contradictory wishes at once, to speak or not to speak, I can only stammer. Literature, for me, in these moments, has had a performative value: my life has suffered a burden, undergone transference of pain. If I am to continue reading, I must, like David Copperfield, read as if for life (Felman & Laub, pp. 1992, 55-56).

In the above extract, there is evidence that the eloquence of the traumatic voice produced in the student the desire "to speak and not to speak", even in this written explanation which presents a coherent narrative. In the gaps of this written account, the student struggles with what he describes as "two contradictory wishes at once" leading him to "only stammer". It is in this admission of incoherence that we can see the eloquent chaos that is embodied within it.

In review, this chapter has explored both visual and verbal representations of traumatic experience, in terms of the in medias res and the in principio voice. I have considered how the composition of a photograph might narrate a humanising story and/or offer a "snapshot" of unassimilable and unspeakable trauma; how autobiographical representation may be punctuated by the eloquence of the chaotic traumatic voice of atrocity. I have suggested that written words often convey a narrative structure, a temporal quality, which the spoken word of the atrocity survivor frequently does not. "Atrocity", in this account, evades notions of a healed autonomous self-regulating human subject, making notions of the single self unviable given the multiple voices employed in attempts to narrativise experience. Experiences of trauma may lead to forms of subjectivity which escape mainstream notions of integration and healing as put forward by the human sciences. The eloquent chaos that is produced in the juxtaposition between "normal" autobiographical memory and traumatic or implicit memory opens up further possibilities for understanding the effects of trauma and what makes for a viable life.

Furthermore, in this chapter I have explored how the notions of wholeness and integration are linked to the production of a humanist subject, an achievement which many survivors of extreme trauma cannot attain. The "failure" of these survivors to place stories of genocide and war into seamless autobiographical accounts may attest to a resistance to the accommodation of experiences and events which can only ever be dehumanising. Thus these traumatic accounts need to be given the space

for validation, if not normalisation, and in so doing, different kinds of human subjects may emerge who defy the current limits of the social imagination. I suggest that the traumatic voice must not be expunged from accounts of trauma if the causes of trauma, war and violence and inhumanity are ever to be challenged. The traumatic or in principio voice is another rhetorical form of narration which can function to provide more information not less, about the terrible effects of terrible events. This voice challenges the idea of pathology, because it mimics the mode of experience that provokes it. In so doing, trauma therapy, does not have to always reconstitute the humanist subject – it can, as in this form of research, invite a different but viable kind of (inter)subjectivity, post trauma. In the next chapter I will move to examine whether an "acceptance" of the eloquence of chaos in survivor accounts of atrocity opens up a greater potential for therapeutic work which may otherwise be foreclosed with the constant push for coherent narrative.

Chapter 6: Transformation in Therapy

The person who experiences trauma has no choice but to either grow from or be diminished by the experience, as the experience is too potent to be ignored. To successfully master a trauma, it is necessary to accommodate a personal theory of reality so that it can assimilate the trauma in a manner that makes life livable and worthwhile. This means cutting the inductively-derived beliefs from the traumatic experience down to size, so that they are recognised as only representative of part of realty, not all of it, and modifying the extant personality structure accordingly

(Seymour Epstein, 1991, p. 84).

… [W]e are increasingly required to understand self-transformation as a key issue in relation to how we manage the circumstances of our lives. We are continually addressed as subjects who are capable of understanding, judging and amending our own psychologies as solutions or resolutions to problems in relationships, the world of work, within the school, social work offices and law courts

(Lisa Blackman, 2001, p. 90).

Should it even occur, as it does occasionally to me, that experiencing another's and my own suffering brings a tear to my eye, (and one should not conceal this emotion from the patient), then the tears of doctor and patient mingle in a sublimated communion, which perhaps finds its analogy only in the mother child relationship. And this is the healing agent...

(Sandor Ferenczi, 1932, p. 65).

There's a moment, I suppose you'd call it the Ah-ha experience, when I know that I've hit the spot with the client and the client is overcome with feelings and thoughts which at last make some sense to them at a profound level. It's as though I can see the person's heart and mind

meeting in some painful but powerful integrating encounter. Some connection has been made that is transformational for their life. The client will say words, such as “That's it!” and they usually experience a deep outpouring of emotion. I know that they feel really understood. And for me as their therapist, I know too that I have really met that person where they are at in their struggle. I know I have somehow helped them open a door or a window into some new future possibility that they did not know existed before. Not only is there also some sense of having been understood, but the client has become able to see through this pain into a bigger context. They have put something to rest or have moved something away so that they are no longer held back by it from living their life. Something has moved; there’s a shift. So what once seemed insurmountable now seems to be not quite so impossible. And there’ll often be smiles all around. Sometimes, I have to admit, I’ll be wiping tears from my own eyes a little, tears of joy and sadness and pain and relief. And there’ll be a sense of energy for me and the client. And, this energy registers on the physiological. I’m more alert. I’m very present with the client. They know I have seen into their heart and mind and recognised their struggle at a deep level but also helped them find a way out and somehow in that space between us, something has shifted. And they appear more energised too. It’s almost like a good dose of caffeine, you know, [laughing]... But we have both shared this transformational moment. What was impossible before, at least because of all the person's conditioning or trauma now becomes possible. For me, I suppose, I feel thankful; there’s some gratitude. Also a certain satisfaction that all this work has come to such a point of intimacy, of a joined and shared experience, so that in itself seems to bring a mellowness, an excitement. There’s a joyfulness, there’s a contentedness – all those kind of things that come with knowing, you know, that God is in His heaven or Her heaven as the case may be and all is well on earth, in spite of what it looks like. You know, it’s that moment of grace. I don’t know. How do you describe it? How do

> you describe a banana if you've never eaten one? You know, it has a flavour of its own and unless you've tasted it, you don't know it (Antoine).

Throughout this thesis so far, I have explored many of the threads that weave the fabric of the problematisation of trauma to try to make sense of the possible ways subjects engage with these notions to explore potentialities for subjectivity and for viability. Particularly mindful of the stories of overwhelming suffering that emanate from war, torture and genocide, I however found myself wondering how I, as a therapist, could do any thing, to promote this viability in the face of the (im)possibility of its achievement under such conditions. In saying that the in principio voice of trauma should not be expunged, I wondered about the efficacy of therapeutic work at all with survivors of trauma. My poststructuralist positioning and reflexivity in its engagement with trauma, had certainly undone me in my perception of my subjectivity as an agent of psychological change, a humanist construction if there ever was one, but one in which I had endowed much purpose and value.

So here, towards the very end of my thesis, I found myself revisiting the stories of transformation that had been evoked through the original parameters of my research, whilst reflecting that this may be an attempt to subvert the feelings of hopelessness and despair that had come with my engagement with stories of profound human suffering in previous chapters. I reflected, though, that I wanted this thesis "to do justice" to accounts of transformation, those moments that "changed a life" in which I had been privileged to participate as a therapist. So in this chapter I revisit clinical work, even if there is an inevitability that this will lead to a part reiteration of some of the very discourses I am seeking to challenge, in order to explore the subjectivity and viability that are evoked by experiences of transformation in therapy.

In support of this focus, I had come across the work of Daniel Stern (2004), whose book, The Present Moment in Psychotherapy and Everyday Life

provides an analysis of moments which are described by therapist and client alike as transformational healing moments. These moments, whether they are felt experiences which last only a few seconds or minutes in therapy, communicate that a metamorphosis has taken place in the client's inner experience in relation to their perception of the world.

Further support for my enquiry came from the notion of quantum change theory, which is connected to the idea of posttraumatic growth (PTG), a term used to describe a substantial positive change that could evolve as a result of overwhelming life experiences (Tedeschi & Calhoun, 1995). So in this section, I will briefly discuss PTG, and then go on to outline the underlying discursive elements that make up these particular transformational experiences, both from the accounts of therapists who undertook my own research project and from those therapists whose work has informed or laid the basis of current theoretical models.

Originally, the subjects of my research often described these moments of transformation as moments of spirituality in therapy, moments of "grace" as did Antoine in the extract above. Taking up on this, I will explore the possibilities for subjectivity and viability that emanate from moments in therapy that are described as transformational, and often figured in the language of spirituality, in light of the relational cure of therapeutic work. In addition, I will touch on the ways in which spiritually discursive language evokes similar forms of subjectivity to that of the traumatic voice of the subject and the possibilities that emerge from this.

Meanwhile, Blackman (2001) reminds us that a strong desire for "transformation" in therapy is itself discursively produced and that a focus on self-transformation has in contemporary times been mapped into all areas of social life. As a therapist, I cannot disavow an interest in psychological change, but I do want to reflexively knowledge how an emphasis on 'transformation' is implicated in the production of the neoliberal subject and how it can heighten possibilities of "failure" for the subjects of traumatic experience. With this in mind, in this chapter I will also look explicitly in

this section at the "problem" of dissociation that affects many severely traumatised clients and ask how this might challenge assumptions about integration and transformation as the end points of therapy.

As both therapist and theorist, Stern examines the nature of "the present moment" in therapy and in everyday activity. This focus on the present, like Antoine's use of the expression, the Ah-ha moment, places such work in the humanistic tradition of therapy, which assumes that such moments have an integrative function in moving toward awareness and "wholeness" for the authentic human subject. To counter the limits of humanist thinking, I draw on the theorising of B. Davies and Gannon (2006) who have embraced a poststructuralist perspective in their construction of the idea of "mo(ve)ment" to represent a joining of the operations of "movement" and "moment". This term then illustrates how potentialities for subjectivity, access to alternative discourses, and agency are opened up in unexpected ways in spaces which are fluid and transient.

However, it is Stern's understanding of the implicitly unspoken nature of this transformative entity that holds particular relevance to my thesis so far. Stern is a psychologist whose theoretical orientation privileges the therapist/client relationship within a psychotherapeutic framework. His work positions the present moment of therapeutic work in which some transformation takes place for the subject, at the epicentre of psychological change. My work, whilst building on Stern's examination, intends to go further in that I highlight in this chapter the potentiality inherent in accounts of healing or transformation after trauma in which the narrativisable components may remain limited. First, I intend to discuss the notion of transformation and its function in and outside therapy, and second, discuss viability in regard to the ideas of integration and healing that are perceived to occur in the ah-ha moment in therapy.

Posttraumatic Growth

The proposition of PTG is not a new one (Frankl, 1963; Maslow, 1954; Yalom, 1980) and involves a shift in beliefs about one's "assumptive" world (Parkes, 1971). Beliefs about the world and a person's place in it are generally unquestioned until the experience of overwhelming events and what has previously been believed about the world, no longer resemble each other. For many survivors, if "the malevolence and meaninglessness" of their experiences are absorbed in such a way as to become the sum total of a person's view of their assumptive world, "the result will be profound anxiety and despair" (Jannoff-Bulman and Berg, 1998, p. 42). According to Tedeschi, Calhoun and Cann (2007) posttraumatic growth does not do away with all of these profoundly disabling effects of trauma. It is a phenomenon that "clearly demonstrates the reality that people who experience PTG also recognise the many negative aspects of what has happened. Both positive experiences and negative outcomes remain clear in the experience of people reporting PTG" (Tedeschi, Calhoun & Cann, 2007, p. 400). Drawing on the work of Frankl (1963), Tedeschi et al. view PTG as constitutive of a change in attitude and/or a pull towards action, depending or not whether action is possible" and see any growth as nevertheless imbued with "tragedy" (Tedeschi et al., 2007, p. 401).

The above account of PTG depends strongly on a theory of integration, in which initially unassimilable negative life events become an intelligible part of a viable post-traumatic life. However, it is the 'how' of this transformation that holds particular interest for my project. Miller (2004) turns to quantum change theory, which has its origins in the study of physics, to explain sudden and idiosyncratic transformational changes that are productive of posttraumatic or stress-related growth (SRG). These transformational changes are divided into two categories: "the mystical or epiphany type, which lasts only a few minutes, and the insightful type, which is more related to insight or knowing and may have a longer duration. Both result in a permanent change in perspective or worldview" (Jennings,

Aldwin, Levenson, Spiro & Mroczek, 2006, p. 118). However the authors state that to date there has been very little research into understanding these transformational changes.

Although a poststructural theoretical approach leads me to question the "permanency" of such changes, Miller's proposition of sudden and idiosyncratic moments of transformation, together with Stern's theorisation of therapeutic change in the present moment, propelled me into revisiting the therapists' stories that I had first collated and then subsequently dismissed. These stories make an account, even if incoherently, of moments of transformation in therapy. Moreover they underline the relational component of moments described as transformational in therapeutic work.

Sitting alongside the assumed integrating nature of the narrativisation of experience as outlined in earlier in this thesis, the relational cure, as discussed in Chapter 3, is perceived to create a space in which therapist and clients undertake reparative interpersonal work so that healing and transformation occur. It is within the context of a trusting therapeutic relationship that many distressing cognitions, feelings and behaviours can safely be validated and/or challenged as the case may be, however building trust and attachment bonds is often not easy with survivors of trauma. Successful therapeutic work with survivors is perceived to include increasing a person's ability to maintain safe attachments with significant others including being able to develop feelings of trust, safety, and enduring connection in relationships (Harvey, 1990).

As already discussed, Briere and other theorists claim that early implicit beliefs about self and others are encoded implicitly from the start of infancy, and that, in the presence of another person, subjects may be triggered into experiencing similar behaviours and emotions whilst being unable to contextualise these feelings and cognitions as emanating from the past. Stern argues that the narrativisation of a memory in the present "rewires the actual neural recording of the past and rewrites the possible memoires of the past. The originals are changed and no longer exist in the way they were

initially laid down" (pp. 200-201). Whilst the above still sits scientifically at the edge of hypothesis, Stern goes on to say that an ah-ha moment can alter the past "but only in small pieces at a time" (p. 201), given the persistence of some factors, such as traumatic memory. His "Silent Past" is that which operates upon the "felt present, but is not, itself, felt" (p. 202), which includes implicit knowing and memory that autonomically influence a person's experience of self and relationships.

In an experience of nurturing care-giving such as in the experience of "O" (Bion, 1970) described in Chapter 3, a coherence of self is thought to emerge; if a parent responds appropriately to a child's behaviour, a mutuality is conferred that provides a validity to the child's experience of selfhood that can be carried forth into adulthood. Mirroring the parent and child experience, a similar construct exists in Jungian psychology which is perceived as transformational for both therapist and client (cf. Jung, 1929-31); Fordham, 1969, Tower, [1956], 1988). Winnicott (1971) describes a space "in-between", that is, a play space, or "potential" space of un-integration, where awareness transcends subjectivity and objectivity. Martin Bűber described the space as consisting of "the whole abundance of actual reciprocity, a state in which one is no longer cut off ... no longer abandoned, although one cannot tell what it is to which one is linked" (Bűber, [1970], 1988, p. 115). Within all these similar constructs, the emphasis is on a reworking of the care-giving relationship through the therapeutic "container", which creates the potential for an experience of "O" in the space "in-between" so that the client's experience of their relationship with their therapist transforms their experience of selfhood in some profound way, so as to create a "coherence" of self.

Stern argues that present moments of change such as these, contain a "real experience" that emerges unpredictably in the "now" of an interaction between a minimum of two people.

> That now is a present moment with a duration in which a micro-drama, an emotional story, about their relationship unfolds. This

> jointly lived experience is mentally shared, in that each person intuitively partakes in the experience of the other. This intersubjective sharing of a mutual experience is grasped without having to be verbalised and becomes part of the implicit knowledge of their relationship (Stern, 2004, p.22).

At this juncture it is important to note that experiences of the now have been theorised through alternate discourses. B. Davies (2009), in her work related to teaching and learning, has developed the notion of listening through a Deleuzian lens, when she describes it as "an ongoing emergence of oneself in relation to the other" (B. Davies, 2009, p. 1; B. Davies & Gannon, forthcoming). B. Davies makes a crucial distinction between listening as understood as a focus of "self as identity [my italics] (that is relatively fixed, linked to ego and to the defence of oneself against the other), and self as process [my italics] (an emergent relational being, open to the other and to the not-yet-known)" (B. Davies, 2009, p. 1; B. Davies 2000). This construction challenges the implicit notion within Stern's theorising that this "jointly lived experience" is productive of a self whose "identity" becomes more "integrated" and "coherent" as a result. The other important point about this alternate lens is that it incorporates Deleuzian ideas that relate to the notion of "difference". In therapeutic work that focuses on the salience of the transformational qualities of the ah-ha moment, therapists, myself included, are colonised by the notion that such encounters help the client become "different", from "the way they were before". The client is perceived to have undergone a transformation that is productive of a more self-regulating, integrated and coherent humanist subject, who is more "normal", and implicitly, "more like" the therapist who is perceived to embody these characteristics of normalcy. This construction of the notion of transformation demonstrates the lure of identity language, a lure that can capture us and swallow us whole, whilst we affirm the very necessity for us to be eaten alive in this way despite the limiting ramifications for our viability.

To counter this, B. Davies points to a distinction between “difference” and “differenciation” (Deleuze, 2004), in which the word difference connotes a “categorical” difference in much the same way I have just described above when I drew attention to the type of difference towards which therapists are motivated: “where the other is discrete and distinct from the self, with difference lying in the other and normality in oneself. Identity is constructed through a string of binaries in which the other’s sameness as, or difference from, oneself is made real” (B. Davies, 2009). Differenciation, then, is one in which “difference comes about through a continuous process [my italics] of becoming different, or differenciation” where the mo(ve)ment is towards and through “a continuum, a multiplicity of fusion” rather than "divided up, a dimension of separation” (B. Davies, 2009; cf. Massey, 2005, p. 21).

Mo(ve)ment, Differenciation and a Dissociated Penis

I now move to an example of this “differenciating” transformational moment in therapy that occurred in my work with a heterosexual couple. Bryan and Leila[14], who came to me because of the sexual difficulties they had in their relationship. Both had experiences of abuse in their past. Leila had been emotionally and psychologically abused by her mother who would withdraw love for days and weeks when she was a young child if Leila had done something contrary to her mother's wishes. Leila remembers her mother not speaking to her for the whole of the summer holidays when Leila was 12 years old and her mother refusing to come to her wedding because of an argument over the flowers. Leila, who works as a free-lance writer, now had no contact with her mother.

Bryan had witnessed domestic violence perpetrated on his mother by his father throughout most of his growing up. Bryan remembers trying to protect his mother and eventually told me that when he was 16 years old, he stood up to his father physically, knocked him to the ground, and told his

[14] Significant identifying details about this couple have been changed to preserve their anonymity.

dad that if he ever touched his mother again, he would kill him. Bryan had become a policeman and was one of the first men in the 1990's to work proactively in a domestic violence response unit.

Bryan was unable to maintain an erection during intercourse with Leila, and despite a multitude of physiological tests, no biological reason for this had been found. Leila's construction of Bryan's inability to "perform" was that he was actually angry at her and that this was the way he punished her whenever there had been conflict. She also believed the relationship was "on the rocks" as Bryan obviously no longer desired her or found her "attractive enough". However, even during relaxed non-conflictual weekends away, Bryan was unable to sustain an erection during intercourse. Bryan's construction of his inability to perform was that he was "not a man", his sense of his own masculinity inextricably linked to his sexual performance. He told me in front of Leila that he continued to find her enormously sexually attractive and that he loved her with all his heart. He said he wasn't angry with Leila – she should be angry with him as he knew he was "failing" her as a lover.

Early on in therapy, I had formed a hypothesis that the sexual difficulties were somehow linked to both partners' experiences of emotional abuse in childhood. But I had also learnt that Leila had previously suffered from endometriosis, so that sex in the first two years of their relationship had been quite painful for her. Bryan, as a result, had learned to be very attentive to Leila's pain and had become a very gentle sexual partner. However Leila had not experienced painful symptoms for over two years and Bryan's gentleness had been reduced to a "non-event".

Therapy consisted of exploring, and then debunking, Leila's hypothesis that anger was somehow the motivating factor for Bryan's "lack of" performance. But more importantly, the couple's gendered perceptions of their sexual relationship were deconstructed. Bryan was challenged about his belief that his masculinity rested on his ability to maintain an erection. Leila was challenged around her belief that her attractiveness to a man

rested on his tumescence. And both partners were challenged on their construction that an experience of sexual intimacy rested on notions of performance in the act of sexual intercourse (see Schnarch, 1991). This exploration and subsequent confrontation reflected the basic premise that both clients' perceptions were worth exploring in order to validate their own attempts to understand their dilemma:

> Also helpful is the therapist's visible acceptance of the client's needs and perceptions as intrinsically valid, and the therapist's communication to the client regarding the client's basic relational entitlements... [This] approach work[s] with the client in such a way that he or she is able to perceive incorrect assumptions and reconsider them in light of his or her current (therapy-based) relational experience... [for example] although the client may view himself or herself as not having rights to self-determination, these self-perceptions will be contrary to the experience of acceptance and positive regard experienced in the therapeutic session. Such cognitions, when not reinforced by the clinician, are likely to decrease over time. Equally important, as the message of self-as-valid is repeatedly communicated to the client by the therapist's behaviour, client notions of undeservingness and unacceptability are relationally contradicted (Briere & Scott, 2006, p. 152).

In a previous session, there was a moment of realisation for Leila when she identified that the sense of withdrawal and punishment she experienced in her sexual relationship was a transferential response emanating from her experience of her mother's punishing distancing from Leila as a child and adult. In the therapy, I encouraged Leila to remind herself that Bryan's inability to maintain an erection, and premature withdrawal from intercourse did not mean he was punishing her like her mother had. For Leila, this was a salient moment and her fusion with her past emotional abuse began to lift. However the palpable Ah-ha moment occurred in the next session:

1. LM: “So last night with Leila, it was the same?”

2. Leila: “Well of course we thought we should try and have sex before coming back to you after 2 weeks! But yeah, it was the same. I tried not to get angry because I realise now that's my stuff about my mum. So I wasn't angry at you, was I?” (to Bryan)

3. Bryan: “Nuh. No. Not at all.”

4. Leila: “You were angry at yourself though.”

5. Bryan: (Silence)

6. LM: (Waits, her attention is turned expectantly towards Bryan.)

7. Bryan: “Of course. I mean, we still... you know pleasured each other... But...”

8. Leila: (Laughing), “It was good for me!”

9. LM: (To Bryan), “You brought Leila manually to orgasm?”

10. Bryan: “Yeah. That was great.”

11. LM: “But you had intercourse first?”

12. Bryan: “Mmm. Yeah.”

13. LM: “What happened during intercourse Bryan? What were you thinking?”

14. Bryan: “Well I remember telling myself I am just going to focus on intimacy stuff… You know, ya da ya da ya da… Just what you have been saying, ‘I can have sex without coming inside of Leila. This is intimacy

more than just sex. It's about being with Leila.'" (Bryan reels off some of the statements made in the sessions which have focused on de-constructing notions about sex and sexual intimacy. It is obvious he wants to be able begin to work with these ideas but he is having great trouble challenging the dominance of entrenched discourses.)

15. LM: "Sounds like you doing a lot of self-talk that probably distracted from the intimate experience?"

16. Bryan: Yeah... but no, not once we actually were having sex. I just focused on how much I love Leila.

17. Leila: "Yes, you were making eye contact. It felt really intimate. I felt really close to you."

18. LM: "So you were having intercourse ... and then?"

19. Bryan: "I don't know. I just kinda… stopped. I think I was actually still erect when I withdrew?"

20. Leila: "Yeah you were. That was different."

21. Bryan: "Yeah, it's funny, I could have kept going but mustn't have… I didn't…."

22. LM: "What were you thinking, telling yourself?"

23. Bryan: I don't know. It was like.... It doesn't matter. I remember I concentrated on Leila...." (Bryan appears lost in thoughts. His eyes have a glazed quality.)

24. LM: (softly), "...Where are you Bryan?"

25. Bryan: "What?"

26. LM: "You look like you're remembering something?"

27. Bryan: "Yeah, no... yeah. I was just thinking how different my sex life is with Leila."

28. LM: "From...?"

29. Bryan: "My parents."

30. LM: "In what way?"

31. Bryan: "Well, you know, my mother… My dad was abusive… I've talked about that."

32. LM: "Not in relation to their sexual relationship…?"

33. Bryan: "Yeah well… It's sickening really…"

34. There is a noticeable pause as I sense, as probably does Leila, that Bryan is struggling with something. Possibly twenty seconds pass before I comment.

35. LM: (Softly), "You could hear them having sex when you were little?"

36. Bryan: "Yes… No… Well I was supposed to be asleep…" (He starts shaking his head and covers his ears with his hands).

37. LM: (Slowly), "Was Dad hurting Mum?"

38. Leila: "Oh, honey..!"

39. Bryan: (sobbing), "Oh God... Oh God..."

40. LM: (Pausing for approximately thirty seconds, then says), “Bryan, you are not your Dad.”

41. Leila: (Crying), “Oh honey. You would never hurt me!” (Leila kneels and puts her arms around Bryan).

For a few seconds or a minute or two, although I am still not sure, Bryan, Leila and I sat wordlessly in the room. Tears flowed and the room felt full, heavy with emotion and realisation.

In the following session two weeks later, Bryan and Leila returned triumphant. Bryan had maintained his erection during intercourse for the first time in years. The couple had made love a number of times and believed that they were now “cured” and after only one subsequent session, ended therapy.

I had hypothesised that Bryan was aware of his potential to be violent like his father and this was symbolised through the tumescence of his penis. His “lack of function” was to protect Leila from his power to inflict pain, through his penis, through the symbol of his manhood. Of course there were many other enactments, of past relational trauma and experiences of self that moved around this relational system. Leila’s reactions towards Bryan whilst having sex may have reminded Bryan of his father’s criticism of his mother. Bryan’s feelings of failure, which had been absolved in some way when he had overcome his father physically at the age of sixteen, returned when he was called to face another example of perceived “weakness” – the failure of his penis to perform at will.

With profoundly traumatised clients, specifically those with dissociative disorders in which there is a “discontinuity of consciousness, depersonalisation, [the experience of feeling of being cut off from one’s sense of one’s own person], derealization, [the experience of feeling unrelated to one’s surroundings], hallucinosis, and amnesia” (Meares,

2000), the structure or rather the absence of coherent structure to the spoken word indicates whether dissociation is present. In the previous chapter, I discussed this in relation to the in medias res and the in principio voices of survivors of the Killing Fields and others. However I am mindful that a further link has been made between what appears to be a lack of coherence and the notion of dissociation. Whilst this link in and of itself may require challenging from a poststructuralist perspective, what I want to focus on is not so much whether this linkage is "true" or "certain" but rather on the relational meeting that occurs in therapy when some of these ideas are deployed and how, even in their deployment, a poststructuralist positioning can be taken up. So I now turn to Bryan's spoken extracts to examine whether dissociative symptoms appear to be present and the usefulness of looking for these events in working with trauma.

Bryan appears to have been dissociative at a number of times during the therapeutic conversation and whilst making love to Leila. The first example of Bryan's "discontinuity of consciousness" is when he has to ask Leila to confirm that his penis was still erect when he stopped intercourse, and this is apparent when he reflected in session, "I don't know. I just kinda… stopped. I think I was actually still erect when I withdrew?" (Para. 18). Bryan is surprised by this and his physical withdrawal, "Yeah, it's funny, I could have kept going but mustn't have… I didn't…" (Para. 21). And he goes on, "I don't know. It was like... It doesn't matter. I remember I concentrated on Leila...." (Para. 23) and I, as the therapist, noted that his eyes at this point appeared "glazed" and that he seemed "lost" in his thoughts. When the therapist asks him where he is, having sensed Bryan has moved to a memory, he is almost jolted into the present by this question, "What?!" (Para. 25).

I interpret these disruptions to the flow of his narrative as dissociative events. For Bryan, there is a narrowing in his field of consciousness (Janet, [1919], 1925), a consciousness without (my italics) self (Meares, 2000). His thinking is disorientated so his words are too. He struggles to make sense of what he has experienced but there is a loss of awareness in his attempt to

explain what happened. He seems to suffer some depersonalisation, as though Bryan's sense of himself, of his own "me-ness" (Claparède, 1911), and ownership around his personal experience of this specific sexual event has diminished, as if, as Meares described, Bryan is "nobody nowhere" (Meares, 2000, p. 57).

The traumatic voice of his reminiscences is reproduced in the present moment of therapy, as if the event is happening now. The conversation is stilted until Bryan finds his autobiographical voice when he says, "Yeah, no... yeah. I was just thinking how different my sex life is with Leila" (Para. 27). Bryan is about to suggest that his sexual relationship is "better" than his parents' relationship without necessarily having to face the trauma of his implicit experience of his father's violence towards his mother. However this traumatic memory emerges in the form of a flashback, when Bryan says, "Well, you know, my mother… My dad was abusive…" (Para. 31). Bryan's traumatic voice is heard in the gaps and silences, in the pauses, as his autobiographical voice, his attempt at coherence, finishes the sentence "… I've talked about that". When Bryan says, "Yeah well… It's sickening really" (Para. 34), the silence that follows indicates a struggle, a tension. At this moment the therapist watches Bryan closely and has the sense that Bryan is situated in the past of a traumatic experience. For Bryan, the traumatic memory, experienced as a flashback occurs in the here and now as if it is happening in the present moment. Stern describes these memories as "burst[ing] on the scene":

> Nor, do they occur in a felt ambient present inhabited by a self who is existentially situated in the present. The relevant aspects of self are in abeyance. These experiences 'just are'. They are temporally unanchored. Normally memories emerging from working memory seem to walk into the room of the present and sit down in their designated chair. Recalled episodic memories or unrepressed memories can burst into the room of the present in full disorientation and bang about the place before they settle down. In both cases, however, there is a felt past inhabiting a separately felt present. That

> is not the case for some recalled traumatic memories. They annihilate both the felt present and felt past. This is an extreme situation of being temporally unanchored (Stern, 2004, p. 218).

Whilst Bryan's memory does not totally annihilate both the "felt present and felt past", as do the severest of traumatic memories, there is some significant disorientation. However what takes place in the intersubjective space existing between both the therapist and Bryan and Bryan and Leila, is an experience of transformation. I had given an interpretation in which Bryan's reacted emotionally when I suggested, "You could hear them having sex when you were little?" (Para. 35). Bryan stays with implicit experience of the trauma and shakes and covers his ears, as if he is the child that he was *then in the present: "*Yes, No… Well I was supposed to be asleep…" (Para. 36). The therapist asks tentatively, based on her experience with working with domestic violence, "Was Dad hurting Mum?" (Para 37). In response, Bryan cries, "Oh God... Oh God..." (Para 39) and the realisation of the pain of the experience of hearing his father assault his mother is actualised in the room. The next interpretation by the therapist is designed to unlink Bryan from his past by defusing his implicit identification with that of his father: "Bryan, you are not your Dad" (Para 40). Leila, attuned to the perceptual links being made and unmade by Bryan in his reliving of his traumatic past, validates the therapist's statement, "Oh honey. You would never hurt me!" and shows empathy to Bryan with an embrace (Para 41). Whilst Bryan does not articulate the meaning of this experience till a subsequent session, I believe that in the "now" of this session's events, he is in the act of reappraising his sense of selfhood, which can seem like "The whole body and mind is gathered up in the reappraisal, which can feel something like, 'Yes, I really have been like that'. 'That is really who they are and how they treated me'. 'I feel like I have to start over from scratch'. 'Where the hell was I all that time?' 'I have been so handicapped'" (Stern, p. 188).

Stern continues:

> And then a silence follows as the patient takes it in. The silence is a charged moment. The patient is going through an important reorganisation in the presence of the therapist – a reorganisation that has been catalysed by the remarks of the therapist. The patient's reaction is thus an interpersonal and intersubjective event because both the patient and the therapist know, more or less, what the patient is experiencing. This silence, immediately after the interpretation, is a kind of now moment. What usually happens is this: The therapist feels called upon to say something to let the patient know he or she has understood the affective impact of the interpretation. The therapist may say something very minimal, like 'yes', something indistinct like 'hmm', or something more elaborate like 'Yes, sometimes life feels like that'. But the therapist says it in a special way with a special tone of voice that has overtones of empathic understanding, of dipping into their own world experience and expressing that, of standing alongside the patient in this moment of usually painful reappraisal... (Stern, 2004, pp 188-9).

In my session with Bryan and Leila, Leila too let Bryan know she understood something of the enormity of his experience. She too used a "special tone of voice that had overtones of empathic understanding" when she told Bryan she knew he would never hurt her (like his father did to his mother). And this is an example of the power of therapeutic work with couples and families in which the intersubjective experience of members of the same system undergo a moment of transformation when the source of the primary attachment needs in adulthood, the spouse or partner, is part of the therapeutic process.

Leila underwent a change in her perception of herself in the next to last session when she connected her fear of Bryan being angry with her with her experience of her mother's anger towards her as a child. Stern might describe this moment of realisation as one which "altered the patient's

explicit understanding of herself, but not the intersubjective field between her and the therapist" (Stern, p. 190) or Bryan for that matter. However in the last session with the couple, when Bryan connected his childhood experiences with his sexual behaviour, there was what Stern would describe, "a moment of meeting around the impact of the interpretation" that expanded the intersubjective fields of all present, the couple relationship of Bryan and Leila and their therapeutic relationship with me so that Bryan could move forward "on the basis of both an altered implicit knowing and explicit knowledge of [him]self" (p. 190). In reliving the traumatic memory but also re-experiencing it in his struggle in the present, this transformative moment, this "now" experience described by Stern (p. 23), undid the hold of the past of Bryan's actions and delivers the possibility of a new future.

> It is through listening that being is made possible. This is nothing to do with knowing an essential being as a phenomenon that can be pinned down. It is a form of being-in-relation-to-the-other the other that comes from a gift of listening and an openness to the not-yet-known. The self continuously comes into existence and creates events that are evolutionary, unfolding possibilities that are not attributable to one or the other. In this very moment of listening, the self forms itself in relation, in the ongoing dynamic process of being heard (B. Davies, 2009).

What I think has occurred in this meeting is the opening up of a relational space in which Bryan, with myself and Leila, is able to make his actions and his struggles, even the ebb and flow of his tumescence, make sense. This encounter is much greater than any intention by the therapist to be empathic and to "fix" the problem, or for Leila to simply "understand where Bryan is coming from" in a very cognitive way. It involves the therapist "being open to hear what she does not know already" and "what she makes hearable from the other" (B. Davies, 2009). In the here-and-now of this meeting, Bryan can connect with his painful past. Whilst the therapist offers a counter-story that Bryan is "not his father", this was most probably unnecessary and shows sign of a reversion to identity language that may or may not have produced greater

viability for Bryan. However, it is the "haecceity" (Deleuze, 1995, p. 141) of this shared encounter that makes for this differenciation. For Bryan, Leila and myself, our "specificity" our "material existence" and our "histories" constitute the "vital resources for this work-in-relation … each is open to the other and their focus is on what emerges between them" (B. Davies, 2009).

> In the radical pedagogy I am exploring here, in which primacy is given to the self-in-process, and to differenciation as evolution, listening involves stretching the ears, and all the senses. It requires a focussed attention, an intensification of attention to the other and the happening in-between. The neurons of the body must pick up, as a mirror, the being of the other, the minute details of sound and movement, of affect. Listening involves much more than the de-coding of sound for meaning. When one truly listens, the whole body is oriented toward the other. One's lips and tongue, for example, may work to shape the sound one hears in one's own mouth, as an integral part of coming to know or imagine what message the words carry. The neurologists speak of mirror neurons that enable us, through mirroring the pain or the joy or the movement or the sound of the other to know the other through an intimate, social synaesthesia, where the words, the sonority, the affect of one are heard in the ears of the other, but also in their mouths, their eyes, their hearts, their gut (B. Davies, 2009).

An experience of the here-and-now of therapy is embodied – it involves the very physicality of the body and a sense of heightened awareness, which, paradoxically, is open to an engagement with what cannot yet be known in order to create multiple potentialities for subjectivity. Stern is trying to communicate something very similar when he wrote in an extract above "of dipping into their own world experience and expressing that, of standing alongside the patient in this moment of usually painful reappraisal" (Stern, pp 188-9). However my understanding of this in the way B. Davies and Deleuze describe, would be that there was much less of delineation between self and other in any humanist sense. The therapist "standing alongside" the patient does not denote normalcy. The difference is not one between what is normal

and what is pathological. The ah-ha experience in this sense, does not make for an “identity” that is now “found”. Rather subjectivity is multiple and multiplying in a developing and ongoing process of creation through a haecceity that makes no delineation between what is outer and what is inner, what is the focus and what is on the fringe and what is “subject and object and, therefore, humans and nature” (Halsey, 2007, pp. 146).

Experiences such as Bryan’s have the components of story within them: they can be read in terms of build-up, climax and resolution, if the reader will excuse the pun. Stern sees these intersubjective moments as “the building blocks of experience” (Stern, 2004, p. xii). Such “subjective experience – experiences that lead to change” (p. xiii) he continues, are likened to those moment to moment interactions first experienced in the mother and child relationship. He states that a moment of connectedness that builds a self, first sits outside language before being constituted by language after the experience itself:

> The present moment, while lived, can not be seized by language which (re) constitutes it after the fact (Stern, 2004, p. 8).

Stern points out that attempts at privileging narrativisation after the fact has the risk of only capturing some of the elements of the transformational moment and of undermining its power to exact change, if the view is held that “the only clinically relevant psychological reality is conferred when experience is rendered verbally” (pp. 27-28). I agree with Stern that elements of these transformational moments are missed in attempts at narrativisation as moves to place these experiences into language can only ever be partial and incomplete. However what I want to point out here is that there is nevertheless a potentiality inherent in accounts of healing or transformation after trauma in which the narrativisable components remain limited. For example, in the previous extract, Bryan never did attempt to fully articulate what he heard or saw as his mother was being raped by his father, although he did, in a subsequent session, articulate something of the meaning he now made about those events and how that had influenced the

way he experienced his sexual relationship with Leila. So my point is this, whilst some sense was made of Bryan's experience as a child witness of violence perpetrated against his mother, he did not need to make intelligible the totality of this overwhelming event for meaning to be made and a more viable subjectivity to emerge. Stern points out that in order for this to become an aspect of the patient/client relationship, this intersubjective shared moment can be experienced without the necessity for articulation. However my point is that the unnarrativisable aspects of trauma can and do inform "sense".

So an incomplete narrativisation of events can nevertheless be a mo(ve)ment into connectedness and expanded awareness even with many aspects of the shared story remaining implicit. A child's experience of terror still can defy attempts to be articulated into language but the mo(ve)ment of therapy still allows for different experiences of self and relationship to emerge: "That is the secret of the *here and now"* (Stern, 2004, p 58).

The Imperative of Transformation

At the beginning of this chapter I quoted from Blackman (2001) who reminded us that we are constantly hailed as subjects capable of bringing about some fundamental change, that is, transformation, in our lives in order to bring about "resolutions" or "solutions" to the problems we experience in the multiple spaces we inhabit, and in which we are, in fact, regulated (2001, p. 90). Most people enter therapy with a desire for a transformation of their psychology to take place. Bryan needed to transform and reinvent himself both physiologically as well as psychologically in order to preserve his relationship with Leila. Leila demanded that such a reinvention take place in order for her to be happy with her sexual relationship with Bryan. And were it not for the recognition of the possibility that the unconscious beliefs Bryan held were grounded in Bryan's overwhelming experience of the violence in his family of origin, a resolution, even if this resolution

remains in process, in the poststructuralist sense, may not have been found in therapy or elsewhere.

This painful necessity of self-invention (Blackman & Walkerdine, 2001) seduces me every day as a therapist also. I actively worked with Bryan and Leila to bring about some transformation in their relationship. I looked for places in which self-invention could take place and facilitated this process. And this experience, certainly for me as facilitator, participant and witness was a heady one when it took place. The experience is ecstatic, cathartic and sublime. In the "here and now" of another transformative moment, psychologist Antoine, in the extract at the very beginning of this chapter, reported something similar:

> And there'll be a sense of energy for me and the client. And, this energy registers on the physiological. I'm more alert. I'm very present with the client. They know I have seen into their heart and mind and recognised their struggle at a deep level but also helped them find a way out and somehow in that space between us, something has shifted. And they appear more energised too. It's almost like a good dose of caffeine, you know, [laughing] …

Stern also describes this mo(ve)ment as having a vital quality of aliveness, "best captured in kinetic terms such as, surging, fading away, fleeting, explosive, tentative, effortful, accelerating, decelerating, climaxing, bursting, drawn out, reaching, hesitating, leaning forward, leaning backward, and so on" (p. 64). Antoine described the energising quality of this meeting of minds and hearts, like a "good dose of caffeine". These economies of ecstasy, hope, joy and relief which come with this life-filled experience are desired and memorable. They produce a subject, whose access to self invention or re-invention is buoyed by such economies of desire.

But what of the economies of despair, pain, grief and loss? What of a profound hopelessness than can emerge from torture, war and related

overwhelming events which challenge the availability of cultural signifiers to account for them as with those experiences of the Killing Fields, or even, arguably, the experience of Bryan as a child witness of violence? How does the necessity to accomplish transformation work for and against the potentiality of diverse subjectivities if a therapist such as myself is consistently produced and seduced into working towards this often allusive (im)possibility?

"Therapeutic Jurisprudence", Transformation and Recognition

In placing responsibility for change with individuals and the "experts" required to make their situations amenable to cure, not only do we become similarly desiring subjects of such a possibility, some of the causes of profound human suffering may continue to avoid interrogation. Domestic violence is one area in which there nevertheless has been interrogation and intervention, certainly in Australia, Britain and the United States. Feminist family therapists including Virginia Goldner, Laurie MacKinnon, Kerrie James and Carmel Flaskas have informed my practice here in Australia; these women have long been proactive in challenging and intervening in discourses and practices which overtly or covertly condone the proliferation of violence and abuse towards women and children. Alan Jenkins' ground breaking book, "Invitation to Responsibility" (1990) and the Duluth Domestic Abuse Intervention Project Model (1980-81) have also allowed many therapists such as myself to be proactive in some way to continue the work to bring about social, political and therapeutic reform in the area of "intimate" violence, with the focus of intervention aimed at the male perpetrator of violence within a family system, rather than only focusing on helping survivors of familial violence manage its effects. This form of "therapeutic jurisprudence" (Carson, 1995) is said to occur when: "the law, and the criminal justice system more generally, are to be used in order to produce a therapeutic effect upon the actual or potential offender, where that therapeutic effect is largely understood in terms of a reintegration of the individual into the moral and behavioural norms of their community" (Rose,

2007, p.302). In this sense my therapeutic work here is deeply implicated in the technologies aimed at the moral reform of certain subjects.

The following example of a transformational mo(ve)ment takes place during one session in a "Taking Responsibility" group program for perpetrators of domestic violence. This extract highlights how forms of recognition in therapy can promote more ethical encounters with others while still working as a regulatory apparatus. It also highlights the limits and possibilities of this attempt to re-invent certain forms of masculine subjectivity.

A man who we will call Jack, has used considerable verbal and physical violence towards his wife, is participating in a "Taking Responsibility" group designed for male perpetrators of domestic violence. He tells me as one of the co-facilitators that he doesn't understand why his partner puts up with his behaviour. He says that he will shout at her, "What's wrong with you! Don't you have any self-respect? How can you live with a bastard like me?"

He admits to the group, "You know, I even despise her for staying with me. And I tell her that! I abuse her for putting up with my abuse!"

This man is telling the other male participants and the co-facilitators that he doesn't understand his wife and he is pointing to a conundrum in his own behaviour. My interpretation is that Jack is communicating to the group, "I love her but I hate her for loving me, when I don't even love myself."

I ask Jack to enact his behaviour with another participant who plays the part of his wife, Sandra, who stands stoically silent as he verbally abuses her for "putting up" with him. As I observe Jack moving further into the enactment, when his emotion is heightened, his voice more vehement and his tone closer to what I imagine he may use in his "real" life, I interrupt him and ask, "Who are you really angry at Jack?"

Jack turns to me, flustered, “What?” he says.

I say, “Jack. Tell me, who are you really angry at?”

Jack clutches his head with both hands. “What?”

I say, “Jack, it's not really Sandra you're angry at, is it?”

Jack's face appears to contort in anguish. He almost doubles over as if he has been punched.

As the facilitator I am aware of a full and profound silence. It is an alchemical moment and I cannot fully describe the feelings in the room, the feelings of awe and expectation in my body, the sense of reverence that appears to co-*exist in a charged moment of the emergence of Jack’s new* sense of self, others and the world.

He cries, “It's my mother I'm angry at! It's my mother! I'm angry at her for staying with my father who abused her. I wanted her to leave him when I was little. Why didn't she take us and go? It's her, isn't it? And I've been behaving just like my dad did. I've been hurting Sandra, just like dad hurt mum!”

Jack covers his face and he starts to cry. There is a poignant moving silence as Jack and the other participants grasp a new reality.

A week later, Jack returns to the group. He tells us, “I never realised that I held all that anger at my mother inside of me. All the time I was angry at Sandra, I was actually angry at my mum. I was angry that I had been so frightened of my dad, and so angry at mum for staying and putting up with his abuse. But my mum had nowhere to go. She had no family. She had no job. I thought I understood why she stayed. I didn't realise that for all these years I still carried the pain of the little boy who stood by helplessly.”

Jack reports that there has been a major shift in his view of Sandra, and of what he thought was "true". He says his behaviour has changed for the better, as if overnight.

Sandra, Jack's partner tells the co-facilitators that Jack has "changed" and that it is nothing short of a miracle. He no longer berates her for staying, and he is not being abusive. Months later, both Sandra and Jack report that Jack is no longer being abusive.

Nevertheless, the act of recognition by Jack, of his vulnerability as a child witnessing his father's violence towards his mother and the vulnerability of his partner, Sandra in the face of Jack's acts of violence towards her, and my own recognition of Jack's pain and how it was fuelled from the past, inspired a response in me as a therapist that meets and yet goes beyond the requirement for the regulation of moral subjectivity. When I attempt to articulate, in this transcript, what happens in the silence, I find myself turning to the language of the spiritual. I certainly feel swept up into a moment of the sublime. The air is charged and I feel awe and exhilaration as Jack experiences this mo(ve)ment in which a new subjectivity is birthed. There are elements of the divine[15] in this interlude and I am reminded of Emmanuel Levinas who proposes the divine and/or the spiritual are inextricably linked in the ethics of responsibility. Levinas describes this mo(ve)ment which takes place as an "ethical conversion" which "turns our nature inside out":

> God cannot appear as the cause or creator of nature. The word of God speaks through this glory of the face and calls for an ethical conversion, or reversal, of our nature... In this respect we could say that God is the other who turns our nature inside out, who calls our ontological will-to-be into question... God is other than being (Levinas in Kearney, 1986, pp. 24-5)

[15] For an outstanding and comprehensive analysis of the "divine" and Levinas, see the work of Grace M Jantzen (1998) in Becoming Divine: Towards a Feminist Philosophy of Religion. Manchester: Manchester University Press.

Perhaps this is what recognition does. Levinas (1996) proposes, "[t]he Other is the sole being whose negation can only announce itself as total: as murder. The Other is the sole being I can wish to kill" (Levinas, 1996, p. 9). The transformative moment is one in which the desire to kill or to abject, to see an other as less than human and as unviable, is converted to the desire for moral and ethical responsibility, when the face of the other is recognised as human. For me, something spiritual and miraculous occurs in this mo(ve)ment.

Transformation and Spirituality

In examining accounts of transformation in therapy it becomes obvious that the language of the spiritual is often deployed to explain experiences in therapy that evade the usual discursive apparatuses of science and "logic". Some "thing" described as transformational can elicit spiritual discourses when, for example, an experience of awe and wonder is generated, when an experience seems "out of this world" and of course when the explanation for its occurrence is already deeply embedded within spiritual discourse such as occurrences that are deemed "miraculous". Levinas above used the spiritually discursive to describe the call to an ethical encounter he described in the previous section when he said, "we could say that God is the other who turns our nature inside out, who calls our ontological will-to-be into question... God is other than being" (Levinas in Kearney, pp. 24-5). Jung talked about "God-images", saying that he too has "such experience also, which I call God" (Jung, 1972, cited by Dunne, p. 200). Jung's construction of God, whilst it predates Levinas, is very similar. Jung stated

> It is the experience of my will over against another and very often stronger will, crossing my path often with seemingly disastrous results, putting strange ideas into my head and manoeuvring my fate sometimes into most undesirable corners or giving it unexpected

> favourable twists outside my knowledge and my intention. The strange force against or for my conscious tendencies is well known to me. So I say: ‘I know Him.’ But why should you call this something ‘God’? I would ask: ‘Why not?’ It has always been called ‘God’ (Jung, 1972, cited by Dunne, p. 200).

Whilst Judith Hubback (1999) interprets Jung as meaning he trusts his own subjective experience of God, I view Jung’s quote quite differently. For me, Jung’s positioning is one in which he deploys spiritual language to refer to a moral or ethical encounter. In this way, he uses the spiritually discursive to make this event recognisable.

This recognition can happen in a number of ways. First, in the absence of an “other” to recognise one’s vulnerability, spiritual discourses place the power of this recognition outside humankind and into the realm of a godhead, through religious or spiritual writings, teachings or prayer, for example. Second, this occurs when pieces of an experience are not recognisable within alternative discursive metaphors. These pieces of experience become recognisable when the language “of the spiritual” provides them with a coherent narrative that works so they are no longer threatening or confusing. Also, a spiritual metaphor can reduce anxiety about something not making sense. Spiritual language allows an occurrence to “make sense” with the knowledge that “sense” is made within a relationship that is reliant on modes of sense making that have a currency in the social. Most interestingly, spiritual discourses operate even within the realm of secular mainstream psychology to describe transformational events. For example, some experiences may be overtly attributed to a spiritual realm, or the spiritually discursive can be deployed in the way a therapist tries to communicate some thing about the charged and ecstatic elements of an ah-ha moment, such as how I relate something of my experience in working with Jack in the “Taking Responsibility” group.

Anna, a psychologist in private practice who was interviewed for this research project, told me of her experiences working with a young woman,

Therese, whose mother had been murdered by her step father. Therese, who had suffered a debilitating depressive illness for many months had recently ended therapy with another well-regarded psychologist, whom Therese described as helpful, but that she had never felt comfortable telling the previous therapist all her story. She told Anna there was something that happened that she was afraid to tell the other counsellor for fear of being seen as crazy.

> Therese told me she needed to know that I too had experienced loss and death. And I told her that I had experienced death and I disclosed that I too had experiences that I could tell only some people because they were so precious to me. And Therese looked at me and *said, 'I will tell you.' And then she told me how she had fallen down* in grief onto the soft grass of her garden one early Autumn day after many days of despair contemplating her own suicide and that she had *suddenly felt the warmth of the sun's rays on her back. Therese said, "It felt like the sun was my mum lighting me... She was giving me a* message, that even though she was not in the body she was here. And *I want you to hear that it felt really like it was her!"* (Anna).

Anna continued to describe her perception of Therese's fear of not being believed and how important it was to her to find a therapist who could listen without judging her. The relationship between Anna and Therese opened up a space in which Therese's story could be both voiced and heard for the first time. Therese openly used the language of the spiritual to make sense of her experience of suddenly feeling "the warmth of the sun's rays on her back" at a time she was despairing. Anna's disclosure that she too "had experienced death" and that she also had experiences she "could tell only some people" recognised Therese's struggle to find a listener to her own account and in so doing provided a narrative within which Therese could tentatively tell her story, held secure in an empathic meeting.

Jonathan Wyatt's (2004) theorising provides another way of reading Therese's desire to tell something she "could tell only some people". In

Wyatt's study, which looked at how psychodynamic therapists responded to clients who expressed some kind of religious or spiritual faith, spiritual discourses could function as transitional objects for clients, that is, "the symbolism of religion, whether its language or its 'furniture', can enable the counsellor and the client to make emotional contact" (Wyatt, 2004, p. 33). From this perspective, Therese's need to find a therapist who could hear all she wanted to say, could be indicative of a particular form of emotional contact in which Therese wanted to be a participant, where the spiritually discursive was an expression of that relationality.

Wyatt goes on to refer to the work of Bollas (1987) and Shafranske (1992) by discussing how religious faith can also be perceived by psychotherapists as a "transformational" object in which there is again some replication of the mother and infant relationship. In this delineation, the infant seeks the object, the mother, in order to be satisfied, for example, to be transformed "from hungry to full, or from sad to happy" (Wyatt, 2004, p. 34). Interestingly, in Wyatt's research, it was the perceived "pathological components of their clients' faith that preoccupied" the therapists he interviewed (Wyatt, 2004, p. 36).

It is this point that I explore in the next section, whilst emphasising that theorists such as M. Epstein (1998) have challenged the "legacy of Freudian and Lacanian contempt" for spirituality or religion:

> … the early preverbal and preconceptual mind of the infant is idealised into a blissful state of union with the mother in which the newborn is thought to dwell. This early state of oneness is treated as a kind of Garden of Eden by the psychoanalysts, who then interpret any spiritual urge as seeking, in Freud's words, 'a restoration of limitless narcissism' and the 'resurrection of infantile helplessness' (M. Epstein, 1998, p. 32).

M. Epstein is arguing that the psychoanalytic figuring of an early undifferentiated state appropriates a spiritual discourse then turns that into an injunction against clients having a spiritual motivation to their lives. An example of this is Bion's (1959) description of "O" that was discussed earlier in this chapter in relation to the experience of "at-one-ment" (see also Stein, p. 184). This experience, depicted as necessary and growth-producing events of maternal reverie and containment for the baby as well as for the patient of psychotherapy, is also described as a profound event indicative of "ultimate reality, absolute truth, the infinite or the thing-in-itself" representative of "'darkness' and 'formlessness'", as well as "the unknowable aspects of psychic reality" (Bion, 1959). Bion deploys spiritual language to make these claims and Stein also describes the experience of coherence that develops in the ah-ha moment of transformation for the client as a "… sense of O/God/mother" (Stein, p.184). Bateson (1972), the outstanding systems thinker, described the experience of human connectedness as "a large Mind of which the individual mind is only a subsystem... [This] larger Mind is comparable to God and is perhaps what some people mean by 'God', but is still immanent in the total interconnected social system and planetary ecology" (Bateson, 1972, p. 461).

J. Rubin (1997) sees this conundrum as indicative of the way psychoanalysis is situated within the culture of individualism that underpins it, making particular emphasis on the development of the psyche of the "psychological" subject who arose out of the "devaluation, marginalisation and pathologisation" (J. Rubin, 1997, p. 81), indeed, the "despiritualisation" of subjective reality (Kovel, 1991). And M. Epstein adds to this conceptualisation when he elaborates on Winnicott's notion of "unintegration" thus:

> By unintegrated Winnicott meant something … where the usual need for control is suspended and where the self can unwind. He meant losing oneself without feeling lost, hearing the self's innuendo rather than just its inflection (M. Epstein, 1998, pp. 36-37).

Romain Rolland (1927), a friend of Freud's, responded to Freud's (1927) critique of religion in The Future of an Illusion by saying that Freud's work was valid, but that it failed to identify the most important religious sentiment, the "sensation of 'eternity', a feeling of something limitless, unbounded" (Rolland, 1927, p 65), perhaps because Freud had never experienced such an "oceanic" feeling himself. Issroff (1999) goes further and makes a paradigm shift in conceptualising these oceanic feelings as aspects of the abjected or even unrealised "female element", or the reappearance within discourse of the "hysteric" of the 19th Century:

> … when such a dissociation or split exists, for the individual concerned the 'female element' is not experiencable! Accordingly, this whole area of conceptualisation may be beyond the grasp of those… eminent… psychoanalysts, who themselves are defending against primitive agonies by a flight to the split-off intellect; a basic personality fault, where existential and experiential 'in touch-ness' is missing or 'female element' dissociation also exists (Issroff, 1999, pp. 111-112).

The ability to simultaneously disappear and observe, participate yet reflect upon an experience, as described by Meares (2000, pp 9-10), was considered earlier in this thesis. The felt experience of some "thing" may require the deployment of the spiritually discursive because of the way in which we may "let go" and "surrender" to a particular experience (J. Rubin, 1997, p. 84) so that a new subjectivity emerges that sits outside the notion of the individual autonomous self:

> We get lost in the contemplation of a beautiful scene, or face, or painting, in listening to music, or poetry, or the music of a human voice. We are carried away in the vortex of sexual passion. We become absorbed in ... a deeply stirring play or film, in the beauty of a scientific theory or experiment or of an animal, in the intimate closeness of a personal encounter (Loewald, 1978, p. 67).

Fateaux (1997) argues that spirituality is “neither an unconscious undertow that drags people deeper into its grasp, nor an idealised state free from the relentless pull of underlying needs. The experience is regressive... when Nirvana and union with God are analysed as a loss of ego boundaries and a restoration of maternal unity. But... the dismantling of self and return to unconscious processes that takes place in religious experience can be as reparative as the regression that takes place in experiences such as creativity and therapy” (Fateaux, 1997, p. 11).

Here Fateaux theorises that the contemplation inherent in creativity and in healing encounters in therapy can be described as “regressive” given the “dismantling of self and return to unconscious processes” that can occur. However J. Rubin reasons that such dismantling be it through experiences described as spiritual, therapeutic or otherwise have been marginalised and pathologised because “oneness experiences may stir up various internal and interpersonal anxieties and dangers, including fears of engulfment and self-loss” (J. Rubin, p. 84). Eigen, too, holds that this fear is actually unfounded because pure states of primary fusion and undifferentiation, or of autonomous isolated selfhood, do not exist as lived realities:

> Separateness and connectedness... arise together and make each other possible... Pure merger and isolation are abstract terms which do not characterise living experience (Eigen, 1986, p. 363).

Fateaux (1997) concludes that a state of “oneness with God” is not the final point of religious experience if one is psychologically healthy. It only becomes the final point if one remains attached to preserving those feelings that an oceanic state elicits rather than moving forward into the challenges of the next level of awareness. Fateaux uses the example of an artist's retreat from unhelpful distractive preoccupations to find inspiration and thus emerge able to manifest this creative expression in some object of art. In a similar way, deep reflection, meditation, or even respite from the vicissitudes of life may evoke the use of a spiritual metaphor such as a

person having the sense they achieved “oneness with God” which then leads to some motivated action.

Therese needed Anna to understand that her story was not that of a mad person – Anna's utilisation of the word “precious” denoted something that was desirable rather than abject (MacKay, 2001). Charlotte Spretnak, (1991) describes experiences like Therese's as “moments of graced consciousness so intense that they bring revelation ... experienced as being joltingly outside of cultural frameworks, making it nearly impossible for one to discuss the occurrence afterward except in oblique approximations” (Spretnak, 1991, p 81).

Nevertheless, spiritual discourse may simply provide a dialectical account of a sublime poetic religious experience that changes the person, who then returns renewed to the world of everyday experience, ready for action. This could be the meaning that is taken from Therese’s experience. In this sense, a spiritual discourse is just part of a grand narrative that tells the story of a dismantled humanist subject who transcends adversity through a spiritual awakening that works to re-invent agency and autonomy. In many ways, this is similar to the account of posttraumatic growth, which can function to recreate the fiction of a re-invented humanist subject, in “rising above” previously disabling traumas. However the spiritually discursive can also make recognisable the potential for transformation to occur in the face of the (im)possibility of “actualising” an autonomous subjectivity in an unsettled world. Spiritual discourses, particularly those emanating from Eastern religions, undo Western preoccupations with the individual autonomous self even as it is this undoing of the notion of a humanist subject that leads me now to one of the most important points I am making in this thesis, that is, how to understand transformation in the light of working therapeutically with survivors of trauma from a poststructuralist perspective.

A Poststructuralist Transformation

Transformation is described by B. Davies & Gannon as mo(ve)ments that draw attention to the ways in which subjects are vulnerable to "discursive power" (2006. p. 6). These moments and movements do not pull us into constituting ourselves as autonomous agents situated at some point of linear time. Instead they make visible our formation as certain types of "subjects-in-process" (p. 6), opening up the possibility of our resistance to modes of subjectification that would deny or reduce viability. Thus the necessary "ingredient" of such a transformative process is a transparency that elicits an engagement with yet unimagined potentialities for subjectivity.

In exploring the language of spirituality as a resource within therapeutic work with survivors of trauma, I am not suggesting that spirituality exists outside of discourse and relations of power. Spiritual discourses do not necessarily make visible our inculcation as governable and regulated subjects. Technologies that regulate populations can both naively and strategically utilise spiritual discourses to control certain groups. This is not to say that this regulation is necessarily contrived in the sense of being counterfeit. In recent times practitioners of interventions such as the introduction of Vipassana meditation to prison populations (Shah, 1976; Khurana & Dhar, 2000) genuinely adhere to these specific spiritual principles. However the operations of governmentality deploy such techniques to reduce recidivism and create a more "content" and "moral" subject. The Buddhist practice of "mindfulness" has been colonised by the West and appropriated in therapeutic practice because it is efficacious in the creation of feelings of wellness, in the reduction of oppressive emotional and psychological symptoms and generally in the alleviation of personal suffering (Hayes, Strosahl & Wilson, 1999; Kabat-Zinn, 2005). The "control log" used in "Taking Responsibility" groups (an extract of which I have included earlier in this chapter), draws on notions of mindfulness to the minutiae of the present moment in order to facilitate self-reflection, greater impulse control and therefore changed behaviour leading to the production

of a certain reformed and ethical subject. Thus the evocation of spiritual discourse, even in the moment of transformative pain and realisation, has a normalising and regulatory dimension. However as the work of this thesis unfolded and spiritually discursive accounts of healing in therapy were examined, some "thing" about the spiritual and its transformative function provided a poststructuralist turn that I was not expecting.

To illustrate this, I now draw attention to two examples of the way spiritual language was deployed by therapists to explain their own experiences. In the first extract, Brigitte attempts to voice the significance of acknowledging "the spiritual" in therapy, but her attempt to "language the unlanguagable" in this regard verges on incoherence:

> Brigitte: I wonder if I'm very messy, the way I talk. Is it, is it clear enough?
>
> LM: Yes… yes, you are… you are.
>
> Brigitte: Thank you. I just wanted to make sure because [laughs]... It's very moving and exciting for me to be doing this interview with you, hearing the kind of things you are talking about, and um, because certainly I think, um, um, yes... There's something that happens in me even in hearing you, where I would, you know, like, like you might say of a client, I might say to you now, this is, this is a pearl that we don't throw down easily. We have to know that it going to be picked up and carried and seen for what it is, a thing of great beauty and so, in doing this, I want to, that is my intention, to pick up the pearls but you are speaking so many pearls... Because English is not my first language and I've never done it before, so I thought… I hope I speak clearly enough, that's all.

Because English was Brigitte's second language, the at times, incoherent account could be explained by the language barrier. However in the next

extract, another therapist, Jackie, struggles to make intelligible another experience in the therapy room that has evoked spiritually discursive language:

> Jackie: How do you....? I don't know quite... it was.... something...um...something.... magical....I can't think....bitter/sweet.... lump in ... throat ..um... talking..... special for me and my client. Do you know what I mean?

When I showed the latter extract to some of my psychology students, most were quick to point out its incoherence and therefore its invalidity as research material. I asked them how they perceived this woman and they told me she sounded “off the show”, like she was “on drugs or something”, or “crazy”. I was acutely shocked by this. In attempting to show the difficulty languaging an experience in therapy that this woman described as spiritual, a direct link was made to the (female) psychotic subject.

Implications

I am struck at this point by how, in the above instance, the prescription of the psychotic subject can be equally applied to survivors of trauma and to therapists who work them. The slippage here, between incoherence and psychosis, speaks once more to the centrality of narrative coherence in constituting “normal” subjectivity. I am even more struck by the proposition that emerges through these considerations. What does it mean, for both neurobiological and discursive theorisations of trauma, if the unspeakability of ecstatic experiences mirrors that of traumatic ones? It is beyond the scope of this thesis, which is not experimental in the scientific sense, to propose that the sublime and the traumatic act upon the mechanisms of speech and the brain in a similar way. However, we are undone by trauma and the spiritual. We are undone by the grief of trauma. We are undone by grief. For Butler, this undoing is indicative of “the thrall

in which our relations hold us, in ways that we cannot always recount or explain, in ways that often interrupt the self-conscious account of ourselves we might try to provide" (2004a, p. 23):

> I might try to tell a story here about what I am feeling, but it would have to be a story in which the very 'I' who seeks to tell the story is stopped in the midst of the telling; the very 'I' is called into question by its relation to the Other, a relation that does not precisely reduce me to speechlessness, but does nevertheless clutter my speech with signs of its undoing. I tell a story about the relations I choose, only the expose, somewhere along the way, the way I am gripped and undone by these very relations. My narrative falters, as it must (Butler, 2004a, p. 23).

Similarly, experiences of the sublime evoke feelings of the "ec-static" that is, the sense of feeling transported, of being "beside oneself" (Butler, p. 24). This experience of rapture cannot be fully or coherently articulated. Yet like Page's and Ut's photos, which pointed to something outside of the frame, something of the precariousness of life was revealed with the consequence that the hegemony of representation is challenged. This is the work of "fractured" accounts of trauma and of the divine. This is the eloquence of chaotic accounts of spiritual transformation. In the faltering words and fissures and breaks that disrupt coherence, there is a fluid mo(ve)ment towards a visibility that produces greater potentialities for beingness than otherwise were thought possible. When the (im)possibility of autonomous self-regulating agency is seemingly foreclosed, its very "disappearance" makes more visible the inscriptions and carvings of discourse. In an ethical encounter, one in which my "I" recognises a "you" who has been marginalised and dehumanised, a transformation takes place in the very recognition that points to something "other" that can still defy attempts at narrativisation and intelligibility.

So to summarise, I have examined how moments of transformation in therapy, sometimes described as "present moments" or ah-ha moments, or

moments of quantum change, can function as nodal points in the narratives of therapeutic work, often occasioning a remarkable turn toward the possibility of viable lives and relationships for sufferers of trauma. I proposed that these moments can be located in spiritual or psychological discourses and encoded in the language of the psychological and/or the spiritual. I suggested that such moments occur, in therapy, within the context of a carefully shaped therapeutic relationship and thus evoke a recognition that confers something life-giving to the subject of trauma. I attempted to interrupt the dominant humanist narrative of therapeutic transformation by proposing that such instances may be thought of as mo(ve)ments, as ec-static. I also examined instances of transformation in the context of disassociation, often a limit-case for therapy as a work of integration. I briefly questioned the dominance in therapy of notions of integration and transformation, acknowledging my involvement in contemporary regimes of the governance and moral regulation of the self. Lastly, I suggested that attempts at the symbolic representation and languaging of moments of transformation may encounter similar difficulties to those experienced in the attempted articulation of trauma narratives. This symmetry between ecstatic and traumatic representations critically challenges the privileged status of narrative coherence as a marker of normality and viable subjectivity

In my next, and concluding chapter, I draw together the diverse threads of analysis that run through the proceeding chapters. I revisit the tensions between a poststructural theoretical framework, trauma theory and the domain of therapeutic practice. I reflexively acknowledge my own imbrications in relations of power, and how my ability to assist my clients to recover their lives and relationships from the effects of trauma inevitably involves me in the production and regulation of contemporary moral subjects. I offer a conceptualisation of an unlanguagable excess in therapy – whether that be profoundly traumatic or profoundly transformative. Finally, I attempt to reconcile “the spirit” and “the subject” in therapeutic work with trauma survivors, by reasserting and expanding the theoretical basis for the primacy of relationship and recognition as the “curative” factors in therapy.

Chapter 7: Conclusion

> One would need to hear the face as it speaks in something other than language to know the precariousness of life that is at stake. But what media will let us know and feel that frailty, know and feel at the limits of representation as it is currently cultivated and maintained? If the humanities has a future in cultural criticism, and cultural criticism has a task at the present moment, it is no doubt to return us to the human where we do not expect to find it, in its frailty and in the limits of its capacity to make sense
>
> (Judith Butler, 2004a, p.151).

A reflexive focus upon my embeddedness within certain discursive regimes of power and my resistance to them has allowed both my work with my clients and my work throughout this thesis to be something "other", as Blackman (2001, p. 97) proposes. It is a work that has necessarily evolved over time and through contemplation in order to reflexively explore and transform emergent potentialities for human subjectivity.

As a family therapist, my work is situated, obviously, at the "site" of the family. I therefore cannot directly intervene in national or world politics that can end wars or stop genocide. The action I can take is to be aware of how I too am constantly inculcated as a subject to come to desire the very tools of my own and my clients' oppression. However, in my roles as therapist and researcher, this necessary reflexive diligence is often allusive and chaotic. I struggle with the ambivalence of holding so many competing discursive threads together in order to work to reduce their limiting effects in the development of a multiplicity of subjectivities for my traumatised clients. However, despite this ambivalence, I have not been without a

certain discursive agency. In this work, I am a "subject-in process" (B. Davies & Gannon, 2006, p. 6):

> … not so caught in definitions of herself as she might have been. She finds herself in mo(ve)ments, and as she scrapes her way through post-structuralist writing, catches herself in the act of being subjected and, sometimes, drags her individualized subjecthood behind her, she is above all, in process, vulnerable to inscriptions that may be opaque to her and yet developing the powers to make the discourses and their inscriptive powers both visible and revisable (B. Davies et al., 2006, p. 181).

In this thesis, I have provided examples as to how dominant technologies of self, such as identity language, function in trauma discourse to elude and limit the mo(ve)ment of possibilities for subjectivity and viability. My thesis attempted to subvert this pull towards identity language by puncturing both the notions of biology as a static entity and embodiment as simply attenuated to discourse. This argument was further developed by exploring how "experience" itself evades a fixed and unchangeable status. Rather, it is an ongoing project that involves activity and flux, so that whenever an experience is languaged, it is transformed consequent to the ways in which subjects meet with it and the meaning that is made, given that both the biological and the social are inextricably linked to the body. However, because the original trauma discourses cannot disappear, even when they are confronted by an alternate lens, the challenge then remains to maintain a reflexive awareness of this tension. This awareness was not always sustainable – this was demonstrated by the way I constantly found myself sliding into humanist language and concepts that reduced the opportunities for potentialities of subjectivity to emerge.

For instance, in examining my relationship with neurobiological discourse in Chapter 2, pertaining to "what the brain does", I have come to the idea that, when I provide psycho-education about brain functioning in my

therapeutic practice, even if only in the deployment of a very simple diagram of the brain, I implicitly constitute what I am saying as valid and true because of the constitutive power of neurobiological explanations. Clients then are inculcated into subjects who map their own experiences onto the brain. This "voluntary" mapping entices subjects to seek out solutions to their problems via this neurobiological discourse and the practitioners who deploy it, not only because it makes some experiences intelligible, but because, paradoxically, an overt de-pathologisation takes place, even as pathological prescriptions continue to be made. Clients are simultaneously reassured that their problems are a "normal" response to the effects of trauma upon the brain, at the same times as those effects are produced as pathological. Thus, when I talk with my clients about what is "normal" and what is "not", I am implicated in producing human subjects who are then even more amenable to intervention and more desirous of achieving the allusion of a humanist subjectivity.

Similarly, when the focus is on psychological discourses that predicate the view of a "damaged" trauma survivor, whose selfhood has been diminished in some way, as I discussed in Chapter 3, then I reduce possibilities for subjectivity. Binaries that are deployed throughout trauma theory and therapeutic practice that assume that "integration", "narrative coherence" and "wholeness" are "facts" of healthy human functioning, and that disintegration, unlanguagable accounts and fragmentation denote lack and disability, lessen these potentialities. Yet it is within these constructions that I often found myself regulated, constitutive and constituting of the trauma survivor.

So when therapists demand that trauma is articulated into language, they do so from what I now consider to be a more tenuous position than previously thought. Given what appears to be the indelible carving of language on and into the body, as outlined in Chapter 4, extensive narratives which convey accounts of trauma, do not, in and of themselves, produce the conditions for healing. Even so, there is a drive by trauma sufferers to make a coherent

account of their experiences. However, such attempts can either promote or evade viability, either in retriggering the trauma so that viability seems lost, or in its retelling, producing an articulation that restores the viability of the subject. Language can work as a tool of oppression, as Levi noted in Chapter 5, but conversely it was the tool of Levi's resistance such that he could regain a sense of human beingness. As an active project, the narrativisation of trauma can be mobilised within or beyond therapy to evoke a recognition, but different forms of recognition, including misrecognition, have startling different consequences for subjectivity, experience and recovery from trauma.

Therapists must also be mindful, as a result of this project, how they may engage in limiting possibilities for their own subjectivity when they take on the "responsibility" for bringing about positive change in a trauma sufferer's life. This responsibility is not just mobilised by wanting to do "good" therapeutic work with clients. While governments and other regulatory structures have divested themselves of responsibility for the origins of trauma, responsibility for the governance and "ethicalisation" of the subject of trauma has increasingly shifted into the therapeutic domain. Therapists, then, are produced as agents of normalisation, but they are also interpolated as ethical subjects who have demands made on them by the face of the other. The way I, as one of these therapists, respond to that hail, or not, produces a form of recognition which may promote viability or diminish it.

One of my main claims in this work is that viability, and the question of its availability, may need to be revisited again and again at multiple points in a person's life. This may "account" for why the articulation of trauma into language by Levi and Celan did not provide for a sustained viability. Moreover, their recognition as viable and grievable human beings may have been flawed in that the recognition was not actively maintained through the reiteration of ethical responses that promoted viability. I make the point then that, if the viability of the subject is itself a partial and incomplete process

rather than a fixed entity, then clinicians need to approach therapeutic work with survivors of trauma differently, even while therapy alone cannot meet the demands of making a space for this ongoing project throughout the life cycle of a trauma sufferer. Again, this has implications for governments and researchers: who takes responsibility for supporting this ongoing project of establishing viability and recognition again and again? Who will recognise that this suffering demands an ethical response that has obligations and effects well outside the therapy room?

In turning to the interface between unspeakable events and memory in regard to the sustainability of a viable life, the unintelligibility that emerged in the traumatic accounts was explored to highlight what "non-sense" can nevertheless reveal. Taking into account both visual and verbal representations of overwhelming experience, I reflected on the humanising effects of images which also point to something "outside" that is not fully represented, such as the precariousness and grievability of a human life (Butler, 2004a). This understanding was couched in terms of the in media res and the in principio or traumatic voice of attempts to articulate traumatic memories. I have examined how the work of a photograph can articulate a humanising story whilst at the same time providing a frame of trauma that can never be assimilated or represented in adequate speech. A consequence of this, and this is also an important argument of my thesis, is that autobiographical and coherent narrative representations may be disturbed necessarily by the eloquence of chaos produced in unspeakable acts that sit outside any available cultural metaphors.

If the production of a humanist subject is an achievement that trauma survivors can barely attain or sustain, the consequences of this in relation to therapeutic imperatives to achieve wholeness and integration are profound. The inability of stories of genocide, atrocity and war to move into a smooth autobiographical narrative may indicate a refusal to appropriate dehumanising experiences and events into a life story. This rebuttal then makes an ethical demand on the therapist and listener to not

eliminate these accounts through the limits of what can be articulated, in order for these stories to be given credence and validation. In this way, new and different human subjects can present themselves. These beings then extend the boundaries of who can be imagined to inhabit sociality and who counts as human. Further, if the in principio or traumatic voice demands a recognition that calls into account the ethics of care in the human encounter, opportunities for a confrontation with inhumanity and dehumanising processes become available. Thus the in principio or traumatic voice reaches out for a recognition that takes place in its very failure to produce a humanist subject. This does not mean that coherence should be abjected from therapeutic interventions related to trauma. Coherence, control, mastery over feelings, a reduction in suicidal thoughts and the amelioration of the debilitating symptoms of traumatic experience are worthy goals in therapy. It doesn't matter that they are humanist and only ever partially and incompletely achieved. What is important to note, however, is that the constitution of a humanist subject that pervades therapeutic interventions may perhaps only ever "fail" in the face of overwhelming atrocity where grievable lives sit outside cultural and political norms of viability and ethical recognition.

If there is one more pairing of ideas that I want the reader of the thesis to take away, then it is an awareness as to how a conflation of unintelligible speech with psychosis speaks once more to the centrality of narrative coherence in constituting "normal" subjectivity. Further, I want the reader to ask themselves, what might it mean, for both neurobiological and discursive theorisations of trauma, if the unspeakability of ecstatic experiences mirrors that of traumatic ones? As I have already stated, it is beyond the brief of this research to suggest a neurobiological basis for a symmetry between the traumatic and the sublime speech in the brain. However, that a symmetry does appear to exist between ecstatic and traumatic representations critically subverts the privileged status of narrative coherence as a marker of normality and viable subjectivity.

But the pull towards some achievement of a normative regime is strong. It impels therapists and their clients to work towards achieving some fundamental transformation of their lives so as to manage their everyday experiences as subjects. The more that these subjects, of which I do not escape inclusion, come to believe and desire that the solution to their problems can be found through such a process of re-invention, the more responsibility shifts away from the very power/knowledge systems that produce (un)viability. Nevertheless, experiences of transformation in meaning making, in experiences of selfhood and in the way we connect with others, do “happen” in therapy. These momentary here-and-now experiences of quantum change seem to echo something of the sublime when they occur. When working with traumatised clients who have dissociated from aspects of their experience, transformative moments in therapy are profound. There is a moment of realisation that opens up the possibility of self-reinvention; indeed it as if this reinvention is taking place as a mo(ve)ment that exceeds the limits of narrativisation, whether this mo(ve)ment emanates from traumatic spaces or whether it emanates from spiritually discursive spaces. As a therapist, I look for implicit signs of a client’s memories and experiences. I find such signs, I believe, when I encounter the fractured speech of a trauma survivor. Without the traumatic voice of the survivor’s reminiscences, some of the struggle and pain and dehumanising affects of overwhelming experience would not be communicated at all. However I do not necessarily always need to ensure the account is narrativised further. Sometimes it is enough that there is a recognition, an ethical recognition of self and other in this exchange.

I have suggested in this thesis that there are striking parallels, between profound grief and trauma, and ecstatic experiences. If being beside oneself with pain or joy transports us outside language, then such transport must not be (mis)recognised as a condition of unviability. The implicit, the unlanguaged and the in principio voice of traumatic experiences demand of the therapist an ethical encounter. The demand is that the face of the other is not abjected. Thus the relational cure of therapy is one landscape where

subjects can be recognised as human and called into beingness without normative forms of subjectivity being the only forms that are deployed.

B. Davies & Gannon (2006) point out that the mo(ve)ments of poststructuralist writing and research

> ...are not towards the transformation of ourselves into new subjects in linear time. Rather, the transformation lies in a particular form of attention to the remembered moment, an attention that makes the subject's vulnerability to discursive power starkly visible while also making visible the constitutive powers of the subject-in-process. The movement is thus not towards a new fixed but transformed subject. It lies in the process of making visible the discursive powers of particular discourses and the modes of subjection they entail. It is that visibility that makes transformation possible, not just of ourselves as individuals, but of our collective discursive practices, of our social contexts, of our capacity to imagine what is possible (B. Davies & Gannon, 2006, p. 6).

What this means for myself as a therapist is that transformative processes in therapy simultaneously relate to a "becoming" and an "undoing" for a traumatised client. The client, having already been 'undone' through the experience of overwhelming events, is subject to another undoing when called into recognition, through an experience of the ah-ha moment, of their own vulnerability and enslavement to the power of discourses that are inscribed into their bodies. The subject moves into beingness when these processes of subjectification are exposed within a relational context where the subject's humanity and viability can be ethically re-cognised. This, I think, is what "transformation" may entail in the haecceity of the relational encounter of therapy.

Therapy, at its best, demands that we turn towards the face, hearing the "agonised cry" in order to recognise the human that paradoxically is called into being at the point of divergence which makes representation

(im)possible. This does not occur because “nothing” is communicated. In the gaps and silences, in the space of dissociative utterances, in the portrayal of extraordinary images, in the revelation of our inscription in and through discursive practices and in the relationality of the therapeutic encounter, potentialities for human subjectivity and viability emerge.

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