

Insidious Trauma – Between the Political and the Psychoanalytical

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ABSTRACT

The article attempts to understand the affliction known as insidious trauma and its link to social and political situations. The medical establishment finds itself hard pressed to provide an adequate response to traumas of social and political origin, rooted in oppressive regimes or environments. To the best of our knowledge the psycho-political model of recovery should take into account active resistance on the part of the individual suffering from insidious trauma. Subjectivity that is exposed to insidious trauma, but is not at the same time exposed to representations of resistance, remains external to the discourse. By assigning a name, a language and a voice to insidious trauma, the discourse is shifted from intrapsychic psychopathology to social psychopathology, thereby imparting to it both a social and a political context.

Keywords: Trauma, Insidious, Psychoanalysis, Social, Political.

INTRODUCTION

Insidious trauma is a term used to express the crucial effects that unrelentingly oppressive social and political situations have on mental states. Relatively new, the concept may be located on the dividing line between the medical discourse on trauma and the critical theory of cultural research.

The common medical definition of trauma as an "extreme event" does not provide an adequate answer in the context of social or political traumas. "Extreme trauma" describes trauma that took place in the past and that came to an end (e.g. physical abuse, incest). In contrast, insidious trauma is the product of ongoing states of oppression (e.g. sexism, homophobia, nationalism) that occur in the present time. It may be said that the relentlessness that characterizes insidious trauma is the result of an unceasingly traumatic social reality.

Naming the phenomenon "insidious" suggests politicization of the "ruling" medical discourse that has taken root in the professional world. A discrete, categorical definition of trauma, with its assumption of clear-cut boundaries to the traumatic event, is not sufficiently accurate in this case. Indeed, such a definition encourages severance of the symptom from the culture that created it.

In neglecting to take into account insidious trauma, the governing definition of trauma predestines it to transparency and silence. The predominant medical construct disregards the political factor generating the trauma, thereby confining it to the bounds of a narrow, highly specific therapeutic concept.

Perception of trauma as insidious views the proactive approach of resistance as an integral part of the essential process of healing. Resistance is a central factor in the therapeutic approach as a whole, based on the understanding that therapy without contextual, practical change cannot ensure recovery.

Use of the term "insidious trauma" is intended to underscore the traumatic effects of unrelenting institutionalized oppression on subjectivity. Roth & Brown (1991) were the first to coin the expression in an attempt to address the phenomenon of social traumas that endure day after day. Brown (1991) proposed the term "oppression artifact disorder" in describing states of psychopathological distress caused by living under unbroken oppression, intending to give voice to the role of the social element as a significant factor in creating the psychopathological states.

Arthur Kleinman (1982) invented the term "social suffering", conceptualizing vast expanses filled with social traumas. Kleinman (1998) developed a socio-somatic model that is constantly monitoring bodily manifestations in a social context. Kleinman thus infers that the somatic body is a reflection of the social body.

Additional studies by Alan Young (2011) have made a significant contribution to the historiographic and ethnographic discourse relating to political use of the concept of trauma. Extensive anthropological and sociological literature exists on the political dimensions of the therapeutic dialogue in general, and the dialogue around the subject of trauma in particular.

The clinical terminology dealing with trauma relates to only the barest extent on traumas of social origin. It thus greatly limits understanding of the trauma and its treatment.

As stated, insidious trauma refers to the traumatic impacts of unrelenting institutionalized oppression on subjectivity. The governing hierarchical medical model is thus not suited to interpreting the phenomenon. Brown describes psychopathological patterns of distress stemming from continued institutionalized oppression, such as abject poverty. Brown's (1991) aim is to recognize a life of distress or oppression which has hitherto been tagged as psychopathological, ascribing it to individual personality problems (such as personality disorders). According to Brown, this undermines the role of social psychopathology in generating the disorder. A correspondence is seen with a host of terms from the fields of medical anthropology and psychiatry, whose idea it is to view the trauma in a political context.

RHIZOMATIC MODEL OF TRAUMA

A model that appears to be much more suited to understanding insidious trauma is the rhizomatic model. Its aim is to expand the narrow concept of the trauma prevailing in the field of therapy. Whereas in the hierarchical model trauma is perceived as a serious violation of normal reality, the rhizomatic model also accepts the existence of isolated traumas that do not stand on their own but are an integral part of an extensive insidious social system of traumatization. It follows that trauma should be defined as an event that has occurred in the past as well as a phenomenon that exists across a tiered network of events, both isolated and linked, continuing into the present time. The transition from the hierarchical model of trauma to the rhizomatic model poses no mean challenge for diagnosis between past and present, or between exceptional and normal. In examining the rhizomatic model it may also be possible to

discern a non-hierarchical multiplicity of traumatic manifestations: extreme past traumas, ongoing post-traumatic stress, and inter-generational traumas existing in a closely interlocked pattern. The extreme traumatic event can now be understood in its wider political context, with insidious traumatic blows, countless in number, amplifying the context and demarcating its outline, even if it is not linear or continuous.

INSIDIOUS TRAUMA IN ITS FULL COMPLEXITY

When Freud (1977) abandoned seduction theory (in which he claimed that hysteria is a symptom of early sexual trauma) and switched to wish fulfilment theory (claiming that hysteria does not involve sexual trauma but rather a wish fulfilment or Oedipal fantasy), it was a defining moment in which the political element was eliminated from the discourse on trauma.

It is well known that many of Freud's patients complained about sexual trauma in their past. However, because of the pressure that was brought to bear on him, Freud offered up wish fulfilment theory. He subsequently refuted his initial findings and backtracked on his conclusions regarding seduction theory. All the while, he was rewording what he had originally defined as "traumatic women's memories", coming up instead with "Oedipal fantasies invented by patients".

The switch Freud made from seduction theory to wish fulfilment theory marks a shift in the psychoanalytical emphasis from the investigation of intrapsychic regions as a response to an event that actually happened, to investigation of these regions as a phantasmatic domain, managing and influencing reality, and distorting it according to its needs. This conceptual change on Freud's part contributed to a dismissal of the political and interpersonal reality as being responsible for and causing human suffering, as well as for medicalizing that reality. In other words, Freud's new perception transferred the cultural-social-political context to the fringes of the discourse on trauma, if not altogether beyond it. For if trauma is the transferential and phantasmatic product of the intrapsychic and not a direct reaction to a present reality, then no importance is attached to the external reality, which becomes nullified. If Freud had not made the transfer from seduction theory to wish fulfilment theory, it is possible that a dialogue or political protest would have been ignited with respect to the prevalence of incest in his age (many of Freud's patients complained to him about incest and related problems). However, the switch to wish fulfilment stonewalled any support for justifying his patients' claims, even leading to the abandonment of any discourse on ongoing trauma in the face of incest.

To use psychoanalytical lingo, insidious trauma may be worded according to the term used by Bollas – "the unthought known" – or that used by Stern – "the unformulated experience". To the best of our knowledge, what cannot be given to representative thought or formulation is in essence the result of political and social elements splitting away from the psychoanalytical discourse. Robert Stolorow (2008) too claims that a nameless pain can become a trauma. Pain in itself, according to Stolorow, is not pathological; however, the absence of sufficient attention to the painful emotional reactions of sadness is what renders them feelings that cannot be contained, constituting the origin of psychopathological and traumatic states.

"Failed witnessing" in the words of Stolorow (2008) attests to a paucity of language, leading to an absence of linguistic somatic interaction and transforming pain into trauma. This understanding is also essential in all matters related to insidious trauma. Since insidious

trauma is transparent, principally on the level of discourse, it paints a picture of failed witnessing, thus intensifying the murkiness, the experience of inferiority, the melancholy, and even the shame. All these are the "psychic tumours" of insidious traumas, the products of unspoken pain.

The socio-somatic model Kleinman (1982) arouses suspicion since diagnoses such as anti-social behaviour, depression, chronic fatigue, despair, failure and shame could possibly point to a mental and physical reaction to states of oppression.

In order to re-identify the clinical manifestations of insidious traumas, the somatic physical manifestations must be recoded. Shame, for example, could serve as a litmus test for pinpointing the effect of oppression on the mind. Shame is a characteristic that attests to the presence of insidious trauma, a kind of relational memory embedded in the body.

To date, post-trauma has been considered to be a "symptom of history" (Caruth, 2016). Caruth emphasizes the fact that the psychiatric definition of post-trauma is phrased in the past tense, referring to the time that has elapsed from the conclusion of the traumatic event to the appearance of symptoms reacting to the event. The emphasis on an action that has ended (past simple) rules out insidious trauma since the latter exists in the present continuous tense. The ongoing nature of insidious traumas is closely related to unrelenting social depression. Even when the severity of exposure to social traumatization undergoes a change in the individual's life in terms of level and extent, insidious trauma is still a continuing phenomenon, posing a permanent threat to the self.

The existence of insidious trauma in the present time leads to a shift in the major emphasis placed in the medical discourse on the memory of past trauma. Memory in the context of insidious trauma is very different from memory as presented in its traditional format. Insidious trauma is characterized by relational, ongoing memory which is manifested in attachment patterns and inferior self-perception. Relational memory is composed of connections between unique experiences and inferior perception of the experience embedded through them.

The fact that insidious trauma is ongoing causes limited and particularly hard processing and healing conditions. For the self is in constant need of emergency mechanisms in order to cope, on a permanent basis, with regulating the experiences. This is very different from traumas that took place in the past: in that case it is possible to separate oneself during the process of recovery from the tension and arousal that were so essential in the throes of the condition but are no longer relevant in the present time. The destruction potential inherent in insidious trauma derives from the fact that its development is so gradual, and that when the symptoms begin to appear, resulting in an awareness of its existence, it is already firmly entrenched and very difficult to uproot. This dimension then demands not only reformulation of the concept of oppression but also that of recovery.

The current therapeutic narrative regarding trauma conceptualizes recovery in a linear manner. This is based on assumptions about pre-trauma, typified by idealization of normality and normativity. Trauma is thus perceived as an event that violates and erodes the confidence and stability ascribed to "normal life", of the kind experienced prior to the trauma. Hence recovery from the trauma includes rejection of the traumatic event to a realm outside of life

and a return to "normal" life, based on a recognition of the exceptional nature of the event. A perception of this kind assumes depressive resignation, with the tendency that secure reality has to be violated by events beyond its control, characterized by badness and irregularity. Such resignation lies at the end of the bereavement process, viewed as a key factor on the way to recovery.

In contrast, the rhizomatic model of trauma challenges the assumption regarding a stable and secure pre-trauma reality, while ruling out recovery towards such a reality. Thus the rhizomatic model of trauma calls for formulation of a recovery model that contains a political element as well. This is a psycho-political model which assumes that insidious trauma exists along a continuum, both before the extreme traumatic event and after.

AHEAD OF DIAGNOSIS

The present article seeks to formulate diagnostic conditions that can render terminology usable in clinical environments that are strongly opposed to any elimination of political matter. Instead of the usual medical diagnosis, the following questions should be posed: "What are the minimum conditions required for a state of oppression to become an insidious trauma?" "What is the definition of suffering or oppression?" "Should the concepts of normal and normative be redefined?" "Who would be responsible for formulating such a definition?"

Our working assumption is that an approach which enables ongoing political oppression to be diagnosed has in no way an established significance that is known to all, but is rather derived from a specific glossary of terms anchored in the therapist's world. As such, and in attempting to circumvent the therapist's sovereignty, we seek to demarcate the boundaries of the diagnostic definition in terms of the "analytic third", a term coined Ogden (2004) that refers to diagnosis as a joint construct by the therapist and patient together. In other words, it is possible, in our understanding, that when oppressive social states are likely to have a traumatic effect on the mind, they create an active awareness in the therapy room, enabling multiple interpretations. An interpretive space thus opens up for intersubjective negotiation. The patient will be invited to define for himself the boundary between a permanent depressive state and a depressive state that he chooses to formulate as a trauma for himself.

For example: the therapist assumes that women in our world are given to states of existential depression which could lead to trauma; however, the patient will be invited to map her individual traumatic afflictions, interpret their particular impacts on her mind at a certain point in time, and determine the range of choices at her disposal using resistance. Such an approach presupposes that certain strata of insidious trauma will not be formulated by the therapist as such, although they will be by the patient. We therefore propose intersubjective derivation of a definition that will allow reference to all cases in which it is found that the oppression suggested by the therapist is indeed far removed from the patient's sphere of significance. This will open up a realm of rich, extensive awareness from where it will be possible to observe diverse diagnostic states, such as borderline cases and negotiation over meaning, as part of the diagnostic and therapeutic process. The opening up of a wide interpretive intersubjective space is an integral part of the rhizomatic model, bypassing the established say-so the therapist has vis-à-vis the patient.

Finally, since the definition of insidious trauma assumes a severe blow to subjectivity, any therapeutic step that is bolstered by active political awareness should include rehabilitation of subjectivity, as also the identification of resistance mechanisms whose growth has been inhibited.

CONCLUSIONS

The psychoanalytical narrative, entrenched in familiar protocols, normativity and recurrent classification of humankind into categories such as "normalcy" and "pathology", has to our understanding abandoned the discourse on political resistance as an integral part of the recovery process.

To the best of our understanding, the psycho-political model of recovery would benefit by concerning itself with the formulation of a critical approach of resistance as an integral part of the process of recovery and coping with trauma.

Subjectivity that is constantly exposed to insidious trauma, but is at the same time not exposed to representations of resistance, remains external to the discourse. Assigning a name and language to insidious trauma shifts the discussion from intrapsychic psychopathology to social psychopathology, imparting to it both a social and a political context. Displacement of this nature enables a reflexive, political and critical approach, signalling "deterioration" in a specific social reality instead of placing the burden of deterioration on the self. In parallel, this reflexive approach invokes in the self the possibility of resistance.

The encounter between the therapeutic dialogue and the critical dialogue of cultural science can yield a storehouse of new representations that will foster an awakening of awareness on the way to developing subjectivity that is no longer bound by the invisible chains of insidious trauma.

Bibliography

- Bollas, C. (2017). *The shadow of the object: Psychoanalysis of the unthought known*. Routledge.
- Bourdieu, P. (1991). *Language and symbolic power*. Harvard University Press.
- Brown, L. S. (1991). Not outside the range: One feminist perspective on psychic trauma. *American Imago*.
- Caruth, C. (2016). *Unclaimed experience: Trauma, narrative, and history*. JHU Press.
- Cushman, P. (1996). *Constructing the self, constructing America: A cultural history of psychotherapy*. Addison-Wesley/Addison Wesley Longman.
- Freud, S. (1977). *Introductory lectures on psychoanalysis*. WW Norton & Company.
- Frost, L. H. (2008). Human agency and social suffering. Frost, L., & Hoggett, P., 28(4), 438-460.
- Grand, S. (2013). *The reproduction of evil: A clinical and cultural perspective*. Routledge.
- Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psycho-Analysis*, 27, 99-110.
- Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in China. *Culture, medicine and psychiatry*, 6(2), 117-190.
- Kleinman, A., & Becker, A. E. (1998). "Sociosomatics": the contributions of anthropology to psychosomatic medicine. *Psychosomatic medicine*, 60(4), 389-393.
- Miller, G. H. (2009). Commentary: The trauma of insidious racism. *Journal of the American Academy of Psychiatry and the Law*, 37(1), 41-43.

- Ogden, T. H. (2004). The analytic third: Implications for psychoanalytic theory and technique. *The Psychoanalytic Quarterly*, 73(1), 167-195.
- Samuels, A. (2018). *Politics on the couch: Citizenship and the internal life*. Routledge.
- Sennett, R., & Cobb, J. (1993). *The hidden injuries of class*. WW Norton & Company.
- Stern, D. B. (2013). *Unformulated experience: From dissociation to imagination in psychoanalysis*. Routledge.
- Stolorow, R. D. (2008). The contextuality and existentiality of emotional trauma. *Psychoanalytic Dialogues*, 18(1), 113-123.
- Young, A., & Rees, T. (2011). Medical anthropology enters the 21st century. *The Journal of nervous and mental disease*, 199(8), 592-596.