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Contextualizing PTSD as Diagnosis and Intervention: Situating Trauma and the Subjective Experience of Suffering in Locally Meaningful Worlds

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by

Emilia Rose Orsted Holmbeck

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ABSTRACT OF THE THESIS

Contextualizing PTSD as Diagnosis and Intervention:
Situating Trauma and the Subjective Experience of Suffering
in Locally Meaningful Worlds

by

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Master of Arts in Anthropology
University of California, Los Angeles, 2022
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This paper examines the diagnostic classification of PTSD in view of how traumatic experiences are perceived, articulated, and responded to in locally meaningful ways. Drawing on cases from Haiti (James 2016) and Indonesia (Lemelson, Kirmayer, and Barad 2007), two disparate social contexts that have both incurred deep suffering under acute political violence, I reflect on the applicability of the PTSD construct to cultural contexts that are different from the Western-scientific milieu from which it was born and became institutionalized. I argue that making sense of individual suffering requires close attention not only to the circumstances under which the traumatic experiences unfold but also to the ways in which individuals interpret and respond to their suffering. In this context, the PTSD category is but one of many cultural systems of meaning that provide a framework for understanding and responding to one's pain. As such, uncritical and

universal applications of Western notions of trauma that disregard locally situated experiences of suffering, its meanings, and culturally salient coping strategies run the risk of both misinterpreting behavior and prescribing treatment that conflicts with locally meaningful categories of understanding. Simultaneously, understanding traumatic experience necessitates a recognition of its critical relational dimension, not only because trauma often involves painful ruptures to social relations but also given the role that social relations play in healing processes. The implication of this is that psychiatric models that pathologize trauma and neglect the role that culture and social relationships can play in healing are insufficient for explaining and treating subjective suffering everywhere.

The thesis of Emilia Rose Orsted Holmbeck is approved.

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1. Introduction

In both clinical and colloquial contexts, notions of trauma and PTSD have long been commonly invoked labels connoting something of complex experiences of suffering and its lasting psychic wounds. In recent decades, these conventionalized concepts have been scrutinized by scholars preoccupied with the subjective experiences of trauma and its conceptual and practical use value across disciplines and geographical borders. At the core of the issue is the fact that suffering simultaneously constitutes a human universal while the embodied experience of suffering is inevitably unique to the subject. In turn, subjective experiences of suffering are contingent upon the social and cultural context in which the individual is embedded. As anthropologists have observed, traumatized individuals often draw on available cultural resources to make sense of those violent experiences that have disrupted their lives and rendered their world unsafe (Hollan 1994, 2013; Lemelson, Kirmayer, and Barad 2007). Yet, in Western psychiatric and psychotherapeutic tradition and discourse, the conventional approaches to making sense of and treating trauma have tended to downplay the work of culture (Jackson 2005, 372; Obeyesekere 1985, 147-148).

This paper seeks to examine the trauma and PTSD concepts in view of how traumatic experiences are perceived, articulated, and responded to in locally meaningful ways. By drawing on cases primarily from Haiti and Indonesia, two disparate social contexts that have both incurred deep suffering under acute political violence, the paper reflects on the concepts' applicability to cultural contexts that are different from the Western-scientific milieu from which they developed and became institutionalized. Specifically, the paper draws on Erica James's ethnographic work in Haiti (2016) to illustrate how present violent conditions impact subjects' coping strategies and interpretations of past trauma as well as how the pathologization and treatment of individual trauma can be problematic when continuous political and structural violence engender present collective suffering. It then draws on Robert Lemelson's long-term, person-centered ethnographic research in Indonesia to show how individuals experience, respond to, and cope with the very same environment of

political violence in distinctive ways, in part depending on the cultural and material resources at their disposal (Lemelson, Kirmayer, and Barad 2007).

Examining these anthropologists' empirical data, I consider what is shared and what differs between individuals' experiences of and responses to trauma in Haiti where structural and political violence remain urgent, and Indonesia where the political violence of the 1960s has left palpable marks on survivors still evident today. In so doing, this paper reflects critically on the PTSD construct and the assumptions about its etiology, diagnostic criteria, and the prescribed treatments it embodies, born from Western psychiatric practice and theory yet applied broadly to situations of suffering in vastly dissimilar contexts. Along with scholars such as James (2016), Derek Summerfield (2000, 2001), and Cécile Rousseau and Toby Measham (2007), I argue that the PTSD diagnostic category *can* be useful for making sense of the lasting psychological, emotional, and behavioral outcomes of suffering, but a universal application of the concept can be problematic. This is so because universalizing models of trauma that disregard locally situated experiences of suffering, its meanings, and both individually and culturally salient coping strategies run the risk of both misinterpreting behavior and prescribing treatment that conflicts with locally meaningful categories of understanding. Ultimately, I argue that making sense of and treating trauma requires attention to both interpersonal and cultural differences. In turn, understanding traumatic experience also necessitates a recognition of its critical relational dimension, not only because trauma often involves painful ruptures to social relations but also given the role that social relations play in healing processes, however such relations are configured. The implication of this is that psychiatric models that pathologize trauma and neglect the role that culture and social relationships can play in healing are insufficient for explaining and treating subjective suffering everywhere.

2. The construction, looping effects, and universality of PTSD and its implications

Making sense of traumatic experiences necessitates an orientation towards the empirical and theoretical contexts from which the trauma category and PTSD diagnosis emerged. As Byron J. Good and Devon E. Hinton have noted, the terms made their way into U.S. popular discourse in the 1970s and remain household terms for describing the cognitive and emotional symptomatic manifestations of trauma (2016). Pertaining to the common conceptions of trauma, they argue that:

> The ideas that reliving such traumatic events through intrusive memories can reproduce the terror associated with events and lead to social withdrawal and impairment, that repressing and re-remembering such memories is possible, and that working through these memories in some form of psychotherapy can lead to improvement are now deeply embedded in popular American understandings of trauma, illness, and recovery (Good and Hinton 2016, 3)

In other words, the notion that a person can relive a traumatic experience (despite being physically and in some sense temporally removed from it) through disturbing memories which may elicit the same feelings and fears suffered when the occurrence was unfolding has become a common notion frequently invoked to make sense of subjective responses to suffering. According to Good and Hinton, these common notions of trauma and PTSD can be traced to two separate historical debates centered on suffering, the outcomes of which nevertheless came to be described in similar symptomatological terms. The first source inspiring the development of the concept and eventual diagnostic category was the suffering incurred by Vietnam War veterans upon their return to the U.S., many of whom experienced vivid flashbacks, emotional numbing, nightmares, and sleep disturbances (Good and Hinton 2016, 10). Second, the debate about child sexual abuse and domestic violence traced back to the 1950s, too, has become inextricably linked with the concept, though it was not labeled in terms of PTSD until the 1980s (Good and Hinton 2016, 10-12; Fassin and Rechtman 2007, 78). Good and Hinton thus illustrate how the trauma category as it is known today emanated from attempts to make sense of and treat these immensely dissimilar empirical and historical experiences of ongoing suffering, both of which nonetheless manifested in "alterations between intrusive reexperiencing and

general numbing of responsiveness" (2016, 12). The implication of this, they stress, is that any definition or set of diagnostic criteria such as those listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) reduce the inherently irreducible experiences of suffering and individual responses to the same.

The criticism about reducing complex experiences of trauma to a PTSD diagnosis is particularly salient in the context of non-Western societies because the insistence on framing subjective experiences of trauma in Western-scientific terms may render local articulations that do not fit this model invalid or superfluous. To illustrate this point, Good and Hinton draw on Kimberly Theidon's work with Peruvian Quechua, a group that endured severe, sustained violence during the Shining Path era, to demonstrate the problem of the so-called "trauma industry" and its relation to historical imperialism and racism (Good and Hinton 2016, 8-9). According to the authors' interpretation of Theidon, the effects of the trauma industry on humanitarian work manifested both in the way organizations framed their approach to mental health as well as how the Truth and Reconciliation Commission coded interviews (Good and Hinton 2016, 8). Pertaining to the latter, Theidon notes that individuals' disparate experiences of intense embodied distress, which she terms "sensuous psychologies," were coded merely as "trauma" (Good and Hinton 2016, 9). By not including locally meaningful understandings of pain and distress that are not contained in the DSM's PTSD diagnostic criteria, the influence of mental health workers' framing of trauma ultimately "represented a much deeper and long-standing view by urban, professional Peruvians of the indigenous communities as backward and incapable of abstract thought, a people whose complaints required translation into the modern language of trauma to be comprehensible" (Good and Hinton 2016, 9). Though the focus of this paper is not primarily how the trauma category is deployed in nongovernmental work, it is worth noting that the historically situated conception of what constitutes trauma, born from Western scientific tradition, may contribute to perpetuating what Derek Summerfield refers to as "medical imperialism" (Good and Hinton 2016, 8-9; Summerfield 2000, 427). Thus, rather than alleviating the pain in the communities they intend to aid, global mental health efforts

and organizations may inadvertently contribute to maintaining such communities in a relationship of dependency by insisting on the necessity and validity of Western therapeutic interference to the exclusion of other models of understanding and treatment (Kurytnik 2021, 215-219). Further, as Summerfield contends, "if mental health, and mental ill health, do not mean the same thing everywhere and are not subject to standard definitions, then the term 'global mental health' is an oxymoron" (2013, 1). Well-intentioned as such work undoubtedly is, ethical questions inevitably arise pertaining to the validity of imported (or perhaps more accurately: exported) Western brands of therapy (Boehnlein 2002, 702).

Though not the first social theorists to critique the universal application of the trauma/PTSD categories to situations of profound suffering (see e.g., Brewin 2003; Fassin and Rechtman 2007; Summerfield 2001; Young 1995), Good and Hinton's tracing of the concepts' historical development reminds us that they cannot be divorced from the Western scientific and biomedical traditions from which they emerged. Yet, as the authors note, a result of the globalization of the trauma discourse or the "political economy of trauma" (James 2004, 127-128), is that over time the categories become viable in and of themselves in diverse contexts (Good and Hinton 2016, 10). Thus, even if the PTSD concept *is* a constructed category, this does not imply that individual conceptions about its meaning do not *also* figure into the ways people make sense of their own experiences of suffering, as they argue: "the traumatic memory is made real, penetrating people's life worlds and shaping self-knowledge" (Good and Hinton 2016, 4). To make this argument, they draw on Allan Young who, in his book, *The Harmony of Illusions,* argues that, in fact, "the reality of PTSD is confirmed empirically by its place in people's lives, by their experiences and convictions, and by the personal and collective investments that have been made in it" (1995, 5). By Young's own account, the title of his book refers to Ludwik Fleck's (1979 [1935]) work in which the latter argued that the perceived timelessness and stability of scientific fact is the product of the "harmony of illusions" that develops in the course of research (Young 1995, 9). The implication of this is that so-called scientific facts are but products

of the researcher's "technologies, practices, and preconditioned ways of seeing" things and, by extension, all scientific phenomena constitute techno-phenomena because their "discovery" and representation rely on technologies and situated practices (10). However, as Young contends, to argue that "traumatic memory and PTSD are constituted through a researcher's techno-phenomena and styles of scientific reasoning" (10) does not discount nor delegitimize the real pain felt by those who are or could be diagnosed with PTSD. Rather, his project is to situate trauma in its historical context and to challenge what he considers to be the generally accepted image of PTSD as *true* and *timeless*, while recognizing that people's suffering and traumas are *real* and valid experiences (5).

If the question ever was whether PTSD is a valid and diagnosable disorder, this is no longer a pertinent interrogation. As the Thomas theorem reminds us: "if men define situations as real, they are real in their consequences" (Thomas and Thomas 1928, 572). Androcentrism aside, what sociologists Dorothy Swaine Thomas and William Isaac Thomas bring to our attention is the social life of "situations" (which I take to include objects, phenomena, categories, and experiences). In other words, the subjective perception that a given phenomenon is real will produce action in the social and material world regardless of the phenomenon's objective reality, if such a thing can be established. Applied to this paper's object of study, while the trauma and PTSD categories may or may not be able to capture the complex experiences of suffering alone, their legitimization, adoption, and widespread application by mental health professionals and laypersons alike make these concepts real *in their consequences*.

Despite the dominance of the "veritable trauma industry" (Summerfield 2001, 322), however, the adoption of the PTSD category itself has not been universal. As previously discussed, the PTSD diagnostic category was formulated in response to the lingering psychological symptoms exhibited by U.S. veterans returning from Vietnam, yet curiously, PTSD is virtually absent in Vietnam according to Vietnamese psychiatrists (Barak 2021, 132). This is so, Narquis Barak argues, not because Vietnamese individuals have

somehow evaded the psychic wounds of war - quite the contrary – rather, PTSD has not been widely diagnosed locally because the construct is incommensurate with distinctively North Vietnamese conceptualizations of the ways in which painful experiences manifest and affect people (2021, 134). As she relates, "the unique biology of war suffering that emerged in the battlefields of northern Vietnam and in the aftermath of the war evolved from an epistemological foundation that differed substantially from that which birthed PTSD" (134). In this North Vietnamese context, medical practitioners and theorists regarded the social and bodily realms over the Western emphasis on "the intrapsychic and individual" (134). Barak traces the origin of the distinctively North Vietnamese perspective on trauma to a combination of external and local contexts, mainly European (and primarily French) medical traditions and Soviet psychiatric practice which became fused with local notions of the ways in which certain experiences could generate emotional reactions (sometimes lingering). Whereas Western psychiatrists at the time were preoccupied with the pathological impact of trauma on cognitive function (particularly in terms of the traumatized individual's memory of the event), North Vietnamese practitioners were concerned with "the effects of psychological trauma throughout the central nervous system" therefore regarding trauma as "affecting the balance of an individual's neural processes as a whole, or, in traditional medical terms - affecting the balance of *âm dương"* (139). According to Barak, in Vietnamese traditional medicine, there are seven categories of emotion (a system referred to as *thât tình*), all of which could potentially be a source of harm as each is linked to a particular organ which could become diseased in various ways (138-9). The implication of this is that a distressing experience could produce a disorder, but "it does so opportunistically, owing to biological vulnerabilities peculiar to an individual" (136). By extension, the reverse was also true: pathology or trauma in an organ was thought to give rise to particular emotional states as well. Additionally, where Western psychiatry regards the traumatic *event* as highly salient and often the focal point when attempting to understand veterans' psychological suffering, clinicians and family members of traumatized individuals alike in North Vietnam considered recent

experiences and psychological factors to be of much greater significance (151). The consequence of the influence of *thâ't tình* is that conceptualizations of psychological trauma were wider in scope and, here, *any* event, conflict, experience, or situation could potentially produce a form of psychological trauma broadly conceived as an overabundance of emotion (140).

Vietnamese psychiatrists' rejection of the PTSD construct *in Vietnam* did not imply a denial of the validity of PTSD as a disorder from which someone could suffer and, as Barak notes, traumatogenic disorders and syndromes were indeed well-established among and treated by Vietnamese psychiatrists (156). What the local psychiatrists did dispute was the insistence on PTSD's biological inevitability, catalyzed in response to particular experiences. From the perspective of Vietnamese psychiatry, PTSD was instead "a result of the Americans' specific social and cultural experience of the war and postwar life" (156). In Vietnam, the local history of psychiatric philosophies, the emphasis on the intersubjective realms of experience, and the resulting conceptions of how psychological trauma manifests, thus resulted in an entirely different medico-cultural matrix in which the PTSD construct did not serve as an "ideal framework for understanding traumatic suffering in the context of war" (158). This rejection, Barak adds, may not be based solely in differences of experience and articulation of suffering, rather, it could also be understood as a refusal of a foreign vision of the meaning of the war embodied in a narrow diagnostic framework of PTSD (2021, 156). Taken together, Barak's Vietnamese case illuminates the importance of situating phenomena in their cultural and historical context. Yet, the fact that Vietnamese psychiatrists are still responding to the construct itself signifies precisely the dominance and inevitability of this Western psychiatric paradigm, even if its uptake is not a given universally. To stress the importance of analyzing phenomena in their social and cultural matrices, the following section turns to social philosopher Ian Hacking who famously coined the term the "looping effects of human kinds," referring, on a basic level, to "feedback effects in cognition and culture" (1995, 351) or interactions between ideas (about people) and the people themselves (1999, 34).

Though not the first to explore the interactive relationship between (e.g. psychiatric) classifications and those they seek to describe (see e.g. Scheff 1963; Szasz 1961, 1970), Hacking's work is arguably the most frequently cited and broadly applied. Rather than limiting his theory to diagnostic labels and classifications, Hacking refers to *human kinds,* defining these as systems of classification of people, specifically: "kinds of people, their behaviour, their condition, kinds of action, kinds of temperament or tendency, kinds of emotion, and kinds of experience (1995, 351-352), further specifying that he is interested in the "kinds about which we would like to have systematic, general, and accurate knowledge; classifications that could be used to formulate general truths about people; generalizations sufficiently strong that they seem like law about people, their actions, or their sentiments" (352).

Hacking's notion of 'human kinds' is derived from 'natural kinds,' or the kinds of facts about the world that can ostensibly be objectively ascertained through rigorous scientific exploration. Echoing what Bruno Latour and Steven Woolgar's referred to as the assumption of objective facts' "out-there-ness" (1986, 175), a part of Hacking's project appears to be to blur the lines between the realm of the social and that of the natural (1995, 365). Though *reality* and *construction* regularly appear to be diametrically opposed to one another, Hacking thus operates under the assumption that they are neither fundamentally divergent nor mutually exclusive (1995, 365; 1999, 102). To illustrate this point, he draws on the example of child abuse, arguing that "[children] were abused before 'child abuse'" (1995, 366) which is to say that, as a 'natural kind,'[1] child abuse is something that happened *out there* in the world long before it emerged as a 'human kind,' that is as a category molded by a particular social (including legal) context. Simply stated, child abuse simultaneously constitutes 'natural' and 'human' kinds.

[1] Having laid out what Hacking meant by natural kinds, it should be clear, here, that terming child abuse a 'natural kind' is, of course, by no means intended to rationalize or justify abuse of children in any manner or under any circumstances. In other words, the intent here is not to commit the naturalistic fallacy in the sense of implying that just because a phenomenon can be observed in the world, it *ought* to exist and is morally defensible in any capacity (Moore and Baldwin 1993; Teehan and diCarlo 2004). Rather, my aim is to draw attention to the unfortunate fact that child abuse was occurring "out there" long before *child abuse* assumed the meanings it had at the time of Hacking's writing as well as those it has acquired since (Hacking 1995, 366)

Returning to looping effects of such human kinds, or the interactions between ideas and the social settings they inhabit (1995; 1999, 7-10), Hacking argues that classifications interact with the people who may fit into a given category who, in turn, may be(come) aware that they are so classified and may modify their behavior in response by "[making] tacit or even explicit choices, [adapting or adopting] ways of living so as to fit or get away from the very classification that may be applied to them" (1999, 34). In turn, he argues, these exact adaptions, adoptions, and/or rejections have consequences for the precise group or kinds of people invoked (34). Precisely because the kind *changes* as it absorbs and comes to define still new individuals, what we know of a kind will continuously transform and new knowledge acquired "in turn becomes part of what is to be known about members of the kind, who change again (…) Those changes demand revisions of the classification and theories, the causal connections, and the expectations. *Kinds* are modified, revised classifications are formed, and the classified change again, loop upon loop" (Hacking 1995, 370; italics in original).

One of Hacking's most consequential arguments is that viewing another person (especially one whom you love) *or yourself* as being "of a kind" can lead you to alter your "entire set of perceptions" (1995, 354). This is so because human kinds are often perceived and presented as "scientific [fact] and hence value-free, but they have often been brought into being by judgements of good and evil" (354). In other words, human kinds contain strong moral underpinnings. Thus, the human kind of child abuse encompasses what 'we' consider the knowledge about child abuse and, over time through looping effects, its meanings have transformed, the kind itself subsuming the different meanings it is given by individuals or groups and – sometimes - reified institutionally. Child abuse as a human kind is also laden with values that dictate how those kinds ought to be treated: as victims (366). Yet, Hacking argues, there "is a regular attempt to strip human kinds of their moral content by biologizing and medicalizing them" (367). The example he gives is that of child *abusers* who are regularly framed as sick and in need of help rather than innately bad, often

manifesting in various rationalizations: "Their crimes are not their fault. They were abused as children, and that is why they abuse their own children (…) let us not blame them, let us medicalize them" (367).

Hacking's concept raises questions of *stability* – at what point (if ever) does a category become fixed? Despite cautions from some of psychiatric anthropology and even philosophy's most recognized practitioners (see e.g. Fleck 1979; Good 1993; Kleinman 1973, 1988, 2020 [1989]; Foucault 2012 [1963], 1965; Waxler 1981; Young 1995), diagnoses, such as PTSD, are often considered to be fairly stable categories -- though diagnostic criteria, too, are the products of biomedical convention and tradition: clusters of symptoms and averages. Yet, as scholars such as Arthur Kleinman have argued, diagnoses of mental disorders must meet resistance in the empirical world precisely because they represent institutionally molded interpretations of behavior and emotion which do not correspond in a one-to-one fashion to the ways in which an individual recognizes and understands their own symptoms of suffering (1988, 7-9). In the context of conceptualizing the cluster of symptoms that is given the diagnostic classification of PTSD - as a "thing" out there, from which someone can suffer – we cannot forget that the object of study today is different from what it was and what it will become. This is not due to some linear accumulation of knowledge about trauma from various intellectual disciplines and research, one that predicts that we will know more in the future than we know now and that we now know more than we ever have. Rather, it is because those who may be classified as traumatized, whether based on formal diagnostic nosology or even self-ascribed as such, contribute to the continuous transformation of the human kind itself. Thus, as Hacking reminds us, the object of study is not a fixed target to be investigated "if only we can get there," rather, more often than not, the object of study is a moving target precisely due to the looping effects discussed here (1999, 105; 1995, 382). The implication of this is that new knowledge about "the traumatized (person)" becomes known to the people classified as such and, in turn, it changes the ways in which these individuals act and orient themselves to the classification, thus looping back to compel changes to the knowledge about the kind itself.

Taken together, trauma and PTSD are classifications that are or have become available to people to make sense of their own experiences and those of others. Describing trauma as "a relatively new kind of human experience" that denotes "a kind of mental event in the lives of people – the psychic wound, forgotten but ever active," Hacking argues that we did not know of trauma as a possibility until relatively recently, "or, more paradoxical but more true, [traumatic experiences] were not a possible kind of experience to have had" (1995, 369). Simply stated, it has become a human kind in the last century, a development which has made possible the link between such disparate experiences as rape, terrorism, child abuse, shell-shock, oppression, and many other so-labeled traumatic experiences (369). This is not to say that certain forms of suffering did not linger and manifest physically and/or psychologically for individuals prior to these conceptual developments, rather, the idea is that 'trauma' and 'PTSD' as human kinds have become culturally available categories imbued with meanings, meanings that cannot be held apart from those to whom it is now applied. In this way, trauma not only became something to work to avoid (in the future) through identifying its causes and manifestations, but it also extended into the past by affording to individuals a new framework for remembering and perceiving painful experiences undergone in childhood such that one could now begin to talk about childhood trauma, for instance (Hacking 1995, 369).

Combining the ideas of the Thomases and Hacking, the fact that the meanings afforded to the trauma and PTSD categories may shift as a consequence of interactions in the social worlds in which they are embedded, and thus the looping effects they engender, strongly suggests that these classifications and diagnoses are not only malleable but also at times uncertain. The implication of this is not, however, that they are better off discarded altogether. On the contrary, the categories have proved themselves to provide a meaningful (but certainly contingent) vocabulary for those suffering from, treating, and studying what may be called post-traumatic stress disorder, aiding the clinical as well as colloquial conceptualization and treatment of the kinds of lasting suffering that may be labeled as traumatic. Therefore, the categories cannot

be discarded, but conversely, they must be included as viable categories for understanding how people experience and articulate their suffering in diverse contexts, perhaps – but not necessarily nor exclusively - in the psychotherapeutic and psychiatric terms embedded in the DSM-5. This aligns with one of Good and Hinton's main arguments, namely that the trauma concept *can* be useful and ought to be explored in making sense of and responding to extreme suffering, but, crucially, it must be understood as *one* label for a set of symptoms among a complex amalgam of experiences of and responses to suffering, varying in part by local history and culture (Good and Hinton 2016, 14-16) and, inevitably, by the particularities of an individual's life course and perception of the same (Hollan 1994, 83).

Another aspect of the post-traumatic stress disorder construct is worth noting, namely, the problem of the "post"-prefix: according to Robert Lemelson, Laurence J. Kirmayer, and Mark Barad, oftentimes in cases of sustained violence, suffering, and trauma, there is no identifiable "post" period because the trauma is not manifested in discrete events isolated in the past but rather as ongoing and continuously unfolding in the present (2007, 464-465). As the empirical cases highlighted in this paper will show, it makes little sense to treat subjective traumatic experience as somehow situated in a delineated past and thus separate from the present. Rather, more often, present suffering can become indistinguishable from previous traumatic experience, particularly if one's present circumstances continue to be marked by violence, or the potential for violence, and a lack of socioeconomic stability. It is precisely circumstances of ongoing suffering that throw into relief the relativity or fallibility of PTSD's *post*-prefix, as the following sections will elucidate by examining a context that has not arrived at any such posttraumatic period.

2.1 Traumatic locality: ensekirite, the ongoing ontological uncertainty in Haiti

To illustrate the importance of an orientation towards both locally meaningful articulations of suffering as well as the complex historical, political, and socioeconomic circumstances that may lend

themselves to forms of traumatic stress that are ongoing, this section turns to Erica James's (2016) work on political violence and other forms of prolonged insecurity in Haiti. Contributing to the dialogue about the historically and institutionally contingent notion of trauma that is mobilized in global mental health work, James argues that "the DSM's PTSD construct implicitly assumes a set of psychosocial and material conditions that may produce individual behaviors of avoidance of contextual and environmental triggers" (James 2016, 361). In other words, the American Psychiatric Association's assumption is that a subject's traumatic experiences instill in their body a heightened sensitivity to things associated with their trauma, which may be encountered in their surroundings, compelling them to avoid such triggers in turn. In James's Haitian empirical context, however, avoiding such environmental cues is not an option for many, particularly for those living in communities continuously marred by violence and poverty. Making sense of trauma in this context thus requires an understanding of an emic Haitian Creole term, *ensekirite,* which has come to capture the experience of living under constant threat of physical and structural violence (James 2016, 361-362). As such, in what follows I draw on James to outline the origins and meanings of *ensekirite,* a concept that helps to illustrate the social life of trauma as it unfolds and is experienced locally over time (2016, 362).

According to James, though the term *ensekirite* did not become a part of local Haitian discourse until the 1980s, its origins trace back to the necropolitical terror tactics employed by the Duvalier dictatorship beginning in 1957 (2016, 364). These brutal tactics involved the systematic use of "the power of death to violate moral, social, and physical boundaries" including rape, murder, placing corpses on public display, disappearances, to name a few (James 2016, 364). In brief, after Jean-Claude Duvalier (son of Francois Duvalier who reigned in Haiti from 1957-71) was ousted and exiled in 1986 and violent upheavals ensued in the five years that followed, *ensekirite* became a commonly invoked term to capture both the continuous, pervasive violence caused by Duvalierist reactionary forces as well as the particularly oppressive force exerted upon impoverished communities (James 2016, 364). Though Jean-Bertrand Aristide, the oppositional leader

promoting socioeconomic and political justice, was elected president in 1990, it was not long before his government underwent a military coup during which the same necropolitical forces were deployed against his supporters (James 2016, 364-365). The term *ensekirite* widened in scope in the late 1990s (at the time when James conducted her fieldwork at several humanitarian mental health clinics) to include what had by then become a regular yet unpredictable threat of criminal and gang violence in addition to sustained political violence (2016, 365).

By James's definition, *ensekirite* embodies the negative counterpart to what Anthony Giddens referred to as "ontological security" defined as the "confidence or trust that the natural and social worlds are as they appear to be, including the basic existential parameters of self and social identity" (Giddens in James 2016, 365). Thus, the experience of *ensekirite,* or "ontological *in*security," for Haitians involves profound political and socioeconomic instability in an environment marked by fear which continues to rupture daily routines and the sense of safety that can otherwise be developed through routinization (James 2016, 365-366). Taken together, *ensekirite* has come to "[index] the ontological uncertainties and dangers of an everyday, criminal, and interpersonal violence that has flourished amidst growing risks of environmental and infrastructural harm" (James 2016, 361). Not only does *ensekirite,* characterized by routinized ruptures to daily life, therefore challenge the universality of the post-prefix of PTSD because no post-traumatic period has arrived in Haiti, these circumstances of ontological insecurity also highlight the problem of diagnosing *individual* pathology without an orientation towards the social matrix that continuously (re)produces disordered subjectivities (James 2016, 363). In what follows, I draw on two Haitian cases to illustrate how *ensekirite* is experienced and to show the social and material exigencies it engenders, neither of which are necessarily captured or aided by the DSM's PTSD diagnosis. In so doing, I seek to illuminate that an uncritical application of the Western-scientific PTSD concept runs the risk of misrecognizing local manifestations of suffering thereby erroneously diagnosing social problems in terms of individual pathology (in the case of

Haiti) and potentially discounting modes of coping not valorized by Western psychotherapeutic and psychiatric practice and discourse.

2.2 Medicalizing traumatic suffering: the case of Jean-Robert

The first case of two distinct subjective experiences of suffering in Haiti is that of Jean-Robert Paul, who, from the perspective of Western nosology, would be given a diagnosis of PTSD comorbid with schizophrenia (James 2016, 371). According to James's description, Jean-Robert was locally considered *fou* (Haitian Creole for *insane*) and had been diagnosed with schizophrenia both by local and international mental health professionals whom he had encountered at different rehabilitative facilities for asylees and victims of political violence (James 2016, 371-4). While the fact that Jean-Robert had received the same diagnosis from local and international mental health specialists alike may lend credence to the validity of such labeling, arguably, this is just as telling of the hegemony of Western psychiatric practice and its expansive diagnostic tradition that has made the PTSD category a viable category in diverse cultural settings. Nonetheless, before delving into the symptomatology of Jean-Robert's suffering, it is worth devoting a moment to trace some of what is known of his life history: Jean-Robert was a twenty-one-year-old groundkeeper at the Human Rights Fund Rehabilitation Program ("the Fund") where James first encountered him (James 2016, 370). At age seventeen, he witnessed the slaying and beheading of his parents on the count of being Aristide supporters. Immediately after his parents' brutal murder, Jean-Robert fled Haiti and arrived in the United States, having survived the dangerous boat ride from Haiti to the coast of Florida. Here, he quickly received asylee status and was sent to a rehabilitative program for unaccompanied minors in Boston which was where "he began to unravel," according to James (2016, 373). While at the program, Jean-Robert disclosed his experiences to his case workers, a move that marked the beginning of what they considered his psychosis which manifested in hallucinations, paranoia, and violence towards others (James 2016, 374). The primary source of treatment he

received came in the form of medication, supplemented by psychotherapy, seemingly against his will, an approach which was mirrored upon his return to Haiti in different institutions, where eventually he was transferred to the Fund. Here, he acquired beneficiary status as an "indirect victim" of the necropolitical violence flourishing in the early 1990s and thus received some economic, medical, and social support (James 2016, 370-371).

Though little is known of Jean-Robert's life prior to his parents' murder and temporary emigration from Haiti, what becomes clear from his years in different institutions is that considerable emphasis was placed on medicalized responses to his symptoms instead of addressing what Jean-Robert himself explicitly requested, namely amelioration of the socioeconomic conditions preventing him from carrying on living (James 2016, 374). As James notes, Jean-Robert's trauma report explicitly mentioned his concrete desire for employment, social assistance, and the opportunity to return to the United States, tangible needs which were only exacerbated when beneficiaries like Jean-Robert were stripped of their economic support and left to rely on the unstable Haitian government in 1999 (2016, 374). Thus, by treating the symptoms of his suffering rather than responding directly to the needs he explicitly identifies - needs that are tied to the socioeconomic and political constraints characteristic of *ensekirite* continuing to hinder his capacity to develop a routine and sense of security - the efforts to help him seem to have been virtually futile. Adding to this, the way in which he was transferred between institutions may itself be interpreted as yet another rupture to the routinization of daily life for although clearly it did not involve the violence associated with the ontological insecurity described above, certainly it did not allow him to form meaningful, trusting, and stable relations with the world around him.

James recounts an episode of what she describes as "the irruption of the traumatic past into the present" (2016, 371): Upon hearing the news that he would not receive additional funding while at the Fund, Jean-Robert suddenly became enraged and overtaken by another persona, appearing removed from his

surroundings. Based on the author's description, Jean-Robert's comportment and voice transformed from that of a slight and soft-spoken individual into that of strong and demonstrably indignant man passionately voicing his feelings of helplessness and desperation about his situation (James 2016, 371-372). The mental health professionals' disregard of Jean-Robert's explicit requests for financial support in part had to do with a lack of resources, but more importantly for the present purpose, his aggressive outbursts were reduced to and treated as a symptom of PTSD when other explanations linked to *ensekirite* were available and could help to interpret these drastic emotional and behavioral changes.

According to James, in traditional Haitian models of personhood, the self and body are embedded in a matrix of interconnected relationships involving the living people, their ancestors, and *lwa* or divine spirits (2016, 368). In local belief, the *lwa* spirits can possess individuals during which dissociative states, such as the one described above, are both common and even desirable under certain circumstances (James 2016, 370). However, in Jean-Robert's case, the dissociation was considered an undesirable spirit possession stemming from his traumatic experiences involving "ruptures in the linkages among the individual, community, ancestors, and the *lwa*" (James 2016, 370) which occurred both with the violent death of his parents and his subsequent "abandonment" of his community when he fled to the United States. As James argues, the institutional contexts where Jean-Robert received treatment frequently "medicalized, and in large part, depoliticized the grief and feelings of loss (and righteous indignation) that Jean-Robert suffered when he desired social support, the right to work, health, justice, and security" (2016, 375). Thus, while Jean-Robert was still perceived to be ill by local standards, the pharmaceuticalization of his being disregarded local perceptions of the self, body, and relation to the external world as well as the deeply entrenched ontological insecurity suffered by many Haitians. As such, James argues, in the process of diagnosing and treating PTSD, the mental health professionals effectively pathologized his grief by placing it in biomedical categories, expressed in dissociative episodes which were sustained and exacerbated in a context marked by *ensekirite*

(James 2016, 380). Yet, the case of Jean-Robert also affords credence to a part of Hacking's argument about looping effects, namely that despite the authority of diagnostic classification, individuals can reject the imposition of diagnoses like PTSD, just as Jean-Robert does by insisting that he did not need nor desire psychiatric treatment and instead ascribes his malady to material insecurities preventing him from living (374).

By the same token, mirroring Good and Hinton's argument that attention must be afforded to the PTSD category's relevance and mobilization in complex local matrices, James stresses that cases of *under*diagnosing PTSD, too, are in fact the result of disregarding local manifestations of suffering which may fulfil some of the DSM's criteria. One concrete example of the deficiency of DSM criteria involved cases of deep depression among some Haitian immigrant women resulting from political turmoil and socioeconomic instability, but because the women did not exhibit "disturbances to weight, sleep, attention, and mood" their traumatic suffering was not categorized as such (James 2016, 361). Thus, just as the trauma category cannot be applied uncritically, another risk is that it is *not* mobilized in individual circumstances where it should be. In the context of humanitarian efforts where the official labeling, i.e. the diagnoses that are accounted for on individuals' medical records, has an impact on the resources invested on the part of the international community in rehabilitative efforts, *under*diagnosing trauma, too, may have dire consequences. Thus, the central issue at hand is not whether or not the PTSD and trauma categories are viable or not, rather, what cases such as that of Jean-Robert illustrate is that diagnostic categories and imported brands of therapy are less likely to capture local experiences and have a long-term effect (if any at all) in the context of mental health work insofar as they do not take into account locally meaningful understandings of the self and the world (James 2016, 379-380).

2.3 Ongoing trauma and avoidance as coping: the case of Odette

James's second case illustrates the difficulty of coping with one's trauma and grief when continuously confronted with environmental cues that bring violent traumatic memories to the forefront of one's consciousness. At the time of James's fieldwork, Odette Jean was a woman in her late fifties who had endured immense and continuous distress and trauma since childhood. James describes how a recent unrelated case of neighborhood murder elicited feelings and memories of Odette's own trauma associated with a brutal attack eight years prior to her interview with James in 1999 (2016, 364-365). In recounting the story of the local murder of one of her friends' sons in the hills above her home, Odette oscillates between narrating what she has learned of the murder and recalling her own traumatic experiences.

In short, Odette lost both of her parents at a young age and was abused by her stepmother which led her to escape to live in the slums on her own (James 2016, 376). Eventually, she was hired as a maid in a French home, fell in love and became pregnant only to be abandoned by the father of her child and forced out of the house. Being homeless while pregnant and unable to afford the medical care required to deliver her baby, she attempted to give birth on her own over the course of four days, ultimately resulting in the baby's death (James 2016, 376-377). Years later, in the early 1990s when Aristide was gaining popularity, she had (successfully) had five children, lived with her siblings and three of her own children and had found work at a market. It was in the environment of fear, vast political tension, and *ensekirite* during the early 1990s that one of her sons was killed for supporting Aristide, Odette's own house burned to the ground, her daughter brutally raped by individuals involved in the coup, and one son disappeared (and was presumed to be dead at the time of James's fieldwork in 1999) (James 2016, 377). Additionally, Odette's daughter became pregnant from the rape and abandoned the child who, according to James, eventually became aware that Odette was her grandmother and came to her for food and support – both of which she was unable to provide (James 2016, 377). To Odette, however, the most painful part was the uncertainty associated with her son's

disappearance for without his body she was unable to perform the mortuary rite enabling "his soul's passage from living kin to the realm of the ancestors" (2016, 378).

The news of the neighborhood murder evoked profound distress in Odette, reminding her of "her inability to protect her children" and care for her grandchild (James 2016, 378). According to James, a psychiatric assessment of Odette's case would likely produce labels and symptoms such as survivor's guilt and avoidance in that she had chosen to move down the hill from where her family's assailants and other perpetrators of violence still lived in order to "avoid triggering horrific memories of that day" (James 2016, 378). Yet, upon conducting a CAPS assessment (Clinician Administered PTSD Scale – DSM-IV), the clinical standard for PTSD assessment (Blake et al. 1995, 75), James found that Odette, whom she described as being "among the most troubled individuals whom [James] encountered in therapeutic contexts in Haiti" (378), responded negatively to many symptoms on the CAPS symptom checklist. Much to James's surprise, Odette did not suffer from negative affect, startle response, dissociation, a feeling of emotional isolation, or hypervigilance (James 2016, 378). The fact that Odette did not experience most of the symptoms of PTSD listed in the DSM-IV raises questions about the psychosocial experiences of trauma and "the ways in which PTSD may *or may not* manifest" (2016, 363; italics added). Indeed, several scholars have noted that many individuals who experienced profound suffering do not develop PTSD (Good and Hinton 2016, 15; Shalev 2007, 207). As Arieh Shalev argues, when people undergo extreme suffering and trauma, most people do initially exhibit some of the psychosocial symptoms captured by the PTSD diagnosis (2007, 207). What this suggests, according to Shalev, is that such initial responses in a sense constitute "normal" or expected responses to trauma and that eventually the intensity with which those experiences are felt will decline so that most people largely recover without sinking into a state of PTSD (Shalev 2007, 207-211, 214-215). By extension, Shalev argues that PTSD ought to be interpreted as the result of "disturbances of recovery from the early and normal response to traumatic events" (2007, 219) rather than the inevitable outcome of traumatic

experience. Thus, depending on the prevailing conditions and individual circumstances, a person may or may not develop PTSD in response to brutality in some form (Shalev 2007, 208).

Applying Shalev's argument to the case of Odette, it seems that her situation of ongoing ontological insecurity, *ensekirite*, constitutes a significant source of disturbances to her recovery. Based on this it may have been expected that she would develop PTSD, yet this does not appear to be the case – at least not according to the DSM's diagnostic criteria. As James argues: "To some extent, PTSD (…) has been useful to describe the profoundly disruptive impacts of ensekirite and can assist in describing what for many Haitians has been a paradigmatic shift in the mode of being-in-the-world. But PTSD still fails to capture the complex effects of ongoing uncertainty in Haiti" (2016, 366). Certainly, Odette's life history, filled with immensely distressing experiences in the context of *ensekirite,* is one of severe, sustained trauma. It is also possible that hers is a case of underdiagnosing PTSD because the DSM's diagnostic criteria are arguably too narrow in scope to capture her experience of ongoing suffering. These lingering questions are difficult to answer, but what is clear is that Odette's story raises the issue of the "post"-prefix of PTSD for, in her case, the traumatic experiences cannot be situated in the past, rather, they play out in her present leaving her unmoored in time and space (James 2016, 378).

However, by actively practicing her faith, helping other women who had suffered in similar ways, and by suppressing intrusive memories, Odette found a way to live on even in her situation of unimaginable suffering (James 2016, 378-379). Crucially, Odette's survival, in her own words, relied on forgetting her past and avoiding triggers, and as James argues: "[Odette's] strategies for survival and hope challenge contemporary conceptions of posttraumatic stress that would view avoidance of distressing thoughts as pathological and would pose treatments that would encourage greater confrontation of and engagement with traumatic memories" (2016, 379). In Odette's case, such engagement with her traumatic experiences was neither desired nor possible if she was to find a way of carrying on living.

2.4 Diagnostic interpretation and prescriptive coping strategies

Odette's desire to forget in order to live on is perhaps not surprising given her experiences. Indeed, her case defies diagnostic reductionism precisely because her way of addressing the suffering she had incurred neither aligns with nor seems to be aided by the DSM's conventionalized notions about the therapeutic benefits, even necessity, of exploring ("working through") the traumatic event directly. This section expands on the normativity underlying the diagnostic classification of PTSD, including its implicit assumptions about what healthy versus unhealthy healing looks like. In turn, it challenges clinical approaches that uncritically pathologize trauma precisely because the PTSD construct itself is the product of an institutionalized medical gaze which, in practice, involves a trained individual *interpreting* the complex experiences of an individual's trauma. As such, diagnostic practice is not a sure science but rather one that relies on a specialized clinician's interpretation of complex articulations and symptoms of suffering. By extension, clinical practitioners that adhere strictly to the DSM's prescriptive notions of what healthy healing can look like run the risk of neglecting (at best) or preventing (at worst) the different ways that individuals address their experiences of suffering.

In their discussion of posttraumatic suffering, memory, and the potentially transformative aspects of trauma, Cécile Rousseau and Toby Measham argue that forgetfulness can indeed serve to subdue the overwhelming and perplexing nature of traumatic experience (2007, 283). Yet, in Western psychotherapeutic tradition, avoidance and dissociation are considered counterproductive to healing whereas confronting the traumatic event(s) is assumed to be an inherently ameliorative coping strategy. Embedded in Rousseau and Measham's argument is precisely a critique of narrow and normative conceptualizations of what coping can and ought to look like. As they argue, such perceptions are a byproduct of the tendency to pathologize trauma because in the process of labeling traumatized individuals as suffering from a disorder (as opposed to merely responding to suffering in healthy and expected ways), the DSM simultaneously dictates what constitutes

pathological versus "normal" behavior (2007, 280). This becomes all the more problematic to the extent that the DSM is predicated on what Good and Hinton refer to as a "remarkable act of simplification" of the immensely complex cognitive, behavioral, and emotional aspects of subjective lived experience of suffering, as previously discussed (2016, 13). Additionally, as Arthur Kleinman reminds us, "a psychiatric diagnosis is an *interpretation* of a person's experience" (1988, 7; italics in original). In turn, such interpretations of symptoms, and what registers as a symptom, inevitably differ depending on social, cultural, and institutional context, as Kleinman argues, adding: "Psychiatric diagnosis as interpretation must meet some resistance in lived experience, whose roots are deeply personal and physiological. The diagnosis does not create experience; mental disorder is a part of life itself" (1988, 7).

Certainly, it may be true that a diagnosis produced by a clinician contains an element of subjectivity based on that individual's background, specialization, and experiences in their field. After all, and as Kleinman argues, "[disease] is what practitioners have been trained to see through the theoretical lenses of their particular form of practice" (2020 [1989], 3). In other words, the clinical gaze acquired through specialized training teaches clinicians to look for pathognomonic signs and as such, patient complaints are interpreted as clusters of symptoms with the ultimate goal of determining the best-fitting diagnosis for the perceived pattern of symptoms with which the given patient presents (Kleinman 2020, 7, 14-15; Holmes, 2011, 874; Holmes, Jenks, and Stonington 2011, 107-108; Foucault 2012, 108-109). In this process, the patient's subjective account or illness experience is delegitimized or at a minimum afforded a subsidiary role until "it can be quantified and therefore rendered more 'objective'" and thus legible to a biomedical practitioner (Kleinman 2020, 15). Kleinman may also be correct in arguing that the *diagnosis does not create experience* in and of itself. *However*, recalling Good and Hinton's notion that the trauma and PTSD categories have been made real over time, insofar as psychiatric diagnostic categories are held to be viable and widely valorized categories (a notion strengthened by the looping effects Hacking conceptualized), they *can* contribute to creating

subjective experiences. At the very least, diagnostic categories may serve as a framework for subjective experience, still varying depending on context. Thus, while mental disorders are indeed a part of life itself, and therefore not pathological by definition, the existence and authority of Western diagnostic tradition may have an effect on the meanings individuals afford to their own experiences.

On the topic of pathologization, Rousseau and Measham argue that the specific set of behavioral and emotional responses to experiences of suffering rendered "appropriate" or expected figure into the construction of the victim as pure and innocent, an idealized image epitomized in the DSM-IV's diagnostic criteria for PTSD where the victim's feelings of anger beyond irritability, such as aggression, are not accounted for (Rousseau and Measham 2007, 277). It is worth noting here, however, that the fifth edition, DSM-5, does incorporate aggressive behavior as one component associated with what is referred to as the diagnostic cluster of 'alterations in arousal and reactivity' which, in turn, constitutes one out of four such symptomatic clusters characterizing PTSD (the remaining three include intrusion/re-experiencing, avoidance, and alterations in cognition and mood) (American Psychiatric Association 2013, 271-2). According to the revised diagnostic criteria in DSM-5, the arousal component involves "irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects" (American Psychiatric Association 2013, 272). In the DSM-5's elaboration of these diagnostic features, such reactivity may manifest in quick temperedness and/or recklessness or self-destructive behavior, heightened sensitivity to potential threats as well as a "heightened startle-response, or jumpiness, to loud noises or unexpected movements," and a generalized elevated arousal impacting sleep and often inducing nightmares (275-6). Beyond this brief mention of aggressive behavior as one symptom of trauma, however, the DSM-5 does not account for the ways in which other antagonistic responses to violations of the self, e.g. revenge fantasies (Lemelson, Kirmayer, and Barad 2007, 456; Horowitz 2007, 24-25), may figure into subjects' responses and coping strategies. As several cases in this paper show, anger and aggressive responses are rather

common responses, at least periodically, thus challenging the idealized image of victims as incapable of fostering violent proclivities and desires.

According to Rousseau and Measham, psychiatric and psychotherapeutic discourses favor certain coping strategies labeled "positive" over other "negative" ones (2007, 280). By extension, the prescribed trauma treatment comes to operate on the basis of a set of dichotomies: a patient's efforts to locate meaning in the traumatic experience is valued over recognizing its absurdity or meaninglessness; disclosure in the therapeutic setting is regarded as integral to healing rather than remaining silent or avoiding certain issues; trusting the therapist is considered healthy whereas distrust is held in negative regard – expected though it may be to be distrusting, depending on the circumstances (Rousseau and Measham 2007, 280-284). Finally, "isolation as opposed to reestablishment of social ties and dissociation as opposed to good contact with reality" constitutes another common dichotomy informing the therapeutic approach to trauma (280).

Yet, clearly, not all situations of suffering allow for the kinds of coping strategies that have been rendered positive/healthy by the Western-scientific community. Additionally, there is indeed vast inter- and intra-cultural variation in response to traumatic stress, and the very same person may employ different, seemingly opposed, coping strategies at different points in time. Therefore, it is perhaps more productive to acknowledge that shifting between these poles may be helpful for dealing with the ambivalences that can be associated with traumatic experience insofar as the context lends itself to it (Rousseau and Measham 2007, 283). As Rousseau and Measham argue, this becomes particularly pertinent in situations where past traumatic memories and present traumatic experience meld into each other and the individual finds herself in an "ongoing state of peril" (2007, 281) – as in the case of Odette described above. This is so whether such peril is manifested in an immediate danger present in the environment – as is often the case with political and organized violence - or the equally potent sensation of being under threat. Drawing on Ricoeur, the authors thus stress the positive potential in "the dialectic between approaching the past and moving away from it"

embodied in the movements between the dichotomies outlined above (Rousseau and Measham 2007, 282). Rather than pathologizing the different ways in which some individuals find ways of surviving in the face of suffering, they argue that creating a space that allows for oscillating between, for instance, avoidance and disclosure might just serve as a source of transformation over time (2007, 281-282). At the very least, such an approach may enable a person like Odette to persist despite the kinds of intrusions, reactivities, and affects that can be aroused by the traumatic experience. Thus, by nuancing our perception of trauma, and the disparate ways in which individuals cope with it, beyond the DSM's pathological classification and the treatment it prescribes, it becomes possible to recognize it for its fluid nature. What the case of Odette also illustrates is the potential for posttraumatic growth, for Odette manifesting in the energy she channeled into practicing her faith and aiding other women who had undergone similar traumatic experiences. To emphasize how individuals commonly cope in ways that defy neatly categorized and prescriptive recovery strategies, the following section turns to the case of a West African refugee in Canada whose coping strategies, like those of Odette, challenge narrow perceptions of what recovery can look like.

2.5 Transformative potential of culture: the case of James

Briefly, the empirical case of James (not to be confused with Erica James) outlined by Rousseau and Measham elucidates both the importance of cultural contextualization as well as the significance of affording attention to the movements between coping strategies conventionally rendered positive or negative for understanding the complexities of suffering and healing. At age thirteen, James arrived at a rehabilitative institution in Canada from an unnamed West African country. Though little is known of his life history, what the authors do learn is that he had been the victim of organized violence, his hands severed by machetes, burned with gasoline, and he had likely witnessed the slaying of his entire family (Rousseau and Measham 2007, 285-286). For the first months at the rehabilitative institution, James refused to disclose his experiences,

nor would he speak his native language with a mental health worker at the institution who spoke his language, and every therapeutic session began with him making a phone call to his school to announce to them his new Canadian name and of his whereabouts, though, of course, they were already aware of both. Adding to this, James frequently burst into fits of rage so intense that the school staff began to fear him (Rousseau and Measham 2007, 285). However, shortly after receiving the news of his approved refugee status, his behavioral patterns began to change, commencing with his request for West African music in the therapy sessions: "...lullabies that he hummed softly (…) little by little he reclaimed his mother tongue and disclosed fragments of his history, the other story, structured around traditional proverbs, daily gestures, and familiar smells" (Rousseau and Measham 2007, 286).

What this case shows is, among other things, that the uncertainty associated with his asylee status in Canada necessitated that he created an explicit distance from his past by avoiding disclosing his memories, insisting on the legitimacy of his new name and identity, and refusing to speak his native language. But the approval of his refugee status marked the beginning of a transformation that enabled him to invest in his present surroundings and relationships by slowly reconnecting with parts of his lived experience and culture without initially dealing directly with his traumatic memories (Rousseau and Measham 2007, 287). James's inaugural recovery relied on affording to him a space where he could negotiate, on his own terms, the space between his traumatizing experiences, his embodied cultural memories, and his newly evolving relationship with his host country (Rousseau and Measham 2007, 286-287). The efficacy of the work of culture in his process is captured poetically in the words of Karl Marx: "one must force the frozen circumstances to dance by singing to them their own melody" (Marx in Fromm 1970, 57). In the case of James, the melodies he so strongly associated with his culture enabled him in a very literal sense to begin to give meaning to and derive strength from his experiences. In a figurative sense, too, the "melody" represents the movements between willingly exploring his past and moving away from it thus opening up to a potential space of transformation

from his "frozen circumstances." Therein lies a key point for Rousseau and Measham, namely that traumatic experiences do not unequivocally engender psychopathological states and negative outcomes in perpetuity. Rather, sometimes, suffering can serve as a source of "transformation or metamorphosis that evokes both strengths and vulnerabilities" (2007, 291), a notion to which the following cases from Indonesia provide further empirical support.

2.6 Traumatic experience and (potential) transformation in Indonesia

The section that follows outlines three empirical cases from Indonesia to illustrate how trauma manifests and is responded to in distinctive ways for different individuals, even when those individuals' traumatic experiences are rooted in the same history and environment of political violence. In so doing, it accentuates a point made above, namely that culture contains resources for potential transformation of traumatic suffering. Yet, simultaneously, it demonstrates that while culture can serve healing purposes, the different avenues of recovery provided by culture tend not to be equally available to all of its members.

In a discussion of responses to traumatic experience in an Indonesian context, Robert Lemelson, Laurence J. Kirmayer, and Mark Barad outline the cases of three individuals based on Lemelson's long-term person-centered ethnographic fieldwork. Common to all three cases was that each individual had undergone profound trauma as a consequence of the political violence beginning in 1965 and continued to live under tense and uncertain political circumstances through the 1990s (Lemelson, Kirmayer, and Barad 2007, 451-452). In all three cases, the subjects had witnessed the violent death or disappearance of family members on account of their affiliation with or suspected sympathy towards the communist party, Partais Komunis Indonesia (PKI), which had unsuccessfully attempted a coup in 1965 resulting in the killing of 80,000-100,000 Indonesians over the course of a few months in late 1965 to early 1966 (Lemelson, Kirmayer, and Barad 2007, 452). The first case involves Pak Nyoman, a farmer in his early to mid-fifties at the time of

Lemelson's fieldwork beginning in the 1990s. According to the authors' account, Nyoman's present illness emanated from witnessing the massacre of community members suspected of being PKI members in 1965 when he was twenty-one years old, himself sympathetic towards the PKI (Lemelson, Kirmayer, and Barad 2007, 452-455). For over thirty years, Nyoman avoided speaking of the episode, though he disclosed to the ethnographer that his illness stemmed from the incident, labeling it *ngeb,* an emic term referring to "a state of being caused by witnessing something horrific, frightening, or bizarre" (Lemelson, Kirmayer, and Barad 2007, 454). Nyoman's *ngeb* was manifested in periodic social withdrawal, nightmares involving brutal murders, feelings of anxiety and terror, "inner pressure," loss of appetite resulting in weight loss, a weakening of his life force or *bayu*, dissociative episodes, and sleeplessness (453).

At some point, little black figures emerged while Nyoman was farming. In the Indonesian cosmos, such visions are considered common occurrences - though potentially dangerous - visits from spirits, *wong samar*, and Nyoman began to cultivate a relationship with them (Lemelson, Kirmayer, and Barad 2007, 453-455). Nyoman became increasingly invested in the *wong samar* world, as he called it, and would periodically disappear for days, thereby exacerbating his social withdrawal. When he would no longer go to work, his family took him to a traditional healer who determined that his *ngeb* was caused by witchcraft wished upon him by other village members. Nyoman's mental state deteriorated until he voluntarily retreated into a state of "muteness," more or less completely isolating himself from the social world, until he was committed to the state mental hospital where he was given antipsychotic medication (Lemelson, Kirmayer, and Barad 2007, 454). Nyoman's visions of *wong samar* became increasingly blurry and infrequent and he was released from the institution three weeks later which was followed by years of slow recovery, according to the authors (Lemelson, Kirmayer, and Barad 2007, 454-455). Though his anxieties gradually lessened over time which, by Nyoman's own accounts, partially had to do with some of the known perpetrators having passed away,

Lemelson and colleagues note that Nyoman had since periodically withdrawn into his anxiety-laden state of *ngeb*, onset by particularly tense political conditions (2007, 455).

The second case involves a thirteen-year-old boy, Joko, who had not been alive during the political upheaval in 1965 but was nevertheless exposed to politically motivated brutal violence directed at his family years later. Moreover, the family itself is described as dysfunctional, marked by hostility and domestic violence (Lemelson, Kirmayer, and Barad 2007, 455-456). When Lemelson first encountered the boy in 2005, he had been in treatment with a local psychiatrist, brought there by a school nun due to his social and academic difficulties (2007, 455). According to the authors' description of Joko's symptomatology, he experienced frequent nightmares, chest cramps inhibiting his breathing, dizziness, debilitating stomach cramps, and frequent suicidal thoughts (2007, 455-456). Joko attributed his own illness to an episode where he had witnessed the torturing of his older brother, Paidjo, then seventeen, Joko himself just nine years old at the time. Both Joko and Paidjo were intermittently taunted and tortured by other villagers due to their father's previous alleged status as a member of PKI, but to Joko, this specific episode registered as particularly brutal and humiliating: the brother was beaten, attacked with rocks, and coerced into walking naked on his hands, all the while calling out in agony to his younger brother (Lemelson, Kirmayer, and Barad 2007, 456). In the years that followed, Joko experienced frequent flashbacks that caused him immense anxiety and distress manifested in labored breathing, aggression towards other people as well as material objects, heart pounding, and on occasion running hot to the point of fainting. In addition to these psychogenic symptoms, he frequently fantasized about taking revenge on his brother's tormenters, often dreaming vividly about torturing and killing those who had harmed his brother (Lemelson, Kirmayer, and Barad 2007, 456).

Though Joko's parents and brother were still alive, the conditions at home ultimately prompted his school nuns to pressure his parents into placing him in an orphanage when he was eleven. Perhaps unsurprisingly, the violence between his parents, too, appeared to be rooted in the violence and political

tension catalyzed by the PKI's failed coup attempt. Joko's father is described as a temperamental man who had been imprisoned for 14 years, having been accused of being a PKI activist by another young man with whom he shared a love interest (Lemelson, Kirmayer, and Barad 2007, 457). Upon his release, the father married Joko's mother-to-be who at the time was unaware of his previous status as an alleged PKI member. Due to his low social status, poverty, and the awareness in the community of his supposed previous affiliation with PKI, referred to as *anak PKI* meaning "children of the communist party," Joko's parents were frequently harassed (sexually, in the case of the mother) by other villagers, a fate which extended to their children (Lemelson, Kirmayer, and Barad 2007, 458). By his own admission, the father linked his violent behavior toward his wife to the years of torture he had undergone in prison which continued to inhibit his ability to control his temper. According to the authors, Joko's own traumatic experiences and ensuing psychosocial patterns and disruptive behavior made him unable to complete junior high school and he continued to have revenge fantasies on a daily basis (Lemelson, Kirmayer, and Barad 2007, 458).

Finally, the case of Bu Lanny, a well-educated English teacher born in 1952 to Chinese-Indonesian parents, whose traumatic trajectory began with the 1965 political turmoil. Like Joko, the most painful part of Bu Lanny's traumatic experiences, by her own account, revolved around the brutal treatment of the person she felt closest to growing up, namely her father Alex (Lemelson, Kirmayer, and Barad 2007, 459). Though it was unlikely that Alex was a member of the communist party, being that he was a fairly well-off Chinese-Indonesian businessman and community leader, their family became the target of violence during the 1965 upheaval along with many other Chinese-Indonesian families in the community (Lemelson, Kirmayer, and Barad 2007, 459). One day, protesters surrounded Bu Lanny's home, throwing rocks and axes and firing shots while shouting her father's name. Terrified, the family sought refuge from the shots behind sandbags, but Alex himself abandoned his family, running away half-naked only to be captured and imprisoned (Lemelson, Kirmayer, and Barad 2007, 459). Though Bu Lanny was able to visit her father in prison, eventually he

vanished, and the circumstances of his permanent disappearance remain unclear. According to the authors, since then and still at the time of Lemelson's fieldwork, Bu Lanny experienced severe headaches and panic attacks upon recalling memories of her father in prison where he had been brutally tortured, often triggered by visual stimuli in the form of vertical stripes which reminded her of the prison bars keeping her apart from him (Lemelson, Kirmayer, and Barad 2007, 459-460). Adding to this, Bu Lanny became quick to anger, was often forgetful, and had dissociative episodes involving what she referred to as "mental blankness" during which she would suddenly find herself in a place unable to recall how she had arrived there (Lemelson, Kirmayer, and Barad 2007, 460).

Bu Lanny's way of coping with the imprisonment of her father and the economic strain that ensued was markedly different from the strategies of Nyoman and Joko, both of whom struggled severely with engaging in social relationships in contexts where they were continuously confronted with reminders of the sources of their suffering (such as antagonistic neighbors and villagers). Though Bu Lanny was clearly devastated by her loss, she described herself as the toughest remaining family member despite her admission that she had begun to view "life as full of hatred and vengeance" (Lemelson, Kirmayer, and Barad 2007, 460). Based on the authors' descriptions, Bu Lanny was hardened by her experiences, oftentimes overtaken by her own anger, acting hostile and controlling towards others, and exhibiting limited sympathy and patience for individuals she perceived as sad or weak. As coping strategies, these affective and behavioral changes seem to have allowed her to go on living while simultaneously exacerbating her suffering to some degree (Lemelson, Kirmayer, and Barad 2007, 460). These behavioral patterns persisted until she had a religious experience in which she heard a voice reassure her that God was by her side and would never leave her, providing her with a sense of, in her words, "wonderful peace" (Lemelson, Kirmayer, and Barad 2007, 460). Later, Bu Lanny had another spiritual experience which compelled her to practice Buddhist meditative practices, allowing her to gradually calm her feelings of anger (461). Thus, in Bu Lanny's case, by directly

addressing her rage and hostility through reinvesting her energy in religious practice and helping others, she found a way to live on, though environmental cues (such as vertical bars) and encounters with community members who still did not trust her family continued to remind her of her traumatic experiences (Lemelson, Kirmayer, and Barad 2007, 466).

The coping mechanisms employed by Bu Lanny afford credence to what Gananath Obeyesekere labels the "work of culture" which he defines as "the process whereby painful motives and affects (…) are transformed into publicly accepted sets of meanings and symbols" (1985, 147). Having previously conducted research with ecstatic priestesses in his native Sri Lanka, Obeyesekere found that, prior to assuming their role as priestesses, many of these women's lives had been characterized by what might be considered traumatic experiences including combinations of early life parental abandonment, social marginalization, the loss of loved ones, difficult marriages and spousal conflict, abuse, and betrayal, together leading to "[withdrawal] from the social world, forsaking family and friends, cutting [themselves] loose from [their] social moorings" in order to cultivate relationships with deities (Obeyesekere 1981, 21). Common to all the women with whom Obeyesekere worked were their matted locks, a symbol of their religious devotion which held both deeply personal meanings and simultaneously constituted a culturally salient ascetic practice that allowed the women to engage in the world anew in what Douglas Hollan characterizes as a "nonstigmatized culturally communicable form" (2013, 730). Similarly, something about the culturally available Buddhist meditative practices resonated with Bu Lanny, gradually – through the work of culture - enabling her to begin to redirect her energy and emotion into a culturally valorized practice, thereby using a culturally available resource "to express or contain psychiatric distress" (Hollan 2013, 731), or perhaps shifting between expressing and containing her suffering at different points in time.

Drawing on Veena Das's work on violence as a part of ordinary life, Hollan argues that "*any* cultural resource, including the most mundane, secular, and conventional ones" (2013, 731) could enable an individual

to cope (however such coping may look to a particular person at a particular time). According to Das, in the aftermath of "world-annihilating violence," life is "recovered not through some grand gestures in the realm of the transcendent but through a descent into the ordinary" (Das 2007, 7-8). Granted, in the case of Bu Lanny, a part of what allowed her to slowly carry on living was indeed a religious transcendental experience, or at least such an epiphanic experience seems to have initiated a profound and positive change in her. Yet, in places where religion is more likely to be an integrated part of the daily life and routine, such practices could very well qualify as "ordinary." In Bu Lanny's case, what began as the kind of profound experience that Das ultimately renders less significant to recovery than the ordinary domain of experience, eventually morphed into the realm of ordinary activities when she began working as a teacher of meditative practices. What is clear from her life following the events that disrupted her world is that Buddhism, and Buddhist meditation in particular, became a fixture of her everyday routine. Over time, this cultural resource "led [her] to confront her strong feelings and transform them into motivations for personal empowerment and growth through her teaching and meditation practice" (Lemelson, Kirmayer, and Barad 2007, 462). By channeling her energy into everyday Buddhist practices, Bu Lanny was not directly confronting or receiving treatment for her traumatic stress in the way Western-scientific practitioners might prescribe. Rather, it appears that her descent into the ordinary served as a valuable and culturally salient recovery strategy, and indeed the only recovery strategy she attempted to enact (Hollan 2013, 734), based on the information provided by Lemelson and his colleagues. Thus, as Hollan argues, a significant part of the "work of coping and recovery from emotional distress and trauma goes on in mundane everyday contexts (…) outside the scope of clinics or official healing ceremonies, whether religious or secular" (2013, 735). For Bu Lanny, this certainly seems to be the case, even if the mundane in this case consisted of an everyday religious practice.

The three cases of Nyoman, Joko, and Bu Lanny outlined above offer important insights into the different ways in which people respond to experiences of trauma – even if those experiences may in some

ways look alike or emerge from the same circumstances of sustained political violence. The implications of these cases are manifold, but one important insight they offer is that if interpreting trauma "merely" from the perspective of Western psychiatric nosology then it would be expected that individuals undergoing similar traumatic experiences would respond in similar ways which, in turn, should warrant the same treatment. Though Nyoman, Joko, and Bu Lanny all exhibited some of the same emotional and behavioral patterns, including anger, sleeplessness and nightmares, dissociation and social withdrawal, and deliberate avoidance of environmental triggers, the specific manifestation of their trauma as well as their responses and (unconscious) coping strategies diverged in significant ways (Lemelson, Kirmayer, and Barad 2007, 462). As previously discussed, the value-laden dichotomies embodying what the Western psychiatric community considers pathological versus healthy healing strategies are not necessarily useful for making sense of the multifarious manifestations of trauma (Rousseau and Measham 2007, 280-281). As is evident in these Indonesian cases, all three individuals exhibit symptoms of and responses to PTSD which, by the DSM-5's definition would be considered pathological, when in fact their various psychosocial behaviors and reactions could just as well be perceived as rational and expected responses in the contexts in which they played out. Specifically, exhibiting willing engagement with one's social reality and directly verbalizing one's experiences (both of which are valued in Western psychiatric and psychotherapeutic practice) rather than unconsciously resorting to dissociation and avoidance may in these cases have constituted a risk to their lives due to the extant hostility and suspicion directed at them by virtue of their own and their families' suspected past political affiliations.

Rebecca Lester makes a similar point, arguing that Western psychotherapeutic principles favor disclosure over avoidance based on the rationale that in reexperiencing the traumatic memories through verbalizing one's experiences, the individual begins to attach new associations and feelings to the event (in the safe place that is the therapeutic setting) thus gradually affording new meanings to the traumatic memories

removed from the actual or perceived threat (2013, 758). In Freudian terms, the efficacy of reexperiencing the traumatic event in a therapeutic context lay in the patient's innate capacity to bring the buried traumatic experience into consciousness (e.g. through hypnosis or – later – exposure therapy facilitated by the clinician), a process Freud referred to as abreacting, through which the emotional energy is detached from the traumatic memory over time by means of exposure removed from any present threat (Freud and Breuer1974, 59-62). Over time, these novel affixed meanings can serve to transform the experience so that when the subject later remembers, reflects on, and recounts their experiences, the exchanges with the therapist and the (re)interpretations the therapist offers "become a part of her frame for experiencing the memory" (Lester 2013, 758). Yet, as several cases outlined above have shown, recounting traumatic experiences is not always desired by an individual nor the only way to transform the experience and, in some cases, suppressing the experience may be a necessary means to survive. This is so whether the suppression occurs in response to an immediate threat to one's life or, as Hollan reminds us, "to assaults on or erosions of one's identity, honor, self-esteem, dignity…" (2013, 729).

In different ways, avoidance and dissociation created a space for these individuals to carry on living: for Nyoman this involved the periodic retreat away from the community where known perpetrators still lived and into the world of *wong samar* with whom he cultivated a trusting relationship (Lemelson, Kirmayer, and Barad 2007, 467). Choosing silence over disclosure had been crucial to Nyoman's safety for many years, but as many of the perpetrators had died before or around the time of Lemelson's fieldwork, the risks associated with disclosure were no longer as urgent, enabling him to speak of his experiences, even though he still periodically withdrew into a state of *ngeb*. Such intermittent shifting mirrors Rousseau and Measham's notion that shifting between such dichotomous psychosocial states can be conducive to transformation allowing the individual to survive by distancing themselves from their past when necessary and approaching and perhaps deriving strength from it when possible.

In Joko's case, the authors argue that his anger and vivid revenge fantasies constituted a form of dissociation and avoidance from the continuous discrimination and torment he suffered but also as form of displacement of resentment he felt towards his own family (Lemelson, Kirmayer, and Barad 2007, 467). Finally, by reinvesting her energy into everyday religious practice and meaningful social relationships, Bu Lanny's traumatic experiences became a source of personal transformation allowing her to live on. By her own accounts, Bu Lanny's status as a survivor of political violence contributed to her tenacity and resilience because it afforded to her "an achieved status that has its own value" which she was able to situate within the wider historical framework (Lemelson, Kirmayer, and Barad 2007, 469).

Importantly, in examining these different Indonesian stories of suffering and survival it becomes clear that interpersonal, social, and socioeconomic factors may play a part in individual's responses to trauma and consequently their possibility for imagining a future for themselves. It is difficult to ignore that Bu Lanny, who had grown up in a well-off family and remained close to her surviving relatives, may have been better positioned to reframe and derive meaning from her traumatic experiences within a historical framework where testimony and witnessing were valued (Lemelson, Kirmayer, and Barad 2007, 469-470). At the same time, Nyoman, too, found a system of meaningful reference which enabled him to live on, in this case through appropriating cultural symbols and interacting with beings that held both personal and cultural significance. In this way, both Nyoman and Bu Lanny were slowly able to derive meaning from their experiences of deep suffering through the work of culture, even if the cultural resources they drew on (and economic resources at their disposal) differed significantly in content. But, for Joko, it seems that he did not have access to the kinds of resources that aided Bu Lanny and Nyoman. Still, Joko's revenge fantasies may have attenuated his suffering to some degree, at least to the extent that they afforded him a sense of reclaiming the dignity, agency, and strength that had been violated during his upbringing and youth where he had continuously been rendered defenseless. As Lemelson and colleagues note, it is also possible "that the very intensity of these fantasies

serves to deflect his attention from the more intimate betrayals he has endured" (467). Ultimately, Joko continued to be plagued by nightmares, intrusive and suicidal thoughts, anger, behavioral problems, and the virtual inability to (re)establish trust in others and invest in his surroundings. Thus, unlike Bu Lanny who retained social and material support throughout her hardships and Nyoman who seemed to cope by cultivating a trusting relationship with the spirit world, it appears that such avenues of recovery were largely unavailable to Joko.

3. Temporality of trauma, work of imagination, and their implications for healing

In the sections that follow, I return to one of the critiques leveled at the PTSD diagnostic category, namely that of its "post"-prefix, in order to elaborate not only on the explanatory constraints it imposes but also to elucidate the temporal model of trauma that it produces. Specifically, I highlight what has become the somewhat constrictive notion that a prerequisite for clinically validated traumatic stress is the occurrence of a singular etiological event, one that is immutable and situated in the temporal past. One of the implications of the idea of "trauma" as inherently defined and bound by an unalterable past experience, I argue, is that such a perspective disregards the efficacy of imagination which can work to reshape one's perspective of, emotional associations with, and command over the meanings of the traumatic event(s) in the past, present, and future. Subsequently, expanding on the potential for transformation embedded in imaginative ability, I argue that making sense of the various ways in which individuals attempt to cope with abject suffering requires an openness to forms of imagination that have often been labeled unhealthy and counterproductive to institutionally prescribed approaches to coping with trauma. Thus, only by creating a space for and affording attention to the diverse ways in which an individual may reshape the meanings of their traumatic experience by maneuvering between past, present, and future, can efficacious treatment and recovery occur.

3.1 The temporal structure of trauma

The Indonesian cases discussed above afford credence the critique of the "post"-prefix because in each case, the individual continued to experience stigmatization and threats to their safety in varying degrees because of their own or family members' suspected affiliation with the PKI. Thus, in these cases of sustained traumatic suffering, the "social and political circumstances determine the temporality of trauma and may not allow the "post" of PTSD to emerge" (Lemelson, Kirmayer, and Barad 2007, 466). In other words, those who have suffered and continue to be immersed in social and political circumstances that can trigger the traumatic memories or directly cause them additional suffering, do not necessarily reach a "post" phase in their trauma trajectory but rather carry on living while recurrently responding to persistent threats whether "real or imagined with equal effect" (Lemelson, Kirmayer, and Barad 2007, 466). Pertaining to such ongoing trauma, Lester argues that in Western psychological discourse, the conventional conceptualization of the word "trauma" constitutes an identifiable, bounded sequence with three components: pre-trauma life, *the* traumatic event, and post-trauma response (Lester 2013, 755-757). She refers to this perception as the conventional developmental arc of trauma about which she argues that the idea of a singular, isolatable traumatic event obscures the fact that a central aspect of trauma is that it is a continuous experience which extends beyond the traumatic incident(s) (Lester 2013, 757). In other words, experiences labeled as traumatic do not end once violations of the body and mind cease (if these do cease), rather, similar or in fact the very same sensory experiences of pain initiated during the event may be experienced over and over again, at times so intensely that the individual cannot discern the event from what comes after (Lester 2013, 757). In both the Indonesian and Haitian cases above, uncertainty and threats remain legitimate concerns thus speaking to the limitations of models of trauma treatment that operate on the basis of what Lester has labeled the developmental arc of trauma.

The Haitian cases of Jean-Robert and Odette, in particular, support Lester's critique. Under circumstances of ensekirite, it would be virtually impossible to establish any distinct pre-trauma life, singular traumatic event, *or* post-trauma response. This is so because not only have both Jean-Robert and Odette endured several traumatic events in their lives, but they have also lived through grave political turmoil and violence in addition to the structural violence that the majority of Haitians have confronted for decades. Though the Indonesian cases, too, developed from political instability and violence, in Haiti, the collective traumatic stress is constant and appears to be ever more pervasive. Thus, while all cases discussed above provide empirical evidence supporting the argument that the "post"-prefix is not applicable to nor necessarily achievable in all situations of trauma, the Haitian situation where *ensekirite* is both chronic and urgent leaves no question that the actual temporal structure of trauma is highly contingent on local contexts and their histories.

In their influential book on the origin, development, and dominance of the trauma category and industry, Didier Fassin and Richard Rechtman (2007) make a similar argument. Having traced the way in which PTSD/trauma has been conceptualized in different editions of the DSM over time, they point to what has become the centrality of *the* traumatic event, arguing that not only had the traumatic event become a "necessary and sufficient etiological agent," the event was now considered "the *sole* etiological factor" (2007, 86-87; italics added). The implication of this is that the event itself was thought to produce pathology and consideration of the person's psyche and personality structure prior to the traumatic event was rendered insignificant. Thus, as a consequence of the social reform of psychiatry in since the 1980s, trauma came to appear as "solely attributable to an unfortunate encounter between an ordinary person and an extraordinary event" (Fassin and Rechtman 2007, 87). Allan Young, too, discusses the centrality afforded to the traumatic event and the temporal-causal relation of PTSD, observing that without the etiological event, "PTSD's symptoms are indistinguishable from syndromes that belong to various other classifications" (1995, 7) and

experiences. The question then becomes: which events qualify as traumatogenic and to whom? As Young and others have noted (Hollan 2013; Devereux 1980), what constitutes a traumatic event is not only culturally contingent, but it can also vary greatly within cultures and subgroups (Young 1995, 127). To this end, George Devereux distinguishes between events that are "merely" stressful and those that are traumatic, arguing that only when stressful events are atypical (or, to use the DSM's terminology: *unusual*) or if they are abnormally severe or unexpected can they be labeled as traumatic. Further, according to Hollan's interpretation of Devereux, "by atypical stressors, Devereux meant those that are not buffered or mediated by readily available cultural resources and defenses of various kinds" (Hollan 2013, 728). Additionally, Hollan argues, even anticipated stresses may become traumatic for individuals "when they are unable to utilize whatever buffering resources the culture might provide" (728).

As the cases in this paper have demonstrated, those individuals who have cultural and material resources at their avail are indeed typically better off than those who do not. Even so, all the cases presented here involve experiences that would qualify as traumatogenic by Devereux's definition, given the severity of these experiences alone (such as the violent loss of loved ones). Simultaneously, the political turmoil in Indonesia (most acute in the mid-1960s) and the ontological uncertainty engendered by *ensekirite* in Haiti are, by and large, *typical* given their pervasiveness. From Devereux and Hollan's standpoint, then, the outcome for any given individual socialized in such contexts will vary depending on that individual and their social network's access to buffering resources. Even so, it would be reductive to term the ever-urgent situation in Haiti anything less than severe even if experiences of structural and everyday violence are typical. Nonetheless, it is safe to say that individuals' coping strategies will still vary greatly depending on their individual histories and experiences of the same, the resources at hand, and perhaps also their capacity to manipulate and transform the cultural meanings of their painful experiences (Hollan 1994, 83).

Despite encompassing a wide variety of qualifying traumatogenic events, the DSM-5 leaves little room for inter- and intra-cultural variation and simultaneously seems to downplay the meaning of the event in its sociocultural context and the fact that trauma is an inherently local experience (Hollan 2013, 727-729). Additionally, the insistence on the prerequisite of *an* event may devalue forms of trauma that cannot be traced to a single or a series of events, such as the traumatic experience of systemic oppression which is not captured by the DSM's Criterion A of the PTSD diagnosis which otherwise stipulates a wide range of possible traumatogenic events (Holmes, Facemire, and DaFonseca 2016, 314). As Samantha Holmes and her colleagues argue, systemic oppression may be better contained in the diagnostic criteria of Complex PTSD (C-PTSD), though C-PTSD has yet to be officially recognized as a diagnosable disorder by the American Psychiatric Association (2016, 316). Curiously, C-PTSD is included in the International Classification of Diseases's 11th edition (ICD-11) which describes C-PTSD as "a disorder that may develop following exposure to an event or *series of events* of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g. torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse)" (World Health Organization 2019; italics added).

Beyond available diagnostic manuals, however, those preoccupied with conceptualizing and alleviating traumatic suffering have recognized both causes and effects of oppression as trauma on both individual and collective levels (Holmes, Facemire, and DaFonseca 2016, 316; Kira 2001, 73; Kirmayer, Gone, and Moses 2014, 300). As such, it seems the emphasis on or rigidness of the necessity of an isolatable etiological event is shifting, in part in response to the recognition of prolonged exposure to experiences that can produce what psychiatrists have referred to as Complex PTSD. Perhaps this shift is also, in part, attributable (particularly in anthropological spheres) to scholars like Lester and Young

who have critiqued the artificial temporal separation between the etiological event and the appearance of symptoms stipulated in existing diagnostic manuals.

Lester thus calls for a broadening of the perceptions of trauma to extend beyond notions of a traumatic event to include the "ongoing psychic, emotional, embodied, interpersonal life" of trauma (Lester 2013, 758). This has important implications for the possibilities for individuals to imagine a future for themselves, that is, to live on, because in viewing trauma as a continuous experience extending from the past into the present *and* future, one is not limited by the idea of a singular past traumatic event which cannot be undone, and, as Lester argues, "such a revisioning allows for a different ending" (Lester 2013, 758). As both the Haitian and Indonesian cases above showed, over time, many of the subjects found ways to negotiate the space between past and present by drawing on different cultural resources and strategies.

It is in these movements between past and present that Michael Jackson locates *potentiality*, arguing that one's past is brought about in the present, a process in which imagination and culture play an integral role (Jackson 2005, 356). Here, Jackson mirrors psychoanalyst D. W. Winnicott's notion of culture as situated in the "*potential space* between the individual and the environment" (Winnicott 1967, 100). As Winnicott argued, the role of culture and life experience in this space is to enable to subject to (re)invest in the social world when trauma has caused a rupture in life's continuity (1967, 97-100). As such, culture serves as an enabling resource in the individual's negotiation between their embodied self and the external world, which becomes particularly pertinent when distressing experiences have disrupted the individual's capacity "to feel that life is real, to find life worth living" (Winnicott 1967, 98). Similarly, to Jackson, the key is that individuals can draw on cultural resources and subjective experiences to "restore faith in common sense and conciliation" (2005, 367). That is, in the process of giving meaning to the past, inevitably influenced by present social and political pressures and cultural frames of reference, traumatized individuals begin to remake the world so that it becomes inhabitable, and life feels worth living once again (Jackson 2005, 372). In Western psychiatric and

psychotherapeutic discourse, however, it seems that the role culture plays as an enabling resource is largely downplayed – at least insofar as the specific manifestation is incommensurate with the diagnostic criteria listen in the DSM.

3.2 Transformation through imagination

Pertaining to *physical* experiences of violence, Elaine Scarry argues that the lasting effects of such experiences can be difficult for the subject to make sense of and articulate (1985, 161-162). This is so, she argues, even though physical pain is as fundamental to human experience as any other sensory, physical, and psychological experience because unlike these other core human experiences, physical pain does not have a traceable object in the world (Scarry 1985, 161). In other words, what Scarry labels *objectlessness* refers to the fact that the physical experience of pain does not have a tangible counterpart in the material world whereas feelings of, for instance, hunger, fear, and desire usually have an identifiable source or articulatable object located outside the individual: "while pain is like seeing or desiring, [it is] not like seeing *x* or desiring *y*" (Scarry 1985, 162). Simply stated, while the experience of ongoing pain is real and felt internally in the body, it is not directed at nor responding to any material counterpart in the world. Granted, scholars such as Ronald Schleifer have criticized Scarry's idea that pain lacks "referential content," arguing that sources of physical pain often can be identified: "after all, it is our toe that hurts, and the piano that hurts it" (Schleifer 2009, 133). What is perhaps less debatable about Scarry's argument, however, is that there is an inherent inexpressibility about pain, because it is felt internally and thus is unique to the subject (Scarry 1985, 19). As Scarry argues, perhaps it is exactly this objectlessness which opens an avenue for imagination beyond what can be conceived of in the material world: "pain and imagining are the 'framing events' within whose boundaries all other perceptual, somatic, and emotional events occur" (1985, 165). Taken together, in the process of remaking the world in the face of traumatic memory and experience, the work of imagination serves as a potential source

of healing. The case of Joko exemplifies the work of imagination in the process of healing quite well: in the safe space of his imagination, Joko's revenge fantasies offered him at least temporary relief from the continuous threats to his safety while providing a source of empowerment by counteracting the feelings of powerlessness that had characterized the circumstances of his brother's and his own suffering, both past and present.

As it pertains to perceptions of such violent fantasies in psychotherapeutic discourse, Kelly McKinney argues that such fantasies are generally considered a (negative) effect of traumatic experiences "rather than as desires or wishes that reflect a prior and, perhaps, common human capacity for the infantile, aggressive, or vengeful" (McKinney 2007, 285-386). This is related to the construction of the victim as innocent and largely incapable of themselves of harboring aggressive urges – epitomized in the DSM, as discussed above. Combined with the view of traumatic experiences as pure, isolatable events lodged in the past, this contributes to what McKinney refers to as the sacralization of the victim[2] (2007, 289). In this process, any "psychological and moral complexity and ambiguity [is] reduced and simplified, leading to forms of closure, polarization, and exclusion" (McKinney 2007, 290). This apparent need to classify and evaluate individuals' traumatic responses by their correspondence to one set of positively or negatively labeled coping strategies thus mirrors Rousseau and Measham's idea of the value laden dichotomies underlying psychotherapeutic treatment. By denying the value and healing potential in the work of fantasy, aggression, rage, and other emotions and behaviors that are excluded from idealized conceptions of the traumatized victim, such psychotherapeutic and psychiatric approaches essentially deny the humanity of victims. In other words, because being human innately involves the capacity for experiencing and enacting a wide range of emotions and behaviors, some of which have acquired a negative label and others a positive one by medical

[2] The tendency to sacralize victims is remarkable considering the PTSD term's origins in Vietnam War veterans' psychosocial and emotional behaviors upon returning to the U.S., who embodied the complex relation between vulnerability and the equally human capacity for violence.

professionals preoccupied with facilitating recovery, it seems unproductive to preclude certain modes of coping based on these normative, culturally situated assumptions about what it means to recover healthily.

Similarly, Mardi J. Horowitz advocates for a more nuanced and complex view of the emotional content of traumatic experience, including revenge fantasies: "Hate toward perpetrators burns at the core of revenge fantasies, but often a medley of emotions is present (…) Revenge fantasies are persistent because they also provide additional positive emotional effects" (2007, 25). Among the positive emotional effects of revenge fantasies, Horowitz includes precisely the kinds of feelings of empowerment and control that seem to underlie Joko's imaginative violence, as well as "pleasure at imagining the suffering of the target and pride at being on the side of some spiritual primal justice" further arguing that such a self-righteous feeling may be helpful or even necessary for, if surrendered, "revenge fantasies may [instead] activate shame or guilt" (25). To Horowitz, self-righteous indignation enables individuals to feel "solid and coherent rather than frail or empty" (25) thus aiding the kind of self-organization that is necessary when one's world has become undone by traumatic experience. As such, the weak-to-strong conversion cultivated through revenge fantasies may serve as a defense against overwhelming feelings of "sadness, helplessness, and hopelessness" that may characterize posttraumatic stress, thus potentially contributing to the (re)creation and stabilization of "an intact sense of self [that] can contain intense feelings of anger, grief, and remorse" (Horowitz 2007, 25). Though such productive and positive outcomes are far from guaranteed – and some scholars have cautioned that encouraging the articulation of imagined revenge scenarios may increase the future probability of acting out such fantasies (Gregory, Cialdini, and Carpenter 1982; Nagtegaal, Rassin, and Muris 2006) - while others argue that no such correlation can be definitively established (Seebauer et al. 2014) - attention to their therapeutic potential seems warranted at the very least. Insofar as the goal of psychotherapeutic intervention is to enable the patient to gain a sense of reinstated control, coherence, and self-regard, then "[addressing

revenge fantasies solely as reactive anger or urging forgiveness without analysis of the compensatory functions of the fantasies may constitute incomplete treatment," as Horowitz argues (2007, 27).

Precisely because revenge fantasies are often rendered both counterproductive to healing and morally reprehensible, work on their use value for victims is particularly instructive as it shows that sources of healing are not always aligned with institutionally and culturally valorized images of the moral self. Thus, by expanding the view of recovery as a way of maneuvering between and manipulating the meanings of past, present, and future – sometimes a movement that involves a wide range of imaginative and emotional capacities – it becomes possible to conceive of trauma and recovery in a necessarily nuanced and culturally situated way.

4. Conclusion

Lester stresses a core fact in her article, though perhaps often overshadowed by the discursive deployment of the trauma category, namely that *people genuinely suffer* (2013, 754). Whether the source of suffering is physical violence, the violent experience of loss, or sustained structural violence, the fact is that people undergo experiences that cause immense pain and sometimes that suffering lingers, in some form, throughout a person's life (Lester 2013, 754-757). Yet, despite the undeniable universality of suffering, what the cases presented in this paper elucidate is that an approach which assumes the universality of subjective traumatic experiences and responses embodied in the PTSD diagnostic category does not lend itself to making sense of the inter- and intra-cultural diversity of coping and recovery trajectories.

Thus, for all the efforts to diagnose disorder and provide a basis for treatment, Western psychiatric approaches, typified in the DSM-5's diagnostic classification of PTSD, quickly become problematic when applied uncritically and universally. What this paper has attempted to demonstrate is that PTSD and trauma are not fixed, definitive categorizations of human experiences and symptoms of suffering, warranting

everywhere specific forms of intervention, though they may often be perceived and presented as such. As the cases in this paper have shown, there is no such thing as trauma removed from its context. Making sense of individual suffering thus requires close attention not only to the circumstances under which the traumatic experiences continuously unfold but also to the ways in which individuals choose to interpret and respond to their suffering. In this context, the PTSD category is but one of many cultural systems of meaning that provide a framework for understanding and responding to one's pain.

Insofar as the aim of trauma research is to find better conceptual and practical models that enable efficacious recovery and alleviate suffering, attention must be paid to the needs as they are expressed by traumatized individuals. This necessitates a recognition that Western brands of therapy and medicalization may not always be desired nor helpful. Often, culture serves as a mediator of experience as well as a source of healing, though the different avenues of healing within a culture are not always equally available to all of its members. What the cases presented also illustrate is the crucial relational aspect involved in the process of healing and remaking one's world: In different ways, most subjects gradually prevailed by establishing trusting relationships that allowed them to reinvest in the world, whether those relationships were cultivated with other people in their social networks or with beings in the spirit world. By acknowledging the transformative potential embedded in any culture – and in conventionally devalued coping strategies such as fantasy and cultural resources – it becomes possible to conceive of how traumatized individuals can begin to imagine a future for themselves, neither entirely anchored to nor detached from their traumatic experiences.

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