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In Search of the Real: Communication Around, About, and Of Psychological Trauma and its Subjects

Lisa R. Irvin
University of Colorado Boulder, lrihorizon@yahoo.com

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IN SEARCH OF THE REAL: COMMUNICATION around, about, and of PSYCHOLOGICAL TRAUMA AND ITS SUBJECTS

By

LISA R. IRVIN

B.S., Appalachian State University, 1994

M.A., University of Denver, 1999

A thesis submitted to the Faculty of the Graduate School of the University of Colorado in partial fulfillment of the requirement for the degree of

Doctor of Philosophy

Department of Communication

2014
This thesis entitled:
In Search of the Real: Communication *around, about, and of*
Psychological Trauma and its Subjects
has been approved for the Department of Communication

__________________________________
Professor Gerard Hauser

__________________________________
Professor Bryan Taylor

Date

The final copy of this thesis has been examined by the signatories, and we find that both the context and the form meet acceptable presentation standards of Scholarly work in the above mentioned discipline.
As social readjustment and recovery efforts among military populations suffering from Posttraumatic Stress Disorder (PTSD) continue to perplex researchers, mental health professionals, and veterans, dynamics of social stigma are increasingly problematized and targeted as sites of intervention in public health campaigns and inter-disciplinary research inquiries. In response to these problems and attributions of stigma, this research investigates historical, theoretical, and institutional sources of stigmatization in the diagnosis and treatment of psychiatric casualties suffering from the condition now known as PTSD. Through archaeological analysis of this history, the research identifies pivotal scientific controversies, competing theoretical perspectives, and shifts in psychiatric treatment that display on-going tensions characterizing psychiatric science in relation to changes in socio-political sensitivities implicating dynamics of social stigmatization. Close analytic attention is directed towards examining the politics and practices involved in the instantiation of a Therapeutic Community experimental model of post-combat treatment in a U.S. Naval Hospital conducted by Dr. Harry A. Wilmer with Korean War Veterans in 1955 designed explicitly to intervene in stigmatizing institutional configurations and socio-cultural attitudes.

Research findings reveal that discourses highlighting the role of psychological trauma, overwhelming stress, and sexual or physical domination emerged as counter-discourses that challenged dominant neuro-psychiatric theories which purported neurological inferiority, genetic susceptibility, and moral weakness as conventional explanations of post-traumatic
reactions. These reductive explanations are further argued to predispose psychiatric diagnostic discourse to stigmatize survivors of trauma through the instantiation of discursive suspicion in association with malingering and interiorized pre-conditions that politically diffract attention away from the concrete events productive of traumatic injury.

Analysis also reveals a lineage of counter-theories that underscore the role that interpersonal, doctor-patient, and public communication has for not only in producing self stigma and identity altering interactions, but also in sustaining and recovering from post-traumatic reactions. Findings demonstrate how interventions in systemic cycles of stigmatization and patterns of pathological communication in treatment contexts can be facilitated by organization culture alterations encouraging staff discursive reflexivity of transference communication, and patient social support encouraging narrative reconstructions of self and others through utilization of meta-communicative techniques.
Dedication

This thesis is dedicated to the late Dr. Harry A. Wilmer and an enduring lineage of like-hearted military psychiatrists, mental health professionals, and citizens whose work is guided by conscience, dedication to maintaining human integrity, and belief in the power of human connection for restoring life after death, loss, and war.
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I am blessed to have the opportunity to acknowledge my friends who have listened ad infinitum and believed in my convictions about this project over the course of many years. I am grateful that there are too many to list, but they know who they are. Specifically, I acknowledge the patience and kindness of Cory Jacobs who assisted with some of the data collection and has endlessly, as well as, painstakingly provided a source of support and encouragement. I gratefully acknowledge the patience and commitment of Lander Harrison who helped with preparing this thesis and editing my record long sentences.

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Chapter 1: INTRODUCTION

1.1 The Problem: Crises of Stigma and Limits of Understanding

Post-combat disturbances and stigma related concerns continue to receive concerted attention as they emerge in awareness as a growing social and public health problem in the U.S. military. As reports of the mental health crisis in the armed forces, as defined by high rates of PTSD, suicide, and readjustment problems, continue to escalate, problems related to stigmatization and mental illness are increasingly the target of contemporary public, private, and military health campaigns, programmatic mental health reform, social science research, and public discourse. Stigma and stigmatization is associated with problems related to social discrimination towards individuals known to be diagnosed with a mental disorder which is correlated with negative impacts on an individual's ability to seek and receive quality health care, obtain employment, the quality of community and family relationships, self-esteem, and quality of life (Kleinman & Hall-Clifford; 2009, Mueller, et al., 2006, Link, et al., 1997, Lauber, et al., 2005, Johnson, 2010). The “stigmatization” theory is increasingly invoked not only as an explanation for service members occupational readjustment issues and choices to refrain from seeking psychiatric services (Britt, et al., 2007, Rand, 2008, Williamson & Mulhall, 2009, Stahl, 2010), but also as a correlative risk factor for suicide, which is articulated as the primary rationale for many of the military suicide prevention programs (CDC, 1999).¹

In response to reports of increased incidence of suicide among military personnel, Department of Defense Secretary Leon Panetta, in a memo to Pentagon leaders, declared, "We must continue to fight to eliminate the stigma from those with post-traumatic stress and other mental health issues, adding that commanders "cannot tolerate any actions that belittle, haze, humiliate or ostracize any individual, especially those who require or are responsibly seeking
professional services” (Meghani, AP, June 7th, 2012). A few examples of recent news and research headlines reflect the growing public awareness of problems of stigma in their association with discourses about mental illness and PTSD: “Culture of stigma is key cause of military veteran suicide”; “Veterans battle PTSD stigma---even if they don’t have it”; “Mental illness stigma entrenched in American culture: New strategies needed”. Research on stigma and mental illness generally indicates that the public, mental health professionals, and even those individuals suffering from psychological distress hold pervasive negative stereotypes of and attitudes towards mental illness, seeking mental health care, and individuals diagnosed with a psychological disorder (Zartaloudi & Madianos, 2010, Corrigan & Penn, 1999, Corrigan & Watson, 1999).

Fear of social stigma among military populations is correlated with troops’ reluctance to seek mental health services due to public and military questioning the validity of post-trauma disturbances. Avoidance of social stigmatization is frequently invoked as an explanation for service members’ choices to refrain from seeking psychiatric services (Hoge, et al., 2004, Britt, et al., 2007, Rand, 2008, Williamson & Mulhall, 2009, Stahl, 2010). Hoge and colleagues (2004) survey of Iraq and Afghanistan troops who met the criteria for a mental health diagnosis reported that 55-62% of the individuals were not interested in seeking help for their problems citing particularly: fear of social exclusion, avoidance of a general public “benevolence” or discrimination, and a concern for the barriers they may encounter if they tried to seek treatment. In a 2009 study funded by the Department of Defense, Dr. Steven Stahl conducted an on-site research study at a WTU (Warrior Transition Unit) in Ft. Hood Texas to assess the stigmatization problem in the military. The study found that 41% of the members of the “cadre” (commanding soldiers at the WTU) believed that soldiers claiming to have symptoms of PTSD were faking or
exaggerating their symptoms, instead attributing mental health problem among troops “to recruiting the wrong people” or “inadequate training to manage stress”, and therefore, not related to their combat experience. The study concluded that “soldiers are receiving mixed messages about the legitimacy of mental illness and may understandably be confused about whether or not to seek care” (2009, p. 681).

Both of these studies suggest that fear of stigma and incredulous attitudes towards PTSD within military culture inhibit troops from seeking mental health services. As explained by a veteran recalling his own struggle with PTSD and thoughts of suicide, “I tried eight doctors before I found one that was knowledgeable enough…and that cared….I know soldiers that will pay money to get services elsewhere, rather than go to the VA.” (Portsmouth Herald, 2011). His story and experience is echoed by troops, citizens, and veteran families around the country through testimonials and reports in social media, congressional hearings, court cases, newspapers, documentary television and film, and other public forums attesting to a lack of concern, care, attention, and misunderstandings within military culture, and the failure to provide timely, effective, and responsive psychiatric treatment to veterans suffering from post-combat injuries.

However, even amidst reports of troops avoiding military health services, the Rand Study’s (2008) meta-analysis of recorded data of troops mental health needs from Veteran Affairs up until 2007 reported quite a bit of mental health diagnostic activity, estimating that 300,000 troops would be diagnosed with PTSD and 360,000 with TBI. A 2009 study conducted by researchers from the San Francisco Veterans Affairs assessed VA records from 2002-2008 reported that of the 37% of troops who sought help from the VA were diagnosed with one or more mental illness, 29% received 2 different diagnoses, 33% received 3 or more diagnoses (Seal, et al., 2009). In
January of 2009, Veterans Affairs (VA), reported that “178,483 veterans of the two wars (Iraq and Afghanistan) had been diagnosed with one or more mental illnesses, including 92,998 cases of possible PTSD, 63,009 possible depressive disorders; 50,569 neurotic disorders; 35,937 cases of affective psychoses; 27,246 cases of drug abuse, and 16,217 cases of alcohol dependency” (VHA Office of Public Health, 2009). In a Government Accounting Office assessment of VA mental health service use between 2006-2011, 213,781 troops from the two wars received mental health diagnosis through the VA including: 96,916 PTSD, 57,638 depression, 38,718 mood disorder, 45,252 neurotic, 36,797 substance abuse, and 2834 adjustment disorders (Oct, 2011). The report also revealed that 90% of the 2.1 million users of VA services between 2006-2011 were veterans from previous wars.

This stigma conversation, however, is not just restricted to military populations. Similar claims and assessments are attributed to civilian attitudes toward individuals with mental illness and in a generalized reluctance to seek out mental health services. Zartaloudi & Madianos (2010) argue that “stigma is often singled out as the primary factor inhibiting psychological and mental health service utilization”, therefore, “minimize(ing) the effects of stigma is a priority for mental health policy” (p. 81-82). According to a report from the Substance Abuse and Mental Health Services Administration (SAMHSA), one out of five Americans experienced some kind of mental illness in 2011, while only 40% sought mental health services. Research conducted to assess changes in mental illness stigma between 1996 and 2006 found little change in public attitudes (Pescosolido, et al., 2010). The research findings were discussed in light of a ten year widespread National multi-agency, anti-stigma “disease like any other” campaign explicitly designed to educate the public about neurobiological, genetic, and medical understandings of mental illness. Though the study showed an increased acceptance of neurobiological
explanations of mental illness compared to 1996, it also revealed an increase in stigmatizing attitudes of prejudice, discrimination, and social distance in relation to individuals diagnosed with a mental. The research concludes that genetic and medical understandings of psychological disorders do not necessarily translate into de-stigmatizing attitudes and in fact may have the opposite effect (Pescosolido, et al., 2000). However, literature meta-reviews of public attitude surveys conducted over the last forty years demonstrate that fear, stigma, and negative stereotypes about persons diagnosed with mental illness have remain relatively stable over time, even amidst changing scientific etiological understandings of mental disorder (Wernstein, 1982, Pescosolido et al., 2010).  

Despite massive public, private, academic, and military campaigns designed to destigmatize seeking mental health therapy, there is little evidence of alteration of attitudes or behaviors towards mental illness or mental health services.  

Within a media-cultural context, reports of the “apparent” increase in violent atrocities committed by persons with a history of mental illness and/or military service raise concerns about unfair and misguided stigmatization are in direct competition with public discourse and claims that the shooters who have committed the last five mass public shootings in the U.S. over the last decade had some kind of history with mental health care.

The public debates over proposed political legislation concerning gun control, background checks for gun ownership, and denial of previously psychiatric institutionalized individuals the right to bear arms are currently infiltrated with conflicting claims over the conceptual link between mental illness, violence, and stigma. Certainly, these connections as exacerbated in media and legislative discourse complicate and intensify the stigma discourse and negative public attitudes about mental illness and its subjects (see McGinty, 2013), but additionally
suggest yet another reason for individuals who need or may benefit from counseling to not seek mental health services, because they know that a psychiatric diagnosis is a matter of public record, social stigma, and subject to legally authorized background checks.

In response to these dilemmas, research attention has turned towards exploring several factors in the attempt to try to understand the problems and design strategies for correction: (1) The role of news and entertainment media in perpetuating misconceptions and negative stereotypes (2) The dynamic through which the mark of a psychiatric diagnosis transfers into public knowledge and social discrimination impacts a persons’ perceived social status, self-esteem, and life opportunities, (3) A historical turn towards Goffman’s (1963, 1968) notion of stigma in an effort to rethink how stigma is conceptualized, measured, and understood, and (4) A re-examination of how clinical practice and the history of psychiatric science implicates itself as a major player in the stigmatization of mental illness. In the following section, I will focus on the last two trends.

1.2 The Social Construction of Stigma: Historicizing and Recovering Key Concepts, Contexts, and Conversations

Numerous disciplines implementing research efforts to better understanding stigmatization make a strong claim that mental illness stigma appears to remain relatively fixed over time. Precipitating a re-evaluation of the constructs used to understand and assess stigma, a historical turn towards Erving Goffman’s work on Stigma (1963) appears in recent literature. In a theoretical appeal to expand the “conceptual umbrella of stigma”, Kleinman & Hall-Clifford (2009) assert that contemporary understandings of stigma are limited by their psychological articulations, and argued as such to provide inadequate frameworks for taking into account local, moral, institutional, and experiential contexts. Arguing that stigmatization is not an internally produced or psychological phenomenon, Kleinman & Hall-Clifford (2009) propose that the
concept of stigma needs to be re-contextualized in terms of social, cultural, and moral processes in order to better understand how stigma effects changes in the individual’s social and relational life that alter lived experience and social status. Drawing upon Goffman’s concept of moral status and Link & Phelan (2001) model of “structural discrimination” of institutional stigma, Kleinman & Hall-Clifford’s call is an attempt to re-think stigma in a manner that accounts for the lived experience of stigma and how “social, economic, and political forces shapes the distribution of stigma within a social milieu” (2009, p. 418). As anthropologists, they claim that ethnographic methods aid in understanding stigma as a relational process that alters social and personal experience and as produced in local, cultural contexts.

While this perspective does not offer a theory of power, identity, or communication which could help with expanding the conceptual umbrella of stigma, it does however highlight the limitations of psychological perspectives in describing social and cultural phenomenon, as well as, outlining the need to consider the concrete social processes, institutional, and cultural contexts. This interdisciplinary exigency calls to expand the terrain of theories, practices, and contexts of stigmatization, and uproot its concepts from psychological interpretations and parochialism in the hopes of reconsidering stigmatization in new terms. When stigmatization is understood as a social and normative interaction between subjects and objects embedded in contexts of meaning constitutive of human understanding (Cummings & Cummings, 1957, Johnson, 2010), then alternative conceptual fields are opened for exploring more sophisticated theories in hopes of developing more effective strategies for intervening in stigmatizing configurations and their concrete contexts.
1.3 Stigma, History, and Contexts of Mental Health

In order to identify significant contexts of stigmatization, I conducted a broad review of the literature on stigma that implicate more concrete forms of representations, relationships, and discursive sites associated with the production of stigma. In addition to media and social contexts, the politics of psychological traumatization and the mark of the psychiatric diagnosis have been discussed as significant influences. Recovering key concepts from Goffman’s research on stigma necessitates a reconsideration of institutional arrangements, doctor-patient-staff relationships, and theories of self-identity with the objective of providing more complex explanations for how identity and status are altered in processes of stigmatization (Goffman, 1958, 1963). Additional contexts identified in the literature for studying stigma include historical attitudes and institutional practice (Hinshaw & Cicchetti, 2000), and negative firsthand experiences the mental health services and treatments (Zartaloudi & Madianos, 2010, Komiya, et al., 2000),

In Goffman’s labeling theory of stigmatization, psychiatric diagnosis is an institutional context which constitutes a private and public marker of a person’s moral status. Relational contexts characteristic of institutional practices such as doctor-patient interaction, examinations, and even the arrangement of physical space are ways of communicating status and marking a meaningful status change (Goffman, 1958, Foucault, 1965). A more literal interpretation of the concept of stigmatization can be extended to include questions of how physical and psychological injuries leave visible markings or other disabilities that implicate exposure to institutional contexts and treatment resulting in these interactions that impact identity and status (Johnson, 2010). How the history of psychiatric theories and treatment modulescontexts interact with the moral status of the psychiatric patients is a ripe area of research exploration. In this
context, the politics of stigmatization and mental illness, as occurring within the lineage of the sciences of psychological trauma studies are also sites for understanding deeper and more recondite elements of stigma. Finally, on a broad scale, legal contexts are increasingly invoking periphery issues of stigmatization that involve attacks on the credibility of persons claiming to be mentally ill or psychologically damaged by violence and human cruelty.

Within these domains, Dr. Judith Herman, clinical psychiatrist and leading researcher in the field of trauma studies, in her seminal work, *Trauma and Recovery* (1992) argues that stigmatization has manifested as a historical pattern of oversight, mistreatment, and questioning of multiple populations including survivors of war, domestic, captivity and torture, rape and incest, domestic violence, and other atrocities. Social and political contexts evidence stigmatization as more the rule than the exception, for instance, among political prisoners treated as traitors, victims of domestic and sexual violence who are treated much more harshly than their abusers both in the courts and those in their communities, and WWI combat veterans whom upon their return from war were dismissed as “hysterical” or “malingering” and confined to holding tanks (Herman, 1992, Coates & Wade, 2004).

Social stigma has a long history as a documented enduring attitude towards individuals diagnosed with mental illness, military veterans, and others subject to psychiatric and rehabilitative institutionalized treatment (Goffman, 1961, Foucault, 1965, Stanton & Schwartz, 1954, Tuke, 1813). Despite the literature and research validating the impact that severe and prolonged traumatic events have on even the most “normal” and well-adjusted individuals, the pronounced tendency to blame, punish, or fear people known to have experienced atrocity still persists (Herman, 1992; Hoge, et al., 2004; Britt, et al., 2007).
Even within therapeutic professions, stigmatization can manifest as a “common tendency to account for the victims behavior by seeking flaws in her personality or moral character” through diagnostic incongruences that dissociate experience from the interpretation of the symptoms (Herman, 1992, p. 116). Psychological research and clinical understandings of trauma related mental illness historically focus on individual “predispositions” in the form of personality traits or other deficits. With the result that “instead of conceptualizing the psychopathology of the victim as a response to an abusive situation, mental health professionals have frequently attributed the (abusive) situation to the victims presumed underlying psychopathology (1992, p 116-188). As such, the ingrained individualist orientation of the mental health field and the diagnostic process are implicated in processes through which individuals are subject to being mis-understood, misrecognized, and marginalized.

Herman is not alone in suggesting that the mental health field and psychological institution play major a role in dynamics of stigma. Foucault and Goffman also elucidate the stigmatization of mental illness as connected to institutional practices and arrangements argued to produce social and internal stigma through altering identity. Together, their work can be read as revealing how the knowledge of “madness” came to be fundamentally altered by medical and psychological “sciences” and in correspondence with institutional arrangements such as asylums, prisons, and mental hospitals (Foucault, 1965, Goffman, 1963). Ian Hacking argues that both Goffman and Foucault’s work are concerned with “how classifications of people interact with the people classified”, a process Hacking calls “making up people” (2004, p. 277, 279). As a social process of knowledge production, stigmatization is related to age old, yet enduring social phenomena of discrimination, prejudice, stereotyping that lead to devalued social identities and social exclusion.
Cummings & Cummings (1956) articulate stigma as a process that acquires meaning through emotion generated between the shamed person and others’ behavior towards him or her as a process that induces shame, loss of reputation, a stain on one’s name, and reduced social competence attributed to changed attitudes directed towards the person. Another consideration of stigma is according to Bourdieu’s concept of “misrecognition”, understood as a cultural-ideological accomplishment that “embraces a set of active social processes that anchor taken-for-granted assumptions into the realm of social life... born in the midst of culture” (Navarro, 2006, p. 19). These studies suggest that processes of stigma are involved in a complex of assumptions, contexts, and concepts that invoke forms and processes.

1.4 Stigma and Communication

Bourdieu describes “ordinary language” as “a reservoir of forms of apperception of the social world and of commonplace expressions, in which the principles which govern the social world common to an entire group are deposited...and are in way primary ideologies which lend themselves more “naturally” to usages conforming to the values and interests of the dominant classes.” (1991, p 147-148). Numerous philosophers, social theorists, and communication theorists have articulated the realm of “ordinary language” as a site or field of operant assumptions that are integral both to the formation and expression of cultural beliefs and political opinion (Habermas, 1989, Hauser, 1998, Craig, 1999). Situating ordinary language as a cultural artifact for assessing “stigmatizations” locates production of knowledge in the realm of the vernacular (see Hauser, 1998) as an a distinct epistemic rhetorical form for examining commonplace assumptions that provide the basis for stigmatization and their correction. “Public” opinion and its formation is a key concept in understanding stigmatization as a dispersed “structure” of practical knowledge in both scientific and vernacular discourse. When
understood through this lens, stigma-constitutive and corrective processes can be viewed as active constructions produced and reproduced at the intersections of institutional as well as vernacular discourses that culminate into commonplace assumptions and everyday language.

Stigmatization has been discussed in the field of communication as a dynamic process of interaction involving both a subject and an object that is produced socially and discursively (Johnson, 2010, Meisenbach, 2010). A constitutive communication frame of stigma views it as a process and social accomplishment that produces rhetorically disabling effects through an alteration in ethos (Pryal, 2010, Johnson, 2010). Johnson’s (2010) rhetorical excavation of the stigma of mental illness argues that “stigmatization” functions as a “constitutive rhetorical act” producing a “disabling rhetorical effect: kakaethos or bad character” through normative values and moral judgments (p. 459). Key to this discussion is excavating the basis of how judgments are formed, according to what theories, and how this process is accomplished and potentiality corrected through alterations in discursive practices.

1.5 Research Questions

Based in these discussions of contexts and interactions involved in the social production of changes in moral status, I have argued that stigmatization is embedded in cultural, relational, and institutional contexts, enduring (mis)understandings, and the social-politics of traumatization and its interpretation. This research specifically addresses questions that are informed by social and political controversies related to stigma that have coalesced around defining, understanding, and treating survivors of psychological trauma. The study of stigma and trauma converge into discussions of history and institutions.

Within the theoretical and methodological framework of Archaeological theory as an historical and cultural method for analyzing movements in social and conceptual formations over
time, the features that are the most revealing and disclosing of how PTSD has come to be understood are two dimensional: First, its evolution within medical and psychiatric literature and research and secondly, it emergence as a social construct within the context of situated socio-cultural influencing discourses and practices. The first is concerned with how PTSD’s instantiation and meaning has emerged and evolved within psychiatric practice as a discipline, consequently influencing the terms of its construction. The second dimension explores the intersection of how the science, culture, and politics of psychological trauma have coalesced into contemporary understandings and tensions over the meaning and response to PTSD and its subjects.

The fact that PTSD did not exist as an official diagnostic interpretation until 1980 additionally qualifies its value as a socially constructed communication ‘configuration’. This is not to claim that trauma and its effects are not real, but rather that PTSD as a diagnosis and ongoing topic of discussion can, without negating experience, also be viewed as a socially constructed, interpretive “configuration” in the sense that its meaning, knowledge about, and related controversy has been generated within and through scientific, public, and cultural discourses and practices. Concurrently, these discourses continue to interact, construct, and negotiate common or contested meanings of PTSD as a diagnostic interpretation of human responses to traumatic conditions.

On a broad scale, this research seeks to examine how contemporary and historical debates and controversies converge and diverge in order to inform and speak to continuity and changes in public and scientific discourse, specifically in relation to issues over stigmatization and PTSD among military personnel. With this in mind, the following overarching and open ended research question guides this inquiry:
1. How have post-traumatic reactions come to be constructed and understood in their current form and in association with social and self-stigma?

Additionally, the two dimensional feature of PTSD’s current articulation provides the primary trajectories from which to first examine the development and changes of trauma-related diagnosis in medical and psychiatric literature about psychological trauma and its subjects. The following subsidiary questions are designed to explore significant trends, shifts, and controversies in the history of combat trauma-linked diagnosis and treatment over the course of its psychiatric articulation, in the context and conceptual construct of stigma.

- What are the predominant disciplinary controversies in psychiatric science over the etiology, diagnosis, and treatment of PTSD, particularly in relation to the needs of military populations? What are the main points of consensus and dissensus?
- How do these discussions address, implicate, and influence dynamics and components of stigmatization in the context of PTSD and trauma-related mental disorders in military populations?
- How have shifts and changes in understanding in psychiatric-medical science constructed the character and status of the subject of psychological trauma at significant moments in time?
- What practices and theories are useful for understanding and correcting practices involved in stigmatization of traumatized populations?

The second dimension of the inquiry addresses the how the social-political-cultural context and surrounding discourses have intersected with and contributed to the emergence and evolution of PTSD. Thus, in order to explore the political-cultural-social trajectory and contextual dimension of the question, the following sub-questions will be explored:
How have significant social and political controversies invoked questions of stigmatization in relation to post-traumatic symptomology?

How have cultural attitudes and opinions around combat veterans changed over time and in relation to changes in survivors’ voices and changes in psychiatric science of PTSD?

How does the interaction between communication around, about, and of psychological trauma demonstrate changes, contingencies, and stability in epistemologies and trauma-related diagnosis over time?

1.6 Data Collection and Description of Texts

Data collection for this project entailed extensive search and survey of recent and historical academic theories addressing categories, diagnoses, and terms related to trauma, theories and research addressing stigma and/or trauma, a broad search for any research or theories that addressed trauma and communication. Historical data collection consisted of reading primary, secondary, and research texts. Data collected for the case study entailed collection of the primary texts about the experiment produced in academic research and viewing its TV production in the UCLA film archive.

The case is centered around a therapeutic experiment conducted between July 1955-April 1956, Ward 55 of Oak Knoll Naval military hospital in Oakland, California, endorsed and funded by the Bureau of Medicine and Surgery of the Department of the United States Navy. During the ten month experiment, the ward eventually consisted of a total of 939 military psychiatric casualties from the Korean War. The project was led by Captain of the Medical Corps, United States Naval Reserve, Dr. Harry Wilmer, who modeled Ward 55 in alignment with the first two ‘therapeutic community’ experiments implemented in British military hospitals.
The data and observations of this experimental research were compiled into a 373 page monograph entitled, “Social Psychiatry in Action: A Therapeutic Community”, a multi-model ethnographic case study that contains a wealth of quantitative and qualitative data sets used to document and analyze this research. A military-directed version of the study was submitted to the Naval Medical Research Institute on July 1, 1957 in the form of a 60 page research report, published in November 1958, entitled “Report on Social Psychiatry: A therapeutic community at the U.S. Naval Hospital Oakland, California”.

In 1956, Wilmer’s reports of the research, as well as the psychiatric-medical and military community’s response and reactions to the model, started to appear in major psychiatric and medical journal articles and then taper off roughly ten years later. In 1957, the Walter Reed Army Institute of Research, in conjunction with the Walter Reed Army Medical Center and National Research Council, hosted the “Symposium on Preventative and Social Psychiatry”, with two of the five topical sessions devoted to discussing research advances in group and therapeutic community models for military psychiatric medicine. The experiment was produced into an hour long television “docudrama” entitled ”People Need People” that aired as the premiere of ABC’s Alcoa film series on July 10, 1961, hosted by Fred Astaire, was viewed by over two million people in the U.S. and Great Britain over its two showings that year and nominated for five Emmy Awards (Wilmer, 2004, iaap.org)10.

This case represents a time in the diagnostic history of trauma related diagnoses when the only applicable diagnosis in the DSM-I for combat trauma was ‘gross stress reaction’, which did not account for delayed or chronic post-war disturbances (See Scott, 1992). Thus, military psychiatric casualties were divided among the available diagnostic categories of mental illness at that time, which offers a perspective that excludes knowledge gleaned in later years. The
experiment was visited by military officials, scholars, and hospital administrators and staff members from other hospitals. The depth and breadth of the records, data, documents, photographs, film, and reports produced about and during the case is rare and striking, both for its time and patient population.  

1.7 Chapter Preview

The current chapter has situated PTSD and stigma within an expanding academic field and growing societal concern proliferating stigma and mental health treatment problems related to PTSD and mental illness. Research suggests that problems of stigma and stigmatization are conceptually and relationally linked to institutional, identity, and social contexts and the realm of vernacular and societal communication.

The next chapter reviews academic and institutional responses as well as sources of controversies over psychological trauma, PTSD, and the credibility of claims to post-traumatic injury. The literature review highlights how the topic of psychological trauma and PTSD in cultural and academic discourse has instigated explosions in research and theory, as well as, revealing of contemporary and historical controversies within and between psychiatric, vernacular, and political contexts. Offered as alternatives to traditional psychological interpretations of post-traumatic reactions, literature from feminist, anthropological psychiatry, and communication studies are reviewed to provide empirical and theoretical counterpoints. Highlighting research that investigates the impact of psychological trauma and communication contexts on interruptions in post-traumatic discourse and social recovery, the review warrants further attention and investigation of the social, communicative, historical, and theoretical contexts of PTSD and psychological trauma as a contemporary phenomenon with a complicated and enduring history.
Chapter 3 outlines the central concepts and analytical tools of Foucault’s (1972) Archaeological method of theoretical and historical analysis and, discusses the methodology as an appropriate perspective from which to approach politicized scientific inquiries in their social, political, and historical contexts. I discuss how strategies of Archaeological method for analyzing overlaps of discourses and how these are involved in historical articulations and controversies invoking the status of psychological trauma and its subjects. Framed as a critical historical discourse method useful for explaining and analyzing the social formation of epistemologies, this chapter summarizes and applies Archaeology’s primary principles and sensitivities for approaching “discursive formations” in order to underscore the methods’ theoretical premise that discourses construct and reflect social processes of knowledge and opinion formation.

The analysis in chapters 4 and 5 traces phases of stigmatization and epistemological apprehension of named formations, in particular hysteria and shell-shock as are historically and conceptually associated with contemporary politics and science of PTSD. Beginning with “hysteria” in antiquity and following its social-historical presence and transformation in meaning prior to and after the Renaissance, the analysis follows its discursive etiological shifts according to changes in institutional authority and scientific exploration. These changes are discussed in relation to how its articulations implicated or relieved the moral character of individuals believed to be suffering from hysteria with dynamics of social and institutional stigmatization.

Chapter 5 examines the research of Jean Martin Charcot and his contemporaries through describing the scientific scene and its controversies around hysteria as an emerging medical diagnosis in late 19th century France, highlighting specifically competing theories of hysteria and the emerging concept of psychological trauma. Debates in Post-WWI Great Britain are also addressed in the context of competing theoretical premises and their implications for indicting
the moral status of hysteric and shell shocked populations. The analysis focuses on moments of controversies and rival theories as they relate to stigmatization and treatment of psychiatric combat casualties into WW-II in the U.S.

In Chapters 6, the research analyzes the episteme of social psychiatry in relation to the induction of the Therapeutic Community model of treating post-combat psychiatric casualties in post-WW-II and Korean War in the U.S. The analysis focuses on the emergence of the model in the U.S. in connection with scientific attitudes in social-psychiatry that converged around practical rationality, institutional suspicions and critique, and the human relations school of organizational studies and intervention.

Chapter 7 frames the Therapeutic Community Model experiment as a strategic and systematic intervention engineered precisely to alter commonplace and stigmatizing treatment methods, totalizing institutional arrangements, and authoritative relational dynamics. The experiment is comparatively analyzed for its critical intervention effort and interests that overlap with Habermas’s critical social science agenda. Specific strategies and communication techniques are analyzed and addressed for how they performed a therapeutic critique and intervention for traumatized patients and the participants that transformed conventional practices and core assumptions.

Chapter 8 explores unique features of the experiment and analyzes the discursive regularities of the designer’s cultural, scientific, and visual texts about the experiment. Wilmer’s presentations of empirical data and the patients’ pathology as represented in scientific and cultural texts (e.g. *Social Psychiatry in Action* and *People Need People*), are analytically compared for how they construct the patients’ disorder and position the audiences in relation to patterns in the experiment’s communicative and textual *techne*. 
Research findings implicate the pivotal role of interpersonal and public communication contexts around survivors of trauma for influencing and exacerbating the post-traumatic experience and survivors’ attempts to recover and readjust to social life. Changes in stigmatization dynamics are found to be in direct association with the degree to which social and diagnostic articulations invoke or relieve the moral character of individuals as concomitant with discourses in social and institutional contexts.

The analysis of the communication practices and theories of psycho-pathology that provided the logics and relational sites are discussed according to discursive and symbolic strategies designed to induce recognition, visibility, and observation for how they altered the field of discourse and status of the patient. Findings discuss how communication theories and practices were used as analytical and technical tools that accomplished shifts in patients’ identity, staff narrative understandings, and public communication. These techne are analyzed for their role in fostering a therapeutic and supportive organizational culture capable of instantiating discourse from which to reconstruct self, social, and public knowledge of traumatic psychopathology.

Findings reveal how the practical techne of theories of communication functioned to alter patient, public, and scientific discourse about this type of psychiatric casualty. Dr. Wilmer role as a witness and author(izer) of new subject, staff, and public subject positions suggests how strategies of conscience and the use of communication technologies in visual media, metaphor, and cartographic intervenes in the discursive and visual field.

Relational contexts of doctor-patient-staff interaction are argued as paramount factors in patient recovery from post-traumatic disorders in conjunction with highlight the social impacts of while downplaying the diagnostic demarcation of the disorder. Diagnostic, epistemological, and
institutional contexts are suggested as pivotal sites that communicate and construct self and social stigma in contemporary discursive formations of PTSD.
CHAPTER 2: In Search of the Real: Communication around, about, and of Psychological Trauma and its Subjects

2.1 The Problem with Trauma: Wakes, Waves, and Aftershocks

Not surprisingly, the current era is alternatively characterized as the “age of trauma” (Stolorow, 2007), a “crisis of witnessing” (Felman & Laub, 1991), a “post-traumatic century” (Felman & Laub, 1991), and a posttraumatic culture (Farrell, 1998). If we have watched, we have witnessed: our mind’s eye filled with images of planes crashing, flaming and falling buildings, communities submerged by waves of water, snipers and bombers of all ages attacking public and private spaces. We have listened to verbal accounts of veteran suicide and been devastated by veterans’ murder of teammates, family members and random civilians; we’ve been shocked by the sexual assault crisis in the U.S. military, with 26,000 incidents in the year 2012 alone; we’ve heard cautionary and conflicting reports of the “mental health crisis in the military”; we’ve been stricken by the unspeakable horrors of the Afghanistani and Iraqi, and by the sad histories of those, trapped in time, still fighting the “war after the war”. “Posttraumatic stress disorder” or PTSD has once again become the focus of intense controversies and hauntingly familiar debates sparking a flurry of cultural, academic, and scientific dilemmas.

The prevalence of trauma-related impacts and syndromes has been extensively cited as an increasingly significant economic, social and public health problem of global proportions (Rand, 2008, Zizek, 2008). Researchers estimate that between 5-10 percent of the American population, 20-70 percent of military veterans from the wars in Iraq and Afghanistan, and up to 40 percent of entire populations in countries that have experienced mass violence and genocide, have or will suffer from post-traumatic syndromes (Rand, 2008). Post combat studies assessing PTSD related symptoms exhibited by veterans from WWI, WWII, Korea, and the Vietnam War find a lifetime incidence of post-traumatic syndromes ranging widely from 17 to 62 percent (Egendorf, et al.,
Prisoners of war, Holocaust survivors, and other populations subject to torture and captivity exhibit a lifetime prevalence of PTSD distresses upwards of 50% (Fontana & Rosenheck, 1994). Additional populations, at risk of suffering from the after effects of trauma, include victims of domestic violence, survivors of sexual abuse or rape, children exposed to or involved in domestic violence, physical assault, stalking, bullying, serious injury or accident and shooting or stabbing, individuals experiencing unexpected death or life threatening illness of a family member or friend, survivors of natural disasters, persons subjects to terrorism and torture tactics in prisons, jails, and drug rehabilitation centers, kidnapping victims, as well as emergency response and police personnel (www.ncptsd.va.gov).

In terms of social, economic, and behavioral impacts, numerous direct consequences and delayed aftereffects are associated with unresolved traumatic exposures to violence, terror, and stress. Research correlates trauma and stress related disorders with increased risk of suicide, susceptibility to physical disability and disease, depression, domestic violence, drug and alcohol abuse, higher rates of divorce, increase in legal altercations, decreased work performance, higher rates of unemployment, homelessness, and schizophrenia (Rand, 2008. www.ncptsd.va.gov). Quantitatively and qualitatively, what has come to be known as “psychological trauma” is a growing contemporary problem of global exigency requiring multifarious investigation and interdisciplinary examination (Stolorow, 2008, Grey, 2007). Socially, politically, culturally, experientially, and globally, PTSD is a salient and significant matter of public concern which raises issues that are at once, empirical, theoretical, and ethical in nature.
A review of the literature of the communications field, identifies only two explicit attempts to conceptualize trauma in terms of the interests, perspective, and potential contributions of the field of communication (Grey, 2007, Frank, 2009). My intent is to build upon these attempts, frameworks, and related trajectories of thought in order to connect previously disparate, although related, literatures in the discipline of communication that have provisionally studied the processes and consequences of, resistance to, and recovery from conditions related to “psychological trauma”. As Jennifer Grey (2007) suggests, trauma’s conceptual presence has served as a driving force, a “pervasive subtext”, and an “invisible thread” connecting large bodies of communication scholarship across interpersonal, family, organizational, critical-cultural, rhetorical, health and historical sub-divisions in the discipline. Frank (2007) insightfully contextualizes the foundation of rhetorical theory as a response that attempts to work through and respond to overwhelming losses of life and humanity due to the trauma of war, totalitarianism and mass atrocities.

In establishing the prevalence of psychological trauma as a growing interpretation in societal spheres of talk, texts, and policy, the first part of this chapter offers an overview of the topic of psychological trauma through exploring the surface of its emergence as a rhetorical and cultural theme in public and academic awareness. The second section explores PTSD as a controversial psychiatric diagnosis involving struggles over survivor recognition and social stigmatization overshadowed by institutional, legal, and policy contexts which are increasingly drawing more attention to the politics of PTSD and demand augmented precision, accuracy of assessment, diagnostic specificity, and refinement of understanding. Thirdly, the “psychologizing of trauma” will be explicated as an enduring contextualization of trauma that currently functions as a socially dominant and culturally unquestioned theory of human reaction.
to traumatic exposure that provides an inadequate paradigm in part because it is often at odds
with and in contradiction to accounts of lived experience and to more socially complex
perspectives of psychological trauma. In a culture infiltrated with psychological discourse
(Parker, 2008), the mounting number of interdisciplinary critiques of psychological theories of
trauma provide a springboard from which to begin to explore trauma in its social, political, and
communicative dimensions. Fourth, the final section of the chapter excavates the communicative
dimensions in the etiology, symptomology, and social interaction of psychological trauma.
Through a selected theoretical and empirical literature review of communication,
anthropological, and psychiatric perspectives, I will discuss literature that focuses upon
communicative and interactive patterns as important relational and social contexts from which to
examine psychological trauma.

2.2 Trauma’s resurgence: A new frontier of explanation, interpretation, and
spectatorship

In order to establish the growing prevalence of psychological trauma as an interpretation
in societal spheres of talk, texts, and policy, the first part of this chapter offers an overview of the
topic of psychological trauma through exploring the surface of its emergence as a rhetorical and
cultural theme in both public and academic awareness. During the second decade of the twenty-
first century, trauma continues to emerge as a significant area of study and debate in academic
disciplines, the culture industry, and in political realms (Brewin, 2001, Micale, 2001),
subsequently influencing policy in the legal, financial, and judicial domains of decision making
(Stone, 1993, 1994). The explanatory power of the psychological trauma concept continues to
expand not only into these overlapping discursive spheres, but moreover into commonplace or
vernacular discourses. For instance, in everyday talk, terms such as “trauma”, “traumatic”, and
“traumatizing” are increasingly employed in nonchalant descriptions of an individual’s,
culture’s, collective’s, nation’s, or era’s disturbed emotional state or experience (Keightley & Pickerling, 2009). Claiming that the concept of psychological trauma provides a new culturally ascendant platform of explanation, Farrell (1998) examines how the concept of trauma is employed in cultural narratives during cultural crisis and discusses this discursive regularity in terms of how humans “interpret and adapt to the world” as evidenced in narratives employed during “cultural crises” (p. x-xi).

On the one hand, Farrell argues that the concept of trauma assumes an interpretive role for individual and cultural sense making in a world where power and authority are “overwhelmingly unjust”. On the other hand, he claims that the term is used strategically and practically to stimulate an empathetic response or some form of social recognition from others, to request special treatment, or to demonstrate eligibility for monetary compensation (1998, p. 24). As a skeptic, Farrell explains, “People not only suffer from trauma, they use it, and the idea of it, for all sorts of ends, good and ill. The trope can be ideologically manipulated, reinforced, and exploited” (1998, p. 21). In addition to an attitude of skepticism over the term’s widespread dispersion as a sense making or strategic device, cultural critics also highlight how the cultural application of trauma, as used to interpret cultural moods and behaviors, aligns with themes articulated within PTSD diagnostic discourse (Kirby, 1998, Kansteiner, 2004). For instance, Keightley & Pickering (2009), critical/cultural scholars of collective memory and media studies, critique the widespread dispersion of the psychological term in depicting cultures, collectives, and nations, arguing that the “loose and indiscriminate application” of the terms “trauma” and “traumatic” in cultural studies and in vernacular discourse (as intended to describe a briefly shocking or injurious episode) actually downplays the debilitating, disabling, and enduring impacts of trauma’s original conveyance of the “immensity of suffering that is involved in war
crimes or systematic racial oppression” (p. 239). Analogously, Kansteiner (2004) claims that the psychological conceptualization of trauma and its corresponding research assumptions are fundamentally incompatible when applied as an interpretation of cultural trauma. He states that “the attempts to integrate these very different research traditions and concepts of trauma have ultimately not been successful. The writings on cultural trauma display a disconcerting lack of historical and moral precision, which aestheticizes violence and conflates the experiences of victims, perpetrators and spectators of traumatic events.” (p. 193). The cumulative significance of these critiques is twofold: first, they are situated within a growing interdisciplinary skepticism of psychological interpretations, second, they evidence the degree to which related discourses are insidiously making their way into unquestioned doxa in social science and vernacular opinion.

The extent to which psychological trauma continues to exhibit rapid growth as a subject of inquiry in academic, clinical, and medical inquiry is evidenced in the literature. A recent search on Web of Science, spanning the period between 2003 and March 26, 2013 cites 17,364 articles with psychological trauma or PTSD as the keyword or topic (published in the Science, Social Science, and Arts and Humanity citations databases); 13,931 of those were published between 2006 and 2013 (Webofscience, March 26, 2013). The same search criteria cites only 6662 articles published between 1980 and 2003 (Webofscience, March 26th, 2013). In addition to an increase of research inquiries centering on psychological trauma, evidence of trauma’s salience in human spheres of activity further suggest an overlapping influence in both scientific and cultural discourses, as concurrently a topos and a theme.

However, cultural representations of “trauma”, the “traumatic experience”, or the “traumatic event” are not a new phenomenon. Long before psychological trauma became both the subject and object of empirical, theoretical, and vernacular discourse, the profound
impact of life-shaking atrocities and catastrophes inherent in the human condition had been an recurring theme in literature, art, film, and music (Friedman, et al. 2011 Kaplan, 2005, Caruth, 1996). Starting in 2004, numerous documentary and feature films have attempted to represent and narrate the combat and post-combat experience of military personnel involved in the U.S. wars in Afghanistan and Iraq. Scholars are beginning to consider the potential of such narratives for aiding individual and cultural resilience. For instance, Ashuri’s (2010) research on cinematic representations of trauma explores the healing power of witnessing for personal reconciliation of traumatic pasts through the presence of witnesses in facilitating a collective experience and transformation of loss. Related studies focus on how aesthetic representations of human trauma facilitate reinterpretation and social validation which enable working through the disorienting effects of trauma. Similarly, Koutras (2010) describes cultural trauma studies as engaging the various repercussions and representations of human suffering, inarticulating trauma itself as an issue of “translation…finding ways to make meaning out of it and to communicate catastrophes that happen to others as well as to ourselves” (Kaplan, 2005, p. 19).

“Cultural-historical trauma studies” is an interdisciplinary alliance that is a related, yet more critical research trajectory for approaching the cultural, historical, and political discourses around psychological trauma through illuminating the concept of trauma as intricately connected to historically situated cultural, social, and political conditions. Historian Mark Micale (2001, 2009) identifies one strand of this research that is making a substantial mark on the map of trauma scholarship as the “new historical trauma studies” that has emerged out of disciplines such as psychology, history, sociology, anthropological, law, and literary studies. This branch of research draws heavily on psychological trauma research from widespread locales and disparate time periods in order to reconstruct the cultural and chronological contexts that shaped the nature
of the traumatic experience in question, and the epistemological and ontological assumptions underpinning the research inquiries. Within this research genre, one approach adopts a critical deconstructive perspective towards historical understandings in order to contextualize socially the political and epistemological controversies that have coalesced into different representations of trauma-related symptomology, epidemiology and etiology of traumatization, and trauma-related diagnosis at different points in its clinical and theoretical history, and in a variety of professional and social domains. Through critical reflection on the genealogy and the environmental context of the psychiatric intellectual history of trauma, these approaches are able to construct significant landmarks out of a disjointed history (Caruth, 2006, Herman, 1992, Friedman, et al., 2011, Silko, 2006, Leys, 2001, Micale &Lerner, 2001). Central to this perspective is the claim that conceptualizations of traumatic and post-traumatic conditions have evolved over time, generally alongside major social and political upheavals (Herman, 1992). This approach is most closely aligned with critical-cultural communication studies adoption of a social constructionist position towards social and scientific knowledge that takes into account socio-historical-political contexts in considering both the episteme and the relatively unquestioned “common sense” in any given context (See Berger & Luckman, 1996, Shotter, 1993, Foucault, 1972).

The interdisciplinary convergence of interest and urgency around trauma as an area of empirical, interpretative, and critical inquiry not only verifies its status as a cultural and academic hot topic, but, more importantly, demonstrates a pattern of widespread academic response. At the intersection of a myriad of discourses, new discussions evidencing an enduring political history surround and call into question issues of trauma-related diagnosis, treatment, and symptoms while reflecting on the changing nature of the historical and scientific understanding
of psychological trauma. Despite claims about use, misuse, or overuse of trauma as a
contemporary trope, trauma is a growing socio-political issue, and a large presence in public
discourse: as Stone argued in 1993, “The concept of PTSD has demonstrated an almost awesome
capacity to rework the psychological narratives of life experiences....PTSD offers a new frontier
of explanation” (p. 35).

2.3 PTSD: A History of Politics and Paradoxes of a Diagnosis

Post-traumatic stress disorder (PTSD) has been referred to as “the fastest growing and
most influential diagnosis in American psychiatry” and singled out as exerting unprecedented
influence in legal settings, appeals to justice, and recognition of survivors’ rights (Micale, 2001,
p. 5). According to Stone (1993), “no diagnosis in the history of American psychiatry has had a
more dramatic impact on law and social justice than posttraumatic stress disorder” (p. 23).
Before PTSD was formally recognized as a psychiatric and medical diagnosis, syndromes and
symptoms associated with post-traumatic reaction included: hysteria, railway spine, Da Costa
syndrome, neurocirculatory asthenia, gross stress reaction, shell shock, traumatic neurosis,
soldiers heart, combat trauma, combat fatigue, situational maladjustment, rape trauma syndrome,
post-Vietnam syndrome, prisoner of war syndrome, concentration camp syndrome, war sailor
syndrome, child abuse syndrome, and battered women syndrome (Friedman et al., 2011,
Herman, 1992, Hacking, 2005). Prior to the development of the PTSD diagnosis and its
instantiation in the DSM (Diagnostic and Statistical Manual of Psychiatric Disorders) in 1980,
gross stress reaction was the only “official” diagnosis, that had assumed a place in the DSM in
1952 as an entry for war-related trauma, later to be removed, for unknown reasons, was from the
DSM-II publication in 1968 (Scott, 1993).
In Wilber Scott’s (1993) account of how PTSD came to be an official diagnosis, he states that “PTSD is in the DSM-III because a core of psychiatrists and veterans worked consciously and deliberately for years to put it there” (p. 307-308).19 The ten year struggle to instantiate PTSD into the DSM-III is hailed by many as a victory in the politics of recognition, symbolically acknowledging those champions who fought for the diagnosis’ inclusion on behalf of others or themselves (see Lifton, 1973, Scott, 1993, Herman, 1992). Prior to the official diagnosis, the majority of the treatment and research on Vietnam veteran post-combat disturbances occurred outside Veteran’s Administration hospitals and the formal discipline of psychiatry (Lifton, 1973, Scott, 1993). Three primary overlapping, reasons for this shift in institutional treatment are generally cited: the demeanor of the veterans, the unique socio-political climate in the U.S., and the broad trend of de-institutionalization in mental health care. According to military psychiatrist and combat trauma researcher, Robert J. Lifton, Vietnam veterans returning in the midst of the anti-war civil rights movement, were an angry and “alienated” group, distrustful of authority and concerned with social problems (1973, Scott, 1993, Herman, 1992). He reports that the young veterans were disgruntled with and bitter towards VA hospitals for interpreting the veterans’ fears and anger as a psychological flaw, rather than as a social problem (1973, p. 35-36, Sedgwick, 1983, Scott, 1993). VA hospitals, according to patient and staff accounts, were in a state of tension and even disarray over the (in)adequacy of services provided in relation to the increasing number of veteran patients (Scott, 1993)20. In a report submitted to Dr. Phillip May, Director of Psychological Services at the Brentwood VA hospital, Shad Meshad noted that “the veterans were hostile, the staff was afraid, and ...the traditional VA services ... useless” (quoted in Scott, 1993, p. 36).
In a grassroots response to this combination of factors evidencing an apparent veteran demand for readjustment support, formal and informal “Rap Groups” emerged in cities, on “storefronts”, within the newly formed veteran’s organization Vietnam Veterans Against the War (VVAW) and in “Re-socialization Units” in some VA hospitals across the U.S. (Lifton, 1973, Scott, 1993). Rap Groups are generally considered the predecessor to veteran readjustment treatment and a more palatable than the services offered at the V.A. (Lifton, 1973, Scott, 1993). Military psychiatrists, who had an extensive epistemological-experiential history of understanding veteran readjustment issues, led the groups. When the psychiatrists joined efforts with the VVAW, this collaborative group of soldiers and psychiatrists formed a unique therapeutic unit that not only met in Rap Groups to talk and process through their combat and post-combat experience, but also united in a political effort to defend the soldiers’ honor and give voice to their experience. This union resulted in the infamous Winter Soldier Investigation at a Howard Johnson’s Motor Lodge in Detroit Michigan which presented shocking public testimony about combat atrocities witnessed and/or participated in during the Vietnam War, footage from which was later produced into a documentary film in 1972. In the Spring of 1971, the mission known as Operation Dewey Canyon III was a VVAW caravan that proceeded to Washington D.C. to protest the war and present testimony to Congress (Scott, 1993).21

Over the next ten years, the same core group of psychiatrists continued to pursue both public empathy and therapeutic/readjustment for the veterans. They formed active alliances with the American Psychiatric Association, attended APA conference appearances, submitted publications to APA journals, and maintained concerted contact and conversations with leading psychiatrists, heads of the DSM and APA committees, Vietnam veterans, and citizens. These efforts eventually resulted in PTSD’s recognition as an official diagnosis in the DSM-III in 1980.
The next step in the movement involved working with the U.S. Congress to legislate funding for veteran education and counseling programs, disability benefits, and “Vet Centers”. The legislation established the grounds for the GI Bill and compensation programs related to Veteran readjustment and treatment.

The emergence of the PTSD diagnosis can be viewed through Herman’s (1992) observations that the patterns in the study of trauma developed concurrently with a political movement that historically aligned researchers with patients who were situated in a civil rights movement that paved the road for the eventual instantiation of the PTSD diagnosis. From within this frame, the convergence of psychiatry, mental health professions, veterans, citizens, and veteran advocates groups produced a unified positioning of veterans who insisted on participating in how they would be defined and recognized. Clearly, this formation was situated within the zeitgeist of a larger social movement that united sub-groups on the basis of equality, civil rights, and resistance to official interpretations (Young, 1992, Scott, 1993). This formation is particularly important because it highlights how the PTSD diagnosis emerged out of a localized socio-political movement as a perceived victory in the struggle for veteran rights and an acknowledgement of the oft deleterious consequences of combat.

In terms of how the diagnosis has impacted understanding of the dynamic between the traumatized and the traumatic event, critics are skeptical of just how complete a victory it really was, noting that the focal point remains on the individual, while lacking reference to the broader political context (Kleinman, 1995, Fassin & Rechtman, 2009). Lembcke (1998) claims that the advocacy of the PTSD diagnosis was a form of a medicalized political dissent that distracted attention from the political issues of the war and the social adjustment issues of the veterans, and
conceptualized the problems of veterans as a form of mental illness” (quoted in McNally, 2003, p. 230).

As elaborated by Berkenkotter (2008), the DSM-III in particular has played a role in re-contextualizing patients’ narratives into technical language which in turn shaped how patients have come to be characterized, classified, and subsequently represented in policy and research documents which are progressively dehumanizing in comparison to the discourse developed in the first DSM. The broad scale replacement of qualitative accounts of patients’ narrative case histories with large-scale experimental quantitative studies published in the *American Journal of Psychiatry* is evidence of the current prevalence of the bio-medical model (Berkenkotter, 2008).

With respect to the claim that PTSD’s entry in the DSM-III culminated from psychiatrists listening to and studying patient narratives, the extraction of PTSD from its diagnostic history constitutes a devolvement from its instantiation and political transformation as a source of empathetic recognition to a source of misunderstanding and suspicion. This transformation also raises questions as to the extent to which the change in nomenclature in the DSM-III shifted readers’ understanding of the patients, especially if the technical language excludes emotional understanding in service of objective identification of symptoms.

*The Diagnosis and its Contradictions*

The DSM-III version of the diagnosis defines PTSD as a syndrome that erupts in response to a “stressor that would evoke significant symptoms of distress in almost anyone”. The significance of this terminology implies not only an etiological shift of disorder to the event (as opposed to the individual), but also represents a symbolic form of recognition for veterans and others who had been debilitated and injured through experiencing traumatic atrocity (see APA, 1980, p. 236, 238). In this sense, the DSM-III PTSD diagnosis represents a de-
stigmatizing shift in psychiatric discourse and practice, as well as a step towards increasing cultural and public understanding of war neurosis and its long term, delayed effects. As Vasterling & Brewin (2005) point out “PTSD differs from other neuropsychiatric disorders in that it is the only chronic mental disorder in which the experience of an environmentally induced event (i.e. the trauma) is critical to its diagnosis and development”. The majority of other psychological disorders are classified according to the following criteria by the DSM-IV (2000):

A. A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual

B. Is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom

C. Must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one

D. A manifestation of a behavioral, psychological, or biological dysfunction in the individual

E. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual

To expand upon Vasterling & Brewin’s distinction between the diagnostic criteria for PTSD and other psychiatric diagnoses, the criteria listed above clearly highlights the individual as the site and source of abnormal and dysfunctional behavior (e.g. “in the individual”). The criteria also specify that the conflict or behavior cannot be the result of an interaction between
the *individual and society* nor a *response* to a tragic event such as the loss of a loved one. Within these specifications, the etiology of disorder becomes analytically and theoretically isolated from the environmental context and its events. In addition to the clear acknowledgement of the presence of an environmental event as the pivotal distinction between PTSD and other “individually” developed disorders, PTSD is also an exception in that it is articulated as a “normal” *reaction* to overwhelming environmental stressors that could impact anyone.

The general symptoms associated with PTSD include a hyper-alert nervous system, automatic exaggerated startle response, hypervigilance, impaired memory, tendency to “re-experience” the event and related feelings, a tendency to avoid stimuli that trigger memories of the traumatic event and a pattern of emotional oscillation between numbness and intense emotions (DSM-IV, 2000; Herman, 1992, Horowitz, 1997, Vasterling, 2005). In the DSM-V, PTSD symptom criterion are divided among four primary clusters of symptoms: intrusion of thoughts and emotions associated with the traumatic or stressful event (analogous to re-experiencing), avoidance and/or numbing (analogous to the flight survival mechanism), negative alterations in cognition and mood, often accompanied by a persistent and distorted blame of self or others and persistent negative emotional state, and alterations in arousal and reactivity (analogous to the “fight” survival mechanism (pstd.va.gov, dsm.5.org). In this schema, the first criterion is, of course, exposure to traumatic events, worded specifically as “events that involve the actual or threatened death or serious injury, or a threat to the physical integrity of self or others” (DSM-IV, 2000). The DSM-V (2013) version of the exposure criteria expands “exposure” to include not only first-experience of a traumatic events, but also to witnessing the event in person, learning of a life-threatening injury or death of a loved one resulting from accident or violence, and repetitive or extreme exposure to aversive details of traumatic events.
(not including exposure through media, movies, television or photos, unless work related) (www.dsm5.org). The commonality of the traumatic experience is further explained as a producing “extreme alterations in arousal, attention, and perception” described as a reaction state to terror that impacts the encoding and retrieval of the experience (Herman, 1995).

Controversies over DSM criteria establishing prescribed individual reactions to traumatic events are focus of critiques based on the argument that human reactions are diverse, personal, and evoke a multitude of responses that far exceed fear, horror, and helplessness (Herman, 1992, Terr, 1991, Goodwin, 1990, Lee et al., 2001). An additional diagnostic dilemma concerns high comorbidity between TBI and PTSD diagnoses, thus blurring distinctions between the physical and the psychological, and thereby, posing challenges for the requirements of differential diagnosis, especially in light of findings that suggest TBI is a risk factor for developing PTSD (Rand, 2008, Bryant, 2011).

As a cross-cultural critique of the PTSD interpretation, researchers also draw attention to the practical and rhetorical function of PTSD and trauma discourses in international humanitarian aid interventions that attempt to expand global awareness and educate impacted populations about the effects of political violence and natural disasters (Friedman-Peleg & Goodman, 2010). Research on the “globalization” or migration of PTSD discourse into non-Western cultural interventions, specifically designed to help countries recover from violent political and military conflicts, reveal interesting cross-cultural reactions to an obviously “Western” PTSD interpretation of post-trauma reactions and recovery. The findings suggest that expanding PTSD discourse into non-Western contexts often results in a clash of cultural beliefs and values resulting because the target cultures do not share the U.S.’s background acceptance of the psychological frame (Friedman-Peleg & Goodman, 2010, Fassin & Rechtman, 2009). For
instance, the U.S. Agency for International Development sponsored a post-catastrophy aid
intervention in Bali following the 2002 terrorist attack with the aim of aiding the local residents
in coping with their losses resulting from the terrorist acts. Research on the intervention found
that the affected Balinese expressed ambivalence towards the PTSD interpretation which they
perceived as repressive of their political narratives and similarly dismissive of their losses of
income resulting from the attacks. The target population experienced these prejudices as
diffracted throughout the PTSD discourse (Dwyer & Santikarma, 2007).

Friedman-Peleg & Goodman (2010) found similar local reactions to resilience building
programs in Sderot, Israel in the wake of Palestinian attacks. Their study reveals that the
conflicts between local and PTSD discourse emerged in response to the psychologists’ emphasis
on de-politicizing and controlling emotions of anger over injustice through encouraging the
citizens to remain calm, listen to soothing music, and utilize a variety of impulse control
techniques. These intercultural clashes are particularly interesting because they provide support
for claims that PTSD discourse de-politicize the political, and consequently pose a direct
contradiction to local identities in countries where identity is intricately connected to a
collectivist political culture. Psychological frameworks emphasizing a focus on individual
reactions were interpreted as dismissive and out of context. This cultural resistance makes
evident the cultural bias and doxic assumptions embedded in an externally imposed
psychological discourse that seems strange and even offensive in the foreign cultural milieu.

An additional paradox of the PTSD diagnosis revealed through these studies is evident in
the contradiction between PTSD’s foundational recognition of environmental events being
integral to the development of the disorder, but, concurrently focuses treatment on emotional and
cognitive factors, while distracting attention away from the environmental and political context
of the traumatic experience and the consequent material loses. The failure of the PTSD diagnosis to address the varying degrees and ranges of impacts that traumatic events have on social, occupational, and interpersonal functioning is another critique leveled at PTSD diagnostic techniques. In fact, not everyone suffering from painful impacts of traumatic events needs or wants a medical diagnosis and cognitive-behavior therapy (Yehuda & James, 2006). As illustrated in the aforementioned reactions to Western PTSD interventions, the need to recover and rebuild from the economic and material impacts of the trauma often takes precedence over the need for therapy.

Legal contexts and the Scientific Burden of Proofs

The recognition and legitimacy of PTSD as a psychiatric diagnosis with its inclusion in the DSM has provided a medical and legal platform for veterans and other survivors of trauma to pursue disability benefits, compensation, or pardoning for crimes (Micale, 2001, Sayers, et al., 2009). In the United States, a PTSD diagnosis entitles a veteran to disability insurance, treatment, and monetary compensation unavailable to veterans of prior wars. The crucial component in these cases, as explained by Baker & Alfonso (2007), is the “diagnostic validity of these claims...It is important, therefore, for attorneys and others involved in the legal system be able to assess the validity of PTSD evaluations and diagnoses”. Referred to as a “forensic minefield”, PTSD diagnoses are increasingly used in civil litigation as grounds for monetary compensation and have a growing reputation for overuse by many in the legal profession (Sparr & Boehnlein, 1990, Slovenko, 1994).

However, as court cases involving PTSD claims increase, there is a compelling need to distinguish PTSD related symptoms from other mental disorders. According to Ohio State Bar Association, because claims to PTSD have recently increased, “Judges’ skepticism about the
validity of PTSD has also risen because the many factors involved in a diagnosis make it possible to manipulate a PTSD claim. Difficulties in validating PTSD claims range from pinpointing the traumatic event, to proving delayed onset PTSD to identifying the various symptoms.” 27 Many symptoms of PTSD overlap with symptoms of other psychiatric diagnoses, making differentiation between disorders difficult (Herman, 1992). However, increasing demands for validity and reliability of diagnostic distinction are pressuring the psychiatric field for a more substantial and concrete method of PTSD identification, diagnosis, and disability.

In the wake of the wars in Iraq and Afghanistan, diagnostic controversies within the U.S. military underscore the stakes involved in PTSD diagnostic differentiation and accuracy. Reports of misdiagnosis of thousands of soldiers who sought help for TBI and PTSD from the V.A. include faulty diagnoses of Personality Disorder, Alcohol or Drug Abuse, or Anxiety Disorder (Kors, 2010, DeYoanna & Benjamin, 2009). Diagnosis and compensation can become a highly charged political issue because certain psychiatric diagnoses imply by definition that a veteran has a “pre-existing” psychological condition, thus relieving the VA from responsibility for treatment, disability benefits, and long-term medical care. During the PTSD Committee research for DSM-V proposed changes, the V.A. psychiatrist Jonathon Shay explained: “Please keep this in mind as you work through your deliberations. Veterans denied benefits on the technicality of a poorly drafted diagnostic criterion often take the denial as an adverse judgment of the honorableness of their combat service. Combat veterans’ reactions to being dishonored can be very violent and dangerous to themselves and others. We need to get these things right.” (2006, p. 9).

In a related diagnostic controversy, veteran conflicts involving the V.A.’s response to PTSD claims in the US military culminated into an unprecedented class-action lawsuit filed
against the federal government by two non-profit veteran advocacy organizations, Veteran for Common Sense and Veterans United for Truth. The prosecution charged the V.A. with “practices that violate the constitutional and statutory rights of veterans with PTSD by denying veterans adequate procedural safeguards in the VA benefits process, access to the judicial process, mandated medical care, and VA benefits as a result of their PTSD” (dralegal.com). The suit was filed while the VA had a backlog of more than 600,000 unaddressed claims from veterans and a four year wait for veterans to receive official determinations of their eligibility to receive treatment and benefits for PTSD related claims. More specifically, the case claimed that as many as 15-50% troops were currently suffering from PTSD, that their condition would worsen as a result of delays in treatment, and that instead of hiring more doctors and claims processors, the V.A. systematically “blocked” access to critical mental healthcare (dralegal.com).

After two years of failed mediation attempts between the V.A. and veteran advocates’ legal teams, the Appellate Court Judges, in a 2-1 ruling, concluded: “We are presented here with the question of what happens when the political branches fail to act in a manner that is consistent with the constitution …. Wars, including wars of choice, have many costs. Affording our veterans their constitutional rights is a primary one…. The appeals court said the record from the district court case is ‘replete with examples of deleterious delays in the . . . [VA’s] provision of mental health care and shows that many veterans throughout the country have no means available to appeal the delays to which they are subjected.” (Judge Stephen Reinhardt, 9th US Circuit Court of Appeals, Time.com, May 10, 2011). Researchers argue that the costs of PTSD to society and government could be reduced by as much as 27% if PTSD were treated in a timely and effective manner (Eibner, et al., 2008).
To summarize, this section has explored how the layering of complexity involved in the political, economic, and diagnostic aspects of PTSD is cumulatively placing more pressure on scientific authorities to refine the diagnosis as well as on the VA to respond in a timely manner to returning veterans before their symptoms worsen due to lack of access to therapeutic and economic resources. As a result, this pressure has led to intense controversy within psychiatric research and VA treatment, at times, leading to accusations of censorship of research that contradicts conventional findings. As McNally (2003) explains, “the scientific literature is now vast, defying ready mastery, and even the finest, most ambitious works of scholarship are unavoidably synoptic….discoveries are continually mixed with explosive controversies” (p. 230, 245). McNally reviews a legal controversy within the APA regarding research findings on childhood sexual abuse that were temporarily censored because they posed a substantial contradiction to conventional wisdom. Eventually A.P.A. reviewers, determined that the study was legitimate. Like a good scientist, McNally (2003) concludes his discussion of the politics involved in PTSD research with a cautionary tale: “In any event, the overriding lesson of this bizarre episode concerns the importance of maintaining a firewall between science and politics. This is especially true whenever the topic concerns trauma and its consequences” (Hunt, 1999, p. 246).

In contrast to McNally, Herman (1992) argues that both the subject and scientific study of psychological trauma has historically been embedded and immersed in politics, claiming that the topic has “provoked such intense controversy that it periodically becomes anathema….and has repeatedly led into realms of the unthinkable and foundered on fundamental questions of belief….Throughout the history of the field, dispute has raged over whether patients with post-traumatic condition are entitled to care and respect or deserving of contempt, whether they are
genuinely suffering or malingering, whether their histories are true or false and if false, whether imagined or maliciously fabricated” (1992, p. 7-8). According to this argument, the study of psychological trauma has historically invoked fierce controversies over knowledge, more specifically, whose knowledge is true and who will be believed, thus suggesting that the “line” between the science and the politics of trauma and its subjects is imaginary at best (Herman, 1992, Yehuda & James, 2006). Along similar lines, Brewin (2003) notes enduring divisions between researchers, critics, and laypersons who are divided according to the categories of the “skeptics”: those who have historically questioned the legitimacy of traumatic reactions, and the “saviors”: those who aimed to document and legitimize the experiences and reality of trauma survivors.

While some PTSD researchers focus their efforts on how to improve the quality of understanding, diagnosing and treating of survivors of trauma, others are developing methods to objectively measure the presence of reported stressors and the validity of claims to traumatic exposure. In surrounding political sense, the PTSD controversy revives the nature-nurture debate of human health and abnormality through posing a direct contradiction to the very definition of mental illness. In this sense, the scientific and political debates invoked by the exigencies of psychological trauma strikes a chord at the heart of theoretical, public, and historically enduring controversies which inescapably involve discrepancies over human knowledge and humane treatment.

However, the degree to which scientific research on traumatic stress and its trajectories can resolve these conflicts is questionable. Brewin (2003), however, seems hopeful, arguing that, “the good news is that after twenty years of intensive research, an immense amount of information is now available with which one can evaluate these arguments and competing
claims. The field of traumatic stress therefore provides an almost unrivaled opportunity for assessing the extent to which scientific research is able to settle enduring controversies between the Saviors and the Skeptics” (2003, p. 3). As attention to trauma continues to build, the social sciences, medical sciences, and humanities are increasingly addressing trauma and its controversies.

The fact that PTSD diagnostic criteria are governed by medical and psychiatric authority demonstrates the complex layering of the institutionalization of medical diagnosis. The extent to which legal, military, insurance, and compensation decisions depend on the expertise of psychiatry to provide the basis of validity and reliability claims complicates the nature of such authority. Critiques of “exclusionary” psychiatric authority that APA expert committees have in making diagnostic distinctions and defining disorder for the DSM often originate from within the psychiatric and mental health field. Such questioning of the APA process are grounded in claims of censoring and excluding of other scientific perspectives, as well as dismissive of the conditions and impact on experience it seeks to describe (Allen, 2011, Phillips, 2012, Parr, 2000). However, the APA remained open to public and professional comments on the DSM-V revisions, and integrated many comments into the latest revision.

Additional critiques of the professional construction of the PTSD diagnosis argue that its criteria are ill-equipped to apprehend the relational, identity, and contextualized components of trauma and post-trauma reactions (Herman, 1992). This omission, Herman (1992) explains, “attempts to fit the patient into the mold of existing diagnostic constructs generally result, at best, in a partial understanding of the problem and a fragmented approach to treatment” (p. 118-119). Tellingly, leading researchers within the field of PTSD inquiry are currently making strong claims that PTSD clinical practice, empirical research, and diagnostic classifications are
disconnected, incongruous, and fragmented. Awareness within and around the field of psychological trauma reflect the growing sensibility that PTSD “is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, techniques, and narratives with which it is diagnosed, studied, treated, and presented by the various interests, institutions, and moral arguments that mobilized these efforts and resources” (Young, 1995, p. 5). As evidenced in an interdisciplinary effort to expand the psychological trauma conversation, awareness is converging around critiques of the limitations of psychological constructs. As critiques build, the psychiatric discipline may be forced to examine their foundations, which are not only being called into question by its service users and other fields of social science researchers, but also by sub-groups within its own epistemic community.

2.4 “Psychological” Trauma and the “Psychologization of Trauma”

As argued up to this point, the evolution of PTSD as a social historical “construction” and diagnostic category within psychiatric, psychological, and neuroscience discourses has contributed to its status as a “medicalized” diagnosis in institutional contexts (Grey, 2007, Hacking, 1995). The transformation of the definition of “trauma” from a simple physical wound to inclusion of a full range of psychological factors has resulted in part through its historical connection with the term injury. According to Hacking, the process increasingly referred to as the “psychologization of trauma” evolved as the psychological manifestation of trauma became an object of systematic study and theoretical explanation in the late 19th century, (Hacking, 1995). The clinical implementation of trauma as a psychological concept is echoed by its circulation in the vernacular and cultural realms, to the extent that its implications are used as a primary psychological interpretation for everyday behavior. As Parker explains, “contemporary discourse is replete with words and images that locate the causes for our activities inside
individual minds; we increasingly inhabit a ‘psychological culture’ that delimits the horizons of our inquiry” (2008, p. 40).

Critical and historical approaches to psychiatric discursive authority have embraced Michel Foucault’s (1965) concern with how the experience and knowledge of “madness” came to be. Debates continue to focus on over the combination etiological elements involved in the traumatic reaction along eventual, memory, associative meaning or individual vulnerability (Schubert & Lee, 2009). Colonized, radically stigmatized, and fundamentally altered through psychiatric authority. Proceeding with the question, “Under what conditions can one speak of illness in the psychological domain?”, Foucault traced the experience, expression, and interpretation of madness before madness was an “undifferentiated experience, a not yet divided experience of division itself” as a subject of scientific inquiry (1965/1987). Claiming that this new knowledge was produced in the ambitious medical and psychological sciences in conjunction with their corresponding institutional arrangements, Foucault contends that the systematic production of knowledge, in effect, censored and altered the conditions of possibility available for the interpretation of the experience and expression of madness (Foucault, 1965, 1972, 1974). Foucault’s work has inspired a large body of research in the social science, humanities, and historical disciplines that examine the unquestioned legitimacy and rights of definition embodied and exerted thought psychiatric power, preemptive psychiatric arrangements, and implicit assumptions claimed to have contributed to centuries of strife and conflict within the psychiatric-medical communities and even more so among those subjected to their examination and treatments. Such sequestering, he argues, is consonant to an order of demarcation and systematic silencing of the experience and expression of those who have come to be known and signified as ‘mentally ill’ (1987, p. x).

Along these line, a substantial body of scholarship has developed into an interdisciplinary critique and theory that “psych epistemology is, in many respects, an institutional epistemology: the rules governing what can count as knowledge are themselves
structured by the institutional relations in which they have taken shape” (Rose, 1998, p. 61).

While I generally agree with the insight of this scholarship, there is substantial evidence and instance of internal struggle and antagonisms within the psych disciplines. The anti-psychiatry movement, in particular, was a movement generated by psychologists and social scientists from within the mental health field (Scott, 1990, see Cooper, 1970, Szasz, 1974, Laing, 1960 1967). Many of the key figures involved of the anti-psychiatry movement have offered alternative, holistic perspectives that were accepted and utilized to varying extents by the public and within the mental health field. Such alternative interpretations and conflicts still exist, but are not represented in the DSM or in official PTSD discourse. As mentioned, the APA deliberations on the specifications, criterion, and categories contained in the DSM imply a limited paradigm that does not include alternative voices or frameworks, despite their co-presence in the empirical history of psychiatric science. These exclusions are underscored by Grey’s (2007) examination of how issues of authority are paramount to discussions about traumatized individuals that highlight the endurance of how “questions of legitimacy and institutional authority remain central to understanding the dynamics of trauma and its impacts” (p. 186).

The central role of institutional and psych discourses in understanding how trauma and its subjects have come to be understood and treated is a compelling site for studying battles over representation, interpretation, and struggles between the institutional authority of psychology and those who consume, seek, or are subject to psychiatric knowledge. One way to start to understand the task of challenging psychiatric authority and the insidiousness of psych discourse is offered by Parker (2008), who suggests thinking of mental health (constructions) as a cultural practice. In order to capture competing representations of mental health, Parker (2008) suggests directing research to the boundaries of what divides “health and illness” and “normal and
abnormal” thereby accounting for relations of ideology and power in those distinctions. Parker calls for a new way of mapping mental health stating that, “the kind of map we need is one that will lead us from critical qualitative methodologies ... toward a dialectical conception of research, which means that we do not merely interpret the world, but change it” (2008, p. 51). When understood as a cultural practice, theories and theorizing can also conceived as a communication practice embedded in normative communication conventions that function as a meta-discursive practice for interpreting practical knowledge embedded in cultural contexts (Craig, 2006).

2.5 Communication around and about Psychological Trauma and its Subjects

In pursuit of an approach to the systematic study of psychological trauma, Deetz’s (1994) vision for communication studies is particularly suited to the elucidation of “psychological trauma”. He states, “If we are to make our full social contribution, we have to move from studying “communication” phenomena as formed and explained psychologically, sociologically, and economically, and produce studies that study psychological, sociological, and economic phenomena as formed and explained communicationally” (p. 568). Deetz’s conviction derives from two interrelated theoretical critiques and posturing that can be summarized in terms of theoretically challenging the idea of the autonomous subject reflected in a representational view of language on the theoretical and secondly, through the practical claim that “communication as a constitutive process (that) reclaims(ed) the central concern with interaction processes as a site of meaning production” (p. 577). According to a constitutive view of psychological phenomenon then, critical communication inquiries should focus then on the process of ‘whose’ meanings are included through identifying the primary relations involved in meaning production and reproduction.

A critical communication perspective, then, critiques political processes that de-
limit participation in meaning production and delineates the interactive social webs that produce consent (also referred to in terms of hegemony, ideology, strategic apparatus) to ‘other’ versions of reality, interpretation, and common sense (Deetz, 1992, 1994). According to this theory, our attention should turn towards, “the continued production and reproduction of individuals and their interpretive processes as consent in the violent system as both a compelling explanation and useful guidance for intervention” (Deetz, 2001, citing Harris, et al., 1984).

An additional framework for approaching psychological trauma from expertise in the field in communication is provided by Phillips (1999) whose notion of “rhetorical controversy” offers insight for understanding a public and contested problem that involve competing theoretical perspectives. A rhetorical controversy is conceptualized as a social issue that has a multiplicity of “competing histories”, where “arguments and the speech acts forwarding arguments are opposed, the process of public deliberation is problematized, the background consensus is obscured, and the search for common ground is halted” (Phillips, 1999, p. 489, Doxtader, 1991, Goodnight, 1991, McKeon, 1990, Olsen & Goodnight, 1994). According to Herman (1992), the quest to understand psychological trauma has historically developed within a milieu of public and scientific conflict and controversy, bootstrapping itself as a distinct and ongoing “rhetorical controversy” from its introduction as a subject and object of public discourse and scientific opinion. Even within professional mental health circles, there is little indication of consensus as to the empirical nature of the role that exposure to trauma assumes in the development of debilitating symptoms related to post-traumatic experiences. Since 25% or less of people exposed to a ‘traumatic event’ are estimated to develop PTSD, exposure alone does not offer a theory.
As a result, current debates amongst PTSD researchers indicate dissension in their claims about the ‘sustainable’ factors in the development of PTSD. For instance, one primary etiological theory of PTSD focuses on fragmentations, distortions, and absence of memory in seeking to explain mechanisms of ‘traumatic memory’ and its apparent dislocation, and thus centralizes a theory around a complex and ubiquitous network (Bremner, 2002, Yehunda & McFarlane, 1995, Hacking, 1995). Research continues to debate the roles that of traumatic stress, a smaller or damaged hippocampus, historical or neurological predispositions, repression/dissociation of meaning and memory, place and space cells, episodic vs. verbal memory (e.g. dual representation theory), play in the development of PTSD (Schubert & Lee, 2009, Friedman et al., 2011). In one way or another, these theories attempt to search for and locate the defining element to explain the sustenance and maintenance of PTSD.

In addition to controversies involving science, another indicator of PTSD as a contemporary rhetorical controversy over contested knowledge claims and clashes of interest has been highlighted by critical cultural communication studies directing attention to doctor-patient relationship and discrepancies of interpretation within institutional settings. As Grey (2007) discusses, problems of interpretation, within doctor-patient relationship, manifest in struggles over representation and questions of ‘who’ is authorized to speak for or interpret the post-traumatic experience of the patient. If, as some have claimed (Kaplan 2005), recovering from the post-traumatic experience is, in and of itself, an issue of interpretation, then post-traumatic communication is a crucial process that aides in “translation…and finding ways to make meaning out of it and to communicate catastrophes that happen to others as well as to ourselves” (Kaplan, 2005, p. 19). However, as Herman explains, “All too commonly, chronically traumatized people suffer in silence; but if they complain at all, their complaints are not well
understood” (1992, p. 118). Foucault (1965) offers insight into how issues of relational authority play out in the daunting context of the psychiatric examination when authority is exerted in preemptive categories used to interpret the “problem”, while simultaneously imposing a discourse that silences the expression and experience of the patient, and consequently excludes the patient from participating in the definition and understanding of their own condition.

Communication research has suggested that from the patients’ perspective, medical and psychiatric discourses present themselves as an unwelcomed authority through terminology, diagnostic procedures, and assessment of symptoms. This disconnect leads to the “necessity that some traumatized individuals feel to speak and author their own experience (which) propels them into dispute with their care providers—a power-laden situation over authenticity, authority, and agency” (see Grey, 2007, p.188). As Herman as mentioned, such challenges are likely to be interpreted in this context as a psychological symptom rather than a legitimate claim. This problematic theme illustrates conflicts over whose meanings matter, thus raising critical questions about the authority of the “experts” and the authority of the patient (Herman, 1992, Grey, 2007). McNamee’s (2002) work suggests that these institutional arrangements and psychological diagnoses position the patient in a ‘deficit discourse” through reducing a legitimate request for support into individual deficiencies. In relating assessment contexts, Foucault (1977) explains how such normative judgments constitute a totalizing system of communication, whereby information offered by the patient becomes translated as a symptom of a disorder, and the person is rendered an “object” of information, rather than a subject in communication.

In summary, the task of excavating the political and relational contexts that pertain to competing interpretations in the study of PTSD through highlighting the enduring controversies
as overlapping in science, politics, and culture offers a trajectory consistent with Deetz’s articulation of how communication studies can assist in reclaiming these issues as issues of meaning, representation, and voice. Hopefully, in reopening old conflicts, this framework offers new grounds for engagement, and a richer insight into the phenomenon of stigmatization and trauma. The next section speaks specifically to the communication of psychological trauma through exploring additional lenses for understanding how trauma and the social complexities of communication are integral to expanding the horizons of inquiry beyond psychological frameworks.

2.6 Trauma and Communication: Narratives, Dialectics, and Traumatic Constellations.

This section explores research and theories that link “psychological trauma” to disruptions and contexts of communication through trauma’s impacts on narrative communication, self-identity, and distortions of literal, metaphorical, and symbolic communication. While not a comprehensive list, these research inquiries suggest a conceptual and empirical link between trauma and communication as deriving from and/or producing abnormalities in conventional communication. Loosely identified as the narrative, dialectical, and the meta-communicative/double-bind theories, these perspectives have been excavated from dispersed locations in the literature with the objective of understanding post-trauma communication problems resulting from distortions of language and meaning systems. The most pronounced aspect of traumatized communication is evident in generalizing that the ultimate testament of trauma is when “language succeeds in testifying to the traumatic horror only when the referential function of words begins to break down” (quoted in Gunn, 2006).

Narrative Interruptions and Trauma
A narrative perspective on psychological trauma reveals the breakdown of language by the presence of fragmentation, loss of coherence and the by the absence of appropriate words to represent experience. The central idea of this perspective is that “trauma affects communication” by producing a fragmented and incoherent narrative. The importance of narratives in connecting human experience, identity, and communication is highlighted in Walter Fischer’s (1984) narrative paradigm of human communication that is grounded in a “theory of symbolic actions---words/or deed ---that have sequence and meaning for those who live, create, or interpret them” (p. 2). The theory highlights man as *homo narrans* or storytellers whose narratives provide order, meaning, and practical wisdom to human experience as based in a narrative rationality in both a symbolic and material composition of understanding (1984). Drawing from Burke’s theory of symbolic action, the heart of the perspective postulates man as symbol using (and misusing) animals who use language as a tool to induce processes of human identification, cooperation, and community. The narrative paradigm further illuminates how people use and live narratives as a means of connection, understanding, and influence (Zappen, 2009, Crusius, 1999, Hauser, 1986).

Research on PTSD indicates that trauma often impacts individuals’ ability to communicate “normally” through producing disruptions in narrative and interpersonal communication (Rosenthal in Hacking, Amir et. al, 1998, Yehuda, 2005, Herman, 1992, Horowitz, 1997, Vasterling, 2005, Scarry, 1996). The narratives of traumatic experience are described as characterized as discontinuous, fragmented, and lacking in temporal and spatial boundaries (Herman, 1992, Pickerling & Keightley, 2009). Similar to the effect of severe physical pain on language, such impacts have been shown to affect the ability to form coherent utterances about the experience of the trauma, both in the moment and afterwards (Scarry, 1986).
Research on children with histories of known trauma show alterations and deficiencies patterns in verbal expression that lack in state-descriptive language, demonstrate communicative passivity, and exhibit reduced requests for information (Pearce & Pezzot-Pearce, 1997, Yehunda, 2005). Individual’s recollections of traumatic events have also been found to lack narrative descriptions, mention of context, and as characterized predominantly by vivid imagery and bodily sensations (Brett & Ostroff, 1985, van der kolk, 1988).  

Similarly, Pickering & Keightley (2009) analysis of discursive indicators trauma argues that traumatization breaks down temporal boundaries and is presented as a breakdown in verbal representation and narrativity. They draw upon BenEzer’s (2004) work which identifies thirteen “communication signals” as indicators that the life story under review features traumatic experiences (p. 246-247). Through utilizing critical discourse analysis, Pickering & Keightley (2009) distinguish between resolved (past) and unresolved (real, repetitive, symptom/expression) trauma by checking narratives for lack of temporal boundaries or distinctions: unresolved trauma is evidenced in a lack of discursive markers that that was then, and this is now. Their analyses conclude that unresolved trauma result in a “disjointed narrative” characterized by lack of coherence or logical progression, distortions of chronological sequence, jumping between episodes without warning or explanation, sentences not fully formed, elusive meanings, fragmented recollections, and repetitious statements (p. 243). Herman’s (1992) observations are consistent with Pickering & Keightley’s and related research postulating theories of traumatic narrative interruption, explaining that “people who have survived atrocities often tell their stories in a highly emotional, contradictory, and fragmented manner” (p. 1).
The “Split-off” Symbol: Narrative and Dialectical Movements

When psychological trauma is viewed from the perspective of a narrative theory of communication, then a breakdown in the narrative representation and expression implicates a disruption not only in the symbolic system, but also in narrating meaning, order, and historical continuity. Habermas extends the narrative theory of communication in examining how conditions of traumatic exclusion and silencing impact narrative formation; he identifies the breakdown of the historic narrative as a failure in the representation function of ordinary language that manifests though its “removal from public communication” that impacts “the linguistic interpretation” whereby “portions of its semantic content are privatized” (1971, p. 263, 257). Within this view, “symptom formation is a substitute for a symbol whose function has been altered...The split off symbol has not simply lost all connection with public language”, but rather believed to have “gone underground” as a “symptomatic concealment of meaning” resulting in a “symptomatically distorted text” (1971, p. 257, 263). Offering a distinctly Freudian explanation, Habermas writes, “As soon as language is excluded from public communication by repression it reacts with a compulsory compulsion, to which consciousness and communicative action bend” (p. 256). This perspective argues for the importance of public communication for recovering the break in the symbol system involved in language representation.

Connected to narrative incoherence and distortions of public communication, Herman offers a dialectical perspective on the impact of trauma on communication that she claims can be observed in dialectical oscillations of extremes in communicative expression as evidenced in excess and deficiency, explained as resulting from “the conflict between knowing and not knowing, speech and silence, remembering and forgetting”, as the “central dialectic of
psychological trauma” (1992, p. 127). The dialectical theory includes the narrative disruption perspective, but provides an addition frame of elusive movement, expression of opposites, and contradictions or fragmentations in communication, knowledge, and verbal retrieval of memory. Herman elaborates the dialectical excess and attrition of trauma communication accordingly: the “conflict between the will to deny horrible events and the will to proclaim them out loud is the central dialect of psychological trauma….”The psychological distress symptoms of traumatized people simultaneously call attention to the existence of an unspeakable secret and deflect attention from it” (1992, p. 1). Herman’s dialectic includes oscillations in the communication of trauma, indicated in extremes in surplus or deficiency of verbalization with similar dialectic patterns in intensity of emotional tone and an ambivalent desire to remember and forget.

Herman’s perspective articulates how communication abnormalities and irregularities have a socially recursive effects on the survivor by constantly reinforcing the social context of stigmatization. Both the narrative and dialectical perspectives direct attention to how fragmentations, contradictions, absences, and extreme oscillations in verbal communication are an outcome, reaction, and indicator of the experience of psychological trauma resulting in a distorted public speech which diverges from normative communicative conventions. Such divergences from social norms of coherence in communication have social consequences (Grice, 1975). As suggested by Herman, the attempt to communicate often serves to undermine the credibility of the speaker and “the story of the traumatic event surfaces not as a verbal narrative, but as a symptom….those who attempt to describe the atrocities they have witnessed also risk their own credibility….and to invite the stigma that attaches to victims” (1992, p. 1-2). The other pole of the dialectic is displayed in the silence and withdrawal of communication, demonstrating the double edged sword of communicating trauma, wounding both in excess and retreat.
The “dialect of trauma”, then, describes two discrete but interconnected expressions of traumatization and reveals how its expression is at risk of negative social interpretations, stranding the trauma victim in the extreme trajectory of movement to “reveal” and “conceal”. Herman’s dialectical frame elucidates how the expression of trauma becomes its symptomology, as well as the how this dialectic reinforces its own repetition and interpretation. In this sense, abnormalities in speech produce a rhetorical disability, not just in social status, but in divergence from norms of coherence, quantity, quality, relevance, and clarity expected in cooperative conversation conventions (Grice, 1975); these indicators of divergence foment social stigma.

**Constellations of Silence: Social Body of Trauma**

Herman’s dialectic of trauma extends to include the interactive contexts in the survivor’s social world and people who have been in roles of witnesses, bystanders, and perpetrators, specifically alluding to how those who see the violation or its aftermath are induced in the dialectical configuration, explained that “witnesses as well as victims are subject to the dialectic of trauma”, which puts further social constraints on the communicative context (Herman, 1992, p. 8). According to this view, “witnesses” or people in the survivor’s world are asked to bear the burden of the pain”, explaining that “when the traumatic events are of human design, those who bear witness are caught in the conflict between the victim and the perpetrator” (p. 8). Claiming that it is morally impossible to remain neutral in this conflict, Herman argues that the survivor’s communication about the trauma forces the bystander to take sides, whereas all the “perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement, and remembering” (p. 8). This situation creates a conflict of interest between victims and bystanders that challenges the ‘veil of oblivion’ that resists painful
knowledge of injustice and human atrocity. (Eitinger, 1980). Eitinger explains that this contrast “...is frequently very painful for both sides. The weakest one...remains the losing party in this silent and unequal dialogue” (1980, p. 127-162). Problems such as these are also evidenced in legal settings and reversal of victim-perpetrator roles whereby the victims is treated more harshly and with less empathy than the perpetrator (Coates & Wade, 2004).

Trauma testimonies invariably involve audience participation, but frequently result in further silencing of the survivor. In the cases of combat trauma, soldiers repeated report that “no one wants to know the real truth about the war” (Herman, 1992, p. 8). This framework illuminates how the silencing of survivors is inherently a social accomplishment involving a complex dynamic of social and moral conflicts of interest which factors into public context of the dialectic of trauma, problems of narrative interruption, and social inhibitors to narrative processing. Especially in cases where there is an identified perpetrator, Herman (1992) argues that the perpetrator strategically uses silencing and deception to promote social forgetting. If silencing in ineffective, then the next step is to attack the credibility of the victim and disseminate a wide array of arguments that “name and define reality” and discredit the victim as a liar, exaggerator, and responsible for bringing it upon him or herself (Herman, 1992, p. 8). All of these dynamics speak to the social body of trauma that surrounds and contextualizes relational constellations around the communication of trauma that help explain the communicative production of social and self stigma as they relate to communication patterns of the perpetrators’ efforts and interests in maintaining the stigmatized status of the victim.

Identity: Traumatic Impacts and Imprints

The dialectic and dynamic of the social body of trauma has further implications and complications for problems of identity and stigma related to traumatization. Herman, Horowitz
and others who have studied trauma extensively as researchers and practitioners have suggested that trauma interferes in a very fundamental way with one’s sense of self-identity (Vasterling, et al., 2005). In the sense of disrupting narrative knowledge or a narrative coherence, trauma could be said to interfere with “the ability to keep the narrative going’ as an integral piece of self-identity as discussed by Giddens (1991). Similarly, Zizek (2008) argues that trauma “destroys the symbolic texture of the subject’s identity” (p. 11). As Herman (1992) has observed, “traumatized people suffer damage to the basic structures of the self…the identity they have formed prior to the trauma is destroyed” (p. 56). Family members, friends, clinicians, and other observers note patterns among PTSD sufferers of “just not being themselves” and in “major personality changes”. Sufferers also report feeling that they “will never be the same again”, “don’t know who they are anymore”, and “cannot be themselves” (Herman, 1992, Lifton, 1970).36

To study trauma is also to study disturbance in the basic structures of the self, identity, as they interact with others and environment. Research suggests that severe, prolonged trauma eventually interferes with an individual’s ability to participate in life episodes and narratives, integrate the past with the present, disrupts their sense of their identity or self, and inhibits the ability to live in relation to the immediacy of the world and others. While the exploration of these implications is beyond the scope of this discussion, the connection between disruptions in language, fragmented or lack of verbal narrative, and the public-social processes of silencing implicate processes involved the rupturing of identity or personality. This again raises critical questions about the connection between trauma, communication, and identity, suggesting an interruption of basic structures of self, in terms of identity and as a shattering of those foundations (Herman, 1992). Narratives of survivors of trauma testify that they feel like they
“belong more to the dead than to the living” and have been found to contain themes of death symbolism (Lifton, 1970, p. 52) and show alterations in the construction of time, evil, and authority (O’Leary, 1994).

**Shattered Assumptions: Doxic Interruptions**

Related to these self and narrative disruptions, trauma has also been conceptualized as a crisis in meaning and a ‘shattering of assumptions”, that calls into question one’s sense of safety, valuation of self, and meaning in the world (Janoff-Bulman, 1992). According to Dr. Robert Stolorow, clinical Professor of Psychiatry at UCLA’s school of medicine and author of *Trauma and Human Existence*, trauma leads to a disruption in continuity between the past, present, and future that normally makes one’s experience of the world relatively meaningful and coherent (2007). Framed as a phenomenological breaching, he further claims that emotional trauma interrupts the “system of illusory beliefs that allow us to function in the world and experience that world as stable, predictable, and safe” and consequently results in a “massive loss of innocence” (2012, p. 443). In this sense, trauma poses a radical disruption to Gidden’s (1991) notion of “ontological security” that is maintained in the “fragility of the natural attitude” that enables a sense of those aspects of existence that constitute the narrative of our existence and presence in the world through a sense of shared reality whereby such absence produces “cognitive and emotional disorientations” (p. 36-37). The natural attitude consists of taken for granted, which according to Giddens a sense include “time, space, continuity, and identity” and the “natural” or taken for granted existential parameters that presume a tacit acceptance of the categories of duration and extension, with identity of objects, other persons, and the self that exists in practical or taken for granted knowledge (p. 37). Traumatization, at its most basic level, from this perspective, shakes or ruptures these fundamental continuities that serve as the basis of
basic existential touchstones. Or, in Bourdieu’s (1977) terminology, trauma poses an interruption of doxa and habitus.

From this perspective, trauma, as interfering with taken for granted knowledge or in Shotter’s (1993) terms “knowledge of the third kind”, disrupts basic assumptions about self, others, and the world through a rupturing of practical knowledge and taken for granted order in the world that generally remains intact and provides a sense of ontological security in everyday life (Giddens, 1992). Traumatic events, when severe and continuous, have the power to “shatter the construction of self that is formed and sustained with others, …(and) undermine the belief systems that give meaning to human experience … violate the victim’s faith in a natural divine order and cast the victim into a state of existential crisis” (Herman, 1992, p. 51).

In summary, I have highlighted research that demonstrates changes in patterns in communication in the form of narrativity, time, absences or fragments, and dialectical extremes of expression to support the claim that “trauma affects communication” (Yehunda, 2004, p. 20, Heineman, 1998, Herman, 1992, 1997, Steinberg, 2000). The communication of trauma, then, is most apparent in what is missing or discontinuous in “narration as a discursive mode of generating intelligibility” of history, time, and relationships with others (Gergen, 1998). Along similar lines, trauma can also be understood according to Janoff-Bulman’s (1992) metaphor of the “shattering of assumptions” and the overwhelming effects of trauma’s that calls into question basic assumptions, illustrative of a shattering of the maps that hold the ‘real’ in place, prompting a crisis and discontinuities in understanding both from the position of the traumatized and those in their social world. Disruption of the narrative provides evidence that at the most basic level of communication, psychological trauma intervenes in public communication though a dissociative
splitting of the symbol from its context and meaning, causing abnormalities in meaning and narrative formation as disruptive to foundations of self-identity and its continuity.

*A Meta-Communicative Theory of Psychiatric Disorder: Distortions of Double Binding*

In 1951, Ruesch & Bateson published *Communication: The Social Matrix of Psychiatry* which framed psychopathology in terms of disturbances of communication in their claim that illusions, hallucinations, delusions, flight of ideas, dissociations, and withdrawal are most evident in abnormalities in communication, hypothesized as a symptom and a clue to the corresponding pathology (p. 80). During this time, psychotherapy was understood as “belonging to the procedures of the psychiatrist designed to improve the process of communication of their patients” (p. 94). Within this theory of psychopathology and psychiatric practice is the assumption that “communication is the matrix in which all human activities are embedded” that helps us explain the “physical, interpersonal, and cultural aspects of events within one system” (1951, p. 13, 15). The approach itself claims to have synthesized a communication systems theory with concepts from psychiatry, psychology, and anthropology (see Craig, 1999, Ruesch & Bateson, 1951, p. 14). Within this model, communication is linked to the empirical study of pathologies of human interaction precisely because the communicative aspect is the observable and external expression of disorder that also displays linkages between people, people and objects, and the interrelatedness of multiple relational systems (1951, p. 13).

This communication theory of psychopathology provided the foundations for a double-bind epidemiology of schizophrenic reactions, theorized to manifest in an inability to discern between communication messages of content (literal) and meta-communicative messages about the context, relationship, and situation that are normative and implied. In collaboration with Watzlawich, Beavin, & Jackson (1967), authors of, *Pragmatics of Human Communication,*
Gregory Bateson was concerned with environment antecedents of mental illness (which at this time was designated by a very ill-defined concept of schizophrenia) able to be re-produced within group interaction dynamics characterized by specific communication patterns. Bateson suggests that mental illness is produced by and manifested in communicatives “tangles”, as evidenced in “when we look at his speech(es), we find that, “ he is describing a traumatic situation which involves a meta-communicative tangle”. Bateson followed the symptom, so to speak, and concluded that the patient must have lived “in a universe where the sequences of events are such that his unconventional communicational habits will in some sense seem appropriate” (1972, p. 212). This reversal in approach towards symptomology reflects a communication systems understanding of human behavior whereby meanings are derived in relation to others in relational contexts. Such a view reflects a positive understanding of human nature which assumes an internal logic to pathological or abnormal communication in that it must have made sense in another communicative context. Bateson claims that “what the patient is up against today...is the false interpretation of his messages” (1972, p. 199).

Within this model, communication symptomology in its extreme form of schizophrenia is defined in terms of distortions resulting in “exaggerated errors and distortions regarding the nature and type of their own messages....the messages they receive from others”, whereby “imagination is seemingly confused with perception. The literal is confused with the metaphoric. Internal messages are confused with external. The trivial is confused with the vital. The originator of the message is confused with the recipient and the perceiver with the thing perceived” and a lack of responsibility for the metacommunicative aspect of his messages (p. 261). Characteristic communication patterns are described in terms of dialectical movements of extremes in the sense of “flooding the environment with messages whose logical typing is either
totally obscure or misleading” or “overtly withdrawing to such a point that he commits himself to no overt message” (p. 261). These symptoms are specifically described as the “loss of the ability to set meta-communicative frames” and therefore a “loss of ability to achieve the primary or primitive message”, whereby metaphor is treated as the primary message (p. 190-191). Most of these symptomologies are further explained as difficulties in discriminating between types of messages in their own and others’ communication, hypothesized as a weakened ego function that has lost differentiation abilities at different levels of abstractions of communication between self and other (p. 205).

These pathologies of differentiation led to the question of “how does a human being acquire the imperfect ability to discriminate these specific signals?”, which was developed into hypothesis regarding the role that systemic “pathological” communication plays in the etiology of what we call “mental illness”. Bateson was looking for an “etiology involving multiple levels of trauma” (p. 198), not surrounding the content or episodes of the trauma…but for a “formal structure” of contradictions in commands and orders of messages of communication assumed to be “played against each other” in order to “generate this particular pathology in this individual” (p. 196). The “traumatic constellation” refers to the communicative context characterized by “double bind” communication sequence, believed to be in part responsible for schizophrenic symptoms and similar distortions in communication and interpretation (p. 199). He sought to describe the “sequences of experience which would understandably train the individual in his peculiar distortions of communication (1972, p 235).

Bateson describes these conditions in terms of “unresolvable sequences of experiences” as the basic of the “traumatic experience”, not explained in traditional psychoanalytic terms of “infantile etiology”, but rather in “characteristic sequential patterns”. The traumatic experience
and corresponding “symptomology” is theorized to result from contradictions in communication messages that continuously put a human being in the wrong for their accuracy of interpretation, in which there is no way to “win”, and who is repetitively punished precisely for “being right in one’s own view of the context” (p. 236). Watzlawick et al., (1967) identified three “ingredients” of the double-bind situation or the “double-binding”: First, the situation is characterized as an intense interaction between individuals where issues of psychological or physical survival are paramount for one or more of them; secondly, it involves the negation or disconfirmation of the messages such that one party is continually put in the wrong for their interpretations and as such is alienated in a paradoxical injunction (p. 86); and thirdly, constraints in the interaction context inhibit the interactants from commenting or reacting to the message. In this context of schizophrenic organization of communication, Bateson describes these forms as having an “ongoing stability whose dynamics and inner workings are such that each member is continually undergoing the experience of negations of self” (1972, p. 243)

Under these conditions, any appropriate manner to clear up the confusions results in the individual consistently being punished for trying to make sense of an unresolvable paradox, further defining individuals as “mad” or “bad” for correctly perceiving the discrepancy between the real and others definition of the real (1972, p. 212-213). This pattern of exposure to content and contextual messages that contradict each other is hypothesized to eventually distort interpretative mechanisms as manifested in symptomatic distortions in speech and interpretations patterns that collapses the distinction between others’ and one’s own literal and metaphorical meanings. These conditions are hypothesized to lead to a “breakdown in an individual’s ability to discriminate between Logical Types”, described most simply as the distinction between denotative and connotative messages that operate on different levels of abstraction in logic, at the
level of explicit and implicit communication, and communication of content and context (p. 208).

The double-bind theory allowed a shift in understanding of a particular psychiatric diagnosis from “a mysterious disease of the individual mind” to a “specific pattern of communication” (p. 215). A double bind situation is contingent upon a communication system that is inherently distorted through the denial of the messages sent to another, which, when responded to at face value, will invariably be denied, a condition analogous to an unresolvable contradiction or paradox. Responses to such paradoxes often lead to active attempts to search for clues to find meaning and make sense of the paradoxes through odd and unrelated phenomena. Therefore, Bateson argues that “an essential ingredient of a double bind situation is the prohibition to be aware of the contradiction involved”, either through a constraint around being able to comment on the contradiction or through secrecy and deception (p. 218). Such conditions are noted for their ability to provoke feelings of helplessness, fear, exasperation, and rage as a general reaction from anyone in response to repetitive situations of meaning denial (p. 221).

Bateson (1972) summarized the characteristics of abnormal patterns in communication in a double bind context as implicating trauma resulting from repeated experiences within a double bind structure that eventually shapes habitual expectations and consequent alteration in communication patterns. The traumatic experience in Bateson’s theory is not contained in a particular episode, but rather in the continuation of an inability to resolve the contradictions of messages or escape the double-bind frame which then “double-binds the double-binder” as manifested in self-perpetuating communication patterns and habitual expectations in regards to human relationships and the world more generally (Watzlawick, et al., 1967, p. 214-215).
Paradox and contradiction as a characteristic of human communication systems inherently challenge apparent reality, thus stimulating the search for meaning and explanations of contradictory messages, which if not resolved can greatly impact interaction, affect behavior and sanity, and challenge beliefs about consistency and soundness of world (Watzlawick, et al., 1967). The double bind theory sought to offer “formal description of the sequences of experience which would understandably train the individual in his peculiar distortions of communication” that would produce related “transcontextual syndromes” which confuse logical types, levels of abstraction, and distinctions of contexts. The double-bind hypothesis is an alternative to psychological explanations of abnormality accomplished through shifting the focus towards understanding the communicative conditions and specificities of the contradictions in context and interaction that literally “make people crazy”. In effect, Bateson is arguing that being “trapped” or somehow unable to resolve the contradictory messages is constitutive, in part, of the “traumatic experience”, consequently preventing an individual from having a correct interpretation and corresponding experience, which in effect, continually disconfirms and negates sources of self. This experience is relayed as “the pain which human beings would feel if continually proven wrong whenever they had been wise” (p. 241)

In summary, Bateson, Watzlawick, Jackson, and Beavin were looking for an “etiology involving multiple levels of trauma” involve sequences of events, meanings around those events, and the “structure” of contradictions in commands and orders of communication that when “played against each other generate this particular pathology in this individual” (p. 196, 198). The “traumatic constellation” as Bateson referred to the communicative context characterized by “double bind” communication sequence, was believed to be in part responsible for schizophrenic reactions and distortions. He provided much evidence that schizophrenic
symptoms could be induced and produced temporarily in normal subjects through replicating these conditions in group communication configurations. On the basis of this theory, he theorized a way out involving the opportunity for the “resolution of the contraries” which translated into a therapeutic application of a therapeutic ‘double bind’ amenable to resolution. The crux of the double-bind theory is based on two assumptions: first, that, “severe pain and maladjustment can be induced by putting a mammal in the wrong regarding its rules for making sense of an important relationship with another; second, that if the pathology can be warded off or resisted, the total experience may promote creativity (1972, p. 278)

Contrary to a-historicized and de-contextualized understandings of the impacts of trauma on its subjects, I have offered alternative perspectives that reposition the subject, their experience, and the context back into intersubjective understandings and communication theories that account for the role that human meaning and relationships have for explaining the traumatizing experience. Along these lines, Ekeland (2010) claims that psychiatry has eliminated the ‘subject’ from their quest for knowledge and has become a discipline without a subject. And herein lies the problem. More contextualized and concrete understandings of the impact and experience of trauma as well as the role of communication and human interaction is needed to correct this growing breach between theory and experience that continues to dismiss and misrecognize subjects who are already struggling to come to terms with overwhelming losses, hauntings, and shattering of meaning.

2.7 Conclusions

In short, this chapter has explored how theories and beliefs about psychological trauma are involved in politics over defining the traumatic experience, understanding-interpreting its subjects, and generating public knowledge about trauma that have been source of social,
political, and historically enduring public controversies. A brief tour of just a few of the legal, disciplinary, and institutional controversies illuminated the lack of consensus, struggles over representation, competing histories, problems of public deliberation, and oppositional arguments that characterize the discursive field about psychological trauma and its subjects. As a communication phenomenon, debates about the reality of trauma highlight how competing interpretations and meaning invoke the study of trauma into a ‘war of positions’, further illuminating the conflicts between experiential, cultural, and scientific opinions and ways of knowing (Herman, 1992, Friedman et al., 2011). As a result, the great divide between theory and experience becomes more evident and socially divisive.

Trauma and its articulations get to the heart of struggles over meaning, interpretation, and its representation that involve radically different accounts and a disjointed history. Survivors of trauma and its epistemologies have long been subject to marginalization, stigmatization, and misrecognition. Trauma in this sense is also a stigmata, symbolically and empirically, as represented through diagnostic category, physical scars and injury, an alteration and violence upon one’s social body (either in position or ethos), or a radical absence or loss of time, identity, meaning, and history that prevents one from participating in the realm of everyday and ordinary life. Shifting towards a communication perspective entails changing the dimensions of contrast and reconfiguring the theoretical and lived contexts of communication that have systematically become abstracted from historical apprehension and narrative coherence.

The push for objective explanations are often at odds with the experience of traumatized subjects’ requests for therapeutic support that invokes questions of marginalization, misrecognition, and agency in mental health contexts (Grey, 2007). The space between represents the ‘limits of objectivity” that constitute a crisis of representations (Laclau & Mouffe, 1986).
1985), summarized by Scott (1976) as indicated when the “attitudes of science leave experience incompletely understood” (quoting Gadamer, 1975). I have utilized critiques of psychiatric discourse as a springboard from which to explore significant histories, contexts, and exclusions of representations of trauma in order to envision an alternative terrain of the sayable and thinkable.
Chapter 3: Archaeological Theory as Method: An Attitude and Strategy for Approaching History in Context

The last two chapters outlined interdisciplinary research suggesting the prevalence of academic, cultural, and institutional discourses implicating conditions of controversy, competing perspectives, and stigmatization around individuals suffering from post-combat, post-violence, post-captivity, post-rape, and post-atrocity traumatic reactions. In search of a bridge between disparate literatures about psychological trauma from a communication perspective, I advanced the argument that psychological trauma and its subjects are not only engulfed in cultural, medical, and public communication about trauma and its controversies, but also pointed to research suggesting that the impacts of trauma may be influenced by and evidenced in discursive discontinuities, incoherence interruptions in narrative and normative communication.

The aim of this chapter is to present Foucault’s archaeological discursive methodology as a fitting theoretical and historical method for apprehending discourses around, about, and of psychological trauma and its subjects in relation to dynamics of stigmatization. Due to its constitutive interest in historical transformations, continuities, and discontinuities characterizing fields of knowledge, the archaeological method as it is outlined in The Archaeology of Knowledge (1972) lays out a theory and method amenable for analyzing the emergence and intersections of discourses across social, cultural, political, and scientific domains that constitute the realm of the sayable, the thinkable, and knowable. While it is important to note that archaeology is analytically distinguished from attempts to offer a general history, Foucault’s general guidelines of archaeological analysis provide a conceptual and technical methodology for approaching historical trajectories of discourses as they relate to the emergence of what is accepted as knowledge in public, cultural, and scientific spheres. As noted by Dupont & Pearce
(2001), Foucault’s *Archaeology of Knowledge* has remained a relatively neglected (in comparison to his later works) theory and methodology in research application. Perhaps, this neglect may result from the difficulty in translation and theoretical abstraction, as Dean (1994) writes “to speak of following ‘Foucault’s methods’ is as paradoxical as speaking of ascending stairs or cascading waterfalls in the graphic work of M.C. Escher” (p. 2).

Nonetheless, despite the difficulty of Foucauldian methodological codification, this chapter will cover four important trajectories and starting points for understanding and applying archaeological principles. First, I explore why it is an appropriate method for studying historical, cultural, and scientific communication about psychological trauma and its subjects, particularly in the context of investigating the dynamics of stigmatization and de-stigmatization as a product of both knowledge and communication. Secondly, the epistemological underpinnings and trajectories of Archaeology will be discussed in terms of the guiding premises about theory, subjectivity, and epistemology shared by poststructuralism in general, and by a specific branch of critical rhetorical studies. Thirdly, in the attempt to contextualize an application of Foucault’s archaeological method, I will touch upon how Laclau & Mouffe (1985) utilized archaeological concepts in their development of Articulation Theory and analysis of hegemony. Lastly, I explore elements of the method found to be useful conceptual starting points, guiding principles, and technical touchstones for approaching the social construction of epistemologies. In conclusion, I rephrase the research questions through the methodological terminology and discuss some implications for extended applications.

3.1 Trauma and Stigma over Time: A Fragmented and “Underground” History

Building on Herman’s insight and claim that the history of the study of psychological trauma bears an ironic resemblance to the conditions it seeks to describe, this research
approaches scientific discourse about psychological trauma and its subjects as another form of communication as an object of inquiry and analysis. Because the literature review suggests a historicity to this pattern, the history of communication around trauma related subjects becomes a site of investigation as well. Therefore, to investigate stigma is essentially to investigate the communication, past and present, believed to be productive of it.

In the effort to further interrogate and explore this history, the research questions are attuned to exploring how and what kind of communication influences stigmatizing patterns, as well as, how and what kind of communication has intervened in this pattern. First, due to the complex layering of communication around, about, and of psychological trauma and its subjects in numerous spheres of opinion, belief, judgment, and knowledge that contribute to dynamics of stigmatization, a relatively complex historical method can more adequately address the open ended and expansive research questions. This method can detect more implicit forms of stigmatization and historical meanings masked within the psychiatric legitimacy of therapeutic discourse. Discursive contexts are inescapable frameworks of the stigmatization phenomenon as connected to discursive and symbolic constellations that propagate enduring histories and repetitive questions about the character, nature, and body of survivors of trauma. The critical impacts are also found in the contexts around the subject inscribed in forms of recognition that assign meaning and place to stigma and trauma’s trajectories. These contexts are part of the ‘discursive formations’ of trauma that have implications for how subjects of trauma and their distresses have come to be recognized, known, and symbolized, thus, inciting psychiatric history as a site for further exploration of the enduring trauma-stigma configuration.

Second, Herman (1992) makes a correlative claim regarding the under-examined historical and epistemological parallels about the role of history in the pathologies of survivors of
psychological trauma and the field of psychiatry that has traditionally studied psychological trauma. She writes:

The study of psychological trauma has an ‘underground’ history. Like traumatized people, we have been cut off from the knowledge of our past. Like traumatized people, we need to understand the past in order to reclaim the present and the future. Therefore, an understanding of psychological trauma begins with rediscovering history...Repression, dissociation, and denial are phenomena of social as well as individual consciousness (p. 2).

The research implications of the parallel trajectory of the history of traumatized people and the history of psychiatric studies of psychological trauma notwithstanding, processes of “repression”, “dissociation”, and “denial” do not have a psychological “equivalent” in archaeology. However, archaeological analysis is aimed towards the surface of discursive appearances or absences; therefore, it becomes possible to analyze discursive exclusions (denial), dissociation of ideas in discourse, and discursive movements that do not integrate (repress) particular discourses into their “official” conceptual configurations. One of the sensitivities of archaeology analysis is closely attuned to what is “not said”, explained by Foucault as, “It is supposed therefore that everything is formulated in discourse was already articulated in that semi-silence that proceeds it, which continues to run obstinately beneath it, but which it covers and silences. The manifest discourse, therefore is really no more than the repressive presence of what it does not say; and this hollow that undermines from within all this is said” (p. 25).

The connection between the history of the study of psychological trauma and the expressions of psychological trauma, as articulated by Herman, provide a strong argument for utilizing a historical method amenable to analyzing how discursive movements, absences, and changes in theoretical formations shape the development of a history. McKerrow explains (1989)
that such a discursive approach identifies “absence as important as presence in understanding symbolic action.....meaning is relational within an ideological system of presences and absence (p, 107, referencing Hall, 1985, p. 109). The history of the concept of trauma as a psychological-psychiatric object of empirical research has arguably shared a disjointed and elusive history that, similar to the discourse of traumatized subjects, is characterized by explosions, fragmentation, and downright disappearances from the discursive field.

Herman (1992) further describes the empirical and theoretical history of the study of psychological trauma as displaying an “intermittent amnesia ....provok(ing) such intense controversy that it periodically becomes anathema” (p. 2). The dialectic of trauma is a useful heuristic for noticing shared patterns in the history of the communication of trauma and the communication/theorizing about trauma, which simultaneously reveals and conceals its presence and history as described by Herman (1992). Accordingly, this dialectic is able to note discontinuities in its discursive history of the representations of representations. As Caruth (2006) has claimed, Sigmund Freud (1939) “carefully linked trauma as an object of study to the nature of the study itself”, as evidenced in the structure of writing about traumatic histories, making a strong case that Freud was suggesting that “trauma and its theorizing cannot be separated and that this is...the very heart of, its insight (Pozorski, 2006, p. 79, Caruth, 2006).

Conceptually connected to “repression”, “dissociation”, and “denial”, the notion of silence is integral to Foucault’s theoretical development of a discursive formation and the archaeological method, which posits silence as a movement in a larger formation. Foucault states, “I do not question the discourse for their silent meanings but on the fact and the conditions of their manifest appearance; but on the transformation which they have effectuated... on the field where they co-exist, remain, and disappear. It is a question of an analysis of the discourses
in their exterior dimensions” (1978, p. 15). The assumption here is that what appears on the surface as a moment in discursive articulation simultaneously conceals an un-articulated element or difference in the “dialectical intelligibility” of a history of a concept or a phenomenon, able to be known through movements of unity and fragmentation (Bhaskar, 1993, Laclau & Mouffe, 1985, p. 95).

However, archaeological analysis begins with detailed, explicit attention to statements as stated in discourse and discursive events. Through such an analysis, Foucault explains that “Archaeology defines the rules of formation of a group of statements….it seeks to shows how a succession of events become an object of discourse, are recorded, described, explained, elaborated into concepts, and provide the opportunity for a theoretical choice” (p. 167). A discursive formation is characterized by regularities in patterns and relations between elements of discourses that appear on the surface of discourse that is not limited to one domain of discourse or one particular time period. More specifically, Foucault (1972) states:

Whenever one can describe , between a number of statements, such a system of dispersion, whenever, between objects, types of statements, concepts, or thematic choices, one can define a regularity (an order, correlations, positions, and functionings, transformations), we will say, for the sake of convenience, that we are dealing with a “discursive formation”…the conditions to which the elements of this division (objects, mode of statement, concept, thematic choices) are subject to what we call the rules of formation. The rules of formation are conditions of existence (but also of coexistence, maintenance, modification, and disappearance) in a given discursive division” (p. 37).

The stigma-trauma association, then, can be understood as a discursive formation in its regularity of dispersion across time in social, academic, and institutional discourse, embedded in
conflicting representations and tangential trajectories of explanation and transformations. As Huyssen (2003) has suggested, trauma is embedded in a thick network of discourses that have elevated it to that of a master signifier, which provides (an inadequate) source of its own explanation, thus suggesting the necessity of contextualizing its discursive formation. For example, the concept of trauma has undergone quite a few articulations and changes over the course of its history. Its historically situated meanings have at times stigmatized and demoralized, and at other times served as a springboard from which to establish common ground and as a platform for discussion about human rights, violence, responsibility, and (mis)recognition (see Scott, 1990).

Therefore, the research questions are aimed towards identifying the regularity of related elements across and between discourses that invoke trauma and its subjects in ways that subject the topic and the individuals’ into a configuration that stigmatizes, rather than understands. Particularly, in relation to military PTSD and problems of stigma, my original inquiry emerged out of a rather naïve and “presentist” perspective, but through archaeological research, has recast what appeared to be a contemporary problem under the light of historical interrogation and insight. Given the volumes of scientific research confirming the positive correlation between extremely violent, stressful, and traumatic experiences and human difficulties recovering from these impacts, I simply did not understand why many military service members were not initially getting the help they needed upon their return from combat, why the V.A. was “overwhelmed” and surprised by these seemingly predictable post-war demands on their time and resources, and why there were so many attributions of military, cultural, social, and self stigma in relation to this problem. The operating assumption in my questions is also a guiding question of archaeological analysis that proposes, “why this configuration and not another?”.
Through tracing the historical lineage of trauma’s articulations over time, it becomes possible to epistemologically and historically investigate this contemporary configuration.

3.2 Epistemological Connections and Theoretical Trajectories: Post-structuralism, Problems of Doxa, and Epistemic Rhetoric

*Post-structuralism and the Role of Theory*

Archaeology is situated in the broader genre of French Post-structuralism and other social constructionism projects that have in general terms, been concerned with, “How do systems of knowledge about kinds of people interact with the people who are known about?” (Hacking 1995, p. 6). Taken further, this question is additionally influenced by the historical context of theoretical formations that seeks to show how “the object of understanding changes according to the conditions in which it was grasped” (Weberman, 2000, p. 45). As a theory driven methodology, archaeology aligns with other French social theories of discourse associated with post-structuralism and post-marxist epistemologies that summarize the role of theory as a practice that aids in critique and intervenes in discursive articulations.

This position general adheres to the intervening role that cultural and theoretical analyses possess through “piercing the veil of illusion and opacity” that maintains the ‘natural’ order of things through common sense and dominant formations of knowledge, particularly in what Foucault refers to as the “Sciences of Man” (Foucault, 1972). The goal of theory and the critic, then, is to ask how common or dominant meanings “came to be”, what was excluded in their formation, and, through analysis, to reclaim the divisions, contexts, and politics of such exclusions. To do this, however, the theoretical and historical exploration often requires going “off-road” to recover the elements involved in the construction of a particular formation, its appearance as real, its silences and exclusions. In alignment with Bourdieu (1977), the corrective to the unquestioned validity and naturalness of dominant interpretations can only
occur “when the dominated have the material and symbolic means of rejecting the definition of
the real that is imposed on them through logical structures reproducing social structures (i.e. the
state of the power relations) that lift the (institutionalized or internalized) censorships which its
implies, i.e. when social classifications become the object and instrument of class struggle can
appear as such....which mark(ed) the passage from doxa to orthodoxy” (p. 169). It is in this
spirit that the work of theory becomes a significant communication and reconstructive practice.

Deconstructing Doxa and Epistemic Rhetoric

Another attribution assigned to themes in French Post-Structuralism is its interest in
unmasking the political function of common sense that is concealed in the construction of
knowledge and opinion. As developed by Laclau (1977), “common sense” is integral for
understanding how a particular social order maintains its appearance as natural and necessary,
explaining that, “common sense discourse, doxa, is presented as a system of misleading
articulations in which concepts do not appear linked by inherent logical relations, but are bound
together simply by connotative or evocative links which custom and opinion have established
between them” (p. 7). Common sense, then from this perspective, becomes a fabric in our own
systems of interpretation and discourses employed to talk about the world. Relatedly, Bourdieu
(1977) conceptualizes doxa as the intersection between the subjects’ embodied history or habitus
and the field of discourses and practices. Doxa, then, becomes a site of deconstructing the
common or taken for granted knowledge assumed to conceal the formation and maintenance of a
social order, especially class and social distributions. The epistemological analytic of doxa can
be applied to popular and dominant ‘scientific’ theories, vernacular opinions and beliefs in
‘culture’, and individuals’ reservoir of commonplace, unexamined positions and understandings.
This authority of a theoretical discourse, as explained by Hariman (1991), “activates a pattern of
thinking which is profoundly social and gives symbols power in a society” exhibiting its power through establishing the “conditions of knowing” (p.41-42). Hariman argues that theoretical critique should be grounded in a reconceptualization of “doxa as created by acts of concealment” in a dynamic of authorizing and marginalizing that guides “what we believe, what we know, and what we believe to be true” (p. 46). *Doxa* is further conceptualized as the “inter-subjective reality of rhetoric” involved in a complex of relations of regard, ranking, and concealment that is located within a topography of authority (p. 48).

Insights from critical-cultural and rhetorical theory utilizing discourse and rhetorical analysis have converged to explain not only the construction of *doxa* of a theoretical construct or formation, but also the *doxa* of practical and cultural knowledge that construct what comes to be known as “common sense”. From this perspective, problems related to knowledge and understandings are explored in the contexts of theoretical concepts, lived experience, and as a social topos of opinion and controversy. As a way to approach the intersection of these domains constitutive of the *doxa* and sociality of knowledge, Hariman (1991) invokes *doxa* as an object of rhetorical analysis in order to “situate the ontological claims with a social history of discourse and a dialect of authority and marginality. The constitutive contribution would be to re-formulate the concepts of being with the activities of the logos as understood through the concept of *doxa*....one should begin by locating the subject and its rationale with a topography of authority (p. 47-48). Contextualizing the concealment of *doxa*, then, involves grasping the field of discourses that surround and provide points of differential positions, which according to Hariman (1986) is located in the “un-discussable” that he, following Bourdieu (1977) references as *doxa*’s concealed status in acceptance and taken for granted understandings.
Concurrently, as Bourdieu suggests, the phenomena of *doxa* is not apolitical, rather it oftentimes functions as a systemic and symbolic form of misrecognition and exclusion. Specifically, the interface between principles of divisions, corresponding ontological categories, and the subjects’ misrecognized, yet legitimated identity, comparatively operate according to what he refers to as the ‘theory effect’, which is similar to a self-fulfilling prophecy within a closed system of knowledge (1977). In other words, this interface produces people in alignment with these categories, divisions, and misrecognitions. Judith Butler (1997) extends the understanding of this process in closed systems of interpretation or a social totality, claiming that it depends upon the active operations of censorship. Butler’s notion of implicit censorship explains that “censorship seeks to produce subjects according to explicit and implicit norms, and that production of the subject.....takes place not only through the regulation of speech, but (also) through the regulation of the social domain of speakable discourse”...and that which constitutes the “domain of the sayable”(p.134). Poststructuralist and social constructionist discourse theory are particularly useful for analyzing how *doxa* and the commonplace lie politically dormant through the unchallenged naturalness of the social world and its theories. Within this frame, common sense or practical knowledge is theorized as a form of ideology linked to the subject who is conceptualized as political site for the maintenance and change of a historical configuration.

Along these lines, Stuart Hall, a critical-cultural studies theorist, claims that these theories have opened up the ideological answer to the question of interpretation and, “asks how ideology discovers its subject rather than how the subject thinks the necessary and inevitable thoughts which belongs to it; it enables us to think about how an ideology empowers power, enabling them to begin to make sense of or intelligibility of their historical situation” (2005, p
141). The subject, then, becomes a context to study ideology and concealed structures of knowledge. The materiality of a discourse can therefore be extended to include “diverse subject positions (that) appear dispersed within a discursive formation” (Laclau & Mouffe, 1985, p.109).

In rhetorical theory, Foucault’s work has been appropriated under the larger project of “epistemic rhetoric” and more specifically in connection with the project of “critical rhetoric” (McKerrow, 1989, Beisecker, 1992, Condit, 1994, Greene, 1998, Phillips, 2002). Scott’s (1967) seminal essay, _On Viewing Rhetoric as Epistemic_, set forth a pluralistic theory of knowledge positing a relationship between rhetoric, knowledge, and ethics, which sparked an ongoing conversation on types of knowledge, how we know, and the role of the rhetorical critic in identifying, constructing, and deconstructing knowledge claims alluding to the good, the true, and the beautiful. These analyses extend the terrain of epistemological analysis to include what is not said, excluded, or represented in a manner that exceeds literal, unilateral, and symbolic-material interpretations. As McKerrow explains, “what is constituted as ‘real’ is not only so structured through discursive practice. What is perceived as real to the populace in economic, social, and political terms---is also created in non-discursive ways” (1989, p. 103).

A notable example of this type of analysis that implements relevant principles of articulation can be found in Hariman’s (1995) aesthetic analysis of political styles, which explores these as a typology of social tropes involving a complex economy of meaning and symbols in representations of knowledge.40 These studies extend the field of meaning to include the interaction of symbols, environment, and history demonstrating that silences are important and context are clues to understanding what cannot be said.

In summary, this section has explored general trajectories associated with and in extension of constructionist and epistemological premises underpinning Foucault’s
archaeological project in order to situate it in a larger field of critical discourse studies and related conceptual configurations. The next section offers concrete example of how Foucault’s archaeology has been analytically applied and advanced into a theory of political and social change.

3.3 Articulation Theory: Applied and Political Archaeology

In order to contextualize how archaeology has been applied in analysis, the development of articulation theory as explained by Laclau & Mouffe (1985) will be excavated as it relates to Foucault’s archaeological method of studying discursive formations, particularly in its ability to identify the material and symbolic contexts that form the substance of an apparent unified entity. Articulation Theory as a method will be discussed as a technique for identifying components and logics of a discursive formations and strategies for their transformation. As Laclau & Mouffe (1985) claim in the beginning of their analysis, their aim is to “establish an “archaeology of a silence” (p. 7). An overlooked aspect of Laclau & Mouffe’s work, I contend, is how Foucault’s archaeological method was utilized to perform an analysis of the theory and discursive formation of ‘hegemony’, which demonstrated a dialectical relationship between a social theory and a social form. Articulation theory has been more generally understood as a method and strategy of democratic social movements and institutional change (Deluca, 1999, Slack, 2005).41

However, upon closer review, Laclau & Mouffe (1985) advance Foucault’s archaeological approach to understand how discursive formations evolve and transform over time. Responding to the theoretical and political obstacles posed by critical theories of ideology, Laclau & Mouffe (1985) demonstrate articulation theory’s ability to deconstruct theoretical and political unities through reconfiguring the elements of their discursive formation from within the postmodern logics of contingency, crisis, fragmentation, difference, and discontinuity. Its
A foundational approach is framed in terms of an “articulatory practice” that intervenes in a previous discursive formation capable of pierce(ing) the “material density” of a “discursive formation”, as inter-connectively structured in “institutions, rituals, and practices”, “discourse” (what is said), enumerative discourse such as “figurative language, metaphors and the symbolic”, and discursive systems of thought (Laclau & Mouffe, 1985, p. 109, Foucault, 1972).42

Using Foucault’s archaeological method to deconstruct the discursive formation of “hegemony”, Laclau & Mouffe (1985) demonstrate the transmutation of a concept from its place in totalitarian logic to one that eventually became a pivotal concept in the discursive constellation of a democratic political movement. For example, Laclau & Mouffe (1985) traced the concept’s genealogy to argue that Gramsci elevated the prior uses of the term to one that became the unifying concept in understanding a concrete social formation (1985, p 7). As they explain, “The concept of ‘hegemony will emerge precisely in a context dominated by the experience of fragmentation and by the indeterminacy of the articulations between different struggles and subject positions” (p. 13). They further articulate Gramsci’s hegemony as a response to a crisis of a pre-discursive absence in history which eventually gave way to a concrete and conceptual possibility of rearticulating material conditions through a transformed theory of hegemony.43 This logic is an integral dynamic to understanding the explanatory force that hegemony came to assume in democratic politics and as a pivotal theory of power and social relations. Their argument highlights that the concept of hegemony transmuted from a descriptive, conceptual term to one that, through a series of discursive and political changes, performed a theoretical intervention through offering a language and position from which to interpret a previously unnamed crisis and totalitarian colonization of systems of meaning and interpretation (Laclau & Mouffe, 1985).
Hegemony, then, formed a positive foundation from which to re-articulate a description of that experience, engage in struggles over meaning, and define reality. This shift, they argue, became possible on the grounds of fragmentation, crises, and discontinuity in histories that created a space that needed to be signified, stating that “the concept of hegemony fills a space left vacant by a crisis”, resulting in an eventual “conversion of hegemony into a theory category” (1985, p. 48-50). Similar to the place and position hegemony assumed in a political economy of ideas, I contend that psychological trauma as a concept is “not determinable location with the topography of the social”, in other words, it has no object referent, but, in a comparable manner to hegemony, describes “a political type of relation or form (1985, p. 139), thus the relations, contexts and subjects become integral to it political construction. The similarities between the hegemony and psychological trauma are sufficient on the grounds that both terms have a discontinuous lineage, both describe a social experience previously characterized by a lack or absence of assigned meaning, and emerged as a political logic from which to articulate grounds to challenge the existing social order.

In the case of PTSD, before Freud’s formal articulation and discursive association of trauma to the psychological realm in the late 1800’s, trauma had been used to denote a damaging physical injury. By 1980, Posttraumatic Stress Disorder was included in the DSM-III and predicated on the psychological impact of a traumatic event. Its instantiation is understood as a symbolic form of political and medical recognition for Vietnam War veterans and survivors of sexual trauma and perhaps more importantly, as a political platform that entitled debilitated survivors to fiscal, educational, and social support (e.g. disability compensation, G.I. bill, V.A services) (see Scott, 1990, Herman, 1982). In this sense, hegemony and psychological trauma demonstrate how concepts transform over time through discursive shifts and historical breaches
that emerge into political theories and demands for social justice capable of providing inventive
grounds for intervening in new logics and subject positions from which democratize normalized
political processes.

In summary, Laclau & Mouffe (1985) specify the conditions of possibility that gave way
to the conceptual formation of “hegemony” which eventually exploded into a social theory and
political logic that broke new ground from which to interpret crisis that established a language
and logic of struggle. Through performing an archaeological analysis of the terms, contexts,
subjects, and logics integral to hegemony, Laclau & Mouffe (1985) trace the term’s
transformation from a naturalized state of class relations and place in totalizing Communist
discourse to its transformative linkage to democratic politics. They demonstrated how to use
archaeological analysis to break apart the apparent unity of a “discursive formation” into its
elements, trace its conceptual movement from one discursive constellation to another, and
explain how a concept became transformed into a political theory of oppression. Through this
analysis, Laclau & Mouffe were then able to describe these elements in terms occupying a space
opened by political crisis and social fragmentation, and then analyze how they came back
together in unexpected ways to form positions from which subjects unite, on the basis of the
rights and violations thereof inscribed in the discourse, to participate in a social and political
movements towards democracy. As Sartre says, “words wreak havoc, when they find a name for
what had up to then been lived namelessly”, explained by Bourdieu (1977) as “‘private’
experiences undergo nothing less than a change of state when they recognize themselves in the
public objectivity of an already constituted discourse, the objective sign of recognition of their
right to be spoken and to be spoken publicly” (Sartre quoted in Bourdieu, p. 170). I suggest that
psychological trauma is emerging into a similar discursive position as hegemony. However, the
still unanswered question concerns what is concealed by the discourse of psychological trauma, which will be explored throughout this research. However, in light of this analysis, analytic attention is turned towards the political conditions of its production that cannot be divorced from relations of domination, power, and ideology of denial, and how these conditions are formative of traumatized subjects.

3.4 Applications and Strategies of Archaeological Analysis

_The archaeological description of discourses is deployed in the dimension of a general history; it seeks to discover the whole domain of institutions, economic processes, and social relations on which a discursive formation can be articulated......what it wishes to uncover is the particular level in which history can give place to definite types of discourse, which have their own type of historicity, and which are related to a whole set of various historicities._

Foucault, Archaeology of Knowledge, 1972, p. 165

This section will draw upon Laclau & Mouffe’s application of elements of archaeological analysis, Foucault’s explanation of its sensitizing and guiding analytics, and my reading of Archaeology of Knowledge (1972) to provide starting points from which to begin to implement archaeological theory and method to analyze the discourses and discursive formation of trauma. While this excavation is not meant to be explanatorily comprehensive, I will touch upon principles and techniques that have proven to be useful in application. As Dean (1994) claims about Foucauldian archaeology, “methodological codification….is best regarded as a summary that revisits and clarifies analysis after the event, rather than a rationalistic plan to put them in practice by analysis” (p. 2).

One of the general guiding analytics offered by Laclau & Mouffe (1985) in their application begins in the attempt to break up ambiguous and abstract terms into their social or conceptual configuration, such as ‘society’, “hegemony”, “ideology”, “institutions” into concrete relations. This strategy breaks down a totalized term and formation such as a “system” to its aggregates and components, such as forms of organizing, practices, and agents (1985, p. 103).
For example, the hegemonic formation, as explained by Laclau & Mouffe (1985), “cannot be referred to the specific logic of a single social force. Every historical bloc--- or hegemonic formation --- is constructed through regularity of dispersion, and this dispersion includes a proliferation of very diverse elements” (p. 142). Therefore, one of the tasks is to identify the elements in a particular formation according to their “regularity of dispersion” which implies a pattern of discursive repetition in the “field of discourses”. A key element here is the term “dispersion” meaning that the patterns of regularity in discourses are not neatly found in one consolidated domain of discourse, but rather that their elusive occurrence spans across temporalities, texts, statements, and fields of discourses. In order to identity and make a claim to a “discursive formation”, one must show such a regularity in discourse, a regularity that is assumed to be elusively patterned and dispersed. For example, in order to demonstrate a historical pattern of stigmatization of survivors of trauma as discursive formation, then one would have to show a dispersed regularity of these elements dispersed over time through “reference to the same objects, common style in the production of statements, constancy of concepts, and reference to a common theme” (Laclau & Mouffe, 1985, p. 105).

Clearly, these elements overlap with Focuault’s identification of the four elements of a discursive formation that constitute the formation of objects, subject positions (enunciative modalities), concepts, and strategies (themes and theories) in a discourse that occur across a set of statements that are not necessarily unified or coherent in temporality, geography, or proximity of sequence. A slight distinction, however, lies in the difference between what Laclau & Mouffe refer to as “style” and what Foucault refers to “enunciative modalities”. In Laclau & Mouffe’s brief summary of enunciative modality, it refers to the style used in the production of statements, for instance, in what Foucault explains discursive characterized by “qualitative descriptions,
biographical accounts, …interpretation, reasonings by analogy, deductions, statistical calculations, experimental verifications” (1972, p. 50). It also refers to the question of “who is speaking”, in the sense of rights and status of the speaker of the discourse, and perhaps more importantly, how the “style” of discourse positions the speakers and subjects exposed to the discourse as subjects in relation to how discourse organizes subjectivity. Foucault (1972) explains one aspect of the enunciative modality in terms of “the various statuses, the various sites, the various positions that he can occupy or be given when making a discourse” in a “field of regularity for various positions of subjectivity” (p. 54-55). He uses the example of how a subject, in relation to, for example, “grid of explicit or implicit interrogations, he is the questioning subject and, according to a certain programme of information, he is the listening subject…” (p. 52).

This element of the discursive formation is particularly relevant for the question of stigma and trauma in the sense of asking how do discourses of trauma position the subjects who are speaking or implicated in the discourse to occupy stigmatizing or stigmatized subject positions. For example, when troops are questioned and assessed through a battery of diagnostic tests to determine their level of traumatization, how does the diagnostic discourse position the subjects’ as being questioned and the questioning assessors as interrogating subjects? How did the discursive practices of the V.A., that perhaps inadvertently, resulted in long delays before contact with the veterans, requiring numerous visits and assessment processes before authorization to therapeutic care or monetary compensation position the subjects as dismissed subjects? How does the practice of pharmaceutical treatment versus social support position the subjects as neurological subjects as opposed to a speaking, thinking, feeling, and social subjects? How do these practices position doctors to be surgical or injecting subjects, rather than listening
and understanding subjects? How did the discursive practices in Charcot’s hysteria experiments position the patients as performing and imitating subjects? How did religious discourses accusing women of demonic possession and witchcraft position the women as evil, carnal, and conniving subjects? In this manner of apprehension, archaeology is in search of “formal analogies or translations of meaning...at the level of the context or of the situation, their effect on the speaking subject”, and the conditions of a discourse’s conditions of emergence, insertion, and functioning (p. 163). How discursive events and practices socially positions and constructs the “who” of subjects in the discursive field is one of the valuable analytics of archaeology that is especially attuned to understanding how discourse produces social stigma through such discursive positioning?

Subject positionalities, concepts, and object positivities are also defined in relation to what they are not. For example, Laclau & Mouffe explain that elements in discursive formations consist of an “ensemble of differential positions”, meaning that these are predicated on a discursive system of “articulated totality of differences”. One of the ways Laclau & Mouffe (1985) clarify how to approach discourse more generally, yet more specifically than Foucault is by explaining that “discourse as a system of differential entities...of moments” that are situated within the terrain of a “field of discursivity” (p. 111). This distinction is important for situating the relevance of discourses and how they function according to how they perform differentiations and equivalences that establish meaning in a field of relations. For example, “psychological trauma” gains some of its meaning in relation to what and how it is distinguished from “physical trauma”. This is not an inherent difference, but rather has been established through ways of making discursive distinctions. When one uses the term “psychological” to describe trauma, it is therefore being distinguished from physical trauma, even through one does
not have to make the distinction explicit because the distinction has already been established as a differentiating factor in the field of discourses. The notion of the field, understood here as a characteristic of a discursive formation, is the “locus in which symbolizations and effects may be perceived, situated, and determined” (Foucault, 1972, p. 163). A discursive practice, according to Foucault “is articulated on practices that are external to it, and which are not themselves of the discursive order” (p. 164). In this way, terms come to have meaning on the basis of what “they are not” through differential movements and distinctions. Laclau & Mouffe (1985) utilize the terms “moments” and “elements” to distinguish between the difference that is discursively articulated, for instance the “psychological” as a moment, and elements as those “differences that are not discursively articulated”, but that establish the meaning of psychological as distinguished from the unarticulated “physical” as the element.

Themes of a discursive formation, which Foucault refers to as “strategies” are assumed to be constitutive of both themes and theories that operates according to three assumptions. First, that such strategies are choices; second, that such theoretical choices simultaneously include concepts and objects at the exclusion of others; and thirdly, that one cannot glean the strategy without understanding the “discursive constellation” and the web of meaning it engenders (1972, p. 66-67). These are further identified by looking for points of “diffraction” in the discourse that at first appear as “imcompatible” objects, enunciations, or concepts in a discursive formation; or by noticing “points of equivalences” of elements that are situated at the same level of coherence (1972, p. 65). As an example of an incompatible diffraction of equivalencies, how did “hysteria” become equivocated with “suggestibility” and how did “suggestibility” become diffracted as a genetic weakness? A key component of identifying these points and therefore the strategies is particularly when the elements do not initially make sense upon first review.
These themes are also identified by paying attention to the “link points of systemization” that form the “economy of the discursive constellation”, both of which are evidenced by groups of concepts, objects, and enunciations that appear together as positivities in a discourse. Positivities are simply understood as when a topic or theme is present in vernacular, public, political, social, media, academic discourses and texts enough to be a familiar and “present” concept. The meaning of positivities are understood as in relation to other positivities in the discursive constellation. In Foucault’s explanation of the sources of a “discursive constellation” he states, “Hence the fact that, taken up again, placed, and interpreted in a new constellation, a given discursive formation may reveal new possibilities….what we are dealing with is a modification in the principle of exclusion and the principle of the possibility of choices; a modification that is due to the insertion in a new discursive constellation.” (1972, p. 67).

When a term is repetitive enough, it is said to have crossed the “threshold of positivity”, meaning that “the moment at which a discursive practice achieves individuality and autonomy, the moment therefore at which a single system for the formation of statements is put into operation” (Foucault, 1972, p. 186). Positivities are eventually placed in relation to other concepts in a chain or constellation that are established on the basis of connection of similarity or difference. Analysis of points of equivocation, diffraction, and differentiation can also be found by paying attention to when the discourse performs “attribution of innovation, analysis of contradictions, comparative descriptions, and the mapping of transformations” that guide the process of identifying and analyzing elements in an particular articulation (1972, p 138). These operate as surface level discursive indications of the action of articulation as a practice of fixation or dislocation of a discursive formation (Laclau & Mouffe, 1985).
In terms of how changes or shifts in a discursive formation (also referred to a world of ideas) occur, Foucault states that archaeology points out irregularies that eventually become a positivity or have a definitive status in the world of ideas. Analysis can pinpoint chronologically the moment that positivities “are born and the moment at which they disappear” where duration is otherwise omitted in the analysis “as if time existed only in the vacant moment of rupture, in that white, paradoxical atemporal crack in which one sudden formation replaces another.” (1972, p. 166). These two guiding analytics, “synchrony of positivities” or “instantaneity of substitutions” are further qualified as making the “possibility of historical description disappear(s). Discourse is snatched from the law of development and established in a discontinuous atemporality. It is immobilized in fragments: precarious splinters of eternity.” (p. 166). Examples of positivities that have disappeared is evidenced in the term “suggestion”, which at one time, suggestion and suggestibility were pivotal concepts of the discursive formation of hysteria that provides theories of the disease and the cure. The concepts became morphed in WW-I when “suggestion” became diffracted into “cure by persuasion” to treat shell shocked in Great Britain by Babinski, and later into techniques of positive group morale in WW-II, whereby “suggestion” and “hysterical suggestibility” dropped off the discursive map of traumatology altogether. The meaning of the terms also changed and even dropped off the map of concepts once placed in a different discursive constellation.

On the other hand, upon first review of the induction of the “therapeutic community” protocol in the U.S., it initially appeared in revolutionary fashion, only to later discover that the model had been implemented in other place and other times, with different names and for different kinds of problems, but that it did not “appear out of nowhere”. The analysis eventually led to the investigation of what Foucault refers to as the “episteme” that is a broader concept that
a “discursive formation”, which loosely describes and analyzes the relations between social, historical, and scientific discourse, and further guided by a general directive for showing “how a particular object of discourse finds in it its place and law of emergence... , the historical conditions required if one is to “say anything” about it” (1972, p. 44). Analysis of episteme discovers in the field of scientificity during a social and historical epoch a normative and networked enterprise of dispersed discourses linking bodies of thought in interaction. It is guided by questions directed towards how a particular formation came to assume a presence through an analysis of “discursive formations, of positivities, and knowledge”, which Foucault compares to a worldview, but with an emphasis on their relation to a “set of relations between sciences, epistemological figures, and discursive practices” that is an inexhaustible field, yet distinctly recognizable in “discursive regularities” (1972, p. 192). In the case of the therapeutic community protocol, what become evident in studying the field of discourse exterior to its implementation was the degree of overlap in concepts, objects, and subject position in public and social scientific discourse that demonstrated similar democratic interests, modes of critique, and positioning of human subjectivity. These overlaps and concomitance between fields of discourse in different domains, I argue, are indicators of elements of the episteme.

On a more concrete and interconnected level, one can approach the analysis of episteme by asking, as this inquiry does in Chapters 6 and 7: What are new and recurring objects, subjects, and strategies in a discursive formation, for instance, constituting the Therapeutic Community? How do these elements overlap with or show direct association, dissociation, or concomitance with present elements in discursive fields in other domains, for example, the field of social psychiatry, objects of political discourses, themes in other academic texts or cultural discourse? What are characteristic strategies of intervention in problems? What concepts are
used to articulate problems as problems? What could be said in this particular epoch or in a particular discursive domain that would generally be accepted which, for example, would raise eyebrows or not be accepted as a sort of background premise in a different domain or epoch? And further, how do these elements come together to “manifest a set of concepts” and what is their relation to changes and trends in the social and scientific discursive field in a particular historical epoch that makes possible their emergence and relative acceptability?

In working from methodological orientation, four interconnected principles or analytic tools are implicated in the analysis of episteme more broadly or through analyzing a specific contained text. The first tool pertains to analytically reading a collection of texts or book as a “node within a network” stating that “the frontiers of a book are never clear cut: beyond the title, the first lines, and the last full stop, beyond its internal configuration and its autonomous forms, it is caught up in a system of references to other books, other texts, other sentences (Foucault, 1972, p. 24). The second principle assumes that “one cannot speak of anything at any time; it is not easy to say something new; it is not enough for us to open our eyes, to pay attention or to be aware, for new objects suddenly to light up and emerge out the ground” (p. 44-45). The third principle builds on the new objects of discourse through identifying elements of a discursive formation according to a “complex group of relations” at the level of positivity of interconnected discourses (e.g. institutional, economic, social, modes of classification, etc.) (p. 45). A final useful analytic is offered by Laclau & Mouffe’s (1985) guidance for analyzing the “discursive conditions” which gave rise to collective action and new nodal points from which to construct relations of subordination into domination and thus on the basis of democratic discourses was able to intervene in politically dominant discursive formations which have come to be analogous

As far as the usefulness of the archaeological method for historical and theoretical research, it offers an insight and guiding response to the claim that meanings, theories, and histories are discursively overdetermined. Overdetermination is a pivotal concept in archaeology and articulation theory that, in part provide the reasons for conducting these types of analysis, on a theoretical level refers to the plurality of meanings available in the realm of symbolic, the social field and subject positions that are concealed by a lack of “ultimate literality” and signifying differentiations (Laclau & Mouffe, 1985). For instance, secondary literature about primary texts in general dilutes original concepts and details that matter, thus losing some the original meaning of the texts. In its time, for instance, the bulk of Charcot’s theory of hysteria revolved around “suggestion” and “suggestibility” as the nodal point of its pathology and for positioning the research subjects; however, the majority of accounts of Charcot’s version of hysteria or hysteria in general leave out this pivotal concept in its formulation entirely.

Sometimes outright contradictions and blatant reduction of meanings are found when historical accounts are compared to the actual historical texts. In reading theoretical texts about older theories, incongruent accounts offer a strategy and an insight. Literature is saturated with contradictory claims of facts about the people, their contributions, their theories, and how their research has come to be appropriated and valued in contemporary psychiatric discourse, but also reveals lost jewels of theoretical and cultural insight into the formation of scientific opinion and dominant epistemologies and theories that are not inclusive, perhaps even exclusive of elements that were at one time pivotal in their original formation. As an example, contemporary interpretations of Charcot’s and Freud’s research more frequently than not rely on what
“everyone else has said” in ways that abstract their theories from their theories into a watered down version. A useful conceptual compliment to the problems of overdetermined and undifferentiated meanings is Latour’s technique of approaching a text in the effort to “under-determine” common associations by tracing these through a journey between surrounding controversies and apparent certainties (2005, p. 23-26). I have applied this technique at the level of surface of discourses consistent with Foucault’s techniques mentioned in the introduction to this chapter (1972).47

On a more general level, archaeology practice and analysis is guided by a logic of historical contingency based in an assumption that contexts that perform a history’s positivity accessed through excavating concealed discontinuities revealed in apparent unities. Historical breaches and fragments in discourse, then, are used both as an analytic instrument and object of research (Laclau & Mouffe, 1985, Foucault, 1972, p 9). Within the frame, Foucault’s (1972) archaeological method can theoretically and methodologically be extended to discursively trace the formation of a theoretical construct, a scientific-theoretical paradigm, a subject position, political formation through attention to what is said and what is not.

3.5 Archaeology: Recovery of new contexts to study old problems

An archaeological method suggests that trauma as an object of inquiry must first be understood within the topography of what accounts for the object and subjects, categorical divisions, prevalent logics or operant assumptions, from within the language and concepts available related to the discursive formation of psychological trauma in its association with stigma. The problem I have phrased as the ‘stigmatization of survivors of trauma” can be understood in terms of two larger problems, first, is the apparent maintenance of “institutionally organized and guaranteed misrecognition (Bourdieu, 1977, p. 171) that is maintained in
hegemonic-discursive formations. Secondly, I position stigmatization as situated within as an ongoing struggle over meaning and representations of traumatic effects and reactions characterized by discontinuous and contradictory theoretical and experiential histories that have been placed in differential positions and adversarial relation to each other in ways that conceal the social and the political.

From within this frame, quite a few questions arise in relation to the method and the object of research that are presented as principles from which to begin to think in archaeological concepts from a communication perspective that provide specific, as well as, a very broad research program for approaching psychiatric and scientific discourses more generally. These are meant to be instructive, strategic, and concretizing of the method used to approach the discursive field. Specifically, how does a discursive formation produce the domain of the knowable, the sayable and what had to be excluded, silenced, or negated for this particular formation to exist in its present form? In other words, what are the lost elements of a formation and on what logic were they excluded? Another question is concerned with how to find a legitimate entrance into the conversation about psychological trauma that calls into question the logics of the “discourse/discursive formation of trauma” in a manner that transforms the conversation beyond the current debates about psychological vulnerability and effects of trauma towards social-political-historical configurations that naturalize, neutralize, and subvert the field of knowledge about trauma? And thirdly, if this analysis has suggested, the experience and politics of trauma are emerging as a theoretical platform to invoke issues of human rights, equality, and responsibility, then what strategies might be useful in facilitating this project, given what is known about what is able to be known and the historical phenomenon of stigmatization and its
doxastic and orthodoxy forms? Finally, what insights can be gleaned from archaeology as a method for concretizing and re-articulate ‘trauma’s’ horizons of intelligibility?

More general questions to ask concern the theoretical trajectory of trauma. Theoretically, how has trauma as a concept been divided, dismissed, appropriated, and maintained in the conversation about mental illness and PTSD? What are the distinctions? How could it have gotten divided differently and what implications might this have today for how mental illness has been classified? What are the familiar conflicts and comfortable subject positions involved in stigmatization? What is concealed in this conflict? How have discourse and silence functioned together in the stigmatization of psychological trauma? How have linkages between social domains contributed to social attitudes about trauma and its subjects? On what logic were these linkages connected? How were the subjects represented in these time periods?

Politically, if trauma is analogous to hegemony as filling in an unnamed condition or political formation, what are trauma’s antagonisms? What are the conditions of possible intelligibility of antagonisms or what is silenced in trauma’s articulation? In analyzing narratives of survivors of trauma or ethnographic accounts of survivors of trauma, what are the elements and moments of their narrative as an articulation of their history? What was interrupted, fragmented, or negated and how was this accomplished by subversion, metaphor, contradiction, and shifts in sequence that would suggest reductionist practices? In analyzing symbolic forms of narrative accounts in popular or alternative culture, such as film and music, how do these articulations configure or re-configure alterations?

Culturally, how have cultural systems of interpretation and re-articulation opened up spaces for that which was concealed and symbolically transformed fixated moments and elements? For instance, how did the Anti-psychiatry movement and the Veterans-Psychologist
social movement intervene and connect to public and cultural changes? What were the necessary conditions, elements, and relations between elements for this movement to occur? How did these alliances shift the symbolic configuration around dominant meanings and interests that expanded the field of equivalents, how were the boundaries around differences reconfigured? How might archaeology and articulation theories be applied to understand the post-traumatized experience and offer insights for intervening in public and self stigma around the traumatized?

Conclusions and Integration

In short, this analysis has suggested a communication approach to studying psychological constructs and theories from an archaeological theoretical method that studies movement and constructs on the surface of discourse. As an attempt to address to Hermans’s insight concerning the overlap between incongruencies in the histories of psychiatry as a field and the subjects it treats, I have explored how archaeology can analyze these repressions, dissociations, and denials through analogous movements and gaps in the discursive field. In the effort to reclaim these histories, both Herman’s (1992) and Foucault’s (1972) argue that psychiatry history is characterized by fragmentation and numerous incongruencies. Their perspectives diverge, however, in their attitudes towards a narrative reconciliation of meaning and coherence for historical congruence. Whereas Herman looks for an “underground” history believed to have been forgotten in a succession of events, Foucault looks to the surface and space of multiple dissensions of a discursive formation as object and “expanses of effects” (1972, p. 142). Herman advocates the recovery of an honest (speak truth to power) narrative, “reconstructed (as) a coherent system of meaning and belief that encompasses the story of trauma” (1992, p. 213). Foucault, on the other hand, maintains a rather discontinuous and contingent view of apprehending history, whereby “knowledge is allowed to create its own genealogy in the act of
cognition” (1972, p 90). When viewed as complimentary arguments, Foucault and Herman’s representations of the silencing of populations repetitively exposed to institutional psychiatric treatment converge into an epistemological critique of psychological methods, theories, and practices. I contend that when juxtaposed, the two perspectives converge into a dialogical-dialectical tension useful for comparing theoretical perspectives and historical trajectories that converge into a loosely configured partially coherent story of a discursive formation (See Craig, 1999 on constitutive dialogic-dialectical meta-model of theoretical discourse).
Chapter 4: Historical Explosions and Inventions: Hysterical Articulations and Conceptual Trajectories of a Stigmatized Diagnosis

4.1 A New Name for an Old Story: Historical Baggage of Hysteria

“PTSD is a new name for an old story” (Bentley, 1991). Part of that story, I contend, begins with the story of hysteria. According to prominent scholars of psychiatric history, the systematic study of psychological trauma, and the emergence of the trauma component of the Posttraumatic Stress Disorder diagnosis as an object of psychiatric-medical science, was sparked by neurological research and experimentation conducted with female patients believed to suffer from a condition referred to as hysteria (Micale, 2001, Young, 1995, Herman, 1992, McNally, 2003). In an attempt to shift figure and ground, I am specifically interested in exploring how discourses around and about hysteria overlap and intersect with socially stigmatizing discourses around and about PTSD.

This chapter traces the “historical baggage” associated with the conceptual and theoretical lineage of what has come to be known as PTSD. In a sense, this historical discursive exploration is an attempt not only to identify one of the storylines of PTSD in its pre-discursive and pre-diagnostic form, but also to show how concepts, theories, and discourses, associated and disassociated, combined or divided to produce the historically enduring stigmatization around hysteria in order to argue that many of these elements are still in circulation about and within the PTSD diagnosis. Bearing in mind the overreaching research questions addressing historical, cultural, and discursive configurations which have contributed to stigmatization and the PTSD diagnostic formation, this analysis more closely examines the hysteria “heritage” of traumatology, specifically how ideas associated with hysteria, especially those concerning the moral character of the patient, linger around the PTSD diagnosis and its subjects. This analysis frames hysteria as a discursive formation appearing in socio-historical texts and cultural contexts.
prior to its emergence as an object of medical research and formalization as a differential
diagnosis in Hospital Salpetriere in France. Part of the analysis will simply identify terms that
were used in conjunction with the various articulations of hysteria, paying close attention to the
categories and concepts used in the formation of its variant meanings over time, in order to
identify their divisions and associations that have contributed to the stigma or in Goffman’s
(1963) terms, the spoiled identity, of those induced and indicted by discourses around and about
hysteria. Drawing upon ancient Greek uses of the term “stigma” as “bodily signs designed to
expose something unusual and bad about the moral status of the signifier”, Goffman further
conceptualizes stigma as a relationship between an attribute and a stereotype, arguing that stigma
derives from an “attribute that is deeply discrediting” in the sense that the identity of the person
is reduced from “a whole and usual person to a tainted discounted one (p. 1-3).

My intent is not to assemble a comprehensive historical account of hysteria, but rather to
examine how the discursive formations of hysteria have emerged and transformed over time to
maintain or alter stigmatizing discourses around what King (1993) refers to as a “name without a
disease”. That hysteria has been a socially, physically, and epistemologically stigmatized and
gendered “problem” for much of its named existence has been well documented by scholars of
psychiatric history. As evidenced in the actual search for the physical “stigmata” of hysteria, as
well as in the ways it has been talked and theorized about throughout its discursive history, the
social implications of the label have generally remained far from favorable or empathetic. As
scholars of hysteria’s history have noted, its numerous explanatory forms are not only deeply
historically contextualized and variant according to socio-political-cultural conditions, but also,
as positive concepts, have remained strangely present and continuous in hysteria’s discursive

In contrast to historical studies of hysteria with research goals of making claims about the validity, components, or expressions of hysteria as an objective condition, this research approaches hysteria with a sensitivity towards the ideas and concepts that have been pivotal to its formulation(s) and how its discursive forms have changed over time, in relation to specific social and political conditions. As argued by Rousseau (1993), “the discourses of hysteria cannot be viewed as neutral texts generated independently of the considerations of gender, ideology, politics, religion, nationalism and professional authority. . . . (P)roduced under specific conditions at particular historical junctures, these narratives naturally reflect their moment…” (p. 107). Scholars who have approached hysteria from this perspective highlight its changing formulations, as well as the degree to which hysteria as a named formation is embedded in the discourses of its time, noting particularly its transformations of meaning, etiology, and political significance over thousands of years.

Through identifying varying articulations of hysteria at pivotal points in its discursive history as a named malady, this analytical excavation pays specific attention to the associations and divisions of concepts connected to hysteria’s formation. I will highlight both continuity and changes in its meaning and social status across and between temporalities, etiologies, and social explanations. Following the principles and conceptual guidance of Foucauldian archaeology as a discourse theory and a postmodern methodological stance towards the social and discursive construction of what counts as knowledge, I will focus specifically on the overlapping elements of a discursive formation identified by Foucault (1972). Discursive formations here are methodologically conceptualized as communication, literally, spoken, written, or otherwise
symbolized, that is similar in theme, subjects, and objects that materially appear across
temporalities, geographies, and institutional or social contexts.

The following two chapters are organized according to three primary movements of
hysteria that I claim are foundational to any history of thought around what has come to be
known, in contemporary times, as psychological trauma and the psychiatric diagnosis of PTSD.

First, I will begin with a brief tour of the conceptual and contextual lineage of hysteria, prior to
its status as a medical diagnosis, in order to illuminate its enduring historical presence, migration
over time and place, and the socio-political conditions that contributed to changing etiological
theories before its “birthday” as a formalized medical disease. In addition to highlighting how
hysteria maintained its distinction as an undesirable label for unexplained, elusive, and gendered
symptoms throughout much of its history, I will also show how the character or moral status of
the “hysteric” has consistently, with few exceptions, been implicated by not just the name, but
also through hysteria’s centrality as a theme in public and cultural discourses. In other words,
articulations of hysteria were intertwined with discourses directly implicating the inferior,
undesirable, or demoralized subject positions of people labeled hysterics, regardless of the
absurdity or rationality constituting hysteria’s assigned etiologies.

In offering a comparative description attuned to changes in hysteria’s articulations, I
identify one notable exception in its historical understanding that I argue temporally dislodged its
meaning from the implications of an inferior or demoralized moral character. Through
identifying the socio-political conditions and conceptual elements constituting a significant
rupture in hysteria’s discursive configuration, I discuss how a conglomerate of (old) theories of
madness, health, and illness in the contexts of emerging social, political, and medical discourses
during the Renaissance briefly relieved hysterical symptomology from its historical connotations.

4.2 Ancient and Pre-modern Formations of Hysteria: Wandering Wombs and Wicked Women

Hysteria as a named, socially marked, and culturally undesirable “malady” dates back to the beginning of textually recorded history. Prior to its status as a modern medical diagnosis and object of scientific research, as Goldstein (1987) notes, “hysteria is one of the oldest disease entities in the canon of Western medicine” (p. 210). In this respect, hysteria enjoys a long history of what Foucault (1972) refers to as the “threshold of positivity” or the first elemental threshold of a discursive formation, meaning that discourses “about” and “around” appear with regularity albeit dispersed across time, geography, and societal domains, at the level of emergence in domains of talk, texts, and other symbolic media (Foucault, 1972).

Hysteria has its etymological roots in the Greek word “hysterika”, a cognate of uterus or womb (King, 1993, Rousseau, 1993). Its textual and conceptual history is said to date back to 1900 B.C. Egypt in what is believed to be oldest surviving document known to medical history, the Kahun Gynecological Papyrus, which describes symptoms of peculiar and unexplained dizziness, convulsions, spasmodic seizures, blindness, motor paralysis, emotional displays, and sensory loss as etiologically explained by a dislocated, free floating, oftentimes angry wandering uterus (King, 1993, Worton & Wilson, 2004). Over a thousand years later, references to hysteria symptoms and its uterine culprit appear in the texts of ancient Greek physicians and philosophers. Hysteria, or more accurately, “hysterika” appeared in Hippocrates’ Corpus Hippocratus as denoting a variety of female complaints, specifically abnormal and excessive emotions attributed to violent movements of the uterus or womb (Veith, 1965, King, 1993). Plato is also said to have implicated the wandering uterus in Timeaus as an acceptable
explanation for female emotional and physical disease stating that “the animal within them (women) is desirous of procreating children, and when remaining unfruitful long beyond its proper time, gets disconnected and angry, and wandering in every direction through the body, closes up the passages of the breath, and by obstructing respirations, drives them to extremity, causing all variety of disease…” (King, 1993, p. 206). Aristotle has also been cited as invoking hysterika in defense of prohibiting female participation in the Greek polis, as excessive emotions were believed to be a hindrance to political ethos and efficacy (King, 1993).

Consonant with this understanding, treatments for erratic uterine wanderings involved techniques believed to tame the uterus and return it to its proper place. For instance, women were advised to ingest a noxious substance in the attempt to push the uterus downward or, if the uterus was believed to be hovering in the legs or feet, aromatic substances were placed around the pelvis area as a method of enticing the uterus upward (Stein, 2010). In 2 A.D., the physician Galen extended the gynecological interpretation of hysterika to theorize that a lack of sexual activity causes hysteria, consequently prescribing its opposite as a cure (King, 1993). This treatment would be recycled as a popular practice during the Victorian Age. According to Micale (1995), these cultural and medical beliefs, grounded in the wandering uterus theory of hysteria, constitute the “gynecological determinism” tradition of hysteria that remained relatively intact as an accepted theory from 1900 BC until early 1900 AD.

However, a major interruption in this understanding of hysteria is noteworthy as well as controversial. In the domain of social and political authority, the Catholic Church’s colonization of the direction and boundaries of thought and human development led to the emergence of a religious interpretation of female behavior and character according to a theory of demonic possession. This interpretation is associated with “the widespread persecution of the afflicted”
during late medieval and early Renaissance periods, which is historically and conceptually linked to the rise and reign of the Catholic Church and the Catholic Inquisition (Katz, 1994, Micale, 2008). As explained by Micale (2008), “Hysteria….in its dramatic symptomology...was viewed as a sign of possession by the devil. The hysterical female was …. a victim of bewitchment, to be pitied, or the devil's soulmate, to be despised”, engendering “the classical image of the disease” that “envisioned the hysterical anesthesias, mutisms, and convulsions as stigmata diaboli or marks of the devil” (p. 10). To aide in the hunt of those believed to be under the influence of demonic possession, the church and courts produced official manuals that include specific “instructions for the detection, torture, and at times execution of the witch/hysteric.” (Micale, 2008, p.10). According to historical scholars, symptoms associated with hysteria became dissociated from an internal organ migration and re-articulated in terms of external demonological intrusions, generally understood as possession of the female body by evil spirits, usually of the male gender.

However, in contrast to research perspectives which have sought to verify that those persons accused of witchcraft, or believed to be possessed, were in actuality suffering from hysteria or another form of mental illness (see Zilboorg, 1935, Veith, 1965, Micale 2008), I instead focus on the discursive association of hysteria, witchcraft, and demonic possession which has resulted in the demonic articulation of hysteria in modern times. The degree to which an explicit connection was made between hysteria and witchcraft during this time is unclear. It appears as if the connection was made retrospectively and exaggerated by contemporary research.

The Malleus Maleficarum, translated as the “Witches Hammer”, is perhaps the most well-known and widely distributed medieval treatise on witchcraft used in justifying widespread,
organized witch hunts and burning at the stake in Europe. Published in 1486 in Speyer, this popular text is associated with the appropriation of hysteria in terms of and according to an etiology of demonic possession (Arikha, 2007, Veith, 1965). In contrast to previous versions of hysteria as the physical movements of an angry wandering uterus and the “animal within them”, the demonic articulation implicates the character of the wicked female, susceptible to evil via her defective and deceptive nature.

The following passage from the text illustrates how, more than merely a change in symptom etiology, the character of the female is deeply implicated and positioned by the discourse as a defective formation of a male. *The Malleus Maleficarum* (1486) in Part 1 Question VI (*Concerning Witches who copulate with Devils. Why is it that Women are chiefly addicted to Evil Superstitions?*) states:

But because in these times this perfidy is more often found in women than in men, as we learn by actual experience, if anyone is curious as to the reason, we add to what has already been said the following: that since they are feeble both in mind and body, it is not surprising that they should come more under the spell of witchcraft.

For as regards intellect, or the understanding of spiritual things, they seem to be of a different nature from men; a fact which is vouched for by the logic of the authorities, backed by various examples from the Scriptures. Terrence says: women are intellectually like children. And Lactantius (*Institutiones*, III): No women understood philosophy except Temeste. And *Proverbs* XI, as it were describing a women, says: As a jewel of gold in a swine’s snout, so is a fair woman which is without discretion.
But the natural reason is that she is more carnal than a man, as is clear from her many carnal abominations. And it should be noted that there was a defect in the formation of the first woman, since she was formed from a bent rib, that is, a rib of the breast, which is bent as it were in a contrary direction to a man. And since through this defect she is an imperfect animal, she always deceives. For Cato says: When a women weeps she weaves snares. And when a woman weeps, she labours to deceive a man. …And all this is indicated by the etymology of the word; for *Femina* comes from *Fe* and *Minus*, since she is ever weaker to hold and preserve the faith.

What is interesting to note in this passage are the claims of female weakness of mind and body, her carnal nature, and a propensity towards deceptions, all of which are claimed to render her susceptible to not only demonic possession, but also copulating with devils. Hysteria in its demonic and witch discursive form invokes feminine nature in direct opposition to the superior nature of men while subsequently constructing the female character as carnal, deceitful, weak in body and mind, and innately susceptible to the powers of evil. These subject positions or enunciative modalities of the discourse position the female as a defective formation of a man by way of a bent rib, carnality, and weakness. While this positioning is clearly a reflection of the male dominance of the church at the time, such an articulation is paradoxical in that the demonic possession became linked not to the “evilness”, deceptiveness, and wickedness of the demon that “possessed”, but to the innate susceptibility to evil that resided in the inborn character propensities of the “possessed woman”. The evilness of the demons was not the primary or secondary concern of the *Malleus Maleficarum*, but rather the moral character of the wicked woman emerged as both the subject and object of the discourse.
There is a clear commonality between the gynecological age of hysteria and the discourses about hysteria as an undesirable description and female malady determined by a “less than male” differentiator. However, at least among the ancient theories of hysteria, the explanation was not as much a judgment of character as a material etiological displacement and object projection that served as an accepted epistemology among men. The ancient formulation of hysteria did not indict the character of the women in the same manner as the medieval articulation of female/hysteria attributed to a weak and wicked, mind and body susceptibility to metaphysical possession by way of evil transgressions. How the “wicked” female became implicated in the religious articulation of hysteria-female-unruliness exemplifies the degree to which interpretations of hysteria had become a form of epistemological domination which relied on the discursive defamation and condemnation of the moral character of the female as dictated by the institutional authority of the Church. Doctors searching for an internal etiology of hysteria eventually explicitly challenged the demonic model (MacDonald, 1991). As we will see, however, this transition manifested as a rather interesting mix of competing and overlapping epistemologies that demonstrate contradictions within the struggle to find new ways of knowing and understanding not only the mysteries of hysteria, but also the mysteries of the largely unexplored world outside religious dogmatic interpretations.

The Church’s ideology and authority became increasingly challenged in the upcoming Classical/Renaissance Period. Consequently, a new configuration of old theories came together to produce a quasi de-stigmatizing articulation of hysteria which placed hysteria front and center in the battle of pre-science and religious interpretations. The role that the witchcraft-hysteria controversy assumed in cultural and medical discourse amidst the world changing shifts of
knowledge production and scientific exploration during the Renaissance era represents a trajectory of this storyline.

4.3 From the Possessed to the Possessors: A Shift in the Ontology of Hysteria in the Trials of Mary Glover and Father Urbain Grandier

This section explores two case narratives that were immersed in public controversies over hysteria and demonstrates the degree to which such debates played a pivotal role in challenging popular belief, calling into question orthodox opinion, and positioning the public in the dual roles of the witness and spectator. This contextualization extends Herman’s (1992) insight into the role that public awareness and doctor-patient alliances have played in de-stigmatizing discourses especially in the context of social political movements powerful enough to challenge hegemonic orthodoxy and vernacular doxa. In this context, the status and etiology of hysteria were challenged in a highly politicized context whereby not only was the moral character of the accused hysterical literally at stake, but moreover a canon of knowledge as dictated by religious authority implicated in this struggle over interpreting hysteria.

As one of many emerging medical discourses challenging the demonic hysteria configuration, Dr. Edward Jorden, author of *A Briefe Discourse of a Disease Called the Suffocation of the Mother* (1603) argued that symptoms of the *hysterico passio* are related to a condition referred to as melancholy, which had possibly been confused conceptually with evil or supernatural possession. According to Rousseau (1993), the “mother” had become analogous with both the womb and the name hysteria—an analogy that was ironically propagated in Jorden’s treatise. Despite its political status as an “alternative theory” of hysteria, Jorden’s version relies heavily upon Hippocratic and Galenic discourses about hysteria as a uterine pathology still attributed to qualities of the wandering womb (Rousseau, 1993). As an articulation caught in a web of paradoxical trajectories, Jorden’s theory marks a transition that
displays threads of old discourses rewoven into emerging thought, about melancholy, the 
humors, and both the body and mind in hysteria’s etiology, according to a new grouping of 
ancient discourses.

Jorden, as a result of his apparent expertise and textual treatise, and three other doctors 
were called as expert witnesses in the trials based in accusations of witchery. The case of Mary 
Glover and Elizabeth Jackson exemplifies a historical public struggle over competing 
interpretations of hysteria. In a heated dispute, Mary Glover, 14 years old, accused Elizabeth 
Jackson of fraud resulting in Jackson shouting “terrifying and malevolent curses of evil death” at 
Glover. According to MacDonald, because the majority of Elizabethans believed curses could 
kill, both the accuser and accused were subject to accusations of witchcraft, which had become a 
capital crime in 1604 (1991). Glover was eventually assessed by eminent doctors, including Dr. 
Jorden, who could not relieve her symptoms of difficulty swallowing that transgressed into 
stomach contortions, chest movements, and continued loss of vision and speech (1991, p. xx). In 
particular, Dr. Shereman of the College of Physicians, an expert on “melancholy” related 
hysterical symptoms, attempted to treat Glover with a technic designed to “cleare the point by 
touching hysterical passions” (MacDonald, 1991, fol. 5v).

After a series of Shereman’s treatments, according to MacDonald, Glover’s symptoms 
worsened into trance-like states and seizures leaving doctors divided between natural and 
supernatural explanations. Because Mary did not respond to the treatments for the hysterical 
passions, the doctors attempted an exorcism in order to test the demonic possession theory. 
However, she did not respond to the exorcism. As a result, the experts ruled out a definitive 
medical or supernatural cause and called for experimental “trials” that exposed Mary to various 
stimuli in order to test the intensification or relief of symptoms. According to reports, these
trials, which occurred in the family home, transformed into a public spectacle packed with townspeople eager to observe and decide upon the causes of the symptoms. The townspeople remained divided along the same lines as the doctors (MacDonald, 1991). The courts decided that Elizabeth Jackson bewitched Mary Glover. Jackson was sentenced to confinement for a year and was periodically subject to stoning, verbal condemnations, and other forms of public mortifications. Eventually Jackson was pardoned. Glover’s fits continued until a “successful” exorcism was reported to have relieved the symptoms (MacDonald, 1991).

One can also interpret this case narrative as an “indicator episode” and precursor to a new ‘medical personage” resulting in new contracts between doctor and patient, and a new relation between insanity and medical thought that endows the doctor with the power of opinion and physical manipulation (Foucault, 1965, p 269). On the other hand, the social and political alliances that occurred between the doctor and the patient, whereby the doctor was able to call into question the authority of the church and challenge its interpretations in a world where the female was not permitted to do so, were not yet on solid epistemological grounding. Despite claims that Jorden was a “hero” in the rescuing of hysteria from its supernatural interpretations, Rousseau (1993) highlights how his “new” perspective was actually quite traditional and gender-biased as it was intertwined in a formulation that maintained elements of mythical and supernatural discourses. However, Jorden is credited with considering hysteria, in both mind and body manifestations, as mediated by the womb that, in Jorden’s formulation, is conceptually linked to both the mind and the rest of the body by way of the operation of the “vapors”, which “symbiotically interact” with the whole organism, causing imbalance and disorders throughout the head (in the forms of “perturbations of the mind”), the senses, and the “animal soul” that manifest in the erratic muscle movements of hysteria (Rousseau, 1993, p. 119-120).
As De Certeau (2000) discusses, a comparable, pivotal case, during the Loudun Possession trials in France in the 1630’s also highlights the epistemological and cultural controversies surrounding hysterical psychopathology. This time, the re-consideration of hysteria occurred in a similar religious-legal context that involved a prominent Roman Catholic Priest named Father Urbain Grandier and seventeen nuns from the Ursaline convent. As related, the nuns began displaying hysterical symptoms after they claimed to have been visited and possessed by demons, all of which had names. After a three year, dramatic culmination of back and forth accusations and accounts of sexual dreams, hallucinations, speaking in tongues, and mass exorcisms performed by priests on the nuns in front of audiences up to 7000, Father Grandier was eventually accused and convicted of sorcery, maleficia, and causing demonic possession. This ruling was supposedly based on evidence submitted to the courts demonstrating that Urbain had signed a pact with the devil and that he had in fact ordered the demonic possession of the nuns. In 1634, he was publicly burned alive at the stake. What is interesting about this episode is not only the fact that the story and its controversies have remained alive in intellectual and cultural discourses in the 21st century, but also that it appears to have marked a turning point in the demonizing discourses about hysteria. In the 17th century, as de Certeau’s (2000) analysis suggests, the Loudun case complicated demonic interpretations by giving women’s voices and accounts legitimate consideration while also shifting legal and public accountability to an unlikely (male) suspect.

An archaeological attempt to map changes and transformation of what counts as knowledge in a given context, illuminates these cases as marking a transitional period in the status of hysterical symptoms and etiology that identifies and re-positions traditional religious interpretations as a contestable theory of female supernatural possession positioned within the
changing spheres of public, legal, and medical opinion. During this time, we see the role of human perpetrators entering into the plausible realm of explanation for hysterical symptoms, even though still connected to the bestowing of evil onto another through supernatural curses. The slight shift in this configuration occurs when the “bewitched” female is apprehended as a “question” in the emerging discourses of inquiry. Along a similar line of thought, the role that the public occupied as witnesses, spectators, and stakeholders in the unfolding drama of public opinion formation should also be considered as bearing a new relation to cultural and orthodox foundational understandings and beliefs involving overlapping spheres of belief, judgment, and conventional knowledge.

Consequently, similar to the Jackson-Glover case, this public controversy elevated the debate into the public multi-vocal realm and opened up a space for previously pre-discursive antagonisms to enter the linguistic arena. The shift of believability from a prestigious religious male to a convent of respected nuns marks another gradual transformation of hysteria’s institutional and cultural history. The shift, when viewed from the question of how concepts and theories change over time, illustrates not only the role of controversy in bringing previously “undebatable” epistemologies into the discursive terrain, but also the gradual trajectory through which transformations of ideology are ignited once the conflict is elevated to the realm of public discourse. In this event, the execution of a priest is more than symbolic of a shift in epistemologization of hysteria. It is also an expansion of the discursive terrain to include a human perpetrator in the environment as an explanation for strange female behavior through materializing what had been construed as a female character defection and innate susceptibility.

Feminist scholars and historians position hysteria in relation to medical, religious, legal, culture, and gender wars as taking center stage in some locations, frequently involving political
scandal and mass persecution that displayed and challenged the very foundations of institutional authority. As argued by Showalter (1993), the historical discourses around, about, and of hysteria extended far beyond its debate as a medical diagnosis. Moreover, throughout the ages, hysteria has consistently evoked crucial questions of culture and human civilization in its centrality and positivity in public discourse in the courts, the church, and the emerging field of modern medicine.

As theories of the humors and melancholy began to converge into a viable alternative to the theory of demonic possession, the human body emerged as a significant object of the theoretical discourse that diffracted attention away from the previously possessed or wicked character of the patient. As opposed to a body and soul possessed, the mind and body became positivities placed in relation to each other that could be manipulated, experimented on, and publicly observed and discussed. In this sense, the body and mind emerged as more than just positivities in the hysteria formation as they began to cross over the threshold of epistemologization when “a group of statements is articulated, claims to validate (even unsuccessfully) norms of verification and coherence, and when it exercises a dominant function (as a model, a critique, or a verification) over knowledge” (Foucault, 1972, p. 187).

Hysteria was beginning to become recycled and dislodged, in small increments and fragments, from its prior articulation once new positivities formed into groups that challenged the accepted canon of knowledge at the time, which gave rise to a new set of objects, subject positions, and concepts to be studied and formed into a new theory. However, the element which appears to have provided the glue of a radically different theory of hysteria and subject positions, for both doctors and patients, is the moment when the “passions” entered into the discussion.
4.4 Discourses of Animality, the Passions, and the Humours: A Unique De-Stigmatizing Configuration of Alliances and Ancient Theories

Among the diseases of women, hysterical affection is of such bad repute that like the semi-daminit it must bear the faults of numerous other affections; if a disorder of unknown nature and hidden origin appears in a woman in such a manner that its cause escapes us, and that the therapeutic course is uncertain, we immediately blame the bad influence of the Uterus, which, for the most part, is not responsible.

Thomas Willis, 1681 (quoted in Foucault, 1965)

By the early 17th century, according to Foucault’s account, “hysteria” had evolved in complexity as it had come to be perceived, in certain medical circles, as the result of an “internal heat that spread throughout the entire body, an effervescence, an ebullition ceaselessly manifested in convulsions and spasms” (1965, p. 139-140). This change in understanding during the early modern era was linked to ideas about the passions, the humors/vapors, and Renaissance view of human madness as animality, which slowly began to dislodge hysteria from its religious interpretations and placed it in the more favorable light of the relation between the hysterical passions, the humors, and melancholy. I will discuss these threads of thought separately, for the purpose of explanation, but my intent is to show how they came together to produce a new discourse about and around behaviors linked to hysteria, which briefly relieved hysterical symptomology from an evil and deceptive character, and culminated in a new configuration for understanding hysteria, health, and emotional imbalances.

With the Church’s power being challenged during the Renaissance period, madness, as a general category, reflected the spirit of the times as linked to raging passions, artistic expression, and breaching the chains of civilization. In Foucault’s analysis of madness in the Renaissance and “Classical Age”, he identifies a particular historical discourse of male and female madness whereby madness was understood as “animality” (Palmer, 2004). Highlighting the association between madness and animality before its apprehension in social order and normalizing
judgments, he further argues that before madness was subject to interpretation or differentiation along lines of “normal” and “abnormal”, “madness in its ultimate form is man, in immediate relation to his animality, without other reference, with any recourse” (1965).

Palmer’s (2004) elaboration on the role of animality in Foucault’s analysis (1965) is useful here:

In the Renaissance the relations with animality are reversed: the beast is set free (se libre), it escapes the world of legend and moral illustration to acquire a fantastic nature of its own. And by an astonishing reversal, it is now the animal that will stalk man, capture him, and reveal him to his own truth. Impossible animals, issuing from a demented imagination, become the secret nature of man. (p. 76)

In other words, madness was understood as the animal within that unlocks and opens a void, associated with wildness and the “beast who is set free”. In this articulation, treatment of madness in its animality involves allowing “madness in the state of nature”, believed to protect and retain the beast, so that the madness “partook of ferocity, preserved him an invulnerability, similar to that which nature...provided for animals” (p. 75). The expression of animality and the “raging passions” confirms the very fact that the madman is not a sick man, and preserves the lunatic “from whatever might be fragile, precarious, or sickly in man in association with the animal solidity of madness, and that density it borrows from the blind world of beasts, inured the madman to hunger, heat, cold, and pain” (p 74). Related to “cosmic madness” and artistic expression during the Renaissance era, madness was not yet embedded in moralized and rationalized interpretations. Foucault notes that, “The day would come from an evolutionary perspective this presence of animality in madness would be considered as the sign—indeed, as the very essence of disease” (1965). However, for a while, the humanistic influence and
intellectual movement attributed to the Renaissance period proved to provide humanizing elements for the upcoming construction of hysteria.

Prior to the split that would eventually contrapose the passions and reason, the animal metaphor of madness was extended into an understanding of the movements of the animal or vital spirits and linked to a widespread acceptance of the passions in the upcoming era, in part because the animal spirits were related to the “soul’s connection with the movements of the animal spirits” (Arikha, 2007, p. 216). When madness became articulated in terms of the passions, a new world of understanding began to open that incorporated a complex system of thought that resulted in a phase where “old accounts of human nature were recycled in complex, imaginative ways, for intensive use in a rapidly changing, expanding world” (2007, p. 110). Medical and popular literary texts about the passions, melancholy, and the humors developed thousands of years earlier by the ancient Greeks, the Roman Galenists, and the Arabic world, during the 8th and 9th centuries, would enjoy a reuptake and recycling in the 16th and 17th centuries (Arikha, 2007).

The transformation of the meaning of hysteria from a female demonic susceptibility towards that of “hysterical passions” depended upon a certain theory and acceptance of the role that emotions play in the manifestation of dis-ease as a function of an imbalance of mind, body, and emotions. During this time, hysteria, as a concept and as an object of investigation, was still related to internal movements in the body grounded in a seemingly humane and normalized understanding that excessive human emotions of sadness and anger disrupt equilibrium in the human body. The discourses which converged around the *hysterical passionales*, during what Foucault refers to as the Classical period, do not implicate the character of the individual as involved in a moral transgression or as a subject of judgment, persecution, or abnormality. We
see the re-emergence of the humoral theory of mania, melancholia, and eventually hysteria, based in elements of humoral physiology, whereby emotions or the passions began to be understood in terms of the movements of the “animal spirits”.

_Hysterical passionales_ was treated by techniques of the vapors, thermal energies, and related balancing technologies (from Foucault, 1965). As explained by Bayle & Grangeon (1682), imbalances of the “humours” were also believed to be related to the passions:

The passions necessarily cause certain movements in the humours, anger agitates the bile, sadness excites melancholy (black bile), and the movements of the humours are on occasion so violent that they disrupt the entire economy of the body, even causing death; further, the passions augment the quantity of the humours...which are customarily agitated by certain passions and dispose those in whom they abound to the same passions, and to thinking of the objects which ordinarily excite them; bile disposes to anger and to thinking of those we hate. Melancholy (black bile) disposes to sadness and to thinking of untoward things; well tempered blood disposes to joy. (as cited in Foucault, 1965, p. 86)

Dating back to Hippocrates’ corpus and the works of Plato, Aristotle, and Galen, humoural physiology constituted a theory and method of health and its restoration through balancing of the bodily humours or fluids and their thermal vapor releases in the body. Noga Arikha in _Passions and Tempers: A History of the Humours_ explains the tenets of this theory:

In the West, the theory developed that the human body was constituted of four of these humours, all central to its functioning. Phlegm was one of them; the three others were yellow bile, black bile, and blood. They were concocted out of the heat of the digestive processes in the stomach: food turned into so-called chyle in the liver, from where, thanks to the heat produced by these digestive concoctions, particles in the blood stream
‘vital spirits’ were expedited to the heart, and from there to the brain. The cerebellum refined some of these spirits into smaller ‘animal spirits’. Heat and cold, dryness and moisture affected the course of the spirits, and determined the effects of each humour on mood, thought, and health. There was a continuum between passions and cognition, physiology and psychology, individual and environment. (2007, p. xviii).

This theory became connected to the ‘temperaments’ as a function of the proportions of the four humors, as imbalances in excess or deficiency were believed to be affected by diet, climate, season, and other environmental influences. With circulation and consumption of the humorist theory of health and illness going through quite a few cycles and recycles over the course of its 2500 year history, the role of the humors would emerge in popular consumption in medical, metaphysical, philosophical, and cultural discourses in the sixteenth and seventeenth centuries (Arikha, 2007). The core assumptions involved in these treatises revolved around a holistic functioning of the mind, body, and soul based in the movements of animal spirits within the human body, which explained and humanized the depths and expressions of passions and their emotional counterparts. Within this frame, the passions were “inalienably human characteristics”, a belief shared by Descartes in his treatise Passions of the Soul (as cited in Arikha, 2007). What becomes interesting is the linkage between the reuptake of the theory of the humours and the ideas involved in animality as madness, which, during this period, became connected to the emergence of the passions as a significant object in discourses about hysteria and madness more generally. This combination would come together in a manner that transformed the demonic possession model of hysteria into a melancholic understanding of hysteria further articulated as the “hysterical passionales”.
According to Arikha (2007) treatises resembling self-help books on the passions became quite popular during the sixteenth and seventeenth centuries. Some of these include Thomas Wright’s, *The Passions of the Mind in General* (1601), Descartes’ *Discourse on Method* (1637) and the *Passions of the Soul* in (1649), and Priest Nicolas Malebranche’s (1674-1675) *The Search for Truth*. Just prior to the cultural circulation and consumption of these treatises on the passions, there was an emergence of related movement in popular texts and intellectual discourses on melancholy and the humors, specifically in response to the demonic interpretation of hysteria related behaviors. In 1562, Johann Weyer wrote *Of Deceiving Demons*, which argues that instead of being caused by demonic possession, cases of what had previously believed to be possession were actually strong emotions associated with the imbalance of passions and what came to be known as melancholy (Rousseau, 1993). Timothy Bright (1586) wrote *A Treatise on Melancholy*, which offers a perspective of the “suffering subject” in the context of imbalances of the humors (Arikha, 2007). London Poet Nicholas Breton published *Melancholicke Humours in verses of Divine Natures* (1600). Robert Burton published *The Anatomy of Melancholy* (1621), which conceptually connects hysteria and hypochondria in terms of melancholy that was connected to sorrow and “love sickness” (Rousseau, 2007, Arikha, 2007). While these certainly do not exhaust the list of books published on the subject, the emergence of these perspectives slowly became incorporated into the constellation of discourses about hysteria whereby old ideas would produce new objects of study, investigation, and conceptual trajectories that blurred conventional distinctions in an effort to integrate metaphysical, pre-scientific, and ancient perspectives with the emerging category of reason in the attempt to understanding human nature and its movements.
Following Rousseau (1993) and Arikha’s (2007) observations that medical discourses and diseases “conglomerated” in the 17th century, in the sense that they became less distinguished from others, we notice an overlap in the discourses of different forms of the same dis-ease for instance in mania and melancholia, hysteria and hypochondria, the humors and the vapors, animal spirits, and emotions. Before reason was articulated as the method of taming the passions, the “emotions”, as explained in relation to their connection to the body, mind, and soul, became the new way of knowing of oneself and others that offered a humanist relief for understanding of the *hysterico* passions and other maladies of the human condition (Arikha, 2007).

On an experiential and reflective note, distinguishing the shifts and differences between the threads of thought and the moments of changing epistemologies has been difficult, perhaps because the discourses and concepts are intertwined and overlapping, not divided along clear lines or boundaries. In this transitional time that discursively debates and displays a near indistinguishable meshing of ancient, metaphysical, pre-scientific etiologies of hysteria, the distinctions between hysteria, melancholy, animal spirits, the passions, melancholy, mania, hypochondria are also unclear and blurry; the categories of pathology are not yet identified or differentiated; hysteria overlaps with a whole range of imbalances in the body, soul, and the newly emerging concept of reason. And while the body and soul maintained a unity through the conceptual thread of the migratory and increasingly concretized animal spirits that integrate the system, the emerging entity of the rational mind would start to enter into the mix of complicating elements.

In a sense, as Arikha and Rousseau suggest, this brief phase of undifferentiated theories of madness, illness, and health in the 16th and 17th centuries was sparked, in part, by explosions
in literature, art, astronomy, global exploration, medicine, and intellectual freedom “in resistance to” the epistemological domination of Catholic Church that occurred during this creative, chaotic, and literally world shifting time in human history known as the Renaissance, translated as “rebirth” and commonly referred to as a cultural revolution.

4.5 Conclusions

In summary, during the early Enlightenment period, discourses about the passions, humors, and melancholy intervened in “stigmatization” of hysteria through a systemic, ecological model of disease and imbalance that was connected to a political movement of the dissociation/struggle in the quest for knowledge expansion to be divorced from religious authority. Doctors functioned as witnesses, gave expert testimony, and served as allies to the witch-accused hysteric within the context of the conflict between the emerging will to knowledge and the metaphysical and dogmatic interpretations of the Church. This inventive interpretation of hysteria briefly dissociated its symptoms from the character of the individual and displaced the imbalances to interactions in the system of the organism. In this manner, this articulation was a de-individualizing discursive formation that subverted attention away from the moral character of the so-called hysteric, as a primary object of the discourse, and substituted a concern with interactions in the body and in relation to various elements in the environment. As we will see, however, with the advent of the emerging fields of neuroscience and psychiatry, hysteria would again be divided up according to emerging medical discourses, scientific methods and technologies of experimentation, and verifications of its status as a disease of the nerves with conversations about the malingering and deceitful character of the hysteric becoming more prevalent than ever. While the 16th and 17th century discourses of hysteria, influenced by humanist sensibilities, were intertwined with hopes of integrating the emerging elements of
human nature, the late 19th century, in contrast, developed a new form of hysteria susceptibility as a disease of the nerves, weakness of the mind in an ironic reuptake of discourses about the malingering and moral character of the patient.

Between the 17th and 19th century, hysteria related symptoms were dislodged from supernatural explanations and treatments and were replaced by new diagnostic techniques and neurological explanations developed in a rapidly growing medical science. Although hysteria, as a concept, was briefly relieved from its (im)moral and immortal implications (prior to its appropriation as a medical diagnosis), the next phase of hysteria’s epistemologization would once again position hysteria and its subjects as hot topics in the spheres of public opinion, cultural consumption, and scientific controversy.

The following chapter situates the study of hysteria in the emerging fields of neuroscience and psychiatry in late nineteenth century France amidst controversial theories postulating the roles of hypnosis, suggestion, simulation and suggestibility in diagnosing and treating hysteria. Through highlighting epistemological debates addressing malingering and the moral character of the individuals under review, I trace the continued evolution and differentiation of the hysteria and shell-shock diagnoses in post-WWI Great Britain. This analysis further explores how suspicion became formalized and institutionalized in the Royal British Military Army diagnostic criteria for assessing psychiatric casualties that is conceptually and subjectively linked to discourses around malingering and neurological susceptibility. Through engendering and instantiating a discourse of suspicion regarding individuals displaying symptoms that cannot be located according to organic or neurological symptomology, the diagnostic discourses about hysteria and shell shock, I contend, are a part of a chain of concepts and discursive subject positions linked to the eventual formalization of an institutionalized
element of stigma in the diagnostic criterion assessment of PTSD that requires that “malingering” be ruled out as an explanation for making claims of disabling trauma.

In the following chapter, I demonstrate that the sticking point or continuity among hysteria’s stigmatized articulations have been bound by discourses of “susceptibility” (uterine, demonic, and nervous) that eventually split into a discourse of predisposition (constitutional-neuro-biological) and a discourse of suspicion (deceit and malingering) around what came to be known as hysteria in both men and women. I further argue that these conceptual splits “transferred” to and are, at least partially, recycled through diagnostic discourses about and around PTSD as a contemporary diagnosis through association of ideas transferred from one context to another.
Chapter 5: Origins of a Diagnosis: Questions of Hysteria and Trauma in the Budding Fields of Neuroscience, Psychoanalysis, and Military Psychiatry

5.1 The Scientization of Hysteria: New Constellations, Old Characters, Inventive Configurations

The word “hysteria” should be preserved, although its primitive meaning has changed. It would be very difficult to modify it nowadays, and truly, it has so great and so beautiful a history that it would be painful to give it up; but since every epoch has given it a different meaning, let us try to find out what it has to-day.

--Pierre Janet, The Mental State of Hysterics 1901, p. 526

Numerous scholars have claimed that the study of trauma began with the study of hysteria sparking ideas and concepts that would be developed into a theory of “psychological” trauma (Herman, 1992, Hacking, 1995). According to contemporary historical accounts, the identification of psychological trauma as an object of scientific research and theorization is traditionally credited to the explorations of hysteria by French neurologist Charcot (1825-1893), his protégé-student, psychiatrist Pierre Janet (1859-1947), and the Austrian psychoanalyst Sigmund Freud (1856-1939) (Herman, 1992). However, it important to underscore that these pioneers of modern neurological and psychoanalytic theories of hysteria did not set out to study trauma as an object of research. A closer look at the discursive constellation of hysteria during this time positions “trauma” as a secondary, or even absent, notion in the discursive formation of the hysteria diagnosis (see Hacking 1995) The theory of sexual or psychical trauma emerged as a periphery, almost radical, etiological explanation of hysteria that did not, in any substantial or formalized manner, enter into the hysteria equation, except to the extent that it was posed as an alternative to dominant theories of hysteria during this time.58

The purpose of this chapter, then, is to apprehend the diagnosis of hysteria according to its conceptual differentiation, discursive contexts, and theoretical trajectories, which I suggest provided foundations for later articulations and dynamics of stigmatization around psychological
trauma as rooted in a persistent rejection of trauma in favor of demoralizing explanations. This research finds itself in agreement with Lerner’s (2003) “counter-history” of traumatic neurosis that claims that the “the refusal of trauma comprises a striking source of psychiatric continuity from the 1880’s-1920’s” (p. 249). In order to provide general background information, I begin with a brief introduction of the scene and the actors affiliated with research on hysteria in the late 1800’s. After describing the hysteria experiments according to Charcot’s understanding of and interest in hysteria, I discuss the public and mediated context of the discursive formation of hysteria in relation to aspects of Charcot’s key concepts, objects of investigation, and logic. I further explore how the validity of Charcot’s hysteria depended not only on discourses that demoralized the character of the hysterics, but also upon its visibility and redundancy in scientific, cultural, and public communication.

Throughout the analysis, I touch upon the formation of counter-discourses and alternative articulations of hysteria and shell shock from researchers who challenged, critiqued, or further differentiated the dominant and formalized diagnostic and/or theoretical formations of these conditions. Framed as emerging from observations and dissonance sparked by Charcot’s research on hysteria, such “counter-discourses” are further discussed in terms of their value for the generation of new concepts and objects as “discursive seeds” that would eventually enter into the discursive field of traumatology and therapeutic models of doctor-patient communication. The analysis identifies conceptual threads of discourses related to the hysteria phenomenon at Hospital Salpetriere that reappear in post-WW-I military medical discourse, cultural debates, and homologous controversies, all of which engendered discourses of suspicion contributive to the stigmatizing formalization of malingering as a distinct diagnostic category. The other diagnostic alternative to hysteria and shell shock malingering was, I contend, a neurologically stigmatizing
assessment as based in discourses of predisposed susceptibility and medical implications of genetic inferiority. Finally, the chapter concludes by articulating how threads of “rejected” explanations or counter-discourses, which were not part of the orthodox or *doxa* of epistemological leanings at the time, re-appear in relation to new discursive constellations at later times and become integrated and reconfigured to form new discursive formations.

5.2 Jean Martin Charcot and Hospital Salpetriere: Influence, Innovations and Contradictions

During a period of political turmoil after Napoleon’s rule, a recently democratized France struggled to rebuild from the shock of rapid industrialization that had cut a massive trail of physical and exploitive trauma, including crippling railway accidents whose survivors displayed unexplained physical and emotional symptoms (Young, 1995, Herman, 1992, Micale, 2001). Formerly a gunpowder factory and the Hospital General, the Parisian Hospital Salpetriere had been the site of institutional humanitarian reform led by Pinel and Esquirol in the early 1800’s after the “Great Confinement” of late 17th century, when the buildings had been used to house the poor, homeless, insane, criminals, prostitutes, hysterics, and epileptics. After it was taken over by France’s Public Health Administration, prior to his tenure in the mid-1800’s, the Salpetriere was described by Charcot as a “vast emporium of human suffering…and a seat of theoretical and clinical instruction of uncontested utility” (Charcot, 1870, OC: 1-1, pp. 2F, cited in Goetz, et al., 1995, p. 20). In 1862, Jean Martin Charcot became head neurologist of the Hospital Salpetriere and the leader of an experimental research program addressing the “Grande Hysteria” (Hacking, 1995). Referred to as the “Napoleon of Neurosis” and “Father of modern neurology”, Charcot is credited with inspiring a whole sub-literature in French medical studies as evidenced in a canon of books, articles, and dissertation publications in the late 1880’s and early 1890’s in the areas of suggestion, hypnosis, and hysteria (Micale, 2001, Goetz et al., 1995).
Many renowned researchers in the sciences of human behavior, including Alfred Binet, Sigmund Freud, Pierre Janet, William James, Charles Meyers, Joseph Babinski, and Carl Jung spent substantial amounts of time at Salpetriere to learn, conduct research, and teach (Goetz et al., 1995). In a sense, the work conducted at the Hospital Salpetriere can be viewed as a localized example of Knorr-Cetina’s concept of an “epistemic culture”, which directs attention to inside the “social relations” and “epistemic space from within which scientists work and identify the tools and devices used in their “truth” finding navigation”, through which knowledge claims are made (1991, p. 107).

In addition to his intellectual and experiential influence on numerous prominent researchers, Charcot transformed the Hospital Salpetriere into an experimental research institute that was renowned for live, public displays of hysterical demonstrations and utilization of innovative medical technologies during the “Tuesday night lectures”, held in the hospital’s amphitheater, which attracted not only an audience of ambitious doctors, psychiatrists, and students, but also prominent members of the French bourgeoisie (Herman, 1992, Goetz, et al., 1995). Innovations attributed to Charcot’s research include the unconventional finding that symptoms traditionally associated with female hysteria were also displayed by male survivors of railway related accidents (Micale, 2001, Hacking, 1995). After observing paralysis, convulsions, contractures, memory loss, field of vision alterations, and aphasia in men, Charcot concluded that grande hysteria in women and traumatic neurosis in men were basically the same syndrome (Micale, 2001, Lerner, 2002). Despite the fact that he was not the first prominent doctor to “discover” that men could suffer from symptoms of hysteria, Charcot seemed genuinely surprised by his “discovery” of male hysteria when he stated, “One can conceive that it may be possible for a young effeminate man…to present hysterical phenomenon….but that a vigorous
artisan, well-built, …, the stoker of an engine for example, … should, after the accident of a train, by collision or running off the rails, become hysterical for the same reason as a woman, is what surpasses our imagination” (as cited in Young, 1995, p. 20, quoting Charcot 1889, p. 222).

Ironically, Charcot is additionally credited with raising the status of female hysteria patient from “mad to ill” (Foucault, 2006). Many of Charcot’s colleagues and contemporaries claimed that his work elevated the status of hysterical female patients, stating that prior to his research, “No credence was given to a hysterick about anything. The first thing Charcot’s work did was to restore its dignity to the topic. Little by little, people gave up the scornful smile… She was no longer a malingerer, for Charcot had thrown the whole weight of his authority on the side of the genuineness and objectivity of hysterical phenomenon” (Freud, 1893, "Charcot," 1893f, S.E., 3: 19). On this point, in 1955, a neurologist credited Charcot with “rescu(ing) hysteria from the psychiatrists” by elevating it to an object of medicinal and differential diagnosis” (Guillain, 1955).61

A few contradictions are apparent here. First, that Charcot elevated the status of the hysteria is valid only to the degree that the alternative to experimentation was incarceration, homelessness, or death. Compared to prior apprehensions of hysteria, after it was demonized, yet before it became scientized, this statement is paradoxical and relative. When hysteria was understood in connection with melancholy, the passions, and the humors, as argued in Chapter 4, the status of the female or their sincerity was not the central question. For instance, in 1622 Dr. Thomas Sydenham, also known as the English Hippocrates, studied hysteria as a category and cluster of symptoms and subsequently ruled out patients’ intentional deceit or malingering, claiming instead that the symptoms themselves “imitated” the conditions that produced the disturbance, meaning that hysteria’s symptoms would vary from patient to patient. As
Rousseau’s (1993) historical research on hysteria reveals, Sydenham, a research associate of John Locke, applied the category of hysteria to both sexes offering the first representation of hysteria that transcended its traditional gendered boundaries in the 1680’s (p. 94). Claiming that hysteria was a “disease of civilization” that “imitates culture”, Sydenham stressed that “felt emotions” related to grief, loss, and pain partially account for “crucial hysterical symptoms” and that such symptoms were “always produced by the tensions and stresses within the culture surrounding the patient or victim” (Rousseau, 1993, p. 94). Rousseau also underscores Sydenham’s observations about hysteria’s “imitative” capacity that endows it with a transformative symptomatic and somatic function in that it not only changes forms, but also displays itself in a “multiformity of shapes” and varying symptoms based such that “the symptom leading to the condition of hysteria ‘imitated’ the culture in which it (the symptom) had been produced” (p. 102). Contrary to Freud’s claims about Charcot’s “accomplishments”, Charcot did nothing to dissociate the notion of malingering with the category of hysteria. In fact, as we will see, he discursively associated the concept of malingering with a deceitful hysterical subject who intentionally imitates hysteria symptoms.

Although such contradictory accounts of “who said what first” are not surprising in the context of historical representation and research, this is not the case here. What stands out is that Sydenham’s interpretations and observations of hysteria as a gender neutral category, as a disorder of culture and civilization whose symptoms change forms accordingly, and as a disease that imitates cultural conditions all became greatly modified in Charcot’s articulation of hysteria. Although we could blame mere lack of exposure to Sydenham’s work, a more plausible explanation is simply that a medical explanation was desirable in order to establish its differentiated status through tangible, observable, and measurable symptoms in order to
materialize hysteria’s formation as a neurological problem. An equally plausible perspective from which to view Charcot’s re-articulation of hysteria is to assume that it was a theoretical choice and a manipulation of a concept. Thus, one of the objects that emerged in Charcot’s discourse about hysteria centralizes around the character of the hysteric who willfully deceives and had an extraordinary talent for simulating symptoms (Hustvedt, 2011). The transmutation of hysteria as a disorder that imitates cultural conditions and symptoms of other disorders into a disease characterized by the willful and intentional imitation whereby hysterics “imitated the imitations”, was embedded in discursive field of concepts and representations propagated in Charcot’s version of hysteria. Reflective of his conceptual choice and explicit shift in meaning, Charcot modified the meaning of imitation to fit with his theory and method of diagnosis. While his logic is lacking, his proclamation that hysteria symptoms are “willfully feigned” is clearly stated in the following passage from Hustvedt (2011, p. 97) quoting Charcot:

It is a matter of simulation, no longer the imitation of one disease by another…but of intentional and deliberate simulation, in which the patient exaggerates real symptoms or creates an imaginary symptomology from scratch. Everyone knows that the need to lie, sometimes without anything to gain, a kind of art for art’s sake, sometimes with the goal of causing a stir or gaining pity, is common, especially in hysteria. We encounter it with every step we take in the clinic of this neurosis and there is no denying that this accounts for the low opinion that is attached to the study of hysteria.

This discursive mutation of hysteria from an imitative disorder into one that is intentionally simulated is a significant diffraction of Sydenham’s meaning of an imitative, as opposed to imitable condition. While Sydenham’s theory of hysteria does not appear to have entered into what Foucault refers to as the “economy of the discursive constellation” in Charcot’s
hysteria, it does however occupy an “absent presence” as the term imitation is posed in contrast to and in favor of simulation further equivocated with “intentional imitation”. Imitation or simulation then enters into a symbiotic relation with the malingering character of the hysteric, whereby “imitation” changed in relation to Charcot’s practices and theorization of hypnosis and hysteria. As argued in Chapter 4, hysteria’s history has almost always depended on a political or ideological fixation on the hysteric’s demoralized character as the central and privileged signifier or nodal point in its many discursive formations, its scientized version notwithstanding. In addition to an outright reduction of hysteria as a disorder that imitates into a claim that people imitate it, these incompatible claims became equivocated in a manner that relinked hysteria with its familiar subject position through a complex web of discourses, new objects to be studied, and exclusions of theories that postulated otherwise. The next section will describe in more detail the architecture of Charcot’s theories and methods of diagnosing hysteria in order to demonstrate the complex of discourses involved in this articulation as interconnected with a moralized, as well as, predisposed pathology.

5.3 The Hypnosis Experiments: The Pathologization of the Trance, Constitutional Susceptibility, and the Power of Suggestions

When the word “hysterical”... is used, its social meaning is that the subject is a predatory individual, trying to get something for nothing. The victim of such a neurosis is, therefore, without sympathy in court, and ... without sympathy from his physicians, who often take... 'hysterical’ to mean that the individual is suffering from some persistent form of wickedness, perversity, or weakness of will.

--Kardiner & Speigel, 1947

This section describe elements of the discursive constellation that constituted Charcot’s theory of hysteria in order to understand how a disease that imitated became modified into a hysteric that imitates, deceives, and malingers the disorder of hysteria and as a constitutional neurological disorder defined by a predisposed susceptibility. Following Foucault’s
methodological guidance for analyzing themes, theories or “strategies” constitutive of a discursive formation, such an analysis operates according to three assumptions. First, that such strategies are choices; second, that such theoretical choices simultaneously include concepts and objects at the exclusion of others; and thirdly, that one cannot glean the strategy without understanding the “discursive constellation” and the web of meaning it engenders (1972, p. 66-67). Situating hysteria according to this perspective highlights how it was actively produced and re-presented in a new discursive constellation in such a form that both modified and retained its moral implications, drawing further attention to contextual, political, and conceptual elements integral to this articulation.

In contrast to his predecessors the “moral therapists” Pinel and Esquirol, Charcot was not concerned by human or emotional factors in his understanding of the neurological illness of hysterio-epilepsy (Marshall, 2003). According to Goldstein (1987), the research at Salpetriere under Charcot and the work of the Republican medical profession was developed as a direct challenge to the authority of religious and supernatural explanations of disease and its treatments. In theory, a rationalized explanation of “real” conditions previously understood as moral transgressions, demonic possession, and gendered derangements would positively intervene in cultural and medical attitudes constructed within these historical discourses (Marshall, 2003). At first, Charcot referred to hysterical symptoms, in relation to mysterious neurological pathways, as a “sphinx”, believed to result from a lesion or injury to the nervous system (Goetz, et al., 1995, Marshall, 2003). However, the goal of his experimental research was focused on locating its origins according to its precise physical location in anatomical terms (Foucault, 2006). As an empirical display of hysteria’s neurological location, Charcot’s experimental research involved the method of hypnosis to induce an altered trance like state believed to replicate, identify, and
display the neuroses according to a theorized correspondence between the stages of hypnosis and
the states of hysteria. Hypnosis, then, was believed to induce, through simulation, a condition
that would mimic the locatable neurological pathology, lesion, or deficiency.

During the hysteria experiments in the amphitheater, women were placed on stage in
front of a live audience, under hypnosis, and were subject to the manipulation of various
mechanical, electrical, and human touch technologies used to stimulate physical reactions (Goetz
et al., 1995, Foucault, 2006). Under these conditions, Charcot’s demonstrations were claimed to
display a remarkable correspondence between the espoused symptoms and stages of the
hysterical fits. The success of hypnosis in evoking symptoms was used to produce and confirm
the existence of a pathological etiology in order to obtain a “differential diagnosis” through the
demonstration of identifiable phases of the hysteria attack of paralysis, epiloid, large movement,
and delirium (Foucault, 2006, Basavanthappa, 2007).

The importance of a “differentiation diagnosis” in neurological psychopathology is
explained here by Foucault that disorders capable of being differentially allocated in anatomy are
the “good” ones, while the “bad” ones are those with irregular, fleeting, confusing, and difficult
to analyze symptoms that are, therefore, assumed to be simulated (Foucault, 2006, p. 307).
Hysteria, also referred to as la grande simulatrice, was a ‘bad’ disorder epistemologically, in the
sense that it often eluded location and codification as well as on a moral belief that it could be
easily simulated and stimulated (Foucault, 2006). However, as simulation became integrated
into the hysteria equation, Charcot’s success with hypnosis and on demand display of hysterical
symptoms was successful enough for establishing its status as a differential diagnosis, and it was
accepted by the French Academies of the Sciences in 1882 (Zilboorg, 1941). Since anatomical
lesions were never actually confirmed in cases of hysteria, malingering or the simulation of
disease was assumed to be inherent in the disorder itself, which according to Charcot’s logic also secured a hysteria diagnosis. On the topic of malingering and hysteria, Charcot states, “It is found in every phase of hysteria and one is surprised at times to admire the ruse, the sagacity, and the unyielding tenacity that especially the women, who are under the influence of a severe neurosis, display in order to deceive … especially when the victim of the deceit happens to be a physician” (as cited in Szasz, 1974, p. 28).

In response to his method of hypnotic suggestion offering the primary differentiating factor in a hysteria diagnosis, Charcot with great pride proclaimed, “…It is truly that we see before us the human machine in all its perfection” (1888, p. 237, 188)…To be able to produce a pathological state is perfection, because it seems that we hold the theory when we have in our hands the means to reproduce the morbid phenomenon (1888, p. 373-385). An account of one of Charcot’s patients named Habill, a resident of Salpetriere for thirty-four years, claims that she had 4506 hysterical attacks, under hypnotic suggestion, in thirteen days, followed by another series of 17,083 attacks in fourteen days a few months later (Foucault, 2006, p. 311). On suggestion, Charcot states, “Suggestion is a difficult agent to handle, it is, if you permit the metaphor, a drug whose accurate dosage is far from easy. The English, who are practical people, have a saying: Do not prophesy unless you are sure. I fully agree” (Goetz, et al.,1995, p. 165).

What was suggestion for Charcot? While he claimed it to be synonymous with hypnosis, certainly other explanations are possible, such as persuasion, charm, or sheer power. However, Charcot’s understanding of its effectiveness had little to do with the practice or agent of suggestion, but rather with a theory as to why patients were able to be hypnotized. Because his entire diagnostic system depended upon his conviction and demonstration of the hypnotic state as pathological, he discursively equated hypnotizability with hysteria, as if they were the same
state, the same disorder, while leaving the orchestrator of the practice of suggestion out of the equation. As explained by Young (1995), Charcot believed hysterics were susceptible to hypnosis because they were already in a state of “auto-hypnosis” or “auto-suggestion”, a trance-like state whereby their “mental spontaneity, the will, or the judgment, is more or less obscured, and suggestions become easy” (p. 19). While Charcot partially explained the trance-like state in men according to the element of surprise and shock of injury, unlike the contemporary opinions of other physicians, he attributed the susceptibility to shock to an already present “self-induced” hypnotic state (Young, 1995). In the cases of railway accidents, the fear and shock from the injury, according to Charcot, triggered the susceptibility disorder even in the absence of a lesion. In women, there was no such explanation other than their weakened condition of hypnotic suggestibility, which was further reduced to imitation and predisposition.

According to Micale (2001), the Charcotian overall model of *les nervoses traumatique* involves a “constitutional, neurodegenerative predisposition, subjected to a (usually minor) physical accident, accompanied by a severe nervous or emotional shock, which, after a quasi-hypnotic period of weakened mental capacity, produced pathological manifestations” (p. 125). The ability to be hypnotized and subject to the suggestions of others became the defining element that constitutes a tendency towards ‘mindless’ imitation or simulation indicative of his or her malleability as a subject (Leys, 2001). Micale further argues that the “constitutional susceptibility” theory as rooted in the medical doctrine of genetic determinism became the primary explanation for hysteria as nervous degeneration, even in men (2001, p. 118-199). This discourse is linked to an emerging belief, during this time, that weakened neurological capacity was a trait of less civilized populations, explained by inferior heredity demonstrated in weakness of mind over body (See Micale, 2001, 118-119, Goetz, et al., 1995). Hysteria’s
symptoms, in Charcot’s articulation, equated the ability to be hypnotized in men and women with a “latent flaw or defect of the nervous system – a tare nerveuse – that at all times was waiting to be activated” (Micale, 2001, p. 118-119). From within these discourses about male or female hysteria, the subjects were presupposed and predisposed to have a degenerative, weakened mental, and inferiorized nervous condition. The diagnostic elements of hysteria psychopathology blurred the boundaries between the etiology, symptom, and diagnostic procedures and were conflated to the same mechanism, with minimal differentiation between cause and effect, theory and method (see Bateson & Ruesch, 1951).

As a result, hypnosis as a method of symptom activation based in a theory of pathological suggestibility assumed a pivotal place in the lineage of hysteria studies and became the source of significant scientific controversy. The degree to which the residual meanings of genetic “flaw” and neurobiological abnormality of psychiatric and trauma related disorders are still evident in an institutionalized assumption operationalized in the current DSM, raises intriguing questions as to its association with Charcot’s discourses of “constitutional susceptibility”. Perhaps this is the dissociated legacy of Charcot without the recovery of the original debate. Despite the fact that most of Charcot’s contemporaries disagreed with his conflation of hysteria and suggestibility, his interpretation of hysteria as a form of susceptibility, albeit neurological, cognitive, moral, or constitutional, has left quite a legacy regardless of its invalidity or theoretical inconsistency. If, for just a moment, the term “trauma” is substituted for “hysteria” and the patients in Charcot’s experiments are assumed to have experienced physical, psychological, or sexual trauma, as understood now, is the thread of the discourse of susceptibility evident? Politically, this discourse subverts attention away from the event, cultural conditions, or relational contexts that
caused the injury and instead positions the subject as preemptively degenerate, inferior, and flawed.

From within this new “scientized” version of hysteria, the elements involved in hysteria’s differentiated status as a diagnosis become intertwined with a questionable and contestable theory of hypnotic suggestion that not only guarantees an infallible method of “detection”, but also a triple bind technique of producing hysterical symptoms. Via an interpretation of a “weakness of mind” (i.e. suggestibility, simulation, auto-suggestion) or a “weakness of nerves” (i.e. constitutional susceptibility) coupled with the mechanical and electrical manipulation of physical reflexes and pressure points on the human body capable of producing seizure-like convulsions, the subject to the hysteria experiments were quite literally bound to produce hysterical symptoms which Charcot attributed to an unfavorable prognosis of predisposed susceptibility.

As if these terminal discourses were not enough to produce a medicalized stigma around the subjects, the public-performative context of the hysteria experiments and their representation in socio-cultural media visually solidified the already spoiled identity of the hysterical subject. The next section will explore the how discursive formation of hysteria became further fixed as a moral diagnosis through its presentation and commentary in the widely distributed Iconographie Photographique de la Salpetriere.

5.4 The Visual Element and Overlapping Spheres of Opinion: Hysteria Re-Presented

This disease in which women invent, exaggerate, and repeat all the various absurdities of which a disordered imagination is capable, has sometimes become epidemic and contagious

French Physician, Joseph Raulin, 1755, in Foucault, 1965, p. 139
The life of hysterics is just a constant lie; they put on airs and devotion and succeed in passing themselves off as saints, while they secretly abandon themselves to the most shameful actions.

French Physician, Jules Falret, 1890, in Foucault 1965, p. 307

An additional contextual and representative element of the hysteria discursive formation concerns its centrality as a matter of public debate and opinion that arguably facilitated its performative and photographic contexts in the live experiments, medical journals and in the three volume, *Iconographie Photographique de la Salpetriere*. As related by Goetz et al. (1995), the publication includes detailed case histories and photographs of the patients in various stages of hystero-epilepsy that captured the attention of medical and public audiences. Didi-Huberman (2004) further claims that the *Iconographie* was instrumental in establishing hysteria as a “real” disease through its “objective” presentation and propagation in the photograph. His research also highlights how visual form of the photographs solidified the characters and their disease “by freezing in time putative phases of the hysterical attack, the camera identified, analyzed and ultimately reified clinical events that had seemed too elusive for investigation” (2004, p. 185). In addition to the photographic realism of the disease produced in the publication, I add here that the combination of the photographed images, Charcot’s medicalized narration, and the inclusion of personal case histories positioned the disease as the plot and its named subjects as iconic characters in what is comparable to an ongoing “reality theatre”, who consequently and not surprisingly, emerged as hot topics of conversation in vernacular and scientific realms. That hysteria was of interest in overlapping spheres of opinion is clearly not a novel phenomenon, but speaks to a historical repetition of the public role that hysteria’s subject has come to assume as both a cultural and medical spectacle.

The publication utilized the largely unexplored technology of photography in scientific representations that displayed spectacular images of the characters of hysteria in positions of
physical contortion, the body in pain, the body in ecstasy, naked and bare, accompanied by expressions resembling visions of demonic possession (Didi-Huberman, 2004, Goetz et al., 1995, p. 194; Hustvedt, 2011, Marshall, 2003). The photographs of hysteria’s phases were narrated in pathological terms describing the stages, states, and interpretations of the disorder according to Charcot’s version of their case histories. The additional framing of the “formal phases of hysteria’s” contributed to the objective presentation of the disorder while simultaneously displaying the patients’ bodies in compromising, grotesque, and sexualized positions. The objectification of hysteria through photographic images, live experimentation, and discursive circulation in overlapping fields of scientific and cultural discourses invoked the character of the women in a quasi-pornographic role that did little to enhance their credibility from earlier centuries when they were believed to be demonically possessed. The scientific narration of demoralizing images further contributed to an objectified version of a moralized disease.

Barthes’ (1977) example of transposition of the “truly traumatic photograph” into technical discourse provides a fitting metaphor for illuminating how the narration of photographic representations functions to block meaning by way of the “rhetorical code which distances, sublimates and pacifies them”, ultimately intervening in the processes of signification (p. 31). The representation of hysteria in a concrete and visual form is not external to the discursive formation of hysteria during this time, but rather integral to its stigmatizing and morally degrading formation, which served Charcot’s ends, interests, and theory of hysteria. Such “non-discursive practices”, according to Foucault’s explanation (1972), provide a functional authority for theoretical discourses that are not external to their formation, but rather guide the appropriation and representation of hysteria as a disease, which as I have argued is inextricably bound with constructions of the character and subjectivity of the hysteric. The
practice of photographic representation and accompanying images are integral to how hysteria came to be known. In Foucault’s terminology, such non-discursive practices “are not disturbing elements which, superposing themselves upon its pure, neutral, atemporal, silent form, suppress its true voice and emit in its place a travestied discourse, but, on the contrary, its formative elements.” (p. 68).

In addition to the iconic photographs, the hospital itself displayed selective paintings as cultural artifacts that temporally linked historical representations of hysteria with its medicalized version. A reflection by Alphonso Daudet on his visit to Salpetireie in 1898, as quoted in Marshall (2003), speaks to this point in the description of his experience: “Fifine has had an attack!” We run. The poor child has fallen onto the cold paving stone foaming, contorted, her arms in a cross, her arched back, [the muscles] contracted, tensed almost into the air. “Quickly, nurses! Take her, lie her there...”...this parcel of mad nerves, screaming, moving, the head thrown back, a possessed at an exorcism, like I had seen in the old painting of the holy saint which I saw in Charcot’s office” (p. 1). While couched in medical terms, the enduring images embedded in historical connotations of demonic and, in Charcot’s time, sexual possession are reinforced by contextual cues in the cultural artifacts that propagate the similar implications of its pre-scientized form. The recirculation of old images, compromising positions, and physical deformities within a reconfigured technical terminology did little to intervene in the historical articulation of the hysteria formation. To the contrary, the hysterical subject evolved alongside the drama invoked by their analogous representation.

In the process of medicine saving hysteria from the demonized interpretations of religion, it merely re-created the image of the monster in a different form. Through methods of hypnosis and actual physical manipulation, Charcot demonstrated that women could be physically and
mentally manipulated into a state of sexual arousal, erratic muscle spasms, spinal contortions, and a trance like state or simulation of one. In contemporary terms, this “disorder” is comparable to a seizure, an orgasm (or a faked one), or perhaps even likened to the Balinese trance dances of the 1940’s. An even more poignant retrospective interpretation offered by Foucault strongly suggests not only a sexual relationship between Charcot and his patients, but also a positioning of the women as sexual pantomimes cooperating and performing hysteria in a relationship with a captor, using their sexual bodies to voice their resistance and their trauma in exaggerated positions of public display, despite the capturing of their physical body (2006, p 320-324). The women, I argue, can alternatively be viewed as coerced imitators of Charcot’s hysteria cooperating, according to their own interests of self-preservation, with their captor under conditions of captivity and domination.

While not much is known about the actual experience of the women in Salpetriere, in retrospect, it is difficult to deny that they were in positions of physical and psychological domination and subject to Charcot’s methods of authoritative suggestion, electroshock therapy, and mechanical genital manipulation (see Didi-Huberman, 2004). If their “performance” in captivity is viewed as both an expression of a domination-resistance dynamic, as well as embedded in a demoralizing discourse of hysteria, under conditions that subjugated the subject’s voice and experience, then how they used their body as their voice to reveal what they could not otherwise speak becomes a source of analytic insight. In reference to political and captive prisoners’ embodied resistance and expression, Hauser’s research demonstrates how resistance and pain reveal "[o]ver and against a discourse of power . . . the body in pain produces its own knowledge through concrete sensory experience of the individual, which, transformed into abstractions, can transcend the body's temporal constraints to speak uncontested truths" (2006, p.
If the framework of political prisoners and embodied knowledge is superimposed onto the subjects of the hysteria experiments, what comes into focus? Similar in logic to Sydenham’s cultural imitation theory of hysteria, the subjects’ physical symptoms display the conditions of their cultural and relational construction, which in this case implies coerced relations of sexual and physical domination in contexts of isolating captivity as displayed by the symptoms of screaming, crying, stretching and freeing movements, agonizing expressions, and sarcastic interplay between captor and captive. From within Charcot’s institutional, methodological, and relational configuration, these reactions were guaranteed to confirm the subject’s pathology, susceptibility, and symptomatic differentiation whereby it was environmentally and physically difficult to escape the ideological and performative web of the hysteria discursive constellation. When viewed as both an over determined and self-reifying configuration, this theoretical and empirical example underscores how scientific and cultural discourses are productive of the subject and objects of which they speak. The women, according to most accounts, were possibly accurately perceived as coerced imitators of Charcot’s hysteria, acting according to their own interests of self-preservation and consequently cooperated with their captor under conditions of captivity and domination.

Perhaps, as some researchers have claims, the institutionalized patients were faking their attacks. Perhaps they were cooperating with their captor, who convinced them that they were more important as objects of scientific discovery than otherwise. Maher & Maher (2003) claim that some of the research subjects were even paid for their participation in the hysteria demonstrations and that others admitted that they were coached by Charcot’s assistants on how to perform their role. On the other hand, as Foucault (2006) has suggested, perhaps they were ironically resisting Charcot’s domination through repetitive exaggeration and over-performance
of symptoms and attacks because they hoped that Charcot’s methods would be debunked if the audience members would just realize they were acting the part. Perhaps this is why a handful of patients from Salpetriere did eventually move into performance roles after their release, subsequently admitting that they were colluding because it benefited them more to cooperate than to not (Hustvedt, 2011, Didi-Huberman, 2004). If they performed their role, they were both a subject and object on an “important” stage. If they did not perform their role as a patient, it was probably unlikely that they were even allowed to be on the stage, which given the alternative, was not a compelling choice. If anything, such a dilemma for the patients caused further damage to the credibility by implying, perhaps accurately, their consent, deceit, and performance during the experiments, thus adding even more layers of meaning to their metaphorical and discursive association with the image of hysteria narrated by recurring discourses of deceit and malingering.

What is interestingly contradictory, is that despite the numerous visiting scholars and rival hospital in Paris who disagreed with Charcot’s conflation of hysteria and hypnotizability and his questionable methodologies that sparked a canon of alternative theories, then why did the character of the hysteria patient still remain on the chopping block and continue to discursively linger around the discursive formation of hysteria? Why wasn’t Charcot’s character on the chopping block, rather than his research subjects? And, why did Freud retract his sexual exploitation theory of hysteria and claim that his patients’ had “made up” their accounts?67

How was Charcot able to produce hysterical symptoms, which he then called a medical disease that depended upon and arguably produced the deceitful character of the hysteric as based in a highly contested and politically satirized “theory” of suggestibility that maintained a dominant influence in cultural and scientific spheres? On this point, Guillain, a French
neurologist who later occupied the same position as Charcot had at Salpetriere in 1923, wrote in his biography of Charcot’s life and work, “It seems to me impossible that some of them [other physicians: my emphasis] did not question the unlikelihood of certain contingencies. Why did they not put Charcot on his guard? The only explanation I can think of, with all the reservation that it carried, is that they did not dare alert Charcot, fearing the violent reactions of the master, who was called the “Caesar of the Salpetriere” (1959, p. 138-139). The wide span of his influence, extending in legal, public, and cultural contexts, in many ways maintained a monopoly on the hysteria discursive formation from all angles through controlling the communication channels/media through which hysteria was demonstrated and represented. From a critical-cultural perspective, the epistemic space from which the discursive formation of hysteria emerged displays the degree to which cultural communication, iconic characterization, and institutional arrangements exert a strong influence on the social construction of what counts as knowledge in its apparent legitimating and objectifying function. In retrospect, it is difficult to find discursive spaces from which to resist popularized articulation without the same access to media, discursive redundancy, institutional authority, and systemization of scientific constructs. With the exception of the Bernheim and the Nancy School, explicit theoretical divergence and disagreement from Charcot’s scientific opinion did not substantially occur until after his death. Despite the controversy surrounding Charcot’s hypnosis experiments and seemingly apparent self-reifying experiments, the character of the hysteric was inevitably invoked in his discursive formation of hysteria, although not without substantial objections and alternative explanations.

5.5 The Moral Construction of What: Questions of Character and Recognition

Charcot: “Let us press again on the heterogenic point. (A male intern touches the patient in the ovarian region.) Here we go again. Occasionally subjects even bite their tongues, but this would be rare. Look at the arched back, which is so well described in textbooks.”

Patient: “Mother, I am frightened.”
Charcot: “Note the emotional outburst. If we let things go unabated we will soon return to the epileptoid behavior”. (The patient cries again: Oh! Mother.)

Charcot: “Again, note these screams. You could say it is a lot of noise over nothing”.

(as cited in Herman, 1992, p. 11)

Foucault argues that the practice of physical manipulation during Charcot’s experiments with hypnosis and hysteria denotes the emergence of the ‘neurological body” as a site of pathological-anatomical localization for the identification of disease and a primary object of display, manipulation, knowledge, and suggestion (Foucault, 2006, p.298). In complement to his claim, I have argued that the moral character of Charcot’s subjects also became a primary object in hysteria’s discursive formation, in the sense of its equivocation into the hysteria equation, whereby “malingering” is implied at every stage of hysteria’s demarcation. Because of the institutional context and their positions as objects of the research, the patients’ moral character was on display in such a manner that it became an object of manipulation and observation of their public sexual bodies during the ceremonial degradation in the Tuesday Night rituals.

If, as I am arguing the subjects’ character became objects of manipulation, measurement, and inquiry, then one must question the potentiality for one’s moral character to be altered if it is repetitively and redundantly positioned as morally reprehensible, intentionally deceitful, and historically demonized? In other words, at what point does the suspicious discourse about the malingering and imitative character, as an object of scrutiny, begin to the construct the conditions under which it is possible to only be the subject position proscribed by its objective display?

While Foucault frames this arrangement as the ‘the great maneuvers of hysteria” because it demonstrates a phenomena of struggle between neurology and the hysterie, this institutional arrangement also directs attention to the asymmetrical positions of the doctor and the patient in the context of treatment, the physical capturing of the ‘neurological body”, and the extension of
their social body in cultural texts. Through playing her role as a subject of medicine and exhibiting phases of hysterical attacks necessary for the performance, the patient could be understood as strategically participating in her own citizenship as a contributor to medical science and to the reputation of her role in society in cooperation with the performance’s iconic conductor. Perhaps this is why Charcot is ironically credited with restoring dignity to the hysterical in that they “acquired the right to be ill and not mad thanks to the constancy and regularity of her symptoms” (2006, p. 310). Together, the doctor and patient perform hysteria, a relationship of mutual constitution in the repletion of traumatic revelations and silences embodied by their coerced consent. From this perspective, the phenomenon of hysteria-hypnosis shifts… from a theory of human behavior to a site of human struggle for recognition, from abject to object (Foucault, 2006, p. 308-309).

The scientific apprehension of hysteria as an illness, however, appears to have done very little to liberate hysteria from its gendered and supernaturally explained origins. If anything, it appears to have advanced, rather than liberated the patient’s character maladies and solidified, all the more, the spoiled moral status of the patient. However, the centrality of the “hysteria craze” throughout history cannot be explained by Charcot’s influence alone (Goetz, et al., 1995). As developed in the first section of this chapter, hysteria throughout the ages has remained central to civilizations’ cultural heritage and debates over belief, knowledge, and moral character. In this sense, hysteria has always been a matter of public opinion called forth by dramatic exigency that touches upon foundational beliefs about what is true, good, and ugly. As a shifting signifier, hysteria has moved from uterus to demon, demonic to genetically flawed, degenerate to malingering, abject to object, hysterical to traumatized, evil women to weak men, and dancing maniacs to sexual pantomimes. As an elusive mystery embodying a perpetual strangeness,
hysteria’s movement as a symbol exemplifies Burke’s notion of “Symbol as Enigma, as both clarification and obfuscation, speech and silence, publicity and secrecy”, which reveals and conceals whatever it is intended to signify (1969, p. 120). Positioned intricately within normative and cultural distinctions, hysteria’s articulations have played an important role in the hierarchy of humans that makes possible the “moralization of status” as a scapegoated and moral protected dialectical term that combines the “contradictory principles of identification and alienation” in a ritually protected “courtship”, described by Burke as an example of the unrest of *Homo Dialecticus* (1969, p. 140-141).

Never have hysteria’s articulations remained neatly isolated in one domain of opinion or understanding, which speaks to the degree to which its rhetorical and visual presence as an object of discourse and theorization confirms that any matter able to invoke such controversy is subject to, and constructed through, processes involving multiple publics, spheres of knowledge, and interconnected discourses. Hauser’s (1999) theory of reticulate public spheres as displaying multiple, local, and interactive webs of meaning and opinion is relevant for framing how the discursive formation of hysteria is also a rhetorical phenomenon as demonstrated in the interconnectivity across and between overlapping historical, vernacular, and institutional domains of discourse. Viewing hysteria as a display of a narrated and fragmented reticulated field of meaning and over-determined interpretation speaks to not only to its discursive continuity and shifts over time, but also, given its continued morally transgressive status, to the unpleasant thought that cultures throughout history have enjoyed these debates. The varying articulations of “hysteria” are retrospectively comical at times, but also indicative of tragic differentiations that conceptually function to establish a hierarchy of superior positions from
which to judge others according to discourses proliferating gendered, moralized, genetic, and/or neurological susceptibility and promulgating human inferiority.

The problem is not that there has been a lack of alternative theories of divergence from what is considered normal behavior, madness, and psychopathology as adaptive, social, environment, and not terminal or predetermined. Rather, the stigmatized version of hysteria has appeared more often than not, independent of its changing etiology over the ages, resulting in a discursive construction of forms of human inferiority that have not only provided the entertainment of the public spectacle, but also a politicized platform for authoritative investigative missions and scientific inquiry, which can also be viewed as an arena for social scapegoating, justifications for human alienation, and, at times, the narcissistic indulgence of the investigator.

5.6 Alternative Trajectories of Charcot’s Hypnosis-Hysteria-Suggestion Configuration: Dissenting Views from the Nancy School, Babinski, Janet, and Freud

Up to this point, I have centralized the discussion around the influence of Charcot’s hysteria experimental research on its social, cultural, and discursive construction of the character and subject position of hysteria patients and raised questions about the enduring impact that such maneuvers have on the moral status of the captive patient when it becomes an object of measurement, visual display, and scientific narration. Although the conceptual threads of hysteria’s moral pathology as connected with suggestion, suggestibility, and simulation have relatively disappeared from the discursive field of psychopathology, the implications of its scientized and stigmatized status maintained a dominant and enduring discursive and formalized presence in the institution of psychiatry that extended into WW-I. However, numerous alternative explanations emerged out of a theoretical dissatisfaction with and in critique of Charcot’s neurological and moral representation of hysteria as based in a theoretical formation of
pathological and degenerative suggestibility. Despite its monumental impact on scientific opinion, stigmatizing character attributes, and contemporary diagnostic differentials for neurological explanations of psychopathology, Charcot’s articulation of hysteria inspired and was arguably generative of counter-discourses challenging his deterministic production of a hysteria diagnosis as based in pathological susceptibility to suggestion. These counter-discourses around Charcot’s hysteria resulted in alternative theories that attempt to explain and differentiate the hysteria-hypnosis-suggestibility-susceptibility configuration of ideas according to alternative articulations of each of these concepts or combinations thereof. Such critiques emerged in cultural, scientific, and even in Charcot’s retrospective career discourses.

That Charcot was the actual orchestrator of the hysterical symptoms became a common critique from French cultural commentaries as well from his research contemporaries and rivals. By the time of death, his research is said to have been theoretically refuted and culturally satired (e.g. “finding hysteria everywhere”). Goetz’s research discusses a cultural commentary addressing Charcot’s fixation on suggestion demonstrated in a cartoon that was published in the French satirical literary magazine Todays Men (Les hommes d’aujourd’hui, 1889). The sketch centers Charcot’s head in the middle being swallowed by a bigger skeleton head with outcroppings of two contorted hands with a few missing and irregularly shaped fingers on each side of the death head, simply entitled “SUGGESTION” in irregular letters (1995, p. 212). According to Goetz et al. (1995), Charcot himself started to question both hypnotism as a “pseudoscience” and the growing “sensationalism” around its fascination in scientific and cultural circles (p. 211). Critics and observers have claimed that he never actually hypnotized his patients, that his hysteria demonstrations were faked, and that his assistants “coached the patients on how to act the role of the hypnotized or hysterical person” (Szasz, 1974, p. 29).
Even in its time, Charcot’s and the Salpetriere’s pathological “doctrine on hypnotism as an experimental neurosis” of hysteria was a source of great disagreement and skepticism among his colleagues, neurologists in Germany and Great Britain, and the neighboring Nancy School led by Hippolyte Bernheim (Goetz et al., 1995).

In the section to follow, I specifically focus on significant oppositions to and alternative explanations of the phenomenon of hysteria put forth by the Nancy School, Babinski, Janet, and Freud according to how they differentiated and/or reconfigured elements of Charcot’s version of hysteria. While these counter-discourses did little to intervene in the dominance of Charcot’s articulation at the time, I suggest that they planted discursive seeds integral to later theoretical trajectories and developments in psychiatry, post-combat traumatology, and communication theories of psychopathology and its treatment.

The Nancy School: Normalizing Suggestibility and the Power of Positive Suggestions

In 1890, Charcot’s Salpetriere School and the Nancy School of thought on hysteria-hypnosis went head to head when asked to testify in the murder trial of Gabrielle Bompard, whose defense claimed she murdered bailiff Gouffe under the hypnotic influence of her lover Eyraud (See Goetz, et al., 1995 for details of this story). The testimony from Salpetriere claimed that no one could be enticed to do something out of character while hypnotized, therefore, Gabrielle was not a hysteric (Goetz, et al., 1995, Micale, 1995). On the other hand, experts from the Nancy school argued that Gabrielle was induced to violence by hypnotic suggestions, citing one of their own research studies to provide evidence for their claim. In the research presented during their expert testimony, the Nancy school’s study hypnotized over 1000 patients and “normals” in order to test Charcot’s theory that the ability to be hypnotized constituted the pathology of hysteria. Their research found not only that most people could be hypnotized, but
that such suggestions would endure over time, with the longest interval between suggestion and execution being a year, concluding that suggestibility was normal, gender neutral, and that suggestions temporally lingered (Goetz, 1995, Micale, 1990, Bernheim 1884).\(^{72}\)

The controversial trial is noted for its *déjà vu* like reappearance and dramatic entrance into the realm of medical, legal, and cultural debate. Gabrielle’s lover Michel Eyraud was sentenced to death and Gabrielle was sentenced to twenty years in prison (Goetz, et al., 1995). What is interesting about this case is not just the fact that hysteria is once again on trial in a public and legal spectacle invoking competing theories, but that Charcot’s theory of hysteria and hypnosis proved to be the chosen school of thought in the verdict.\(^{73}\) Compared to Charcot’s research, the Nancy School’s had a much larger sample size, believed that hysteria symptoms could be relatively cured through hypnotic and “positive suggestion”, and directly challenged the foundational claim of Charcot’s theory and methods. However, such evidence was clearly not enough to counter the dominant school of thought.

Whereas Charcot believed that susceptibility to hypnosis was one of the symptomatic indicators of hysteria, the Nancy School argued that hypnotic susceptibility was not, in and of itself, a psychopathology or a legitimate source of differentiation among “normals” and “hysterics”. In contrast to Charcot’s instrumental use of hypnotic suggestion to reproduce the symptomatic existence of hysteria, the Nancy school utilized hypnotic verbal suggestions in hopes of changing the person’s behavior, beliefs, and attitudes, understood as incapacities associated with hysteria’s symptoms (Basavanthappa, 2007). Believing in part that hysteria was the product of acting according to the wrong suggestions, the Nancy school attempted to replace wrong suggestions with more positive suggestions during both hypnosis and wakefulness (Basavanthappa, 2007). They also disagreed with Charcot’s three stages of suggestion-hypnosis
of catalepsy (a trance like state of inactivity), lethargy (tired and exhausted), and somnambulism (the patient would talk and respond to the doctor’s suggestion) on the basis of their argument that hypnotic stages and behaviors vary according to individuals. Whereas Charcot argued that hypnosis imitates and displays an experimental form of hysteria, the Nancy School argued that Charcot’s three stages of hypnosis were not an indication of hysteria, but rather artifacts of Charcot’s specific instructions and “suggestions” (Maher & Maher, 2003).

The fact that “suggestion” emerged as a controversial object and technique in the Nancy School’s challenge is highlighted here as well as the fact that suggestion became divided into positive and negative as a function of the influence of human communication on “normal” and “abnormal” behavior. In this configuration, the phenomenon of the power of negative and positive suggestion emerged as plausible explanation of psychopathology and its treatment.

*Joseph Babinski: Pithiatism and the Power of Persuasion*

One of the more intriguing re-configuration of elements in Charcot’s theory of pathological suggestibility was articulated by the French neurologist, Babinski (1857-1932) who worked with Charcot at the Hospital Salpetriere for two years (Young, 1995). After observing the experiments at Salpetriere, Babinski (1918) challenged Charcot’s theory of hypnotic suggestibility on the basis that the phases of hysteria exhibited in the experiments were more likely to be the product of mimicry-simulation behavior (due to group wards which housed both hysterics and epileptics) and/or the result of the intentional or unintentional manipulation of the hypnotist (Young, 1995, p. 73). Babinski did not completely dismiss Charcot’s theory of hysteria as pathological suggestibility, but instead divided suggestibility into a pathological and normal form, and hysteria into the “Great Hysteria” (prone from birth) and “little hysteria” (post-reaction to trauma, accident, or emotion) (Phillippon & Poirier, 2009). According to Micale
Babinski was skeptical of Charcot’s distinction between suggested and simulated phenomenon and instead chose to distinguish normality and abnormality on the basis of persuasion and suggestion. Within his framework, “normal” people could be persuaded, while abnormals would be susceptible to suggestion (Roudebush, 2001). Related to the Nancy School of thought on the communicative influence of the doctor, Babinski’s theory and treatment of hysteria was grounded in countering the “bad” suggestions or influences with “good” persuasion, a technique he thought could be used to treat both the genuine and simulated symptoms (Young, 1995). According to this logic, suggestion was an evil by administration and reception, whereas persuasion acted on the will and rationality of the patient.

In collaboration with Jules Froment, *Hysteria or Pithiatism and Reflex Nervous Disorders in the Neurology of War* (1918), Babinski reconfigures hysteria and names it *Pithiatism*, which means literally means to “cure by persuasion”. According the Philloppon and Pourier (2009), Babinski defined the pithiatic disorder as a “disorder created by suggestion and curable by persuasion” (p. 306). Accordingly, counter-suggestion or persuasion could be repetitively applied to remove hysterical symptoms by the authoritative and untouchable role of the doctor who must perform their part “flawlessly and consistently” in their therapy. Babinski outlined the role of the doctor or therapist as the “great persuader” who could direct, perform, and detect. In the Babinski usage of suggestion, suggestion retains its pathological origins, but is nonetheless curable by persuasive processes administrated by the doctor. This configuration replaces hysteria with pithiatism, dissociates it from hypnotism altogether, and rearticulates the condition as “curable” through communication, or more specifically, the persuasive and rational strategies of the doctor (Foucault, 2006).
Pierre Janet: Dissociation, Distraction, and the Power of Forgetting

Also in disagreement with Charcot’s totalizing concept of pathological suggestibility was his student protégé, Pierre Janet, who wrote in The Mental State of Hystericals (1901), “Suggestion requires, in order to be developed, a mind relatively sane; this is an idea already expressed by Bernheim, and we are happy to find ourselves agreeing with him. The first condition of suggestion is a certain strength of mind” (p. 269). While he disagreed with Charcot’s belief that suggestibility is synonymous with hysteria pathology, Janet retains hysteria as resulting from a “moral” pathology, stating that, “it (hysteria) is above all characterized by moral symptoms, the principle one being a weakening of the faculty of psychological synthesis, an abulia, ...If we would sum up in two words this rather complex definition, we should say: Hysteria is a form of mental disintegration characterized by a tendency toward the permanent and complete doubling of the personality” (1889, p. 528). While Janet’s understanding of hysteria maintained the thread of Charcot’s discourses of hysteria’s cognitive and moral weakness, he also proposed alternative explanations for the phenomenon of suggestibility in relation to an explicitly persuasive and controlling position of the doctor for intervening in hysterical symptoms.

As a therapeutic technique, Janet applied hypnotic suggestion as a strategy for inducing what he terms “dissociation”, also referred to as the ‘splitting of consciousness” or “double think”, which he describes as simultaneous altered states of experience while in a hypnotic trance (Herman, 1992, Hacking, 1995, Janet, 1889). These observations led Janet to consider the theoretical and experiential possibility of “simultaneous rather than alternating consciousness” or dual awareness while in a hypnotic trance (p. 323). Janet understood hysteria in relation to an injurious event effecting a double consciousness and consequently utilized hypnosis as a method
of replicating that split in order to utilize the power of suggestion to remove or forget the historical memory. Similar to Babinski’s stance on the curative and persuasive role of the doctor, Janet’s application of hypnosis as a technique relied heavily on the therapists’ authority and direction to influence the behavior of the patient through suggestion, excitation, and outright persuasion. In 1923, he wrote of his role in this task, stating that, “The physician must help this woman stop carrying out these absurd actions, teach her make others, give her another attitude. To forget the past is in reality to change behavior in the present. When she achieves this new behavior, it matters little whether she retains the verbal memory of her adventure, she is cured of her neuro-pathological disorders” (as cited in Leys, 2001, p. 115). Babinski distinguished the role of suggestion in the therapeutic process as a direct product of the doctor’s rhetorical skills for “improving the subject’s mental synthesis by producing modifications in conduct and behavior”.

Employing a technique called hypnotic “distraction” to induce dissociation in his patient Leonie while she was talking to a third party, Janet and others concluded that “The subject, on awakening, executed the post-hypnotic suggestions without knowing who had given them to her, but retrieved them on entering a new somnambulistic state” (1889, p. 330). The therapist then could influence the un-attending state of awareness during hypnosis in order to remove bad memories and suggest new behaviors without the conscious participation of the patient. In terms of an event leading to hysterical symptomology, Janet aligned with Freud in believing that a traumatic event lead to the conditions of dissociation and memory loss, but still thought hysteria was nonetheless pre-determined by mental degeneration and weakness. However, in contrast to Freud’s focus on retrieval of dissociated memory, Janet attempted to induce dissociation as a “state” for the curative purpose of memory erasure and suggestion implantation.
In contrast to Charcot who used hypnotic suggestion to demonstrate pathology and reinforce his theory of hysteria’s numerous susceptibilities, these alternative conceptualizations re-proposed and differentiated suggestion in a curative matter that attempted to therapeutically intervene in symptoms of hysteria through varying forms of communication strategies. In comparing the Nancy School’s, Babinski’s and Janet’s understanding and treatment of hysteria, we see a commonality among their discourse as implicating the doctor or therapist in a position to exercise their powers of strategic suggestion or persuasion on the passive recipient patient position in order for the doctor to “do their work”. Ley’s (2002) describes this orientation to doctor-patient communication according to a “surgical model” of the therapeutic context whereby the patient is simply treated as a puppet and conduit for the contents of the hypnotic suggestion or strategic persuasion to “take”, consequently implying little or no responsibility, participation, or agency in their own treatment or understanding of their condition. As will be discussed in the following section, Sigmund Freud was perhaps the most radical dissenter from Charcot’s orientation to hysteria’s pathology as well as to his belief in the curative potential of the “surgical model” of therapeutic communication.

Sigmund Freud: Psychical Trauma, the Speech Apparatus, and the Power of the Word

In alignment with Bernheim, Babinski and Janet, Freud parted theoretical ways with Charcot on the pathological state of the trance, but additionally disagreed that hysteria could be understood according to organic neurological processes or a distinctly location in the brain. Freud’s work with Josef Breuer countered a moral or mental degeneration theory of hysteria with the concept of “precipitating trauma” as closely linked to the manifestation of hysterical symptoms, stating that: “Our experiences have shown us, however, that the most various symptoms, which are ostensibly spontaneous and, as one might say, idiopathic products of
hysteria, are just as strictly related to the precipitating trauma as the phenomena to which we have just alluded and which exhibit the connection quite clearly.” (Freud & Breuer, 1893).

According to most accounts, Freud initially embraced hypnosis based on the assertion that “hysterics suffer mainly from reminiscences” and subsequently utilized hypnosis as a method of dissociated memory retrieval of the precipitating event for the purpose of abreaction or “attachment catharsis” believed to release stored excitation and affect, which at first was theorized to account for the impact the “precipitating trauma”. Freud’s explanation of the impact of trauma as the precipitating etiology of hysteria is summarized as “a state of paralyzing fear or autohypnosis, for example, blocks a proper reaction discharge …. failure of the nervous system to discharge ‘the attached affect’ and thus the nervous system cannot maintain the ‘constancy principle’” (Young, 1995, p. 36, Breuer and Freud 1893/1955, p. 10-11). As Habermas interprets, “the symptom comes into being through the damming up an affect…. the conversion of a quantity of energy that is impeded in flowing out” (1971, p. 250-251). According to Goetz et al. (1995), Freud was interested in Charcot’s third stage of hysterical stimulation, which he termed the “hysterical passionales” as connected to neurological excitation overload or the “sum of excitation” of blocked emotional impact. By way of this logic, the psychical or social constriction of adequate release of affect was believed to render the nervous system incapable of a return to equilibrium, or a comfortable state of excitation, hypothesized to result in the restriction of the continuity of ideas via association and/or motor reactions (Freud & Breuer, 1893, p. 32). Accordingly, the authors state that it is through this logic that “we arrive at a definition of psychical trauma which can be employed in the theory of hysteria: any impression which the nervous system has difficulty in dealing with by means of associative thinking or by motor reaction becomes a psychical trauma” (p. 32).
While hypnosis was initially implemented as a method of traumatic memory retrieval in service of affective catharsis, Freud soon abandoned hypnosis in favor of techniques that involved the active participation and communication of the patients. In other words, hypnotic catharsis was not enough. As Freud’s discursive and conceptual constellation of the etiology of hysteria as precipitated by trauma expanded, his therapeutic strategies followed accordingly. While Freud is traditionally credited with the “talking cure” as a method of treating symptoms arising from psychological trauma, his primary emphasis was not talking per say, but rather on the function of talking for accessing that which has been “excommunicated” via disassociations of symbolic representations believed to have been disrupted during the cognitive and physical response and reaction to the traumatic event. Set forth in a neglected piece of Freud’s work is a rather complex and holistic theory of the integrative and “therapeutic function of human speech” (Rizzuto, 1997, p. 2). Published in 1891, but not translated in English until 1953, Freud’s On Aphasia: A Critical Study (1891) addressed a “group of speech disorders in which there is a defect, reduction, or loss of linguistic functioning” known as aphasia (Ferber, 2010, p. 133). Inspired by his work and observations with Charcot’s hysteria experiments, Freud presents the concept of the “speech apparatus” to account for how psychical or physical injury, pain specifically, disrupts spoken and/or written communication, reading, understanding, expression, and/or interpreting meaning (Ferber, 2010). 75

In critique of and contrast to the dominant trend in neurological research at the time as hyper-focused on localizing and matching the anatomical function in the brain with the physical symptom or abnormality, Freud rejected theories of speech based in localization and centralization of functional centers in the brain and instead speculated that the speech apparatus was more comparable to a network of associations, dispersed functions, and interconnected
pathways and processes in the brain and body (Rizzuto, 1997, Ferber, 2010). Therefore, aphasias were viewed as resulting from disruptions of associative mechanisms of the speech apparatus which interrupted some aspect of the theorized interconnectivity between object associations, word images, and sensory perceptions assumed to be linked by pathways in the nervous system and nervous fibers extending out into the body transmitting sensory impressions (1997, p. 5). In Freud’s model of the organization of the word, psychical trauma is dependent upon dissociations between representation of conceptual words, the representation of things (objects), and their connection with auditory, visual, and motor images. According to Rizzuto, “the Freudian word is always, according to the model of the speech apparatus, the complex and highly organized processing of perceptions, registrations, and neuro-symbolic transmutations of a bodily mind” (1997). As a counter discourse to Charcot, Broca, Wernicke and other prominent neurological research on pathology and psychopathology intent on finding a precise cerebral location that accounted for the manifested symptoms, Freud’s model de-centered and expanded the function and processes of language into what Forrester (1980) frames as a “zone of language”. Consequently, Freud’s development of his therapeutic technique of “talk therapy” was based in a theory of communication as capable of assimilating, integrating, and reconciling a breach in the system of language (Ferber, 2010).

From this perspective, psychological trauma impacts the symbol system of representation, expression, and understanding in a manner believed to produce distortions in private and public communication and consequently, disturbances in self-knowledge (Habermas, 1971). Habermas’s analytical reading of Freud is especially useful here in highlighting that Freud’s articulation of the “symptom” as a “split-off symbol” or “symbol whose function has been altered” impacts the subjects’ “symptomatically publicly distorted communication” (p.
Read as a symbolically distorted or censored text assumed to reflect a “communication disturbance within himself”, Habermas highlights that within Freud’s work the “split-off symbol” is produced under conditions whereby “the privatized portion of excommunicated language” is silenced, either through limitations of communication produced in the contexts of power relations or by the subject himself (1971, p. 257, p. 228).

During the first phase of Freud’s attempt to understand hysteria etiology, he introduces and tries to integrate the concepts of emotions and their catharsis, psychical trauma, associative thinking, physical motor reactions, traumatic memory, and the nervous system into a complex configuration of interrelated and interdependent processes that could account for hysteria psychopathology. The second phase of his inquiries expands into a communicative approach to therapy that considers how psychical trauma impacts and disrupts a hysteria patient’s speech apparatus. Accordingly, he proposed that the traumatic event displays itself in the “failure of language” assumed to display itself as a “wound in language”, which arguably established the epistemological foundations for “talk therapy” as the corollary treatment as a method of activating, associating, and restoring elements of the speech apparatus (see Ferber, 2010, p. 143, Rizzuto, 1997 for a more detailed excavation of Freud’s work on aphasia and the speech apparatus). Of particular interest in Freud’s articulation is the centrality that communication techniques come to assume in treating symptoms of hysteria theorized as resulting from a traumatic interruption in the representative, expressive, and symbolizing function of the speech apparatus.

From within Freud’s theory and method of treatment, new communication considerations and objects of analysis emerge that are particularly important for understanding the associative and curative role that doctor-patient communication assumes in treating language as a disrupted
symptom of psychological trauma. From this perspective, Freud’s contributions are important as a micro-history of communication theories in the psychoanalytic enterprise. Specifically, he developed the therapeutic strategies of free associative doctor-patient communication, the active participatory and reflective subject position of the patient, and communication about the communicative context and content of the transference relationship between the doctor and the patient.

As dialogic strategy, facilitating “free associative communication” in the therapeutic context works to remove “the blocking force that stands in the way of free and open communication” as a strategy of connecting and expressing dissociated representations of the speech apparatus (Habermas, 1971). In support of this point, Rizzuto (1997) claims that Freud’s methods depend upon “verbalizing experience at the service of the affective expression and integration of memories, fantasies, perceptions, and beliefs accumulated in the complex process of development constitutes the core of the analytic enterprise and technique.” (p. 2). Dialogic communication in the sense of free association of ideas was utilized as a method of removing blockages, gaps, and distortions that inhibit free and open communication in the patient’s account of their life experiences (Habermas, 1971, p. 230). From within this framework, patient expression during free association of verbalized ideas is not talking for the sake of talking, but rather becomes a dialogic method for accessing, connecting, and integrating emotions, symbolic representations, and aspects of one’s history assumed to have become dissociated and fragmented into a symptom formation.

After observing a relief of hysteria symptoms in patients after they talked, the technique of “free association” was also utilized as a method of encouraging patient participation and interpretive reflection (Habermas, 1971). In opposition to neurological and monological
treatments, Freud was convinced that the intersubjective exchanges between the doctor and patient aimed towards achieving understanding in ordinary language through processes of talking and listening possessed the potential to relieve symptoms unsurpassed by other therapies (Rizzuto, 1997). Doctor-patient communication, then, was theoretically articulated as an emotionally invested context of open communicative and collaborative interpretation believed to facilitate what Habermas refers to as “self-formative processes” about which the patient has remained deceived, unaware, and unable to bring into discursive reflection. The goal of the analytic communicative dialogue then was in service of “making conscious…as a process of reflection” in such a manner that engages the cognitive level and is capable of “dissolving” affective resistance to self-knowledge (Habermas, 1971, p. 229). Dialogic free associative communication between the doctor and the patient then positioned the patient as an active participant in interpretive processes whereby “self-formative processes” emerge as an object of therapeutic discourse that simultaneously demands moral responsibility on the part of the patient for the content of their malady (Habermas, 1971).

Related, yet distinguished from free associative reflective communication, is Freud’s theory and technique of “transference communication” whereby the context and content of doctor-patient communication becomes an object of discussion in Freud’s therapeutic discourse. Transference is assumed to occur in the analytic situation when doctor and patient talk and listening to each other in such a way that patterns of communication emerge, between the interlocutors, which are believed to replicate an important unresolved and excommunicated experience in the patients’ life history. As a relational dynamic theorized to maintain disturbing symptoms and a therapeutic contextual construct believed to provide an immediate opportunity to resolve a historical conflict, transference is understood as an important cognitive and affective
dynamic of doctor-patient communication when brought to the level of discursive reflection. According to Freud (1912), the manifestation of transference is rooted in the capacity to love and form emotional attachments that reveal the patients’ faulty associations, distorted emotional transfer of relational contexts, and an ambivalent resistance to change as these are played out in the therapeutic context. When such displaced and patterned emotions and interpretations occur in the therapeutic relationship, they become a source of insight for reflecting upon the patients’ life history and communicating about the threads connecting historical conflict to the immediately accessible communicative and emotion responses in the therapeutic context. Freud strongly advocated that “this is the ground on which the victory must be won, the final expression which is lasting recovery for the neurosis” (1912, p. 322).

I want to underscore that the meta-communicative component, as the primary therapeutic communication technique associated with utilizing transference dynamics, requires that the doctor and patient talk about their relational communication and reflect upon historically enduring patterns of interpretation. During this process, the patients’ self-formative processes and their communication patterns emerge as the object of the therapeutic meta-discourse assumed to intervene in the patients’ “meta-communicative habits”, which are theorized to function as a mechanism of learning, self-knowledge, and a higher level of abstracted reflection (Bateson, 1972, Habermas, 1971). Meta-communication, in this sense, becomes capable of intervening in split-off symbolic dissociations through engaging the speech apparatus at the level of communicative reflection when communication becomes the object of analysis. Freud’s “analytic enterprise” depends on two complimentary assumptions concerning the importance of the doctor-patient relationship and communication technologies that work to bring into examination, that which has remained outside of the immediate cognitive awareness of the
patient. The action of language, and reflection thereof, serves the purpose of bridging associations through procedurally encouraging new ways of talking about and interpreting the past, the present, and the connection between the two. In short, Freud used communication techniques as a means of intervening in the meaning and interpretation of haunting (dis)associations and distorted interpretations of reality by relying upon engaging the speech apparatus to construct not only new objects of discourse, but also a transformed subject through the act of discursive reflection.

5.7 Hysteria and the Emergence of Therapeutic Communication Models

In contrast to his contemporary’s theorizing the role of the patient as passive recipient of hypnotic suggestion and strategic persuasion, Freud radically diverged from the “surgical model” of psychotherapy by postulating the relationship between the doctor and the patient as one of transference communication and the role of the patient as needing to be participatory in the symbolic interaction in order for substantial self-reflection and understanding of their symptoms to occur. These distinctions can be further divided along lines that highlight the preferred type of doctor-patient communication according to a monological or linear mode of communication and a participatory model of communication. Such distinctions also highlight controversies over how to treat the patient that imply significant and unexplored roles of communication and persuasion in the treatment of trauma. Believing that the therapeutic relationship forms the basis for the success of communication and meta-communication to intervene in symbolic dissociations, Freud’s introduced participatory processes of interpretation/analysis that resemble conditions of dialogue in the therapeutic context (Habermas, 1971, Hacking, 1995, p 144). While Freud’s work remains a ripe area of complex understandings of how traumatic events affect over-determined representations and their expression, it has generally remained outside
mainstream, neurologically oriented psychiatric discourse, that Lerner (2003) argues have systematically rejected trauma in the quest to understand psychopathology.

In this exploration of alternative theories to Charcot’s version of hysteria pathology and suggestibility, I want to highlight themes from the Nancy School, Joseph Babinski, Pierre Janet, and Sigmund Freud as postulating four distinct types of therapeutic communication orientation in terms of positive suggestion, rational persuasion, distractive-dissociative communication, and dialogic-associative meta-communicative models. Distinguished by different theories of psychopathology and subject positions for the doctor and patient, they are nonetheless unified by a discourse that appropriates communication processes as linked to the formation of symptoms related to hysteria as well as the development of intervention strategies. Based on this claim, the discursive formation of hysteria prompted the theoretical consideration of the role of communication in the psychiatric enterprise. As argued by Pettigrew (1977), “psychoanalysis is itself a rhetorical venture” which he claims has been neglected by rhetorical, and if I may suggest, communication scholars more generally (p. 46). Thus, one of the neglected and unofficial histories of communication theory, as a practical theory, can be articulated as an attempt to reconfigure elements of Charcot’s hypnotic suggestion and suggestibility pathology that simply did not resonate with conscientious observers. However, Charcot’s articulated linkage between symptoms associated with hysteria and malingering survived quite well in psychiatric discourse long after the theory of pathological susceptibility dropped off the discursive map.

5.8 WW-I and the Royal Military Army Corporation: To Detect the Malingers

Maligner’s parasitic art has progressed with the times; nowadays, he does not hesitate to attempt a counterfeit of the symptoms of diabetes, jaundice, cardiac and pulmonary disorders, etc.….It is often difficult to say whether hysterical mimicry is at work---the epigram of the authors that hysteria gives a
Between 1914-1918, hysteria-like symptoms would once again appear in epidemic proportions across the Western world, particularly in France, Italy, and Great Britain. Only this time, ‘hysteria’ was observed in large scales among male combat veterans in mass proportions, sparking more explosions in theory and debate about traumatic neurosis. Consequently, WW-I provided an immediate exigency as well as an immense laboratory for the development of physical, neurological, and psychological explanations for a wide range of post-combat problematic disorders (Micale, 2001). World War I, also known as the Great War, was responsible for the death of over 1.75% of the world population (16.5 million total civilian, military, and war-famine-related deaths). Twenty million people were physically wounded. Hospitals were built exclusively to house the wounded soldiers particularly in France and Great Britain (Meyers, 2001, Showalter, 1985). Consequently, between 1870 and 1920, “an entire gallery of medical authors engaged the theme of psychic trauma” and offered a large body of literature and research that would be excavated during this post-war time to try to make sense of these strangely familiar and yet still mysterious expressions (Micale, 2001, p.135). And the debates resume.

In this section, I focus specifically on the emergence of questions addressing the mass re-occurrence of hysterical symptoms in men that raise old issues about the moral character of the subject. In addition to malingering entering into the discursive formation of the hysteria diagnosis, it had also become a plausible explanation for post-combat disturbances and eventually assumed a category all to itself in British military psychiatry. While the term and implication of “malingering” did not originate within the hysteria diagnosis, this analysis
suggests that its conceptual linkage and association with the hysteria diagnosis contributed to its eventual diagnostic formalization.\textsuperscript{83} This section is structurally organized similar to the preceding analysis in the sense of centering the debates around the “official” dominant diagnostic formations and differentiations in order to identify their discursive trajectories that appear or re-appear in a concrete place and time, which illuminates elements of conceptual continuity, categorical divisions, and what up to this point I have referred to as “counter-discourses” that emerged in opposition to and/or were immediately rejected in scientific orthodoxy.

In Great Britain in particular, traumatic war neurosis afflicted British soldiers in mass proportions. Debates within the Royal Army Military Corporation (RAMC) in London take center stage in response to the overwhelming psychiatric casualties, with estimates that mental breakdown constituted 40\% of casualties in Britain. Reports indicate that the RAMC went to great lengths to keep this problem concealed from public knowledge (Herman, 1992). In 1914, British psychologist Charles Myers coined the term “shell shock” to denote a nervous disorder used to describe the concussive effects of exposure to explosions (Kudler, 2011). Myers asserted that ‘shell shock’ was the “the result of functional dissociation arising from the loss of the highest controlling mental functioning” (as cited in Meyers, 2004, p. 232; Myers, 1919, p 51). In 1916, Myers began to reconsider a total neurological explanation of the condition and made the distinction between ‘concussion’ and ‘nervous shock’, with the ladder explained by exhaustion, horror of war, and episodes of physical danger. In Great Britain, the category of shell shock became the topic of fierce debate in part because there was a lack of an identified organic location responsible for their symptoms such as hysterical paralysis, aphasia, blindness, deafness, contractures, nightmares, hallucinations, and insomnia (Meyer, 2004, p. 198-199). Charles
Myers disagreed with F.W. Mott and Gordon Holmes, neurologists in charge of the “shell-shock” cases in the RMAC, who believed that the absence of organic causes for shell shock was evidence of “an acquired or inherited neuropathy” (Micale & Lerner, 2001). After Myers was demoted from his position as consulting psychologist to the British Armed Forces, the RAMC concerned itself with making diagnostic distinctions to discern between malingering and “genuinely” impaired soldiers (Roudenbush, cited in Micale & Lerner, 2001, p. 263). There was no consensus in scientific opinion as to whether shell shock was an inherited, nervous shock, or malingered condition, and its presence in scientific and public discourse was a source of both scientific controversy and textual censorship. In 1917, Charles Myers submitted a paper on shell shock to the British Medical Journal that was denied publication due to orders to the press that nothing regarding the subject of “shell shock” was allowed to be publicly released in order to restrict access to such publications by the newspaper press (Jones, et al., 2007). As Jones et al. (2007) underscore, prior to 1917, shell shock was a relatively stigma-free diagnosis because it was understood as the result of a physical injury or neurological lesion. However, because many claims of “shell shock”, as Myers had argued, could not be confirmed in relation to a physical locality, controversy ensued “when the military authorities deliberately discouraged use of the term and suggested an association with malingering, did it become a controversial diagnosis” (Jones et al., 2007, p. 1644).

The topic of malingering, on the other hand, was discussed and consumed “exhaustively in recent publications” for instance, in the Jones & Llewellyn’s (1917) popular text Malingering, or the Simulation of Disease that argued that many of the physical symptoms associated with hysteria, shell shock, and neurasthenia were easily simulated (Yealland, 1918). As an explanation for the human propensity to simulate disease, they associated malingering with an
instinct of “mimicry which teaches animals to feign death when in danger”, further qualified by the authors, as quoted in a New Zealand book review, “This assumption gathers weight…when we recall the extraordinary attraction mimicry possesses for those of limited and or abnormal development---the young child, the savage, the madman”.\(^{86}\)

Medical controversy and commentators focused upon the moral character of the patient, specifically among medical writers calling the patients “moral invalids”, many of whom were dismissed and discharged (Herman, 1992).\(^{87}\) According to Showalter (1985), one of the biggest medical proponents of this demoralizing view was British psychologist Lewis Yealland, author of *Hysterical Disorders of Warfare* (1918), who advocated shock treatment to treat mutism, sensory loss, motor paralysis, and other treatments based on shame, threats, and legal punishment. Reported to have told patients they were lazy and cowards, that those who disobeyed or did not respond would be threatened with a court martial, Yealland’s style of treatment is captured in his quote to a patient, stating that, “remember you must behave as the hero I expect you to be…A man who had gone through so many battles should have better control of himself” (as cited in Showalter, 1985, p. 177). Yealland’s (1917) book on hysteria did differentiate and legitimize hysterical symptoms in contrast to malingering, while still maintaining that sometimes such symptoms are in fact simulated. According to Herman (1992), however, generalized assumptions and scientific opinion around war neurosis were more in line with Mott and Holmes, than Myers, believing that the soldiers who broke down or exhibited non-organic symptoms, had a disorder of diathesis (predisposition) or that they were faking their disease in order to be relieved from service and receive monetary compensation.

During this time, the RAMC divided war neurosis into four categories: shell shock (Myers, 1914), hysteria, neurasthenia\(^{88}\), and disordered action of the heart (Young, 1995,
Herman, 1992). Common among the diagnoses was the institutionalization of the always present alternative explanation of “malingering”. In 1922, the War Office Committee of the Royal Army Military Corporation (RAMC) made the distinction between malingering and functional neurosis in order to then distinguish between “malingered shell shock” and “genuine shell shock” (War Office Committee, 1922, p. 140). Symptoms associated with hysteria, such as blindness, muteness, deafness, paralysis, and frozen or epileptic movements were argued by malingering theorists to be “manifestations of malingering” (Yealland, 1917, p. 237). While neurasthenia was generally believed to originate from a constitutional neurological weakness resulting in emotional and psychical instability and vulnerability with no located origin other than inferior genes; disordered action of the heart was a more specific version of neurasthenia that affected the cardiovascular circuits producing irregular heartbeats that were also believed to result from precipitating accident or shock that activated the heredity trait (Murray, 1918, Talmey, 1901). All of the diagnoses were linked by way of either a suspicion of malingering or genetic neurological weakness; consequently, “genuine shell shock” was clearly not one of the preferred diagnostic assignments, and only a small percent of the British soldiers were diagnosed as such (Jones et al., 2007).

In the report to the RMAC, the committee went on to distinguish between three varieties of malingering: true, partial, and quasi. True malingering was identified as a deliberate attempt to fake shell shock and considered to be rare among soldiers (Yealland, 1917). Partial malingering was an exaggeration of symptoms in order “to avoid service or for a continuation of pension”, considered to be frequent and the most difficult to detect. Quasi-malingering, referred to as scrimshanking or skulking, includes “those who with little or pretense decamped from the battle as opportunity arose, pleading “shell-shock”…their numbers were great...they were cured
ultimately by persuasion or command and returned to duty” (War Office Commission, 1922, p. 141).

In the attempt to detect the malingerers, neurological exams, x-rays, and new technologies were employed to distinguish between hysterics and various types of malingerers, both of whom were believed to deceiving either themselves or others (Young, 1995). Anti-war statements made by soldiers that were attributed to psychological causes, in Great Britain during this time, were subject to court-martial (Herman, 1992). Relying on the Babinski reflex to detect nervous disorder and malingerers, sensory examinations were utilized by the RMAC to detect simulation and judge the credibility of the soldiers (Roudebush, 1993). Because blindness was a combat debilitating symptom that could be simulated by a “clever malingerer”, the Eldridge-Green lantern was used to detect genuine and faked blindness (Jones & Bassett, 1917).89 Beliefs about methods of treating war neurosis during this time, however, range from Yeallownd’s disciplinary-domination methods, persuasion, and shocks to recommendations of the “cure by discharge” method in treating WWI, which returned only 2% respectively to combat (Leys, 2001, p. 218).

Through this brief overview of how war neurosis became divided into diagnostic distinctions in post WW-I Great Britain, we see the presence of malingering as an object of conceptual differentiation, scientific investigation, technical measurement, and discursive suspicion. The analysis additionally suggests an overlap with discourses about hysteria as a simulated, malingered, and suspect condition. A recurrent discourse invoking neurological pre-dispositions as a source of ontological inferiority or weaker genetic heredity also enters into the constellation of discourses justifying excessive and stigmatizing diagnostic evaluations at the expense of immediate and effective treatment. Despite substantial disagreement and scientific
controversy, the discourse and suspicion of malingering was an ever-present element in post-combat diagnoses that invariably predisposed the soldiers to the popularized and political interpretation of a deceitful and cowardice character.

6.2 Alternative Views of Suggestibility, Cooperation, and Emotional Shock: Recurring and Emerging Perspectives

In response to the medical crisis in the British military and punitive methods for detecting malingerers, alternative theories of post-combat disorders were in germination among researchers such as W.H.R Rivers who worked in close alliance with the soldiers. Considered the founder of “field anthropology” and experimental psychology, Rivers, a colleague of Charles Myers and critical proponent of Freud’s work, criticized the dominant explanations of inferior heredity, suggestibility, and malingering. An advocate of the talking cure as well as the humane treatment of veterans, Rivers was interested in how suggestion is linked to human’s evolutionary history and its role in traumatic psychoneurosis. In his attempt to reconstruct what he called “incompatible and contradictory ideas” of Freud’s theoretical configuration of the unconscious, Rivers (1920) noted the “conflict and rancor” about, as well as, the misunderstanding of Freud’s work that resulted in theoretical antagonisms, noting that “It would be humorous, if it were not pathetic, that many of those who object most strongly to Freud's views concerning the role of unconscious individual experience in the production of abnormal bodily and mental states should be loudest in the appreciation of the part taken by that ancestral experience for which they use the term, too often the shibboleth, heredity”.

In stark contrast to Charcot and Babinski’s understanding of suggestibility, Rivers believed that the capacity for suggestion was rooted in a survival instinct that provides three options when threatened: to fight, to flee, and to stay and hide (immobility), claiming that survival requires cooperation with others that involves processes of immobility and suppression.
of other instincts. The suppression he thought, occurs especially in sleep whereby the individual simultaneously intuits cooperation with other members of the group (through mimesis, sympathy, and intuition) and restrains himself through suppression of ‘unimportant stimuli’ (Young, 1995). According to Young, for Rivers, suggestion is a mental process that is born in fear and that ‘belongs to an instinct which is concerned with collective as opposed to individual needs” and that “the presence in Man of both suggestion and intelligence shows that the early protopathic forms of instinctual behavior were modified in two directions, one leading towards suggestion and intuition (Rivers, 1920, p. 99; Young, 1995, p. 49). For Rivers, the phenomenon of suggestion demarcated a biological human instinct that relied on behaviors of cooperation, survival, and suppression, rooted in basic instincts of self and other preservation (as cited in Young, 1995).

Especially noted for his work with Mad Jack and Siegfried Sassoon and his findings about the power of emotional attachments, Rivers sought to understand cooperation as an instinct invoked by suggestion, quite differently from Jones & Llewellyn (1917) claiming that mimicry was comparable to an animal instinct denoting savagery, madness, and infantile impulses. A follower of Freud’s methods of treatment, Rivers elevated the therapeutic relationship to a context of learning and transference according to a spirit of mutual human cooperation. As the result of the relationships Rivers developed with his patients and his attempt to contextualize Freud’s notion of the unconscious, he became particularly interested in the suppression of affect and conflicts as they were symbolically represented in the content of the patients’ dreams (Forrester, 2006). In addition to the re-working of suggestion as an impulse towards cooperation, we see objects of Freud’s discourse of emotional attachment, instincts, transference processes, and attention to understanding war dreams in relation to cycles of wakefulness, sleep,
and a self-preserving suppression of content (Forrester, 2006). But most important here is Rivers empathetic and curious counter discourse of inquiry as related to its opposition to explanations that reduced war neurosis to heredity or irrational/infantile mimesis and thus diffracted attention away from treating and understanding the soldiers’ plight and experience.

Another alternative trajectory of theories that attempted to understand traumatic reactions rather than reduce them to deception or a predisposition is exemplified by the American physiologists Crile & Cannon, who added elements of fear, shock, and emotions as integral processes for understanding shell shock. Crile and Cannon (1942) understood combat related memory loss, not in its relation to its absence or something to be retrieved, but rather as an “incapacity for sustained thought, … It is lack of the power of volitional attention, and is a symptom of easily induced fatigue” (Page, 1883, p. 165 as cited in Crile & Cannon). Drawing on theories developed in late 19th century such as those of Page and Erichsen, who understood memory loss as the “deterioration of intellectual powers as erosions of the ability to calculate and an inability to recall, as opposed to a loss of recollection”, these theorists connected combat related memory loss as impacted by the experience of intense fear or fright combined with the element of surprise and assault (Young, 1995). Related to Herbert Spencer’s (1855) notion that fear is the memory of pain and the expression of a somatic (bodily) state and anger related survival mechanism of fight or flight, Crile and Cannon sought to explain how sustained states of fight or flight account for post-combat reactions.

As a challenge to degenerative or memory related understandings of shock, Cannon (1942) compares traumatic shock to an anthropological concept of “voo-doo death” that was centered around the idea that “the bodily changes which occur in the intense emotional states…such as fear and fury which occur as results of sympathetic discharges, and are in the
highest degree serviceable to the organism in the struggle for existence which exhaust the body’s reserves—the stored adrenaline, and the accumulated sugar—called forth for instant service” (p. 177). These theorists, who reflected upon the misunderstood post-combat disorders of World War I, claimed that fear and nervous shock results in a condition, which “during World War I was found to be the reason the low blood pressure observed in badly wounded men—the blood volume is reduced until it becomes insufficient for the maintenance of an adequate circulation….Thereupon deterioration occurs in the heart, and also in the nerve centers which hold the blood vessels in moderate contraction. A vicious cycle is then established; the low blood pressure damages the very organs which are necessary for the maintenance of an adequate circulation” (Canon 1942:178). Victims then are theorized to “die from a true state of shock, in the surgical sense—a shock induced by prolonged and intense emotion” (Canon, 1942:179). Voodoo death occurs when shock and fear lead to a state where sustained fear push the person to a state of sustained arousal resulting in exhaustion, eventual depression of blood pressure, and, if not relieved, death (Young, 1995, 24). Furthermore, the summation of multiple exposures to intense, intermittent shock eventually accumulates and leads to the changes associated with voodoo death (Young, 1995).

While the impact of shock and exhaustion was questionable, and not adequately understood, during the first World War, which partially resulted in the British military’s exclusion of Myer’s (1914) conceptualization, by the time of WW-II, however, “shell shock”, as a legitimate explanation, slowly crept into public and scientific common sense. According to Cox (2011), in the U.S., the concept of shell shock became instrumental in facilitating public understanding and empathy for the very large numbers of traumatized soldiers after WWI. The popular and generally accepted term “shell shock” served as a “legal, medical, and moral
halfway house in a society used to a clear division between the mad and the insane” (Bogacz, 1989). According to Cox (2001), public and academic demarcations of “war neurosis” or “shell shock”, played a large role in reducing negative assessments of shell shocked veterans: a success Cox attributes to the work of the American Legion, comprised of not-as-afflicted veterans and other organizers who fought to change public perception and increase understanding. By WWII, in the US, it was generally recognized that any man could break down given enough exposure to combat and that such breakdowns could be predicted in direct proportion to severity of exposure (Herman, 1992, Glass, 1957).\textsuperscript{94} Interesting to highlight here is the initial rejection of the shell shock diagnosis that ended in developments in scientific articulation, counter-discourses, and politicized interpretations contributing to the its eventual reuptake in the U.S. during WW-II.

5.10 Conclusions

In this chapter, I have explored hysteria’s construction as a medicalized and stigmatized diagnosis through identifying primary sources of conceptual differentiation and theoretical disagreement surrounding Charcot’s hysteria differential diagnosis. I further discussed how Charcot’s construction of hysteria as based in discourses of deceit and susceptibility contributed to the instantiation of a suspicious predisposition in the field of medical psychopathology to theorize, seek, and find deficiencies in neurological, cognitive, genetic, and moral capacities of the patients according to a reductionist logic that subverted attention away from the concrete conditions and consequences of human action, domination, and physical injury. This analysis additionally suggests an enduring tension between medicalized psychopathology and psychoanalytic thought as based in political implications of claims inciting psychological trauma.

A brief tour of statements from 1681-1947 that have been dispersed throughout the last two chapters from within medical, psychiatric, and cultural spheres demonstrates a relatively
stable attitude of suspicion and stigma among pre-medical and medicalized assessments of hysteria. While this is not a comprehensive list, it establishes an enduring connection through the “regularity of dispersion” over time among medical attitudes about hysteria as associated with discourses of deceit, malingering, neurological weakness, and hereditary predisposition. As these discourses reappear in the attempt to apprehend mass occurrences of British military disorders, including hysteria, an analogous tone of suspicion is further formalized in institutionalized diagnostic procedures and categorical divisions that specify the range of possibilities for how post-combat reactions were apprehended. The emergence of this “grid of specification”, to borrow Foucault’s (1971) term for such epistemological and material divisions, displays both familiar [i.e. hysteria, disordered action of the heart] as well as new objects [shell shock] of inquiry and measurement that were invariably embedded in discourses propagating their possible cowardice simulation and malingering character as distinct objects and subject positions in the discursive constellation of post-combat pathology. Doctors became positioned as detectives during the scientization of malingering, and similar to attitudes of U.S. Army authorities during the Civil War, soldiers were assumed be “malingering until proven otherwise” (Bourke, 1996, Wessley, 2003, p. 35). 96

In the attempt to address the question of “why this enumeration rather than another?”, I have explored stigmatizing processes as connected to the extension of one’s social body in public discourse, which is also related to the consumption of certain discourses at the exclusion and the outright censorship of others. In this sense, malingering (as opposed to shell shock) was clearly the preferred interpretation of the British military and among a camp of scientists who took great pains to not only theorize their inferior character and animal nature, but also spend their energies applying the latest medical technologies for detection of malingering rather than caring for the
injured soldiers. Scientific and cultural interests converged around neurological, heredity, and malingering discourses about the individuals, while theories of shell shock, precipitating trauma, and human instincts of flight, cooperation, and suppression of pain were empirically and politically excluded from the dominant discursive constellation. Similar to Charcot’s relative monopoly on media communication as an advancement of his views, the British military controlled the range of discourses available for public consumption through media control of the objects of discourse in preference of the topic and theories of “malingering” while silencing the circulation of topic of “shell shock”. Medical and cultural commentators, as suggested by Herman (1992), enthusiastically consumed and circulated the deterministic discourses of heredity and suspicious discourses of malingering, both of which deemed the individual a subject of an inferior genetic-neurology or moral character. As conversations about newly implemented Workmen’s Compensation Act, insurance claims, and the costs of military medical costs increased, there were all the more reasons to suspect and detect the malingerers (Jones & Llewellyn, 1917, Wessely, 2003).

In this configuration, the subjects of these investigations become discursively inscribed in diagnostic forms of recognition that pre-emptively tarnish their social body, their neurological body, and their character, which has enduring implications for how patients and their injuries have come to be recognized and known. I hope to have demonstrated a sticking point or continuity among stigmatized articulations as bound by a discourse of feminine “susceptibility” (uterine, demonic, and nervous) which eventually split into a discourse of predisposition (constitutional-neuro-biological) and a discourse of suspicion (deceit and malingering) around what came to be known as hysteria in both men and women. I further suggest that these conceptual splits and threads “transferred” to and are, at least partially, recycled through
diagnostic discourses about and around PTSD as a contemporary diagnosis through continued association of ideas transferred from one context to another. Conversations about the malingering hysterics in France recurred in post WW-I Great Britain, which I have argued engendered and further scientized a discourse of suspicion regarding individuals displaying traumatic symptomology that has since become formalized in the diagnostic criterion assessment of PTSD that requires that “malingering” be eliminated as an explanation for making claims of disabling trauma. In this sense, suspicion of fraud, lying, simulating post-traumatic symptoms, and neurological predisposition, as sources of potential social and medical stigma, have become institutionalized in the PTSD diagnosis itself.

As a cultural critique of this historically enduring discursive formation, a related ritually gratifying pattern is referred to in Girardian anthropology as a universal ritual of sacrifice evidenced cross-culturally in terms of the scapegoat mechanism that serves a dual dialectical function of identification and alienation as described by Burke (1969). Explaining that the scapegoat is dialectally appealing, Burke’s scapegoat mechanism describes how classes of people “deny, suppress, exorcise the elements it shares with other classes” that “leads to the scapegoat [the use of dyslogistic terms for one’s own traits as manifested in an “alien” class] (1969, p. 142). As a function of social order and identity restitution brought on by difficult social issues, the scapegoat mechanism is further understood as a function of cathartic relief for collective guilt linked to cycles of redemption and sacrificial relief. Hysteria and its trajectories arguably have fulfilled this function in catharsis, hierarchy, and comedy in maintaining an unequal balance yet dialectical position with public and scientific culture. Burke (1935) also notes, however, that scapegoating is not inevitable and at times an error in interpretations resulting from faulty linkages, although generally understood as a relatively stable social process.
Within the hysteria-post-combat trauma configuration, the scapegoat appears in repetitive fashion, as have people who have witnessed their victimage. This analysis has also highlighted counter discourses and theorists who have, through various means, resisted scapegoating mechanisms through alignment with research and activism perspectives that have attempted to understand more deeply the enigma and plight of the hysteric, the traumatized, and the stigmatized not out of eulogy, but from a place of pragmatic and humane inquiry. Threads of the humanist and psychoanalytic traditions are one such alternative counter discourse to those engendered by discourses of neurological and moral inferiority.
Great as are the preoccupations absorbing us at home, concerned as we are with matters that deeply affect our livelihood today and our vision of the future, each of these domestic problems is dwarfed by, and often even created by, this question that involves all humankind. This trial comes at a moment when man's power to achieve good or to inflict evil surpasses the brightest hopes and the sharpest fears of all ages. We can turn rivers in their courses, level mountains to the plains. Oceans and land and sky are avenues for our colossal commerce….Yet the promise of this life is imperiled by the very genius that has made it possible. Nations amass wealth. Labor sweats to create--and turns out devices to level not only mountains but also cities. Science seems ready to confer upon us, as its final gift, the power to erase human life from this planet.  

President Dwight Eisenhower, 1953

6.1 A Brief Catchup Session: Directions and Developments in Military Psychiatry

In 1952, the first Diagnostic Statistical Manual was published and prefaced as a concerted attempt to standardize and systemize psychiatric diagnostic classification and nomenclature (DSM, 1952). The forward to the first edition states that “By 1948, then, the situation in psychiatric nomenclature has deteriorated almost to the point of confusion which existed throughout medical nomenclature in the twenties” (p. vi). Citing the need for U.S. military psychiatry to “account accurately for all causes of morbidity” and “for a suitable diagnosis for every case” (in contrast, at the time to civilian psychiatry), the DSM-I forward further explains that military psychiatrists and the V.A. “found themselves operating within the limits of a nomenclature specifically not designed for 90% of the cases handled…. No provision existed for diagnosing psychological reactions to the stress of combat, and terms had to be invented to meet this need” (p. vi). Prior to the publication of the DSM, all known medical diseases were classified in the Standard Classified Nomenclature on Disease (1933) which included a section for psychiatric disorders in the section entitled, Diseases of the Psychobiological Unit. The first
DSM is prefaced as a response to this need, as well as, an inclusion of the “experiences of psychiatrists of WW II” (1952, p.1).

Noteworthy additions to the DSM include “post-combat disturbances”, categorized as “Gross Stress Reactions”, and classified under the rubric of “Transient Situational Personality Disorders”.98 These categories of “personality disturbances” are further divided by their symptomatic “reactions” (for instance, depressive, schizophrenia, affective reactions, etc.). According to the DSM, these disorders are attributable to overwhelming “stress” and stated as “more or less transient in character and which appear to be an acute symptom response without apparent personality disturbance” (1952, p. 40).99 In the manual, hysteria is assigned to the psychoneurotic class and specified as a “conversion reaction” whereby “anxiety is converted into functional symptoms in organs or parts of the body …serv(ing) to lesson conscious (felt) anxiety and ordinarily are symbolic of the underlying mental conflict” (DSM, 1952, p. 32-33).

“Trauma” denotes a physical injury in reference to “brain trauma”, “gross force”, and “birth trauma”, which are classified under the rubric of “disorders caused by or associated with impairment of brain tissue function”, then subdivided into acute and chronic brain syndromes (p. 2-3). As noted in the outline of diagnostic changes to the manual, the subcategory of schizophrenia reactions is specifically highlighted as “increased in numbers and type to allow a more detailed diagnosis” (p. 11).

In terms of trends in treatment modules during this era, psychoanalysis is said to have emerged as a dominant trend in academic psychiatry (Eisenberg & Guttmacher, 2010). In post WW-II military psychiatry, however, the rapidly developing field of social psychiatry began applying research conducted during and after the war WW-II into community and group based methods of treating psychiatric casualties of war (Sedgwick, 1982, Manning, 1989, van der Kolk,
refers to as “milieu therapy” or “therapeutic democracy”, represents a prominent trend that utilized group and social methods as the primary mode of psychiatric treatment. Developed by Tom Main, Maxwell Jones, and Dr. Rees in the late 1940’s and 1950’s, the model was implemented as an experimental treatment method conducted in Great Britain to treat military psychiatric casualties from WWII according to a democratizing vision of institutionalized psychiatric treatment (Sedgwick, 1982, Trist & Wilson, & Curle, 1952, Kennard, 2004).

However, as Whiteley (2004) notes, though the British psychiatrists of WW-II are traditionally cited as the originators of the Therapeutic Community as a named formation, its civilizing seeds had been culminating through decades of “moral, cultural, and social attitudes”. The formal implementation of the Therapeutic Community model emerged in response to mass occurrences and “mishandling” of “shell-shocked” soldiers in Great Britain by “the authorities, varying from punitive excesses to long standing invalidism”, (2004, p. 237).

Upon the funding and endorsement of the U.S Navy, the first intensively documented and empirically studied therapeutic community research experiment of its kind in North America was implemented in a psychiatric admission ward in a U. S. Military hospital (Briggs, 2001).

Prior to the Therapeutic Community Experiment, staff members compared Ward 55 of Oak Knoll Naval Hospital to a jungle and emporium for wild animals, nicknamed “mockingbird hill”, “squirrel hill”, and “funny farm” (Briggs, 2001, Odgers, 1956). Not surprisingly, cautionary tales about the inherent dangers of working in psychiatric wards were a frequent theme of conversation. Odgers (1956), one of the hospital’s corpsmen, recalls, “Everyone spoke of danger and the unpredictability of the emotionally ill patient” giving the impression that the “working code of the psychiatric ward was a slightly modified form of ‘Jungle Law’ or ‘kill or be killed’
The year prior to the implementation of the therapeutic community experiment, as related by Odgers, “en masse disturbances...occurred with regularity. Many times we went to bed at night expecting to hear, ‘Riot, riot on Ward X. Will all NP corpsmen report to Ward X!’ over the public address system” (p. 249). The incoming patients were treated primarily by means of intravenous sedative and barbiturate therapy, accompanied by disciplinary measures of seclusion, isolation, and physical restraint for emotional and violent outbursts. According to extant accounts, there was no active therapy before their military and psychiatric (i.e. administrative) status was determined, and the service members would soon be transferred to a long-term facility or discharged from the military altogether. Prior to the experiment, two rooms on the ward labeled “Quiet Room” are reported to have been in use all times (Wilmer, 1958, Briggs, 2001). Operating as the primary holding and distribution unit for the most severely disordered psychiatric casualties from the Korean War, Ward 55 received patients who arrived in mechanical restraints, heavily sedated, often catatonic, and many classified as “in disciplinary status”, who were consequently accompanied by an armed Marine guard.102

In July of 1955, the experiment began. Patients arriving in restraints were freed from the mechanical apparatus used in their transport; routine administration of sedatives and barbiturates was eliminated; and the “Quiet Room” was pronounced as “no longer an option” for suicide prevention or for disciplining the unruly.103 On the first day of the experiment, the staff were informed of these new operating procedures, then familiarized with the cardinal rule of: “Never, under any circumstances humiliate a patient by himself or in front of others” (Wimer, 1958a). The incoming patients were greeted by the doctor within a few hours of their arrival and again for a more comprehensive interview within a day or two. In addition to the implementation of the new procedural rules, the ward operations were organized around daily group meetings
which were required in attendance for the patients, staff, and any visitors, as well as daily staff meetings immediately following the community meetings. A publically posted “doctors list” provided the patients the opportunity to request meetings with the doctor. The “staff”, comprised of nurses and corpsmen, were indoctrinated into the model according to a method referred to as “on the job training” (Wilmer, 1958). In other words, they were thrown into the fire the day the experiment began, with little or no knowledge, preparation, or training in the new protocol. Upon hearing about the new procedures, the staff expressed reactions ranging from mild consternation to general fear and utter disbelief (Briggs, 2001, Wilmer, 1958, Odgers, 1956, Purdy, 1956). The ten-month experiment (July, 1955-April, 1956) consisted of a total of 939 Naval and the Marine psychiatric casualties, most of whom had no pre-enlistment history of mental health problems (Wilmer, 1958). Their medical records indicated that 11.9% percent of the patients had attempted suicide during a previous hospitalization or confinement period and the majority (44%) classified as psychotic (91% schizophrenic type) (1958b).104

6.2 The Atemporal Crack: Rupture, Episteme, and Convergence of Intellects

“As if time existed only in the vacant moment of rupture in that white, paradoxically atemporal crack in which one sudden formation replaces another.”

Foucault, 1972, p. 166

In light of such a dramatic change in protocol, it is important to note that the model’s historical lineage dates back, at least to, late 18th century and early 19th century France and Great Britain.105 Scholars of the therapeutic community model note its link to humanitarian and humanist reform, moral therapies of the 18th century (Bloom & Norton, 2004), a combination of leadership, charisma and behavioral routinization (Manning, 1989), democratic participation, moral ideals, techniques of group communication, and “a more specific application of these ideas in practice” (Manning, 1989, p. 14). In Great Britain, the Therapeutic Community version arose
in response to the hierarchical social organization of the hospital, and envisioned its ideal alternative as a “democratic egalitarian one” that eliminates the principle of “privileged communication” that consciously “attempted to raise the status of the patient” (Jones & Rappaport, 1958b, p. 939). Jones vision of the therapeutic community model endowed its members the right to speak and participate as equal members of the hospital, as citizens with civil rights and freedom of speech, and with access to information and channels of communication (Jones, 1958). Some versions of the model are guided by goals of participation in daily and policy making decisions as a “re-education for life” (Jones & Rappoport 1958c, Hamburg 1958, Redl, 1958b). In contrast, the U.S. therapeutic community model downplays the protocol as a form of democratic decision making and instead stresses that patient participation is encouraged, that they have a “right to express their feelings and needs”, yet limited according to their capacities (Wilmer, 1958b, p. 880).

Manning (1989) argues the therapeutic community formation derives much of its political and social legitimacy from heightened discourses of civil liberties and human rights that are characteristic of this epoch. Such accounts, however, do not generally address the historical contexts and concrete conditions which precede and accompany these discursive shifts (Stammers, 1999). Of the numerous ways the therapeutic community model in general has been represented in the literature, one of the more compelling analysis is offered by Bloom & Norton (2004) description of its practices and premises as a form of “deep democracy” that seeks to subvert the militaristic, hierarchical, and frequently punitive and retributive control structures characterizing many of our social systems and replaces these obsolete structures with an environment offering different styles of relating that seek to avoid the repeating of past traumas” (p. 230-231). While my analysis of Wilmer’s therapeutic community model reveals a related
insight, I am more concerned with demonstrating not only the more nuanced elements of Wilmer’s models in particular, but also to demonstrate the degree to which it was situated in relation to a confluence of emerging critical and interpretive sensibilities in social science research. Analyzing these discursive regularities illuminate conditions that made way for such an abrupt change in logics and protocol.

In this chapter, I touch upon the alignment of social science with broader socio-cultural concerns emerging from exigencies of war and devastation in post WW-II in order to build upon Bloom & Norton’s (2004) conceptualization of the therapeutic community model as linked to “deep democratic impulses”. I will specifically address the relation of how discourses in social science converged around problems of institutional understandings and authority, practical-moral goals of research inquiry, and presuppositions of an intersubjectively produced self-identity. In order to analyze the epistemological trajectories of Wilmer’s TC model beyond its contemporary articulations, I demonstrate its connection to movements in social psychiatry before comparing those formative elements, logics, and interests to those elements concomitant with a “critical social science” inquiry as articulated by Habermas; this extension makes evident discursive regularities indicative of a practical reasoning orientation, emancipatory interests, ideological critique, and psychoanalytic presuppositions of ego development and the hope of institutional and self-reflection.

However, this does not explain the conditions that made way for such an abrupt entrance into a U.S. military hospital’s neuro-psychiatric ward, where prior to the day before its implementation, operated according to an entirely different logic, routine, and understanding of the patients and their problems. While it seemed abrupt and radical despite its historical lineage, upon further analysis, the discursive seeds building to its acceptance had been planting and
growing over the last decade in social scientific, political, and military psychiatry discourses in the U.S. More specifically, I am concerned with questions that focus attention on: What contributed to the uptake of this model at this point in time? What gave it life? What discourses converged in order to produce a dramatic rupture in the organization of Ward 55? What happened to transform Ward 55 from one described as a jungle to one later praised for civility and community? If this experiment is analogous to the “paradoxically atemporal crack in which one sudden formation replaces another”, then what changes, trends, and discourses contributed to its emergence and implementation at this particular place and time?

This chapter will lay out the discursive threads of the Therapeutic Community model as connected to trends in social psychiatry, socio-political discourses, and military psychiatry, and will be eventually compared to its conceptual and practical resemblance to a critical social science research inquiry (Habermas, 1972, 1984, 1987), as identified by its fundamental elements, logics, and practice through performing a Foucauldian Archaeological analysis (1972). Guided by an interest in understanding the conditions conducive to the concrete articulation of Wilmer’s model as a discursive formation, I will attempt to situate the model according to the Foucauldian heuristic of the “episteme”, which describes and analyzes the relations between social, historical, and scientific discourse, and further guided by a general directive for showing “how a particular object of discourse finds in it its place and law of emergence....., the historical conditions required if one is to “say anything” about it” (1972, p. 44). Analysis of episteme discovers in the field of scientificity during a social and historical epoch a normative and networked enterprise of dispersed discourses linking bodies of thought in interaction. It is guided by questions directed towards how a particular formation came to assume a presence through an analysis of “discursive formations, of positivities, and knowledge”, which Foucault
compares to a worldview, but with an emphasis on their relation to a “set of relations between sciences, epistemological figures, and discursive practices” that is an inexhaustible field, yet distinctly recognizable in “discursive regularities” (1972, p. 192).

On a more concrete and interconnected level, one can approach the analysis of episteme by asking: What are new and recurring objects, subjects, and strategies in a discursive formation, for instance, the Therapeutic Community? How do these elements overlap with or show direct association, dissociation, or concomitance with present elements in discursive fields in other domains, for example, the field of social psychiatry, objects of political discourses, themes in academic texts or cultural discourse? What are characteristic strategies of intervention in problems? What concepts are used to articulate problems as problems? What could be said in this particular epoch or in a particular discursive domain that would generally be accepted which, for example, would raise eyebrows or not be accepted as a sort of background premise in a different domain or epoch? And further, how do these elements come together to “manifest a set of concepts” and what is their relation to changes and trends in the social and scientific discursive field in a particular historical epoch that makes possible their emergence and relative acceptability?  

Although I am not going to attempt to answer all of these questions, they provide a general perspective and focused strategy for reading texts and performing archaeological analysis. I am specifically interested in analyzing the conceptual architecture of Wilmer’s Therapeutic Community Model, which is not in contradiction to its discursive formation, but rather connects it to related discourse and concepts that appear dispersed in discourses across multiple domains. Such an analysis is important because first, the therapeutic model in general has remained inadequately conceptualized and contextualized, secondly, Wilmer’s model
in particular has not been extensively studied or analyzed in contemporary literature,\textsuperscript{109} and thirdly, for offering a glimpse into the exploding and expansive epistemological field of social psychiatric social and military science during this epoch.

6.3 Situating the Therapeutic Community in the U.S: Convergences, Antagonisms, and Emerging Sensibilities

In terms of analyzing the emergence of new objects of intelligibility amenable to analysis in social science research during this time period, Nikolas Rose (1998) has highlighted how the discourse of “the group” appeared in diverse domains of thought and understanding directed towards the factory to the hospital to the battalion, in a manner that extended interpretations of problems beyond individual characteristics (p. 72). More generally, the discourse of the group flourished as an innovational development during the post-WWII era in the epistemological fields of military psychiatry, social psychiatry, organizational psychology, and sociological studies of group conformity and deviance (Rose, 1998, WRAI, 1958). Discursively, the language and relationships defined by the group “made intelligible a range of problematic phenomenon” that were developed into therapeutic and organizational interventions, experiments, and programs of research (Rose, 1998, p. 72). Conceptually linked to democratic styles of leading groups and decision making (Lewin, 1947), the discursive elevation of the group formation came to be infiltrated with ideas about improving organizational efficiency and extending social democracy in “the name of ethical principles, political beliefs, industrial efficiency, and mental health” (Rose, 1998, p. 141). Rose (1998) credits the founders of the Therapeutic Community model with “discover(ing) the group in the hospital, as a system of emotional relations embracing all staff and patients that could form the basis of a new form of therapy through the group” (p. 141, citing Main, 1946). As an object and unit of division in the therapeutic community formation, the group emerged as a distinct form of organizing activity as
well as a technology of analysis and change used to rehabilitate combat psychiatric casualties of war through techniques of socialization and normalization of “maladjusted selves” (Rose, 1998, cf. Kraupl-Taylor, 1958).

Claiming that the social psychology/psychiatry movement was a unique configuration in connection with discourses of the group and democracy, Rose (1998) compares this configuration to “a science of democracy”, expressing a critical skepticism concerning the genuine linkage between democratic ideals and social psychology by suggesting that it became “a way of organizing, exercising, and legitimating political power…for to rule subjects democratically it has become necessary to know them intimately…..” (p. 117). Claiming that Social Psychiatry gained prominence through “…‘translating’ the principles of democracy from the domain of ethics into the sphere of scientific truths and rational expertise”, Rose explains that “problematizations in terms of democracy were crucial internal components of social psychologists’ conceptions from the mid 1930’s through the mid 1960’s….Social Psychology was to provide a vocabulary for understanding those problems that trouble a democracy” (p. 118). Rose concludes with how the social psychology of the group promised a theoretical and practical answer to the difficulty of achieving the contradictory goals of organizational productivity and effectiveness versus “ethical goals of humanization, fairness, justness, and democracy” (p. 148). I hope to offer an alternative view that demonstrates first, that “the group” operated more as a social logic than an individualizing form or technology, and secondly, that the “scientific rationality” he is speaking of was actually grounded in practical rationality that critiqued what we, and Rose, think of as scientific rationality in our current epoch.

In 1957, the group trend, in U.S. military psychiatry, was evidenced in the themes and titles of the 7th Annual Walter Reed Symposium on Social and Preventative Psychiatry as it was
prefaced as “dealing with human group problems” (WRAI, 1958, p. iii). This shift in focus was believed to “indicate the emergence of a consistent theoretical orientation which ...differs from classical psychiatric theory...; the emerging theories lay emphasis on social roles and social environmental contingencies (Rioch, 1957, p. iv). More specifically, the symposium expressed its purpose as the “hope to stimulating operational research on modifications of the external (social) milieu to influence favorably the mental health of members of organized groups...includ(ing) university faculties, industrial corporations, military units and so forth” (Rioch, 1957, p. iii). The list of familiar researchers who presented their work at this symposium include: Solomon Asch, Jurgen Ruesch, Chris Argyris, William Caudill, Robert Lifton, Erving Goffman, Alfred Schwartz and Harry Wilmer. These researchers offered multiple perspectives on how dynamics within and external trajectories of group formations produced alterations in and conflict between individual and collective behaviors, goals, and interests.

From my reading of the symposium papers and discussion, the group concept operated as a background nodal point, perhaps even a general premise, from which to articulate more complex interaction problems and more complex collective forms. In fact, “group forms” were more specifically divided and equivocated with concepts such as “social field”, “community”, “conferences”, “meetings”, “culture”, “sub-cultures”, “social classes”, “mileui”, “atmosphere”, “environmental contingencies”, “socio-technics”, etc. (WRAI, 1958). In the symposium discourses, the group operated more as an accepted logic of form and designating boundary than as a focal point of the discourse, giving rise to more complex concepts that articulated challenges of group leadership, new understandings of individual differences according to cultural and subcultural interests, group influence on values, judgment, and behavior, and a social logic for interpreting human differences, similarities, and psychopathology. Concepts designating
external factors such as environmental and social contingences, epidemiology and ecology of mental illness attempted to articulate the power of groups, large and small, to influence individual and social behavior (WRAI, 1958). The group concept offered a way to think socially and dynamically about conflicts in human interaction. Thus, the overall group concept came to be divided into more micro units of analysis, more complex concepts that extended into other object domains as a way to conceptualize the influence of larger societal groups, such as organizations, institutions, and governments in terms of group interaction, values, communication, understandings, and authority (Miller, 1958, Asch, 1958, Ruesch, 1958, Goffman, 1958, Argyris, 1958).

The therapeutic community model emerged within a unique time in psychiatric history as rooted in a distinctly “social view of psychological disturbance, and a social view of personal change” (Manning, 1989, p. 69, Sedgwick, 1982, Sivodan, 1958, WRAI, 1958, p. 457). Reflective of this growing view, in 1953, the Expert Committee on Mental Health of the World Health Organization stated that “the most important single factor in the efficacy of the treatment given in a mental hospital appears to be an intangible element which can only be described as its atmosphere”. The preface to the Walter Reed symposium states that the military interest in group and social factors stems from the fact that “the formal and informal social structure of the Armed Forces emphasize the roles of the group and of social communication in mental health and of social isolation as a combined result and determining agent in mental illness (1958, p. i). In military social psychiatry, expert opinions that endorsed group, social, and communication theories of individual and collective mental health, human deviance, and psychiatric distress emerged as more the norm than the exception. In this sense, these views operated as social logics utilized to articulate and explain problems such as transient psychiatric breakdown in
combat and/or captivity, group and individual schizophrenic reactions, group brainwashing, cultural coercion, and human domination through interpreting individual disturbances and transgressions according to logics that implicated social and environmental responsibilities.

On a macro social and political level, we see a growing awareness and perhaps fear of how large societies can eradicate human life through torturous and tyrannical methods by convincing others to cooperate through coercion or sheer domination, and consequently exert such a force on human life, death, and human freedom. In Eisenhower’s inaugural address, the themes of good and evil, freedom and equality, prejudice and superiority appear with regularity, especially in regard to defending democratic freedom amidst a growing awareness of how totalitarianism’s presumptions of ideological superiority and de-valuing others based in a bestowal of an inferior out-group status. Eisenhower best touches upon and links these themes: “Conceiving the defense of freedom, like freedom itself, to be one and indivisible, we hold all continents and peoples in equal regard and honor. We reject any insinuation that one race or another, one people or another, is in any sense inferior or expendable” (Eisenhower, 1953). As Frank (2007) has eloquently and persuasively demonstrated, much of post WW-II philosophical discourse and rhetorical theory emerged in response to attempting to understanding how totalitarianism operates and theorize how to prevent the atrocity, tyranny, and trauma known and experienced by so many, thus elevating the “restoration of reason to ethics” to a status and matter of great urgency (p. 314, quoting Conley, 1990, p. 281). Concurrent with these developments, a major group of interdisciplinary researchers affiliated with social psychological approaches began to study authoritarianism, prejudice, dogmatism, culture/sub-cultures, acculturation processes, brainwashing, inter-group relations, and totalitarianism as objects of research as threats to democracy, especially in relation to their problematization around the events and
human actions that culminated during the WW-II and Korean War (see Lifton, 1958, Schein, 1956)

Kemmis’s (1980) broad review of discursive shifts in social science during and after WWII links these changes to themes inherent to the war itself, such as “democracy and totalitarianism, egalitarianism and racial supremacy, the coexistence and subordination of peoples”, further claiming that these shifts “galvanized views about democratic decision making processes and participation in those processes by those affected by the decisions, about the rights of individuals and cultural and ethnic minorities to have their views heard and their special needs considered, and about tolerance for different views.” (1980, p. 6). Within his account, we see the emergence of the democratic voice and inclusive participation in public decision making entering into the interests of democratic formations, perhaps in association or dissociation from the silencing implications of fascism and other threats to democracy.

On this point, I want to highlight two related themes of the 1957 symposium that underscore the reason and ethics restoration. The first theme pertains to the transfer of democratic ideals and participatory forums into the workplace and the mental hospital. In the U.S., one of the first organizational entities subject to organizational studies, and in some instances, interventions, was the mental health organization (Etzioni, 1960). An influential school of thought whose origin is attributed to Kurt Lewin’s work was developed in an attempt to theoretically and empirically link ideals and practices of democracy with organizational change, scientific examination, and ethical values into social intervention efforts (Rose, 1998, See Lewin, 1946). Such an orientation was, according to Etzioni (1960), a prevalent theme in the dominant “human relations school”, reflecting social science’s relatively new interest with researching psychiatric treatment organizations. The human relations approach has been
described as highlighting/defining the importance of role of communication and interpersonal understanding between employees and employers, as well as between staff and patients. Specifically referring to the new articulation of the mental hospital as a “therapeutic community” or “small society”, Etzioni (1960) upholds the idea that organizations structured according this model favor “conferences”, and “participation in the process of decision making”, further claiming that the primary reasons for the acceptability of the human relations approach was due to its congruence with assumptions and techniques of psychoanalysis, particularly in shared emphasis on “increasing self-understanding by communication” (p. 14). In contrast to the human relations approach, the “managerial” school seeks to maintain social distance between the employees and employers based in a belief that “economic, political, cultural, and other ‘real differences’ between workers and management” should be maintained (p. 14).113 Despite his understanding of communication as instrumental and limited in influence, Etzioni’s analysis identifies the concepts of communication, understanding, and participation as assuming significance in association with the psychoanalytically influenced human relations school of thought as new objects of concern and inquiry.114

In the 1957 symposium, both of these orientations are discursively evident, with the “human relations” approach clearly emerging as the favored perspective. Although the defining elements of the “human relations school” extends far beyond Etzioni’s description, I want to underscore a theme in this approach that will be taken up in more detail in a later section, but which displays the emerging democratic sensibilities in social psychiatric approaches to mental health care and industry organization. Primary discursive theme in Goffman, Argyris, and Soloman’s research highlight contradiction and conflicts of interests between individual needs and welfare, and organizational/institutional/bureaucratic performance or demands. A second
theme at the symposium that I want to underscore is a relatively new discourse about the subject and intersubjective relations used in grounding the humane imperative of upholding democratic standards of human rights, equality, and egalitarian participation. In the explanations of these conflicts between “humane standards on the one hand and institutional efficiency on the other”, Goffman, for instance, links individual needs to humane interests and standards as requisite for maintaining identity integrity, and argues that these are systematically violated by practices of institutional efficiency that dehumanize and mortify human identity (1958, p. 69). Relatedly, Argyris argued that growth needs and trends of healthy personality development, as linked to theories of self-actualization, were in conflict with and impeded by subordinate and dependency roles implied in the authority structure of formal organizations (1958). Soloman similarly underscored how conflicts between professional identities and bureaucratic structures imposed divisions between subordinate and superiors that are comparable to incompatible ideologies of authority (Soloman, 1958). The commonality among these problematizations display a belief and genuine concern that the individual suffers, mal-adapts, or has their ego-development stunted in the process of working in industry, health care, or “being rehabilitated” in a psychiatric institution. The thrust of these arguments is ultimately directed towards articulating the human need for more egalitarian and participatory authority structures and communication practices, constructed on the basis of an emerging and apparently accepted theory of a fragile, tender, or socially malleable ego, personality, identity, moral career, to use implicative terms, vulnerable to damage and influence by collective forces.\textsuperscript{115} The underlying and conceptual premise of these arguments infers and at times makes explicit that the right to ethical humane treatment in collectivities should be secured in a democratic society. Within this chain of related concepts,
under the concomitant umbrella of democracy, the institution began to emerge as an object of
critique and inquiry.

This background logic, however, became most evident in a paper and comments made by
a participant who did not share the same understanding. As an exemplar of Etzioni’s (1960)
appropriation of the “managerial” approach to studying organizations that endorsed and
maintained social distinctions, Dr. Fiedler is perhaps the one and only symposium participant
who enacted this view and drew explicit attention to the background and accepted logic that
linked organizations, groups, humane treatment, and democratic practices. He commented in a
question and answer session that, “I have been struck by the preoccupations of executives and
people in business with accounts of democracy in industry and business. I think many of the
papers today and yesterday reflect this. I have also been struck by the amount of guilt feelings
which executives have about giving direct orders” (1958, p. 278-279). In stark contrast to the
positive reactions to Dr. Goffman’s paper on “Characteristics of Total Institutions”, Dr.
Fieldler’s “unpopular” paper entitled, “Non-fraternization between leaders and followers and its
effects on group productivity and psychological adjustment” evoked a quite different reaction.
The paper attempted to demonstrate an incompatibility between the implied “quasi-role
therapeutic” roles of the leader/manager/administrator and the task demands of effective and
productive leaders. Arguing that there is an inherent contradiction between these roles and tasks,
in presenting his research finding, he claims, “The leader who becomes emotionally involved
with his men is less able to perform his job because considerations of a personal nature enter into
his decisions …We have found that the effective leader needs to be emotional distant and
reserved, ready to reject, if necessary, his own grandmother, if she cannot play basketball or sell
farm equipment...the effective leader is therefore, judgmental, critical, and non-accepting of poor coworkers” (p. 341).

In comparison to Goffman’s paper, Fiedler’s paper expresses the means-end perspective that Goffman’s research renders problematic. In a lengthy quote during his presentation, Goffman explains that in totalizing environments: “Persons are almost always considered to be ends in themselves, as reflected in the broad moral principles of a totalizing institution’s environing society….This maintenance of what we call humane standards comes to be defined as one part of the ‘responsibility’ of the institution and presumably is one of the things that the institution guarantees the inmate in exchange for his liberty” (Goffman, 1958, p. 67). This statement and the accompanying background acceptance of Goffman’s critical sensibility and implication of institutional responsibility and instrumental rationality is quite telling. In the question and answer session to follow, no one contested Goffman’s claims that many institutional forms, such as prisons, schools, hospitals, psychiatric wards, and even the U.S. military organization often operated within a context of authoritative relationships and totalizing logics that resulted in mortifying damage to the patients’ personhood. In the conclusion to the symposium, Colonel Glass referred to Goffman’s presentation in underscoring a genuine concern with the effects of institutionalized treatment on human liberty and integrity, justifying the need to take action in order to prevent “many of the dangers which Dr. Goffman spoke about in the mortification of the individual” (1957, p. 454).

In stark contrast, the discussion of Feidler’s paper resulted in a lengthy contestation of his assertion of incompatibility between therapeutic and performance roles, thus illustrating an epistemological and ethical resistance to his discursive display of instrumental reasoning, particularly in the sense of dissociating moral concerns with social action. Put differently, the
symposium participants were “struck” by Dr. Fiedler’s perspective in the same way he was “stuck” by theirs. The following excerpts of the discussion highlight the “unpopularity” of Fiedler’s reasoning and focal point.

Col. Bushard (commenting to Dr. Fiedler): “In this particular area, we are having a phenomenal impact upon large organizations such as, the Army. Sociological-minded behavioral scientists are imposing some of their rather ill-thought through ideas upon an organization which has been functioning….” (p. 387)

Dr. Lifton: “I would like to ask Dr. Fiedler about this concept in which he distinguishes between the therapeutic type of leader and the man who gets results. I wonder if there isn’t room for some further development which distinguishes perhaps a third person who combines these two and yet is something quite different….” (p. 387)

Dr. Fiedler: “…These are rare individuals. What you usually find is an individual who is willing to subordinate his concern for the individual man to the concern for the productivity of the group. I am not passing a value judgment here on the desirability of this. I think this is a cost accounting problem in the psychiatry or social psychological sense. Whether this is good or bad has to be evaluated by empirical research…” (p. 388).

General Marshall: “I gave consent to what was said back here. I want to express my utter disagreement with it now. At a company commander level this an entirely different problem and I would not like to see a company commander who did not take a fatherly interest in his men and their welfare……(He follows this statement with a length narrative about the power of relationships and emotional bonds between a leader and his men)...It is this relationship between the leader at the company level and his men which makes strong companies. If science is going to intervene and say “no” to the Army, then I would be one in the position that would say “Science does not know what the hell it is talking about…” (p. 389-390).

In addition to taking issue with Fiedler’s discursive detachment of the importance of relationships from the context of leadership, the resistance to his discourse was further evidenced in reactions to his implication that science can make the value judgments of “good” or “bad” based in empirical review. The responses to Feidler’s display of instrumental reasoning and his belief in the so-called need for “objectivity” made clear that his research was at odds not only with the respondents’ practical experience, but moreover with its rather blatant dismissal of an interest in the individuals’ well-being in favor of the standards used to measure efficiency and
practicality. This discursive resistance to not only Fiedler’s reasoning, but moreover to how it was exclusive of ethical and emotional considerations, demonstrates the extent to which his discourse diverges from the operant or background logic, and is clearly outside of the integrative and practical norms, as well as the ethical interests of the majority of the symposium’s participants, who did not hesitate to express their skepticism and at times, outright rejection, of the authority of “science” if it contradicts their experience, values, and observations. This episode underscores Frank’s (2007) observation that much of post-WW-II epistemological discourse was concerned with restoring reason with ethics, resulting in this case, a disciplinary norm in social psychiatry from which to call into question instrumental rationality if it is divorced from moral and relational considerations. While explicit references to democratic ideals were only made in the symposium because Fiedler called them out as “preoccupations”, his comment prompted discourse that made them explicit as assumptive logics associated with humane standards and the interests of the individual.\textsuperscript{117} We also see a subtle normative critique of instrumental reasoning in favor of a practical-moral approach to understanding and resolving conflicts between individual and organizational needs. These discussions also contrasted the distinction between “technical” questions aimed towards a “goal directed organization of means and the rational selection of instrumental alternatives” with “practical” questions aimed towards the “acceptance or rejection of norms, especially norms for action” that can be accepted or rejected in reasonable discourse (Habermas, 1973, p. 3).

In contrast to Rose’s (1998) skeptical view that emerging objects of social psychological research were linked to an instrumental science of democracy, both Kemmis (1980) and I have found that ideals of democracy became linked to how science should select and direct their inquiries and inform the standards that judge its usefulness. Therefore, the skepticism expressed
towards “science” in general and Dr. Feidler in particular displays the discursive seeds of a critique of instrumental reasoning used to justify means-ends thinking whereby human beings are objectified and become a non-factor in non-democratic regimes of decision making. With the Frankfort School’s critical theoretical and philosophical investigation of problems relating to ideology, culture, and, science were beginning to circulate in texts by and during the 1950’s, for instance in Adorno’s Social Science and Sociological Tendencies in Psychoanalysis (1946) and The Authoritative Personality (1950) and Marcuse’s Eros and Civilization (1955), we see related undercurrents of these critiques appearing in social psychiatric perspectives and understandings. The avenues through which these critical orientations influenced U.S. social psychiatry and sociology extends beyond the scope of the analysis, but is noted nonetheless as a conceptual overlap perhaps worthy of further investigation.

An emerging, generalized critical sensibility in mainstream and military social psychiatry discourses was evidenced in the symposium’s research problems concerning the conflicts arising out of practical concerns with authoritativeness, total institutions, and dehumanizing practices believed to be contradictory to both human needs and humane standards emerged within this discursive field. These new sensibilities, associated with the “human relations approach”, were further grounded in theories of identity and ego-development in certain factions of social psychiatry discourse and research perspectives as displaying distinct discursive undercurrents of Freudian psychoanalysis, symbolic interactionism, and human needs theory of self-actualization/ego development. Such perspectives have come to be associated with the theoretical groundings and moral arguments of Critical Theory grounded the pivotal notion of an “intersubjectively” produced subject that offer an empirical basis for the humane treatments and extensions of democratic models into new contexts (Haberman, 1972, 1973).
Subtle and implied discourses implicating democratic ideals functioned as a guide for, and justification of, the right to humane treatment couched in a complex discursive constellation and set of conceptual linkages. I want to compare this overlap to what Foucault (1972) describes as a discursive importation of concepts from previously distinct domains of social action that results in the formation of conceptual configurations deriving from the discursive field of concomitance, or discourses imported from another “discursive domain of objects” (p. 58). He explains that these are “active among statements” because they function as “an analogical confirmation, general principle, reasonable premise, a model transferred from other contents, or function as a higher authority” (p. 58). Concomitant democratic interests and rights thereof, indict institutions in a democratic society as answerable to a higher authority and standards upon which to form judgments and critiques of inhumane and non-democratic practices, a theme which will be further explored as discursively forming a normative premise upon which to critique institutional practices. The culmination of these critical and democratic sensibilities constructed a conceptual constellation from which to critique and intervene in institutions and their faulty understandings.

When the so-called democracy movement in social psychiatry is viewed in relation to the broader political context, the move to democratize relations of previously normalized hierarchical relationships based in arbitrary authority places such changes in an antagonistic negation of Nazi and Communist totalitarianism regimes as a presence in socio-political awareness and fears during this time. Even the newly elected President Eisenhower, in the quote from his Inaugural Address, expressed a critical sensibility of the apocalyptic power of the combined institutional forces of science and military advancements for producing outcomes he describes as “evil” and capable of human erasure.
6.4 Epistemological Sensibilities in Social Psychiatry and Society: The Institution and its Understandings as Object of Critique and Reform

Condemned by custom to makeshift expedients, these institutions are unable to do much about the fact that mental illness is often the product of an abnormal environment, or even about the more obvious fact that one does not correct one abnormal environment by introducing another—the still more abnormal environment of the mental hospital ward.

--Dr. Francis Braceland, President of the APA (1956-1957)\textsuperscript{118}

In addition to social psychiatric discourses directing attention to conflicts between individual and institutional interests, broader social and political discourses played a role in calling attention to problems in the mental health care organization. When juxtaposed with a deepening differentiation between democracy and totalitarianism, awareness of practices and conditions in “total institutions” posed a conceptual contradiction when these organizations were positioned under the rubric of existing in a democratic society with the basic premises of human rights, liberty, and equality, and then revealed to be otherwise. While Manning (1989) has highlighted that the therapeutic community formation deriving its authority from a widespread institutional reform movement connected to heightened discourses of civil liberties and human rights characteristic of this epoch, his account does not adequately address the contexts and concrete conditions which preceded and accompanied such discursive shifts (Stammers, 1999).

In this effort, I want to highlight a temporal succession between a social problematization of the state of the mental institution, a spike in the systematic study of the mental health organizations, and the formulation of a distinct form of institutional critique. Kennard (2004) highlights that discourses aimed towards articulating institutional problems are more frequently embraced during times when a country is undergoing significant “democratizing changes”\textsuperscript{119}

In 1946, \textit{Life} magazine published an article written by Albert Q. Maesil entitled, “Bedlam 1946: Most U.S. Mental Hospitals are a Shame and Disgrace” atesting to the horrific conditions
of physical and mortifying human brutality, patient neglect, malnutrition, and overcrowding, as well as gross understaffing as characteristic of state psychiatric hospitals around the United States. The article was accompanied by photographs which had been secretly taken and submitted to Maesil by individuals known as Conscientious Objector’s (COs) who worked without pay in mental institutions throughout the country as an alternative civilian service in provision of their religious or conscience objection and right to refuse military drafting (Taylor, 2003). After reporting the abuse to the superintendents of the hospitals, which was of no avail, CO’s dispersed around the country began submitting photos of the conditions and patients inside the walls of the hospitals to local religious leaders and newspapers in a concerted effort to raise public awareness of these conditions, which resulted in a swarm of articles and publications addressing this problem (see Taylor, 2003, Granquist, 2010). The photos, compared by viewers to Holocaust images, displayed graphic images, entitled “Neglect”, “Nakedness”, “Idleness”, and “Despair” of the emaciated, unclothed inmates laying or sitting on top of each other against concrete walls and floors that were (Taylor, 2003). By the early 1950’s, numerous books, a horror movie entitled “Bedlam”, and newspaper and scientific articles began to emerge with the abysmal state of U.S. mental institutions as the central topic of moral dissatisfaction (see Grandquist, 2010). In addition to prompting the writing of books and book-length articles describing their observations of the atrocities inside the institutions, some of the CO’s united to form the National Mental Health Foundation (NMHF) in 1946 in an effort to raise public awareness and state support to increase funding to state psychiatric institutions (Granquist, 2010). The same year, Congress passed the National Mental Health Act which established and redirected the oversight and funding of mental health issues from the states to the federal level.
The Act authorized the National Institute of Mental Health (NIMH) formally established by 1949 to fund research on neurological and psychiatric disorders.

The dedication of this group of civil servants and journalists in bringing these problematic conditions into public awareness, arguably led to the founding of the earliest branch of U.S. organizational studies as the study of mental hospitals and psychiatric institutions (Etzioni, 1960). Though this political movement brought the state of the mental institution to public awareness and recognized source of serious federal legislative, fiscal, and empirical consideration, it was not enough to transform them into a site of effective psychiatric treatment. However, the influx of researchers able to gain observatory access to the insides of the wards and hospitals rendered the on-going problems more visible and amenable to empirical analysis. Many of the researchers reported episodes similar to ones described in Ward 55 prior the therapeutic community experiment. Such scenes were evidently frequent and problematic enough to have been studied and given the name “The Stanton & Schwartz Effect”, described by researchers who had observed the phenomenon in other civilian and military mental hospitals (Stanton & Schwartz, 1954, Caudill, 1957, Miller, 1957, Parker, 1956, Wilmer, 1958a, 1958b, Goffman, 1967). The phenomenon was also named the “reciprocal effect” by Rashkis & Wallace (1959). Both terms, however, are used to explain the interactive process leading to what they believed to be predictable and patterned outbreaks of aggressive collective disturbances and contacts between the staff-inmate worlds.

Upon closer review, in the 1950’s, in addition to the emergence and influence of Goffman’s research describing characteristics of total institutions, the concepts of “institutional neurosis”, “institutional misunderstandings”, and humane concerns with authoritarianism were gaining ground as justification for institutional reform and intervention. In order to more
closely examine these articulations, I explore Goffman’s (1958) and Stanton’s (1958) research as exemplary of this development in the institutional reform faction of social science, focusing particularly on the objects and topics in their discourse that constituted the basis of their problematization. In Goffman’s work, for instance, we notice a problematization of the characteristics of total institutions on the basis of their production of “totalized identities” and “self-mortification” processes which is explained as inflicting damage on the patients’ “moral career”, defined as “a career laying out the progressive changes that occur in the beliefs that he has concerning himself and significant others” (WRAI, 1958, p. 49). These social processes, Goffman argues, position the institutionalized patient as “stripped of his wonted supports, and his self is systematically, if often unintentionally, mortified...he is led into a series of abasements, degradations, humiliations, and profanations of self, resulting in “radical shifts” in his moral career (Goffman, 1958, p. 49). In this configuration, the institutional context can however become a site of practical intervention through reconstructing the context into its key interactional elements, described in terms of “inmate world, then the staff world, and then something about contacts between the two” (1958, 1961, 1967). Goffman’s research highlights how institutionalized expectations and implicit understandings become a part of a familiar tension between patients and staff, a division he termed the “staff-inmate split”, as denoting the binary and differential positions between the staff and the inmates that produce repetitious antagonisms between these two sub-cultural groups (Goffman, 1958, p. 46). As Goffman explains, the significance of these antagonistic stereotypes is that they develop into a “theory of human nature” explained as a “verbalized perspective (that) rationalizes the scene, provides a subtle means of maintaining a social distance” (1958, p.46, 72-73). He also notes the
tendency of total institutions to “effectively create and sustain a particular kind of tension….and use this persistent tension as strategic leverage in the management of men” (WRAI, 1958, p. 49).

Particularly notable in Goffman’s discourse is how he breaks down characteristics of the total institutional context into the relational dynamics that maintain a seemingly stable and fixed pattern of interactions and their implicit assumptions into potential and immediate sites of intervention. In a dispassionate manner, his concepts of mortification and the moral career of the patients center the discussion on a (de)moralized identity as an inhumane and unnecessary injury to the self as produced in social interaction.\(^\text{128}\) An additional point worth highlighting is how Goffman articulates these problems as a problem of systemic understanding, explaining that “We have institutionalized in our society an understanding that you can drop out of circulation for a brief period of time and become totally under control of a medical person and this doesn’t seem to alter very much the self you came in with” (1964, p. 92).\(^\text{129}\) The emphasis on the “self” elevates its status as a primary interest in the larger problematization as justifying the need for new understandings and identifying faulty understandings as an institutionalized phenomenon.\(^\text{130}\)

Even though Goffman did not use the language of “domination”, he problematized totalizing institutional practices through critically reconstructing the consequences of “praxis” (i.e. social action and its understanding) in terms of concrete relations warranting moral concern for the rights and identities of the patients through teasing out the various damages to the integrity of the self, inhibition of individual autonomy, and dominating of varying degrees. Whereas Goffman seems to be more concerned with problems of social interaction and domination, Stanton (1958) addresses problems of understanding as primary objects of analysis attempting to account for the state of the mental hospital in which civil liberties are called “privileges” highlighting “seriously disturbing conflicts about delegation of authority, about
authoritarianism, about freedom” (p. 254). In his panel presentation on milieu therapy at the Walter Reed military psychiatry symposium in April of 1957, Stanton introduced a theory that attributes the apparent normalcy and accepted status of the demoralizing institutionalized conditions to enduring institutional misunderstandings, explaining, “A misunderstanding is often subtle, serious, lasting, but difficult to uncover...precisely because it offers certain values to both participants in its formation and maintenance, even if it is much more harmful in its effects than the relatively trivial but more obvious values it seems to protect. Created and unconsciously maintained, certain misunderstandings are nearly ubiquitous, apparently institutionalized. It is this aspect which makes them important and open to study” (1958, p. 497). Stanton’s discourse clearly overlaps with psychoanalytic presuppositions by implying that misunderstandings are often not the product of conscious awareness, but rather constitutes an interpretation in a ubiquitously dispersed and unexamined status.

Stanton’s chain of concepts extends psychoanalytic implications to include the notion of “transference misinterpretation” in explaining how human interaction, or lack thereof, between staff, patients, and doctors functions on the level of transference communication. Through applying the theory of transference to problems of institutional misunderstandings, Stanton’s implicates that these kinds of misinterpretations matter, especially in the lives of the patients in ways that cause further damage to the subjects’ identity and moral career. In other words, staff-patient relationships and antagonisms are more than just a benign interaction, but rather constitute a significant familial relationship in the lives of institutionalized populations capable of causing great pain or facilitating human growth and therapeutic recovery. This aspect of “transference misinterpretation” functions as a pivotal logic and assumption in the moral argument of this trajectory of thought highlighting, first, that patients are negatively impacted
within the relational context of institutionalized misunderstandings and resulting practices and, secondly, that such misunderstandings as contextualized in a transference relationship are integral to maintaining the volitional and withdrawal patterns of “collective disturbances”, which are framed as “social psychopathological interactions” and argued to exacerbate and maintain both individual and institutional pathology (Stanton, 1958). Through this critique, the illusion of the “objectivity” of problematic violent outbreaks is dissolved through its reconstruction and re-contextualization as a system of interaction that is reifying and reproductive of the problems as justifying the practices used to control the “objective” problem.

6.5 Summary: Practical Discourse and Critical Hermeneutics

Similar to Goffman’s, Stanton’s argument postulates that the environment of a mental hospital produces and reproduces the problematic and disturbing patient symptoms, which assume a functional place in the informal organization of the hospital, and maintained in misunderstandings that manifest in the relational patterns between its members (1958, p. 342). Both Stanton & Goffman’s research underscore Freudian presuppositions in Habermas’s project that postulate how institutional and individual pathologies are maintained through problematic mis-interpretations resulting from self-deception and/or ideological distortions of understanding that have not yet been brought to the discursive surface and made amenable to critical reflection and retrospective analysis in practical discourse (1972, 1973). Practical discourse here is conceptualized as a communicative practice that addresses the normative and pragmatic claims of a discursive or institutional practice for practical purposes (Habermas, 1973, 1999, Craig, 1999). Accordingly, practical discourse can therefore be equally understood as a form of meta-discourse (discourse about discourse) or meta-communication (communication about communication) which engenders critical self-reflection capable of producing insights and
awareness at a higher level of abstraction through an informed understanding of a historically formed present condition.

In this sense, practical discourse that critiques problems of understanding are simultaneously intervening in the problem through bringing it into discursive awareness. The research themes address the deeper problem of systemic, commonplace, predominant institutional misunderstandings about exclusionary and coercive practices believed to have serious, yet under-considered implications on the freedom, liberty, and civil rights of the patients. The goal of these inquiries is oriented not only understanding problems, but moreover to show how conventional understandings of problems are actually (mis)understandings that are constitutive and facilitative of the actual problems. Such an orientation is consistent with a hermeneutical/interpretive realization of ideology, simultaneously critiques problems of understanding, with an ultimate interest in the implications of such on human integrity (Habermas, 1972).

In short, oriented towards a practical method of correction that links theory and practice, the recurring themes in these perspectives coagulate around interests of human integrity, understanding and institutions as objects of critique, and a practical method of corrective intervention. Through articulating problems as problems of interpretation by critiquing faulty understandings, critical reflection maintains the hope and possibility of restoring a more correct understanding and appropriate practice. My argument focuses on how this constellation of concepts is consistent with theoretical and methodological presuppositions of psychoanalysis applied to an institutional context that is “concerned with those connections of symbols in which the subject deceives itself”, and attempts to describe the mechanisms of its systematic reproduction (Habermas, 1971, p. 218). I have suggested that these elements are formative of
the pre-discursive or pre-conceptual, in the sense of not yet identified or named, underpinning of Critical Theory as rooted in psychoanalytic concepts and reflective critique that was beginning to be applied to institutional pathologies of understanding, but without the customary terms applied to identify it as such.

I hope to have highlighted how these problematizations discursively functioned as a practical style of institutional critique which questioned the dominance of traditional practices and current conditions on the basis of “irrational, unjust, alienating, and inhumane” understandings, social structures, and practices, while also demonstrating the reifying justifications used in their maintenance (see Kemmis, 2007, p. 124, Habermas, 1973). As defining elements of a critical theory orientation, the action of critiquing praxis, understandings, and instrumental rationality characterizes its interest in loosening “the bonds of misunderstanding” built into current systems of interpretation (Kemmis, 1980). Habermas claims that this orientation is guided by a cognitive interest of liberation through facilitation of “the experience of emancipation by means of critical insight into relationships of power, the objectivity of which has its source solely that the relationships have not been seen through. Critical reason gains its power analytically over dogmatic inhibition” (1973, p. 253-254). The process of critiquing relations of power which inhibit liberation is believed to produce “insight” through the communicative work of critical reflection which, in Habermas’s theory, “coincides with a step forward in the progress toward the autonomy of the individual, with the elimination of suffering and the furthering of concrete happiness” (p. 254). This combination of insight produced from critique of domination is defined as a “kind of practical reason” whereby “theory was still related to praxis in the genuine sense” (p. 254-255). I contend that we see these elements in this group of researchers’ (1) arguments as aimed towards critiquing both practices
and problems of understanding, (2) interests in how practices and understanding prohibit human liberation and self development through allowing unnecessary suffering through domination and other means of inhibiting the pursuit of happiness, (3) critical insight into concrete sites and interactions as practical areas of human intervention and moral concern.

Through this analysis, I hope to have situated the military induction of the Therapeutic Community in a constellation of converging discourses in social psychiatry and the public sphere that displayed similar critical sensibilities about relations of authority, presuppositions of democratic rights and ideals, and a form of research inquiry that directs social action towards intervening in problematization of (mis)understandings and blocks to human emancipation. As a crucial component of a critical theory’s conceptual configuration, emancipation here is understood within Habermas’s frame of discourse theory and further articulated in terms of a practical goal of research inquiry seeking to promote emancipation in amelioration of its antagonistic counterpart of “unnecessary domination in all its forms” (McCarthy, 1975, p. xviii). Emancipation is further understood as an explicit “interest” of the research, formulated as “an attitude which is … formed in the experience of suffering from something man-made, which can be abolished and should be abolished” (Habermas, 1986, p. 198). Following Habermas, Deetz summarizes the emancipatory interest as the “human desire for freedom, autonomy, and collective self-determination of the future” striving to “reclaim the choices against all forms of domination or privileging of any arbitrary social formations” (1992, p. 233).

This analysis has situated the therapeutic community model in a context of shared research interests in patient liberation and institutional praxis, as targets of inquiry and critique among a network of social science researchers who converged around general practical and theoretical implications of a socially constructed personhood, understood as being impacted by
changes in the environment, social treatment, and institutional domination. I have suggested that such themes constitute generalized elements of epistemological leanings in intellectual and social discourses as linked to democratizing and liberating sensibilities in social psychiatry, yet also in relation to a convergence of political and cultural discourse as displaying related awareness and arguments. Thus, there was no one determinate space or discourse that facilitated the *kairos* for humanizing understandings of the adverse effects of oppression and injustice on self and society, but rather a series of convergences of democratic interests and awareness of breaches thereof displayed in multiple spheres of public discourse. As I hope to have demonstrated, these spheres are overlapping, connected, and dispersed across domains of social action and discourses, yet influence each other in ways that are not always apparent when viewed independently.

A significant theoretical viewpoint from which to understand the formation of the institutional reform movement of the 1950’s is its convergence around a shared discourse of human rights that connected dispersed, yet overlapping interests between what Hauser refers to as *reticulate public spheres* (1999). Grounded in a dialectical logic whereby general and particular discourse are connected in a web-like network of influence, the concept of reticulate public spheres displays an openness of communication around, about, and of, in this case, human domination that negotiates its discursive formation as resulting from multiple conversations engaged in response to its exigency (Hauser, 1999). The openness of the public sphere, then, is evidenced in overlapping and changing discourses that contest, challenge, and sometimes converge at the intersection of the vernacular, political, and scientific discourses.

The political-intellectual reform movement of the 1950’s demonstrates Gadamer’s (1989) notion of critical hermeneutics that alludes to how “social frames of reference influence researchers questions, which in turn shape the nature of the interpretation itself” (Kincheloe &
McLaren, 2002, p. 101). The horizons of the scope of inquiry, or the worldview affiliations of
the researchers and the social world of discursive resources of interpretation, come together in
what Gadamer termed the “fusions of horizons” or the “hermeneutical act of interpretation”
intended to demonstrate how social, public, private, and intellectual interpretations are always,
already situated in the social field where these horizons converge.

While scholars of social movements designate the mid-1950’s as the beginnings of the
civil rights movement, one must wonder to what degree to the discursive themes of social
science intersected with discourses in the public sphere and made intelligible a critical sensibility
capable of reconstructing social problems in terms of violation of human rights, according to
new fears of the hidden antagonisms to democratic freedoms, and consequently locate such
antagonists in homeland “democratic” institutions. Concurrently, as the next chapters will
demonstrate with a concrete description of Wilmer’s (1958a) Therapeutic Community
experimental intervention, social science was in a phase whereby “social problems manifested in
and provoked by the WW-II created a new environment for social science, an environment in
which the earliest action researchers believed that they could no long pursue only understanding”
(Kemmis, 1980, p. 8).
Chapter 7: The Therapeutic Community in Ward 55: An Experiment in Institutional Reification and Changing Dimensions of Reflection

7.1 A Brief Re-Introduction

In July of 1955, Ward 55 in Oak Knoll Naval hospital in Oakland California was transformed into the site of a high profile U.S. military psychiatry research experiment that tested the effects of the therapeutic community model in treating severely disturbed military personnel from the Korean War. During ten months of data collection and therapeutic experimentation, Ward 55 was visited by administrators and doctors from state psychiatric hospitals, researchers from universities, members of professional psychological organizations, and high ranking military officials (Briggs, 2001, Wilmer, 1958a). Accompanied by a tone of enthusiasm in U.S. military and psychological circles, the promise of the therapeutic community was articulated as an administrative, therapeutic, and humanitarian advance in military and civilian psychiatric treatment (See WRAI, 1958, Manning, 1989, Sedgwick, 1982). The case was also produced as a docudrama entitled People Need People that aired on the Fred Astaire Alcoa Series in 1961 on ABC in the U.S., and the BBC in the U.K., with an estimated audience of two million, and was nominated for five Emmy Awards in 1962 (Wilmer, 2004). The therapeutic community experiment was designed and led by Dr. Harry A. Wilmer, Ph.D., M.D., MC, U.S.N.R., after being drafted by the US Navy in 1955 for a two-year tour and assigned the position of officer-in-charge of Ward 55 in Oakland (Briggs, 2001). Wilmer recruited anthropologist Gregory Bateson and psychiatrist Jurgen Ruesch to serve as consultants for the experiment who subsequently wrote an evaluation included in Wilmer’s monograph.

The Therapeutic Community experiment in Ward 55 is a multi-text case that was explicitly, strategically, and systematically engineered precisely in the effort to alter stigmatizing and commonplace treatment methods and arrangements characteristic of military and civilian
psychiatric institutions during this time period. The archival work involved in retrieving texts pertaining to this case speaks to its status as an “off the map” moment/event, despite evidence of extensive photographic recording, video footage, scientific articles produced, and moderate consumption of, as well as, praise of the texts it produced for psychiatric, popular culture, and military circles. In therapeutic community model literature, Wilmer’s experiment is almost always cited yet has remained relatively untouched, both descriptively and analytically, which is surprising (or not) given its (high profile) institutional and historical status as the “first of its kind in North America” (Briggs, 2001). As a landmark psychiatric research experiment in the treatment of combat veterans in the US, this case is noted for its contribution/addition to an incomplete history of late Korean War/early Vietnam era psychiatric diagnosis, treatment, and understanding of psychiatric combat casualties and therapeutic intervention. Excavation and analysis of the model reveals its resemblance to a critical theory social science therapeutic intervention on institutional, organizational, and individual levels.

This analysis hopes to show the conceptual and strategic connection between critical social science and psychoanalysis, as explained by Habermas, in relation to what and how Wilmer was attempting to accomplish throughout the experiment, as well as, in the texts about the experiment. One of the main underpinnings of Habermas’s (1972, 1973, 1982, 1984, 1987) critical social science project formulation is rooted in a fundamental comparison between the defining operations of a critical theory and the primary therapeutic and theoretical presuppositions of Freudian psychoanalysis. Habermas (1972) presents psychoanalysis as “the only tangible example of a science incorporating methodical self-reflection”, which he eventually theorized to provide the grounds from which to intervene in pathological institutional systems (p. 214). Gross (2010) explains the comparison between individual and institutional
pathologies as “networks of belief that such maladaptive institutions embody and enact are analogous to the disturbances in the psyche that are at the root of systematically distorted communication; they differ in that the systematically distorted communication they generate is shared by significant social groups and even by whole societies” (p. 340). McCarthy summarizes the connection as, “the critical sciences—such as psychoanalysis and the critique of ideology—-that aim at self-reflective emancipations from systematic distortions of communication” (1982, p. xxiii).

In drawing the comparison, Habermas writes that a critical social science, in contrast to “traditional”, or those that are satisfied with the production of “nomological” knowledge, attempts to:

determine when theoretical statements grasp invariant regularities of social action as such and when they express ideologically frozen relations of dependence that can in principle be transformed. To the extent that this is the case, the critique of ideology, as well, moreover, as psychoanalysis, takes into account that information about lawlike connections sets off a process of reflection in the consciousness of those whom the laws are about. Thus the level of unreflected consciousness, which is one the initial conditions of such laws, can be transformed (1972, p. 310).

Accordingly, I highlight two concepts, that conceptually unify the methodology of both critical social science and psychoanalysis, and reflect a concern with (1) “self-reflection” through critique of formative ideologies, which “releases the subject from dependence on hypostatized powers” and is such defined according to an “emancipatory cognitive interest” (p. 310) and, (2) that “theoretical statements” in talk (therefore, amenable to observation) express “ideological
relations” which reify themselves in institutional and individual logics. Through exploring the therapeutic community’s foundational critiques and rationale, I will concretize the relations of these interconnected concepts through comparing key elements of critical social science inquiry to the rationale of the therapeutic community experiment, which was conducted and designed by a trained Freudian psychoanalyst at the time of his leadership. Through this process, I also hope to make connections and distinctions between critical social science and action research, and demonstrate a foundational concomitance between Habermas’s emancipatory vision and Wilmer’s communicative practices of critique and facilitating self/institutional reflection.

With the exception of psychoanalytic research, the connection between psychoanalysis and critical social science remains relatively latent in contemporary articulations and applications of Habermas’s critical theory. In my analysis, I will not rely upon the formation of “systematically distorted communication”, as currently articulated, to explain ideology or communicative distortions. Rather, in the spirit of Foucauldian archaeology, I hope to show the operations of some of the formation’s central tenets in Wilmer’s experiment as applied conceptually and pragmatically, without referring to the name to identify the formation.

7.1 The Problems: Social and Institutional Exigencies

Having grounded Wilmer’s endeavor amongst converging critiques of institutional practices, their interpretations, and overlapping interests in patients’ therapeutic interests in the last chapter, this section will hone in on Wilmer’s rationale, problematization, and the concrete nature of his critiques. According to Surgeon General and Rear Admiral Hogan, Dr. Wilmer advocated the therapeutic community model as the primary rationale and protocol for the experiment, recalling that Wilmer “asked only for an opportunity to demonstrate the truth of his beliefs which were founded on long experience and deep understanding.” (1958, p. 5). Wilmer
prepared for his leadership role for almost a year prior to his command, traveling to England to observe and train with pioneers of the therapeutic community model with similar types of patient symptoms and administrative dilemmas in British military hospitals. Upon his return to the U.S, Dr. Wilmer observed and evaluated the procedural operations on Ward 55 for three months, prior to his active leadership role.

In Wilmer’s social science texts about the experiment, he accurately presents the growing problem of “mental illness” in the U.S. as “unquestionably one (of) the gravest medical and socio-economic problems of our time” (Wilmer, 1958b, p. 879). He noted that that over half of civilian hospital beds in the U.S. were occupied by psychiatric patients and that one third of all medical separations were attributed to mental illness, with some studies estimating the subsequent costs of treating military personnel requiring extended psychiatric care in Veterans Administration Hospitals fell just short of 4.6/3.5 billion dollars (Wilmer, 1958a, 1958b). Wilmer depicted the combination of these factors as an exigent and widespread social problem, which not only exacerbated the already startling “human costs of disorder”, but was further articulated as producing unexpected, trickle-down “astronomical” costs for all primary societal institutions (see Wilmer, 1958a, 1958b). Through maximizing the power of group and social therapies, as opposed to individual therapy, the therapeutic community model was claimed to be able reduce the number of doctors and staff needed for treatment, and re-positioned the doctor or psychiatrist in the dual roles of administrator and therapist. Consonant with Wilmer’s model/argument, the therapeutic community model has consistently been framed as a potential solution to institutional challenges of patient management, hospital administration, staff shortages, rising mental health incidence, and their accompanying costs (Main, 1946, Jones, 1952, Wilmer, 1958a, 1958b, Manning, 1989).
The influence of Kurt Lewin’s participatory research approach is apparent in Wilmer’s experiment as evidenced in his direct citations as well as in his mapping of patterns and movements in the group meetings (1943, 1947, 1951). Lewin, a German social psychologist, is perhaps most well-known for his social field theory, his topological force field analysis for assessing group dynamics and change, and for coining the term “Action Research” (Kemmis, 1980). Action research was developed as a “form of research which could marry the experimental approach of social science with programs of social action in response to major social problems of the day” (1980, p. 3). Specifically, action research proposes a problem centered approach to a contextual assessment, evaluation, and study of social action, that is distinguished from other social science research by its concern with the “relation between theory and practice”, wherein the “intention to affect social practice stands shoulder to shoulder with the intention to understand it” (p. 6). Kemmis claims that the “social problems manifested in and provoked by the WW-II created a new environment for social science, an environment in which the earliest action researchers believed that they could no longer pursue only understanding” (p. 8).

McTaggart & Fitzpatrick (1980) underscore that action research and critical social science share key interests and commitments to “participatory democratic processes for social and intellectual reconstruction”, “linking of the development of theory and practice”, “authentic critiques of practice”, and “strategic use of programs of social action” (Kemmis, 1980, p. 11).

From within this conceptual articulation, the Oak Knoll therapeutic community experiment displays a participatory rationale, theoretical and practical justification, authentic critique, and strategic social action in alignment with an action research, social science methodology. It can be similarly compared to an action research experiment on the basis of the extensive research activities of Dr. Wilmer and his associates involving fact finding, problematizing, planning,
implementing, evaluating, mapping, and intervening in social action through a research structure
that built in the active participation of all members of the ward in the new protocol and its
assessment. While Wilmer’s protocol includes the conceptual and performative aspects of
action research, such a description does not entirely capture the uniqueness of the experiment’s
discursive and symbolic formation, or political trajectories. Due to a few key, distinguishing
elements, Habermas’s concept of critical social science inquiry offers a more fitting comparison
from which to articulate overlapping elements of the discursive formations.

7.2 Critical Assessment of Normative Conventions: Ego Domination and Reifying
Interpretations

Although Wilmer does not discursively frame his problematization as a critique of ideology,
I hope to show how his discursive explication of the therapeutic community experiment’s
rationale was grounded in a critique of illusionary, illegitimate, and contradictory institutional
justifications, and how such normative rationalizations were used in justifying conventional
practices of human physical and ego domination. His primary problematization redefined
traditional hierarchical divisions as problems of domination by not only theorizing their impact
on the patients’ self-ego, ability to recover and exacerbation of their disorder, but also through a
critique of the ideological logic and organizational cultural norms that held them in place.

Consonant with Goffman’s descriptions of total institutions as “shifting and sorting
operations”, Wilmer compared the ward, during his assessment period, to an “emergency holding
and sorting operation” where there “had been little active organized therapy except as needed or
perhaps demanded” (Goffman, 1958, p. 28, Wilmer, 1958). Wilmer then focused his critique
on explaining how the “therapeutic” practices of seclusion, sedation, and physical restraint were
mechanisms of disciplinary control that were not only therapeutically futile, but also pathogenic.
He described the actual organizational conditions, as well as the lasting distress of the patients of
Ward 55 resulting from their treatment in other Naval hospitals, as constituting an exigency and crisis in need of an innovative intervention. Upon their arrival to the ward, Wilmer reported that many of the patients reported fears of dying, being in a “cage” or “cell block” and being killed in the hospital, specifically in the seclusion room. Chapter VI of the monograph, simply entitled, “The Seclusion Room”, documents eleven patient case histories that describe prior experiences of patients who had been routinely, chronically, and oftentimes violently restrained and punitively secluded (1958a, p. 135-149). The patients’ behavior and communication was described as suicidal, homicidal, assaultive, delusional, catatonic/mute/delayed/exaggerated speech, and extremely withdrawn (1958a, p. 109-118, 135-183). The devotion of time and book space to explaining the imprint of social isolation and violent restraint speaks to Wilmer’s understanding of its importance as a problem in the recent past histories of the patients, as well as its enduring form in organizational cultural practices.

Described in terms of its normative role as an exclusionary practice that acted as a “pathogenic catalyst” for the patients’ disorders, Wilmer argues that the seclusion functioned as an integral practice for maintaining pathological disorder on the ward by positioning the patient to enact their “psychotic reactions”. The argument claims that social isolation propels the patients’ into a state of “regression and withdrawal” with the impact of:

- lowering his self-respect, increasing his sense of stigmatization, and reinforcing his fears that he is at the mercy of forces within himself and of those who hold the keys. It strengthens delusions and excites hallucinations and often leads to the formation of new ones by depriving the patient of his one tenuous hold on reality—his social contact with other human beings....it confirms his fear that he
is crazy and by placing him in a situation which invites him to do so, and gives license to fulfill escapist and self-destructive fantasies (1958a, p. 120-122).

The implications of the sequestered experience were further explained in terms of the “absence of others”, thus creating an environment whereby it is impossible for the patient to feel “love”, in part because there are no immediate others in the quiet room, and in part because of the meta-communicative implications of being punitively rejected (1958a). This argument, in addition to tapping into a higher universal principle, extends the frame of the problem as part of an organizational cycle that is critiqued for how the practice positions the subject not only in unnecessary suffering, but also in further regression into their disorders, as contraposed with “reality”, hinged particularly upon social rejection and dismissal.

Wilmer’s critical orientation reframes the conventional practice as dominating and reifying, and also reinterprets the practice and its consequence according to a psychoanalytic conceptual configuration (reality, ego, self-respect, fear, love, narcissism, fantasies, regression, dependency), using terms associated with Freudian psychoanalytic interpretation to explain how the ideological justifications ultimately harm the subject. Habermas (1972, 1973) argues extensively that Freudian theory is guided by an interest in “emancipation from unrecognized dependencies—that is, knowledge coincides with the fulfillment of the interest in liberation through knowledge” (p. 9). In contrast to goals of technical control and prediction of outcomes associated with instrumental rationality, Wilmer’s critique underscores the liberating interests of psychoanalytic interpretation and, through a “reinterpretation” of and engagement with reality, demonstrates how theory aimed toward critique of faulty interpretation is analogous to “therapy” if it facilitates reflection and insight.148
Wilmer’s discursively reconstructs the practice of seclusion as a practice of social isolation that re-produces the conditions that led to the “pathology”, which he argues is then diagnostically apprehended in terms of a pre-existing psychopathology as the conventional explanation of the patients’ antisocial and aggressive behavior. Such an interpretation, Wilmer further argues, results in a posterior justification of “correct treatment” (1958a, p. 124-125). The ritual use of the seclusion/exclusion is critiqued to the extent that it deprives the subject of the intersubjective conditions necessary to be a self, develop an ego capable of learning and civility, and produces the “objective” problem that is reproduced in the organizational, interpretative pattern of apprehension and justification. Wilmer critiqued the practice of seclusion not only for how it socially and pathologically positions the patient to act out their disorder according to the preferred institutional interpretation, but also for how it implicates the institutional context in justifying its own logic and treatment practices.

For instance, The Stanton & Schwartz Effect, as the behavioral locus of Wilmer’s critique, displays a systemic cycle sometimes referred to as “self-referential” or as characteristic of “autopoietic” systems. Drawing upon Habermas’s orientation, Deetz (1992) explains that these reproductive pathologies interfere with learning, in the sense of conceptual, self, and interactive development, and further lead to frozen and stripped identities grounded/stuck in their own internal logics. Therefore, when an organization is said to be, “self-producing and self-referential, attention in (is) drawn to the way in which ... human systems, produce themselves in an environment (as signified) that they have enacted from their own signifying system....they do not simply adapt to an external environment, they enact the environment to which they react....the identity of the subject and the world arise imaginarily in a change of signifiers” (1992, p. 182). Articulated as an interaction system that, instead of responding to an exigency or
problem in the environment on its own terms, produces the conditions to which it responds, is
explained, by communication theorists, as a form of “systematically distorted communication”
(Habermas, 1984, 1970, Deetz, 1992). This cycle also draws attention to how systems of
meaning are over-determined by a reductive logic that conflates cause and effect as discussed by
Ruesch & Bateson (1951). The process of “reification” is similarly used to describe how
theories become systemically reinforced and productive of the objects they intend to describe.
Bateson’s understanding of “reification” describes a communication process whereby a system
of relations is reduced to an object or a thing, and then interpreted and classified as a determined
state or experience (1972).

On the basis of a similar logic and method of interpretation, Wilmer critiqued the widespread
administration of barbiturates and ataractic drugs, which he respectively referred to as “sleeping
medication” and “tranquilizing drugs”. He notes that prior to the therapeutic community
experiment, it was common procedure “to give disturbed patients intravenous barbiturates upon
admission to the ward, often in large doses” (p. 119). Despite the espoused/purported
tranquilizing effects of the drugs, Wilmer reported opposite effects, stating that, “it was our
observation that large or small doses confuses and disorients the patients”, rendering them “more
at the mercy of his delusions and hallucinations and more at a disadvantage in dealing with
reality because they “cloud his consciousness and perception” and “seem to make him less
amenable to psychotherapy” (1958, p. 92). He also observes that the medication confuses
their intellect by increasing delusions and blotting out the memories of what has happened to
them, thus eliminating the “golden moment of diagnosis and therapy” due to the combined
effects of lack of human contact and amnesia (p. 93). Attempting to counter conventional
convictions with contradictory observations and an interest in the patients’ recovery, the “reality
principle” emerges again as a source of practical reasoning used to critique practices that position the patient otherwise. Wilmer’s theory and strategy of emancipation reflects the Freudian tenet that hypnosis without the active patient participation and self-reflection is futile, particularly through Wilmer’s assessment and observations that call into question how practices devoid of human interaction and cognitive awareness, such as being put to sleep and locked up, could be therapeutic or motivational.

On the basis that sedative practices reduce and perhaps eliminate the patients’ cognitive awareness and clear perception, Wilmer further argued that pharmaceutical sedation essentially impinges upon the patients’ ego needs to be awake and aware, therefore inhibiting their self-autonomy without the patients’ full consent. Wilmer’s texts consistently metaphorize the patients’ medicated state, as “putting the patients to sleep”, “drug-induced sleep”, and “unconsciousness”, while he simultaneously points out the medication’s unintended effects of intensifying the patients’ symptoms upon awakening. Ultimately, Wilmer claims that “barbiturates and ataractic drugs are an assault upon the patient’s ego” (1958a, p.103, n.2). This metaphor of “assault” is analogous to violence or an attack on the patients’ self, which clearly denotes Wilmer’s primary objective of therapy in development, recovery, and assertion thereof. Wilmer’s articulation of the drug therapy problem is as a form of domination over the patients’ ego rooted in an erroneous therapeutic justification. The error in this logic, Wilmer explains, is in “assuming that drugs in themselves can perform some miracle on the mental patient. Medication is likely to be as futile a device as quiet rooms and mechanical restraints unless, with the direction of the therapist, the patient is led to analyze the causes of his tension and anxiety and to find within himself the necessary means of control” (p. 92). These practices were further discussed as an involuntary form of domination. Wilmer claims that the patients’ “deeply
resented this type of treatment”, and that their resentment carried over to the new hospital environment, making seclusion “seemingly mandatory”, and creating a situation where the patients become “riper victims for the quiet room treatment” (1958a, p. 92-93, p. 119, n 1, p. 94).

These ideological examinations of practices of sedation functioned as an argument implicating the domination of patient autonomy and liberty through inhibiting their voice, wakefulness, awareness, and capacity for action/agency, which results in their suppression and removal from public contact and meaningful participation in life. Wilmer’s empirical observations contradict the arguments used to justify the practices as “calming”, because the after effects of the medication caused confusion, disorientation, and aggressive reactions in the patients. He re-configured the traditional logics used to justify practices of induced sleep, social isolation, and physical domination, revealing these practices as violations of the patients’ need to be awake, alert and connected to other human beings, and contradictory to the necessary conditions for human agency and recovery from similar/prior totalizing conditions. In direct connection with his and other researchers’ practical-critical articulations during this decade, the discourse of critique constructs the institutionalized subject as immersed in totalizing relations and faulty ideological justifications of practices that violated the constitutive conditions for autonomy, liberty, and happiness.¹⁵³

At the level of theoretical critique of practices sustained through ideology, Wilmer employs a distinctly psychoanalytic perspective as the foundational theory to explain how the normative practices functioned as forms of domination on patients and staff alike, because such practices “assault” their egos, produce mutual fears, and sustain “misunderstanding” as well as human brutality (1958a, p. 41). In conjunction with Laclau & Mouffe’s (1985) discursive strategy of re-articulating normalized conditions of subordination into unacceptable relations of
domination, Wilmer’s articulation addresses the faulty reasoning that underpins generalized institutional justifications of these practices by explaining how they are not only based in a logical contradiction, but also how such distortions of interpretations attack the patients’ humanity.

On a general level, Wilmer equates the logic justifying the aforementioned psychiatric practices with related instrumental and presentist logics used in other institutional settings. He explains this logic through pointing out the paradox in the interpretation of the unruly behavior of the patient founded on “prima facie evidence” used to ‘justify’ the use of seclusion and sedation, explaining that “When parents, teachers, doctors, courts, or jails provoke a nascent antisocial behavior or rebellion in their “charges”, they always take the resultant behavior as evidence that their repressive or punitive attitudes were justified” (1958 p. 125). This type of argument relies on a fixed state of present behavior and belief that provides its own explanation, as if there were no past, interactions, or interactants leading to the current state of affairs and further excludes explanations based on sequences of events or flow/durée of time. The identification of this ahistorical ontology or what has come to be known as “presentist” perspective is also a psychoanalytically infused assumption associated with critical social science’s commitment to diffusing the illusion that “formations” (e.g. self, practices, attitudes, organizations, arguments) are dissociated from historical formative processes, that they are “just the way they are” in the objectively reifying sense of the word (see Dean, 2002).

On a generalizable level, Wilmer’s ideological and practical critique offers insight into reification of doxa and how common sense is reproduced through these material arrangements and logics capable of excluding reflective or sequential reasoning. These are the pivotal arguments central for explicating Wilmer’s rationale: the first of which concerns a theory able to
justify its claims that conventional methods were harmful, dominating, and inhibitory for the open formation of the identities and selves of the patients and the staff; the second is focused on how these practices produce their own internally justified reasoning systems and misguided, yet “productive”, beliefs about the nature of the patients and their problems. This psychoanalytic critique of ideology utilizes the enemy of ideology, arguments based in self-reflective, reasoned explanation that connects and mutually informs concrete observations with theoretical explanations, to critique it. If ideological logic, as Laclau & Mouffe (1985) suggest, reduces/equivocates the concrete to an abstracted objectivity, then its opposite would expand/differentiate the abstract into the concrete and intersubjective.

Similar to Wilmer’s understanding of conventional practices as justified by what he referred to as a prima facie argument and related “error in knowing” and logic, Bateson shares a conviction that a “distorted epistemology” maintains pathologies in individuals and cultural forms (1972). In addition to systems of interpretations confirming their own logic, they also produce subjects, in accordance with the distortions in knowledge, who bear the burden of these misunderstandings through stigmatizing marks and predisposed subject positions for those induced in a systemic cycle of interpretation. Although not explicitly articulated, Wilmer’s theory of patient and staff socio-pathology, regardless of etiological original or environmental contingencies, follows a logic of correctives similar to systematically distorted communication in that it is characterized by the attempt to expose and communicatively intervene in self-referential systems of interpretations and meaning production.

7.3 New Rules, Reflective Practices, and Humanized Interpretations

At the level of designing a practical intervention, Wilmer re-interprets institutional practices as a habitual organizational tendency among the staff to “take the easiest way of out their
difficulty” (p. 93). The complementary practices of seclusion, sedation, and restraint converged, for Wilmer, in a dominating and predictable cycle that had little to do with the patients’ therapeutic interests, but rather serve as illusory panaceas, whose “use is always administrative in nature rather than medical” functioning more to relieve the anxieties and fears of the staff than to help the patient deal with their problems (1958a, p. 119). Wilmer concluded that “the determining factor in their use is the staff’s capacity to tolerate their own anxiety...they should not be misled into believing that it is only helping the patient” (1958, p. 102, p. 119). In support of this hypothesis, staff reactions to the new rules expressed such anxiety. Rather than abstractly “ideologize” the administrative tendencies and errors in logic to a state of unreachable institutional ubiquity, Wilmer instead located the problems in concrete organizational practices, which he translated into the staff’s incapacity to tolerate their anxiety that sustained their misguided beliefs that such practices were in the patients’ best interests.

In addition to setting procedural rules during the experiment to eliminate these practices, Wilmer implemented and utilized the staff meetings as a method of developing the staff’s capacity to manage their anxiety and, alternatively “to find new ways of dealing with the patients” that were reported as “more effective and infinitely pleasant than the old” (1958a, p. 42). In 1956, one the corpsmen from the ward published an article about the communicative and affective changes among the staff that resulted from the experiment, stating that, “Important in promoting such treatment environment is the constant examination of the staff’s feelings….Where formally they talked of ‘riots’, destruction, and other situations charged with anxiety, they now discuss the merits of group therapy, of relating to patients, and compare the progress of various patients. Occasionally they review with amusement the anxieties involved in former methods of caring for patients” and concludes that “trust, understanding, kindness, and
respect for the patient as a human being” (Odgers, 1956, p. 249-251) are the “differences that make a difference” (to borrow a Bateson phrase used to describe changes in systems) in mental health treatment. Through Wilmer’s intervention in the practices and anxieties that sustained the pathological system of interactions, the staff were able to form their own interpretations and experiences based in corrective observations, logics, and moral reasoning wherein the patients’ best interests emerged as the primary object of the new discourse.

These reproductive interaction and interpretive patterns are important not only for understanding how culture is formed around native and naïve understandings that bind them, but also for how these opinions hold a particular view of reality in place, characteristic of certain kinds of antagonistic relationships between cultural subgroups, that implicate deeply held ontologies resistant to modification. The staff-inmate split and their implied antagonisms contributed to relational patterns that maintained unequal and power-laden relationships characterized by interdependency of identity whereby the identity of one group depends upon the identity of the other. Both hold a particular stereotype and expectation of behavior in place that maintain the character of the relational system and the character of the other group in what Bateson termed as complimentary schismogenesis (1949/1972). This pattern also reflects how talk in culture and between sub-cultures is linked to social construction and reification processes involving the transmission of root symbols as well as the tendency of these relational patterns of interpretations to remain fairly stable.155

To use the metaphor of the “split-off symbol”, the symbolic representation of the other and expectations thereof, has formed a life of its own, an interpretative formation that predisposes concrete experience to a preformed opinion, a predictable set of responses and illusory assumptions that are no longer capable of self-correction, but only insofar as the interpretation
remains solidified and concealed from other possible interpretations, interruptions, or suspensions. For example, the role and presentation of “root metaphors” in pre-Wilmer Ward 55 demonstrates how their literal manifestation in discourse organized dominant meanings, cultural understandings, and popular opinion and sustained a particular version of “reality”, which operated according to the metaphor of a jungle, the implied characters, and a predictable plot. More interesting is how Wilmer was able to practically critique ideological formations and intervene in that space of “contact” between the communication around, about, and of the unreflected awareness that, literally and metaphorically, held the reified formations in place.

**7.4 Extended Comparisons: Therapeutic Critique, Public Communication, and Experiencing Reflexivity**

I will highlight three fundamental distinctions that are important for identifying the formative logics of Wilmer’s discursive formation of the therapeutic community experiment according to three prominent concepts integral to Habermas’s critical social science project. First, Wilmer’s rationale displays an explicit interest in patient and staff emancipation from physical, social, and epistemological domination and/or normative power through a cognitive-critical excavation of the ideological justifications and contradictions used to maintaining self and/or institutional (self)deceptions about the logic of their interpretations. Secondly, the experiment displayed a commitment towards changing material reality and conditions of oppression based in a moral conviction to eliminate human suffering and practically enact human autonomy, freedom, and humane treatment through facilitating a social moralizing, expanded, and decentered understanding of the self, other, and, world. In this manner, Wilmer elevated the patients’ best interests to a primary object of discourse and the organizing principle of the ward by counteracting and displaying contradiction within the prior illusory belief. Third, the rationale and resulting practices were grounded in a therapeutic critique of problems of interpretation.
believed to generate insight, reflection, and understanding in overlapping spheres of public discourse, thus opening up communication spaces in public spheres in and beyond the project or group. While these three distinctions do not define the whole of Wilmer’s or Habermas’s projects, they are presented as guiding comparative analytics.

On the first point, Habermas claims that an emancipatory interest “can only develop to the degree to which repressive force, in the form of the normative exercise of power, presents itself permanently in structures of distorted communication—that is, the extent that domination is institutionalized” (1973, p. 22). In contrast, although action research is generally aimed towards intervention in social problems through participatory structures, it does not necessarily have a political intent to critique and expose normalized power, domination, or ideological justifications through explicitly intervening in self-formative communication systems. Critical social science, on the other hand, juxtaposes the concept of domination with human emancipation as articulated according to an ideal and theory of happiness, freedom, and autonomy with psychoanalytic implications of ego domination and suppression. The theoretically grounding of this conceptual configuration in essentially rooted in a progressive developmental logic of ego autonomy and in stages of moral reasoning from which to critique processes believed to inhibit the path towards self and other realization in the process of discursive will formation and a de-centered understanding of the world (Habermas, 1999). The notion of ego-domination was a pivotal argument in Wilmer’s ideological critique that shifted the patients’ interests to center.

The equation incorporates ideology as “self-deception”, in psychoanalysis and ideological critique, as the theoretical comparison grounding Habermas’s agenda for critical social science research, resulting in the technique of “therapeutic critique” as a type of reflective argumentation, aimed to “clarify systemic self-deception” on both an individual and institutional
level, emerging as a pivotal process in Wilmer’s critical practices (Habermas, 1984, p. 21, 1973). Habermas conceptualizes ideology as: “illusions that are afforded the power of common convictions” (1983, p. 184). Gross (2010) expands upon this concept of ideology to highlight its influence in “shared networks of belief that ground self-deception and impede ameliorative change” and to illuminate its embodiment in self-deception for the purpose of the “justification of inequities in power in economic, social, or political life” (p. 340). A critique of ideology, then, can be evidenced in the method or elements of argumentation aimed towards displaying not only the contradictory claims of ideological justifications, but also the ways in which ideologies maintain a logical appearance through cultural forms and are, therefore, resistant to open communication contesting their validity claims and explicit challenges to their background, assumptive “knowledge”. Since many ideologies are not privatized or hidden and alternatively circulate in public communication as conventional sense or doxa, their resistance in part lies in the public elaboration of their “interpretations of the world… taken into service as rationalizations of authority”; such rationalizations and normalizations then “lead a split-off existence that is removed from criticism while simultaneously maintaining institutional stability through their enactment in prevailing social norms and ideological “illusions”, or what Freud referred to as the “mental assets of civilization” (Habermas, 1972, p. 279).

The therapeutic critique, then, as an extension of ideological critique, functions as a reflective attitude towards how ideological maintenance inhibits or damages the self and human development, as based in an inter-subjective understanding of the self that is distinctly related to an interest in understanding problems according to how ideological justifications sustain dominance through the maintenance of “illusionary” understandings of reality, self, and society. I have argued that much of the rationale for Wilmer’s therapeutic model is guided by these
interests, understandings, and demonstration thereof as evidenced in his style of argumentation, critique on the basis of human interests, and a psychoanalytic theoretical grounding.

Third, a key process in Wilmer’s intervention, I contend, involves the public communicative element of his experiment as central to the development of reflexivity on erroneous logics and reversal of ideological justified practices. The third comparison, as Kemmis (2007) points out, is one of the primary differentiators of Habermas’s project and lies in the expansive nature of the intervention, which “recognizes the existence of various kinds of open ‘public spheres’ or ‘communicative spaces’ in which individuals and groups thematize and explore issues and crisis” (p. 2). Therefore, such a project is not content with a localized intervention in a closed system of communication or organizational operations, but rather seeks to “work in the conversations and communication of participants” and “become a process of public discourse in public spheres”, where “social systems collide with lifeworlds” (p. 2). On this point, I will highlight the ways in which Wilmer’s protocol was at least implicitly designed and explicitly evidenced according to a public “reality principle”, not only for raising issues to the level of public discourse across public spheres, but also to provide a safe and “correcting interpretive” site for contact between “system” and “lifeworld”.

As touched upon briefly, the community meetings were the daily “big event” on Ward 55 and were attended by all patients, staff, and visitors to the ward. Perhaps because of the high profile nature of the experiment, and due to Wilmer’s invitation, the ward was visited by high-ranking members of the U.S. military organization, nurses and staff from other departments in the hospital, psychiatrists from other hospitals, and researchers from various universities. During this time, in contrast to the norm of closed wards, an open ward that invited outsiders, was a relatively novel practice. As an antithesis to the previous isolating and totalizing system
described by Wilmer and Goffman, the community meeting was an alternative public and discursive display of the patients’ problems as well as evidence of the civilizing potential of the model’s socializing tenets. Through providing the opportunity for “culture contact” and exposure to and between military personnel, and problems previously been hidden from view and public discourse, the open community meeting then became an invitation to see and be seen where there had been no visibility, transparency, or view. An additional public element of the community meetings was the attendance by the Pacific Combat Camera Helicopter crew who made an audio-visual recording of the meetings for thirty consecutive days (Wilmer, 1958a, Bateson, 1958, Briggs, 2001).

In addition to the high profile nature of the therapeutic community as a military treatment experiment, the severity of many of the patients’ conditions, and perhaps the hope he had in the therapeutic community model, there were other, untold reasons why Dr. Wilmer turned the meetings and the experiment into a public event. While he did not disclose these discursively in his texts, the method to his method, I argue, pertains not only to a humanizing belief that contact between estranged groups will increase understanding of each other, but also to providing an opportunity for the visitors, whether they knew it or not, to see, hear, and bear witness to the patients’ disturbances. Additionally, since the model was such a radical change in protocol, perhaps he wanted to demonstrate and even shock visitors, as he had the staff on the ward, into seeing and believing that the therapeutic community model was an effective and transformative alternative to traditional arrangements and patient-staff positioning. Or, if it was about bringing the exigencies out in the open, especially to military authorities, then experiential exposure was a first step in an attempt to foster an empathetic and understanding insight about the patients, the immediate consequences and human costs of military service, and the problematic totalizing and
inhumane practices in the military hospitals from which the patients were transferred. Through consistent displays of exigency, civility, and progress both in staff and patients, the staff and prominent visitors bore witness to these exigencies and to patients’ “imperfections” retrospectively calling into question the necessity of ‘totalizing’ hospital arrangements. Bitzer’s explication of the rhetorical function of an exigency, displayed or experienced, calls to immediate attention “an imperfection marked by urgency; it is a defect, an obstacle, something waiting to be, a thing which is other than it should be” (1968, p. 43). The experience of publicly witnessing both the exigency and practical display of alternative logics, I contend, intervened in individual and institutional pathologies through restoring a sense of justice, recognition, and ego differentiation for the patients, positioning the participants to see from an expanded private and public perspective, impacting extended cultural and public spheres of organizational communication, and serving as a therapeutic corrective for old interpretations.

First, in terms of the impact of the public context on the patients, this practice can be understood in part through theories postulating how the doctors’ or therapists’ acts of witnessing intervene in cycles of silence and silencing of survivors of trauma through restoring a sense of justice and recognition after having experienced its opposite (Herman, 1992). That the public and recorded nature of the community meeting situated the patients in positions of public recognition takes on new significance when juxtaposed with accounts of their previous treatment and/or military experience. The community meetings also positioned the visiting members of other publics as observers, participants, and witnesses. Herman explains the power of this positioning and recognition in terms of the impact of the “witness” role, explaining that “the therapist is called to bear witness to a crime. She must affirm a position of solidarity with the victim. This does not mean a simplistic notion that the victim can do no wrong; rather it
involves an understanding of the fundamental injustice of the traumatic experience and the need for a resolution that restores some sense of justice” (1992, p. 135). Thus, the public context and the placement therein suggests that the staff, the doctor, and structure of interaction communicated a sense of public dignity to the patients that was, in and of itself, a form of symbolic justice consisting of military recognition and humane treatment.159

In terms of the influence that this public context had for developing the patients’ readjustment capacities to interact in a social lifeworld, the presence of others and knowledge that they are “seen” aligns with the theorized role that others play in the development of the self through a “identification of self in others” presented in humane, tolerant, and empathetic attitudes, which Wilmer strove to engender among staff and visitors to the ward (Bateson, 1958, p. 349). In light of the therapeutic experiment’s goals of helping the patients’ readjust to civilian life through learning to develop “self-control and acceptable modes of social behavior”, the effectiveness of the public factor of the meeting and the ward can also be understood as a positive influence, inducing a pressure to conform to social norms and develop social judgment in a manner that overrides aggressive and self-defeating impulses (Wilmer, 1958a).160 On this point, Bateson’s (1958) analysis relates the near miraculous display that “these men, themselves mentally sick, showed such good judgment in their decisions of when to be impatient and when to be sympathetic” (p. 357). Habermas (1999), for example, argues that “the introduction of an observer perspective into the domain of interactions also provides the impetus for constituting a social world and for judging actions according to whether or not they conform to or violate socially recognized norms” (p. 141).

Second, in addition to introducing visitors to the ward and structuring the meeting as “open”, Wilmer utilized quite a few “observer technologies”, such as photography, videography,
note-taking, and the material presence of cameras positioned in the middle of the room, during the meeting, that demonstrated a reflection of “public consciousness” reinforcing to patients that they were seen, heard, and recognized. This method of ego development through the actual physical presence of the multiple others, who were in fact observing them, implicitly communicated a sense of dignity and affirmed a material reflection of their presence. At the same time, these “observer technologies” can also be viewed in mirror image of how the “observers” were positioned in relation to the patients, the doctor, and the cameras. Through this public exposure, all the participants were positioned in relation to the knowledge that they were visible, in a public context, and subject to later observations, which engenders an awareness of self and others through a different set of eyes and a more abstract level of thinking with the potential to facilitate reflexivity through knowledge of the existence of an observer perspective. Such technologies place the subject in a position to occupy that of a “reflective subject” in relation to the public presence and awareness of an observer perspective (See Foucault, 1972, p. 52).

Third, this practice made visible a previously privatized and largely stigmatized population not only as a matter of public observation, but also according to an discursive assumption concerning the extended “publicness” of the patients, institutional exigencies, and alternative means of treatment and understanding. For instance, Wilmer claimed that the community meetings impacted the patients’ conversation throughout the rest of the day by way of “transmissive education”. Drawing upon the accounts of observers, who listened and overheard the patients’ conversations throughout the day, Wilmer highlights that the topics brought in up the communicative structure of the meeting influenced the patient conversations with observers reporting “a continuous and rather sophisticated discussion usually stemming
from the morning’s community meeting” (1958a, p. 36). Just as he observed that the contents of the community meeting influenced the patients’ conversations, he expected visitors to the ward would discuss their experience and observations in their home communities, which were representative of psychiatric/medical, military, and research publics. Through these extended conversations, such communication had an influence on future conversations and people who were not present on the ward by implicating reticulate public spheres as a cultural phenomenon to discursively intervene in self and other attitudes and opinions about the patients, their problems, and the new model. For example, Wilmer’s monograph includes an account from a corpsman who worked on a separate ward admitting that, similar to his peers, upon hearing of the new protocol, we thought it would be “impossible and snickered to ourselves”. However, he had a friend who worked on Wilmer’s ward and recalls that, “as he became convinced of these newer ways of dealing with the patients I became curious to see what could be done on such a ward” (1958a, p. 44). In other words, the communication in the meetings and on the ward by sparking extended conversations in other sub-cultures functioned as a meta-communicative reflection or examination that emerged not necessarily out of “critique”, but rather from first-hand experience, involvement, and participation in the conversation that changed the content of future communication. In short, extended conversation or “transmissive education” intervened in cultural and public spheres of communication in ways that changed not only the content of conversation, but also discursively interrupted a whole system of beliefs, attitudes, and reifying interpretations.

Fourth, in the context of Wilmer’s accounts of the patients’ anger towards their treatment as service members, a high ranking military presence was representative of authority and an important symbolic and relational context for intervening in transference reactions and historical
associations. I hypothesize this strategy primarily because of Wilmer’s explicit reasoning about the painful association that certain aspects of the patients’ military experience had come to assume in their disorders. He states that, “the patients on the ward came from a group situation in which obedience, behavior, and fulfillment of orders, the chain of command were part of a rigid organization. This very orderliness of the life in which they had been casualties was utilized for their recovery….the Navy culture itself was utilized to strengthen the structure of the unit” (1958a, p. 30, 69). Although Wilmer is specifically referring to the importance of routines on the ward, such as the meeting and other daily events, he also speaks of utilizing the “best features of military life for therapeutic goals” such as conformity, respect and pride in belonging to a group, cooperating for survival, and self-respect. Through re-contextualizing military symbols, authority, and its principled features in a therapeutic and empathetic setting within a military organization inclusive of representatives from overlapping publics under the premises and commitment to “community”, this public exposure and contact provided elements for what Alexander & French (1946) refer to as a “corrective emotional experience”.

According to Alexander & French (1946), this therapeutic principle of psychotherapy is conceptualized as a positive transference phenomenon that seeks to “re-expose the patient, under more favorable circumstances, to emotional situations which he could not handle in the past. The patient, in order to be helped, must undergo a corrective emotional experience suitable to repair the traumatic influence of previous experience” that results in a story with a “new ending” (p. 66, Bridges, 2006, p. 551). In this sense, the symbols of the prior painful experience can be transmuted by experiential re-contextualization, or in Goffman’s (1974) terms “re-keying” old symbols resulting through shifts in meaning from the historical context to the new reality of “what’s going on” in the present. In support of this point, Wilmer understood his role as a
military psychiatrist and authority figure as symbolic of a larger military, who the patients had expressed resentment and mistrust towards, explaining that the military psychiatrist “stands in a unique position so far as transference is concerned, since he wears the uniform of authority, and specifically of that authority with which many of his patients have been in open conflict” (1958a, p. 68). Bateson recalls that Wilmer rarely or never wore a doctor’s coat, but instead wore a white coat, and “performed the functions of a doctor while wearing collar insignia of rank” (1958, p. 338). Wilmer’s experimental techniques relied heavily upon displaying military symbols and enacting familiar military and group rituals as a therapeutic and corrective technique that served to rearticulate the meanings of authority and humanity as able to exist together.

In short, I contend that the public “reality principle” and public military context benefitted the patients therapeutically, socially, and normatively through being recognized, known, and seen in a corrective manner that exhibited the opposite characteristics of the recent military context to which they had been exposed and in conflict. For the visiting and working members of the ward, the public exposure to both the patients and the community experiment facilitated a first-hand experience of the patients and their problems, which contradicted conventional opinions and started to form a “new story” that would, no doubt, be communicated to publics exterior to the ward as news of difference. Insofar as the public exposure and re-contextualization of military authority in a communal and understanding context facilitated the patients’ dissociation and restructuring of historical meanings into new associations corrective to the former, then, they too, would start to form a new story about the past and present. It is at this point that Wilmer’s theory and method of intervention in ideology and human communication
begins to divert and go beyond the role of communication in critical social science as envisioned by Habermas.

**7.5 Conclusions**

In his project of critique and recovery of the split of theory and praxis, Habermas claims that a critical social science orientation is concerned not only with how relations of power systematic block this realization, but must also include a reflexive awareness developed through discursive means of collective will formation related to techniques capable of forming “new value systems within changed configurations of interests and value-oriented needs” (p. 272). In Wilmer’s experiment, there is much evidence to suggest human values and patient interests replaced ideological justification.

By demonstrating that Wilmer’s arguments were directed towards explaining and critiquing ideological logic and “frozen relations of dependence” in hopes of exposing and transforming their illogical justifications and reifying outcomes, I hope to have made clear an overlap with Habermas’s formulation, in terms of design, rationale, and reflexive practice that share the practical, moral, and emancipatory goals and interests. Certainly, communicative practices assumed a central role in the therapeutic intervention, but not necessarily in alignment with Habermas’s theory of communication rationality, explicit argumentation, and discursive or empirical contestation of validity claims. Several pivotal elements of Wilmer’s theory and method of intervention in ideology and human communication diverge from the tradition of rational argumentation in critical social science as envisioned by Habermas. In alignment with Fisher’s (1984) concept of the “public moral argument” and narrative rationality, I want to suggest that the potential of therapeutic critique, or more specifically reflection on self and “irrational” practices, do not always emerge from open contestation and argumentation, but
rather from reflection induced by experience that through gradual and shocking experiential processes, narratively moves one to question what they had thought to be true and good. If, it “takes an earthquake to make us aware that we had regarded the ground on which we stand everyday as unshakeable”\(^{162}\) then, to shakeup background and sedimented opinions, attitudes, and beliefs by seeing and feeling the earthquake is the best evidence that the ground really can collapse.

Though temporally emerging after Freud’s yet before Habermas’s interpretations, Wilmer’s model extends and integrates the “split-off symbol”, as derived from Freudian psychoanalysis, in an attempt to reintegrate symbolic dissociations through bringing into private and public awareness and discussion, the patient’s, military’s, and collective trauma that most likely everyone would have preferred to forget. By inviting participation and exposure, Wilmer’s model provided the opportunity for a “corrective emotional experience”, and public reflection thereupon, induced through experiencing oneself and the other according to new subject positions from which to see and understand. Although I have compared Wilmer’s project to critical social science on the bases of design and conceptual overlaps, a mode of discourse in the form of ideological critique, and an emancipatory interest in freedom from self-deception and domination, the point of divergence lies in a narrative and symbolic mode of discourse that lessens resistance, counter-arguments, and defense mechanisms.

Integral to Habermas’s project of a critical social science research is the theory of “communicative action” which strives to open up “communicative spaces” (Kemmis, 2007) on the basis of a universal, ideal presuppositions of argumentation in practical discourse and “rational acceptability of validity claims based only on reasons that stand up to objections” (Habermas, 2003, p. 106). This view of rational argumentation bases much of strategy in
procedures that structures the practical discourse as grounded in participatory presuppositions of inclusiveness, equal rights and opportunity to speak, norms of genuine and honest communication, and the absence of coercion or communicative processes that censor or dismiss arguments and claims (Habermas, 2003, Kemmis, 2007). These procedural guidelines set up the counter-factual ideal from which to claim that communication is systematically distorted (Deetz, 1992).

While I could persuasively argue that Wilmer’s experiment encompassed and enacted these procedural principles in the community and staff meetings, the mode of the discourse or type of discursive intervention operated, however, according to different “rules” and “procedures for intervention” (See Foucault, 1972, p. 58). Despite the alignment of interests in emancipation from ideology and faulty interpretation, similar objects of critique, and goals of developing moral consciousness believed to be rooted in fundamental, universal, and “moral intuitions of everyday life”, the evidential method of discourse followed a different logic, process, and rhetorical schema. When compared, primary distinction emerge between the models’ techne of communicative action believed to lead to changes in understanding, behavior, and decision making. Most simply stated, Habermas’s techne of communicative action is based on the assumption that rational argumentation and participation through an open, empirical and/or normative, contestation of claims will lead to an expanded, decentered, and morally conscious understanding leading to a consensual decisional course of action that is in the best interests of all participants. In contrast, Wilmer’s techne of “communicative action” as enacted in the experiment and in the discursive practices used to present his arguments belongs to a different order of discourse.
Chapter 8: Narrative and Symbolic Displays of the Patients and their Problems: Objective, Contradictory, and Experiential Frames of Positioning

...You cannot get away from the accumulated suffering of mankind, or shake off the lesson that it should teach us....And that lesson is that what goes on in my neighbor’s house concerns me....If Nature is unkind to him, then I must be kind. There are all simple things, known from time immemorial to any villager. ...but a village, like a family house, still has a sacred place in the heart ....The people emerge as triumphant, and the people---even in the streets with an ocean running down the middle---must recognize one another as neighbors.


The previous chapter demonstrated critical, reflective, and therapeutic elements of the Therapeutic Community Experiment as concomitant with conceptual configurations and emancipatory interests of a critical social science agenda. In this chapter, I analyze Wilmer’s texts about the experiment as related to the goals and interests of critical social science inquiry excavated up to this point, but also demonstrate a pivotal difference through identifying what Foucault refers to as the “rules” of a discursive formation. Accordingly, one of the tasks of archaeological analysis of discourse aims “to define a system of formation in its specific individuality is therefore to characterize a discourse or a group of statements by the regularity of a practice” (1972, p. 74). In other words, how do discourses, discursive practices, and group of statements, such as Wilmer’s experiment and its texts, apprehend and transform the world it describes through the particular objects it references, strategies it employs, concepts configured, and subject positioned in relation to a principled regularity?

Whereas the last chapter focused specifically on concepts and strategies related to a critical social science, this analysis directs attention to the relationship between patterned objects of the discourse and positioning of the subjects. This chapter examines some unique features of the experiment in terms of the discursive regularities in the author’s texts through analytically comparing patterns of representation and construction of the patients’ and institutional problems.
I specifically discuss how the discourses position the public audiences, the staff, and the patients through visual and narrative displays of symbolic associations and experiential dilemmas. As touched upon in Chapter 7, Wilmer’s directed his discursive practices towards intervening in multiple and overlapping public spheres and pathologies, particularly, as I will demonstrate, through narrative, symbolic, and experiential techne.

In connection with the episteme, techne is used here to denote art or skill that carries out the work of practical rationality directed towards an instrumental goal, in an alignment with Aristotle’s “art or skill” (Flyvberg, 2001). For instance, Wilmer’s practical and structural design of the public meeting exemplified how a communication techne was utilized as a therapeutic device directed towards the goals of facilitating intergroup interaction, patient socialization and judgment, and impacting conversations in extended publics and organizational culture and subcultures. Specifically, key discursive events from Wilmer’s texts will be discussed in terms of techne. Wilmer employed the terms “technic” and “technique” interchangeably to reference the designed practices of group therapy, community meetings, and group facilitation. I extend the term to examine how his discourses positioned the audiences and participants, assuming that Wilmer did not disclose all of his methods, technics, and strategies of intervention (see Foucault, 1972). I will further discuss these strategies according to Fisher’s explication of the narrative paradigm for underscoring the impact of the “public moral argument” as connected to a theory of symbolic action, experiential positioning and witnessing, and the Freudian notion of “free association” as clues to the system of formation of Wilmer’s discourses. The chapter concludes with a discussion of patient and institutional psychopathology as rooted in Wilmer’s theory of communicative and symbolic action.
8.1 Systems of Formations and Objects of Discourse

Foucault defines the “relations” of a discursive formation specifically as the “principle of articulation between a series of discursive events and other series of events, transformations, mutations, and processes…a schema of correspondence between several temporal series (1972, p. 74). These “relations” are also referenced as the “system of formation” that describe how the elements of a discursive formation are “related to one another”, for instance how regularities in “principles of distributing objects in a discourse” relate to the “modalities of enunciation” (p. 75). The “modalities of enunciation” refer to the discursive “field of regularity for various positions of subjectivity” that include how the discourse includes who has the right to speak, the institutional sites from which the discourse and speaker is authorized, and how the discourse specifically positions the subject to be a certain kind of subject in relation to regularities in the “domain or groups of objects” of discourse (Foucault, 1972, p. 50-52). Some examples of stylistic patterning of the objects in the discourse, for example, are evidenced in “qualitative descriptions”, “biographical accounts”, “interpretation”, “reasoning by analogies” (Foucault, 1972, p. 50). These connections will become more transparent as analysis proceeds.

On this point, it is necessary to briefly outline what kinds of data or objects of research discourses included in Wilmer’s texts (particularly in scientific articles and the monograph) about the experiment. Wilmer’s monograph on the Therapeutic Community experiment, Social Psychiatry in Action (1958a), and the official report to the military, Report on Social Psychiatry: A Therapeutic Community at the U.S. Naval Hospital Oakland, California (1958b) presented the extending findings and discussions of the research and included an array of quantitative and qualitative data sets. Qualitative data from the monograph and articles included:
• Excerpts from verbatim transcriptions of the community and staff meetings recorded by hand and by audio recording.
• Excerpts from Wilmer’s notes on the patient case histories and patient interviews.
• Photographs of outside the hospital the community and staff meetings (with the patients eyes blacked out).
• Photographs of the audio/video recording devices used to tape the meetings for thirty days.
• Photographs of the film reels.
• Extended interpretations of interaction in the community and staff meetings.
• Observations and analysis from the consultants, Gregory Bateson, PhD and Dr. Ruesch.
• Observations from ward visitor and President of the American Psychoanalytic Association, Dr. William Barrett.
• List of ward regulations.
• Samples of night crew notes to Dr. Wilmer.

Selected quantitative and cartographic data recorded during and about the experiment and the patients included:
• Bar graphs demonstrating the distribution of the “Diagnosis Classification of Ward Population”. (Graph 1, 1958a; Table 6, 1958b p. 903).
• Daily admissions (August 1955-March 1956) and transfers (Sept-Dec, 1955), (Graph 3, 1958a, p. 357; Graph 4, 1958a, p. 358).
• Types of vessels from which 5 or more patients were admitted to psychiatric service (Graph 7, 1958a, p. 361; Type of vessels from which 5 or less patients were admitted (Graph 8, 1958a, p. 362).
• Map of North America and Asia showing the locations from which the patients “Were Admitted to the Sick List” (1958b, p. 899, table 3, 4).
• Status in the military according to “nonrated, rated, and officers” (1958b, p. 901).
• Request for interviews in relation to admissions by month from Aug 1955-March 1956 (Table II, 1958a, p. 76).
• Distribution of patients requesting interviews and interviews requested in terms of number per patient (Table III, 1958a, p. 77).
• Maps documenting the location of the hospitals from which the patients were transported (Graph 6, 1958a, p. 360).
• Statistical representation comparing the patients’ diagnostic classification in conjunction with their experience of loss in earlier years, as measured by death of parents, divorce, and abandonment in the childhood histories of the patients (1958b).
• Daily and successive multi-dimensional maps of patient seating patterns in the Community Meetings (1958c).
• Unit of conversation messages, exchange, and initiation during community meetings (Table 26, Figure 26, 1958b, p. 920; Table 20, Figure 20, 1958b, p. 916; Table 20, Table 23, 1958b, p. 918; Table 24, 1958b, p. 919).
As a distinct “techne” displaying a panoramic, even multiperspectival view of the variables considered during the research experiment, Wilmer’s objects of research and groupings of information included statistical, descriptive, and interpretive data appearing almost excessive in quantity that does not indicate preference of data or analytic angle and is comprehensive of multiple considered and possible factors. While few conclusions or interpretations are offered in reference to the quantitative data, the numerous tables and graphs provided an outline of factors, variables, and sources of information that were measured and taken into account. Many of the data sets initially appear to lack relevance, such as the graphs depicting the various ships on which the patients had previously been deployed, the maps of the hospitals from which the patients were transferred, and graphs of interview requests, except to the extent that they were a method of accounting for the patients’ recent histories. That Wilmer did not address the reasons for the inclusion of the data sets or discursively interpret the quantitative data in his primary texts is noted as a significance absence, but also illustrative of an open research approach that measures numerous variables that may reveal unexpected patterns, factors, or variables of history. Due the epistemological variety of Wilmer’s collection and demonstration of data, his research discourse cannot be categorized according to traditional divisions, but alternatively is indicative of a novel “hybrid” of quantitative, ethnographic, historical, critical, and even, discourse analytic research approaches (See Deetz, 2001 for these divisions). In terms of how the objects of the discourse position the audience of the texts, the subject is positioned to see and think from the same panoramic and comprehensive position, but without the knowledge of the reasons for its extensiveness, and thus also positioned as an investigator. The next section considers narratives included in Wilmer’s texts as significant interpretative tools and meta-communicative frameworks of subject positioning.
8.2 The John Allen Story: Killing the Subject

The allegory of patient John Allen is included in the first three pages of Chapter 1 of *Social Psychiatry in Action* (1958a) and in one of the final scenes in the docu-drama *People Need People* (1961). The incident takes place in a large state psychiatric hospital where Wilmer had worked prior to Ward 55. Answering an urgent call to help a patient, he arrived on the scene to find a patient “lying on the floor, blue in the face, and gasping for breath… choking on a piece of meat” (1958a, p. 3). Wilmer describes the scene: “so with only a scalpel, on my knees by the light of a flashlight, I performed my first tracheotomy, but it was too late; the man died there on the floor”, with the hospital attendants and himself standing over the “limp dead body” against an atmospheric backdrop, described as “the big gloomy ward stretched about me, with long rows of patients, some in restraints, sitting in benches lined against the wall, staring into space silently, unemotionally watching. The moment had a bewildering, dream-like quality” (p. 3-4). Then, a patient turns to the doctor, “slowly and in a melancholy tone” says to him, “It’s been a long day for John Allen”. Wilmer replies, “Is that his name?”. The patient replies, “No, I’m John Allen.” (p. 4). Wilmer concludes the narrative by highlighting the imprint of this experience on his own convictions, writing that, “I walked away from the ward overwhelmed by the utter isolation of these patients, vacant-faced, forgotten, sitting like automations through their empty endless days. No one ever seemed to belong to anyone or even to be anyone. The experience has remained fresh in my memory and has colored my thinking on patient management in all the intervening years” (p. 4).

To analyze this narrative, I draw upon Burke’s (1945) elements of the dramatist pentad (scene, act, agent, agency, and purpose) to demonstrate the narrative’s emphasis and foregrounded elements. The narrative initially centers attention on the helpless dying patient, as
an agent with no agency, highlighting his helplessness and inability to breath, due to asphyxiati. The images and symbols used to describe the scene and the patients are significant for Wilmer’s representation of the patients’ more generally, as dying or very close, in their voiceless, breathless, and helpless existence. The description of the patients in the background as non-reactive automations with no emotional reaction to the death of another patient portrays the ward scene and the agents as barely alive and, incapable of agency, further displayed as unable to notice or react to an instance of death immediately in their physical presence. Wilmer is the only agent in the scene who is described as exercising agency, having an emotional response, or trying to save the patient. The only mention of the staff attendants is in reference to their call, informing the doctor that the patient is choking on a piece of meat, and then standing over the deceased patient. The only other speaking agent in the scene, John Allen, reacts, but only through referencing himself in the third person and translating the scene in terms of his own “long day”. The narrative foregrounds the scene as lifeless and the agents as lacking not only lacking agency and capacity for action, but as displaying their vacant, non-acting presence. Through portraying the absentness of the patients and the staff in their “non-reaction” of passively watching, the narratives highlights the scene as an agent and agency-less context in direct relation to the patients’ and staff’s loss of humanness. The description of the patients as not belonging to and being anyone, not even recognized as subjects by other patients or staff, underscores the sterility of the ward as a tragic human scene. Consonant with Burke’s example of the scene-agent ratio of matching proportion, the lifeless scene contains lifeless humans who have lost their capacity for agency as “dialectical counterparts”, the audience’s sadness is equally divided between the dual description of the environment and the patients (1945/2001, p. 1306). On a general level, the narrative displays the dehumanized scene of institutionalized populations
more generally, and tragically displays the tragic detrimental effects that such configurations have on the mortification of patients’ experience.¹⁶⁴

Founded in Wilmer’s temporary confusion over who John Allen is?, the narrative also reveals a psychoanalytic claim about the impact of the ward scenario on the deterioration of the self evidenced in John Allen’s inability to comment on the patient’s death. John Allen’s utterance displays his inability to recognize the other through diverging from conversational norms of what is expected as a humane response to someone’s immediate death. The patients in the background are represented as psychically departed and “abjected”, in the sense of being neither subjects or objects, a state theorized to represent an absence of ego whereby meaning collapses or breaks down completely, which in this case is represented in direct proportion to not being a subject or object to anyone (see Kristeva, 1982).¹⁶⁵ In addition to displaying the lost capacity to empathize and feel for another, the scene reveals the metaphorical deformation or partial destruction of John Allen’s and the other patients’ ego function in their lack of self-other differentiation. This understanding of the “death of the subject” reflects a symbolic interaction interpretation of ego-development as related to processes of individuation and socialization, and, in doing so, exhibits both Freud & Mead’s works. In alignment with Bateson’s hypothesis, deterioration of the ego function in schizophrenia results from repetitive exposure to double-bind communication scenarios eventually leading to the inability to discriminate between “communicational modes either within the self or between the self and others” (1972, p. 205). Wilmer’s narrative represents the ward scenario as a place where people are losing their sense of self through non-recognition, and literally dying from their experience (or lack thereof) in a state resembling that of homo sacer, or “bare life”, a descriptive term used to depict a similar civil status of broken and demoralized political prisoners (see Hauser, 2012).
The allegory of John Allen offers a moral and practical interpretation of the environmental production of the non-self through the ultimate loss of distinction between the self and the other. When understood as a rhetorical strategy and *techne* of discursive and symbolic design, the allegory is explained as a temporal dialectic capable of inducing a demystifying intervention that splits the symbol into a heterogeneous illusion of non-self/self-representation (Mirabile, 2012, see De Man 1983). Through oscillating between a style of raw realism and humane idealism, Wilmer’s utilization of the allegorical form morally demonstrates and reveals a private, concealed scene narrated by Wilmer’s act of reflection and emotional response. By demystifying and exposing the patients’ experiential devastation and unjust suffering, the psychiatric institution and forgotten dying patients were discursively transformed into an immediate and on-going exigency.

Following the allegory, Wilmer describes another incident that took place in an expensive private sanatorium while he doing his rounds. He recalls a lamp crashing through a glass window of a door, landing at his feet, and leading him to look into the room. In the room, he saw “four or five attendants beating a patient and forcing him to the floor, while a nurse and a psychiatrist stood by”, as the patient in terror was screaming, “You’re killing me!” (1958a, p. 4). In contrast to the first scenario, this episode displays the patients and the staff as taking action and exercising their agency, respectively, with their voice and bodies. The proclamation of “you’re killing me” frames the process in real time, and the patient’s desperate attempts to remain a subject through his resistance and his screaming, ultimately restrain him in a double-bind relation of physically inescapable, totalizing domination that has been, all along, literally killing his “self”. In these representations of death infusing life, the patients, represented as literally and metaphorically dying or being killed by others, take center stage in the narrative frame. This
episode positions the staff as exercising raw brutality, the doctor and nurse as complicit accomplices passively consenting to acts of domination, and the audience as witnesses to the unjust, humanly imposed dilemma of the patient.

Wilmer concludes the narratives by expressing his strong emotions of being “sickened and enraged”, which prompts him to protest to the director of the sanatorium, who responds by normalizing and naturalizing the event, stating that, “But…such things, as you know, are bound to happen from time to time in mental hospitals” (p. 4). Wilmer then reported the transgression to the state medical authorities, but noted that no reforms resulted from his communication. Briefly, Wilmer positioned himself as an agent exercising his authority as a doctor and acting in every way possible to intervene in the local and institutional scene, yet as ultimately helpless to affect immediate change. His narratives framed the scene from the subject positions of the abjected, the dominated, and the helpless social agent. None were able to intervene in this unjust and morally reprehensible scenario, regardless of whether you the agent was an institutionalized patient, a concerned citizen, or a medical expert. The narrative display operated on the level of the shared human experience and subject position of not being able to do anything about an injustice. Through narrating domination and injustice in an unassuming ideological institutional critique, these episodes contextualize and personalize conditions of domination through positioning to audience to feel, see, and hear not only the helplessness of the patients, but also Wilmer’s helplessness, even from his social position as a fully functioning, free human agent, a medical authority, and a determined actor, to intervene in the pathological system.

As a final resolution, Wilmer concludes his narration of these episodes with a clear statement of moral conscience, stating “It was my conviction that such things should never happen in mental hospitals” (p. 4). His reflections culminate into a statement of acceptance of
the injustice and injurious reality and moral resolve that “deadly isolation and brutality are
bound to happen under traditional mental health hospitals of patient management and they are
also bound to have seriously anti-therapeutic effects….I resolved long ago that if I ever had an
opportunity to run any part of a hospital, neither would have any place in it (p. 4). In Burke’s
(1945) terminology, Wilmer’s purpose relieved the pain and injustice of the scene by offering a
glimpse of patient emancipation through the hope of realizing a moral “otherwise” through his
own call to conscience and an ideal prototype where the “people emerge as triumphant” (1958a,
p. 2)

As an external social agent, Wilmer’s narrative critique exemplifies what Laclau &
Mouffe understand as the social imaginary of democratic liberty and equality is needed to
“constitute a fundamental nodal point in the construction of the political” that is capable of
subverting and interrupting discourses of subordination by constructively judging normalized
oppression as relations of domination (1985, p. 155). Accordingly, “it is only in the terms of a
different discursive formation, such as the rights inherent to every human being”, that the
differential positivity of these categories can be subverted and the subordination constructed as
oppression (1985, p. 154). Wilmer’s terms of construction, however, did not discursively frame
the problem in terms of human rights, but rather from a broader equivalency of desire for
humanity, dignity, justice, respect, conscience, and from a shared experience of their loss and
violation. A discourse of conscience transcends the discourse of human rights.

Throughout Wilmer’s texts, his scientific ethnographic representations170 and theoretical
discourses construct the patients as “real” human beings who, above all else, deserve dignity and
respect in an unjust and inequitable world. How he communicated about the patients oscillated
between the depicting of the depth of institutional domination and the patients’ loss of self and
life. His apocalyptic description of the plight of the psychiatric patient placed the audience as experiencing the same tragic dilemma as the patients. In both narratives, Wilmer positions himself as helpless in the dilemma. He could not save the patient who was choking, the patient who was being beaten, nor would his formal complaints and letters as a resident doctor have any influence on local or state authorities who dismissed the transgressions as normal occurrences.

The audience then is positioned in Wilmer’s and the patients’ positions of helplessness and dilemma to which there appears to be no solution. Wilmer’s moral conviction and judgment emerged as a slight resolution, relief, decision, and source of hope. The modality of the discourse positioned the audience as participant witnesses to the primary objects of the narratives that displayed the patients suffering in their self-destruction, isolating and dominating institutional practices, complicit and passive mental health authorities, and loss of human dignity on all of these levels.  

8.3 “People Need People”: Dramatic Consolidations and Revealing Contradictions

The following excerpt is a description of the opening scene of the docu-drama People Need People.

The scene opens with an image of a whitewashed painted door, titled with bright red letters the words “QUIET ROOM”, demarcated by a bright red elongated light bulb above it. The music is ominous. Within seconds, the image shifts to a man lying on a concrete floor in a small concrete room. He is being physically restrained by two men as he is fighting back, screaming in anger and agony. The scene immediately shifts back to a momentary flash image of the sign painted in red letters “QUIET ROOM”. Then, the scene shifts back to the man inside the quiet room, on the floor beside the toilet, being tied down, and stuck with a needle in his arm by medical corpsmen. After the man’s body goes limp, a crew slides his body onto a stretcher while another corpsman report the orders of his transport, loudly commanding, “This one’s going to Stateside Hospital. And tie him tight, Naval Regulations”. A nurse follows up, in a disgusted tone, “They can have him”. The scene then shifts to an image of military airplane flying in the air, then landing at an airport, and then to a hearse-style ambulance pulling up to a large stone building. A small white guard tower with an American flag and a gate is shown in the background. The music is slow, dark, and menacing. The viewer
is still left to wonder if the building is a prison or a morgue and, what will become of the man on the stretcher. **End Scene.**

**Enter Narrator**

A handsome man in a dark suit, white shirt, and black tie looks directly into the eyes of the camera and introduces the setting, the plot, the challenge, and the characters. Fred Astaire in a deep voice explains:

“We are in Oakland California, at the United States Naval Hospital. The year is 1955, the scene of a most unusual experiment. Who occupies this room? Well, there’s part of all of us here, I think. For it’s truly been said, that we never get away from the accumulated suffering of mankind.

Before you can treat the mentally ill, you have to reach them....

In a series of ten day tests, Dr. Harry Wilmer of the medical corp was introducing a new approach.

His object...communication and cooperation, ...even with the most violently disturbed and dangerous. They came from naval hospitals throughout the country and abroad, mostly veterans from Korea, they were officers and enlisted men alike.

Some young, and some like Chief Driscoll, who has served 29 years in the navy....”

**End Narration**

The Scene shifts to a bright, white, entry way of what looks like a hospital. The camera is positioned from inside the lobby pointing towards two large doors, open to the outside, framed on each side by two slightly smaller windows.

Two corpsmen walk in the entryway carrying the restrained sailor, directly towards the doctor, and drop him at the Dr.’s feet, stating very formally and forcefully, “Sir, this is the one from Japan. He is subject to unprovoked rages, suicidal and homicidal impulses!”

The Doctor commands to the corpsman: “Untie him, get him on his feet. No sedation, remove the restraints.”

As the patient is being untied, he loudly screams “Somebody is gonna get killed!.....Put me in the Quiet Room!!!”

The doctor strongly states to the patient, “We don’t use the quiet room”; and then reinforces his command to the corpsmen to take off the restraints.

The patient loudly screams: “Lock me up or let me go!” **(END SCENE).**

As an audience member watching the video in a small room in the UCLA film archive library, the opening scene of *People Need People* invoked a powerful and emotional reaction.

The style of the production resembled an Alfred Hitchcock genre of mysterious intrigue, popular
during this time characterized by light/dark contrasts of cinematography, camera shots of shadows, windows, and doors, as well as, the important element of ominous and dramatic background music. As set up in the opening scene, the audience’s attention is immediately directed to the victimized position of the patient in pain, the uniformed staff displaying raw brutality and angry disgust, and the visual contextual clue that the scene took place in the “Quiet Room”. The formal and personified narration framed the experiment as a suspenseful mystery immediately involving the audience in the patient’s plight and the dramatic contingency that preemptively positioned the audience to experience fear as to whether or not this “experiment” could perform such a radical transformation of “unprovoked rages, suicidal and homicidal impulses”.

Analysis of the film was primary inductive, informed by overarching questions of how the text positioned and represented the patients, and how close the film aligned with thematic regularities in Wilmer’s discourses that generally sought to critique injustice and domination, increase understanding, and intervene in stigmatizing attitudes and beliefs about the patients. In 2004, Wilmer retrospectively expressed pride about the film, but also noted that the screenwriter Henry Greenberg claimed that the story was “his” story, which Wilmer disclaimed, and that they disagreed about a few of the scenes. Wilmer also highlighted that he requested to keep the film and audio recordings made by the Pacific Camera Crew in the effort to accurately inform the screenplay, noting that he was able to retain one reel that was used in the production; but, that the Navy kept the remainder due to audio damage, despite Wilmer’s offer to perform a voice over to fill in the blanks of the voice distortions (Wilmer, 2004).

The opening scene was by far the most effective in addressing the patients’ status and their military experience as integral to the patients’ psychopathology as a critical public problem.
The red letters and red light bulbs designating the Quiet Room implicated danger, silencing, and symbolic associations with the “color” of Communism. Before being given the military context or identity of the characters, the audience was immediately “thrown” into the scene as witnesses of explicit physical brutality and raw violence on the part of the staff. The audience briefly glimpses the experiment’s emancipatory goals through their position as a sympathetic witness, and perhaps as receptors of covert symbolic association between silencing, Communism, the “Quiet room”, and Korean War POW’s. It is well documented that Korean War Veterans were subjected to “Repatriation Programs” upon their return to civilian life (Lifton, 1954, 1961, Schein, 1956) amidst interrogations of Communist brainwashing, some of whom were treated as traitors (Herman, 1992) in the context of a paranoid Cold War American culture. This opening scene is noted for its dramatic representation of the unjust domination that Wilmer’s texts sought to display, while also briefly “flashing” associative symbols which would only be momentarily referenced in future scenes as part of the patients’ hallucinations and crises related to being locked up in a cell block.

The movie accurately reinforced many of the experiment’s fundamental practices and protocol’s changes, especially through the narrator’s commentary and specific scenes. For instance, in the first staff meeting, the doctor asks the staff, “Well, they are our mission, how did they look to you?” One of the nurse replies, “Just like all the others I’ve seen in psychiatric wards over the last twenty years….What makes you think they will be different this time?”. The doctor replies, “We will be different”. He proceeds to explain, “The mentally ill are alone in isolation….each of them are alone in a world of his own, where he hides and guards the secrets of his illness. In this experiment we will not accept this terrible solitude, we are going to have them live as if they were well…..for ten days. We’re going to expose them to the basic conditions of
normal living...sharing and community..... we will accept them as they are ...they will not pay a penalty for something they cannot help being...themselves”. The initial compassionate tone in the screenplay of the film reflects Dr. Wilmer’s humanizing attitude and designed commentary on the patients, as well as, the attitude that he tried to facilitate in the staff and the public audiences of the texts in relation to the patients’ suffering and disorder. Much of the narration and Wilmer’s character consistently reinforced a way of seeing the patients from a position of deep compassion and nonjudgmental understanding through discursive constructing the patients’ humanity as deserving and suffering, but moreover by positioning the audience in the empathetic discourse from which to see the patients’ in the same light. The techne then, similar to the opening narratives in the monograph, especially in the opening scene of the film, was one that positioned the viewer to witness injustice and inhumane human violation through new words and eyes.

However, as the phrase goes, “the movie was not as good as the book”. After the opening scenes and narration of the film, attention was redirected through intense focus on the patients and their hallucinations. Having read Wilmer’s patient case histories in the monograph, many of the key scenes and the characters in the film were cumulative reproductions and condensed versions of psychosis compiled from the most extreme and dramatic episodes that occurred in the real Ward 55 experiment. The impact of the consolidation of many episodes into a few characters did not have a “de-stigmatizing” impact for positioning the patients’ character. The consolidation effect intensified the perception of the severity of the patients’ disorder through merging, what were individualized and dispersed psychotic episodes into a conglomerate of delusions enacted by a few main characters as a unified array of individualized psychosis. In Wilmer’s selected excerpts in the monograph, the psychotic patient’s delusions were repetitive,
and specific for each patient, albeit with overlapping themes. For instance, some patients had a repetitive delusion that they were going to be shot; others that they were hiding from the secret police; some expressing paranoia that other patients were spies; some that they were going to be put in the quiet room and gased; others had delusions of being food poisoned; some that they had special spiritual powers in direct connection with God; others paranoid of medical procedures and doctor’s intentions (1958a, p. 150-180). In other words, in the “real” episodes, the patient’s “delusions” were personal, as opposed to quantitatively varietal.

Despite the striking introduction to the film and sensitive, informative narrations, the final crisis of the main patient character “Anderson” (played by Lee Marvin) culminated into a rather disappointing resolution and paradoxical implication. Physically resembling Jack Nicholson’s character in *One Flew Over the Cuckoo’s Nest* (1975), Anderson was the patient from the opening scene of the movie whose character embodied and enacted the combination of many “actual” psychotic episodes described by Wilmer that occurred on the Ward (1958a). One of Anderson’s psychotic crises occurred one evening as he began having delusions that his wife was dead, that he killed her, and then, referred to a “legion of devils” being against him. The character’s voice changed as he started chanting. The doctor proclaims that “he is hallucinating” and tells the staff to give him the drug. The nurse comments that “it as though someone else is talking”. In contrast to any of the data I reviewed in the monograph, none of the patients’ delusions displayed themes of demonic possession, although some of the patients were referred to as “hysterical” by the nurses (1958a, p. 180)

Despite the doctor’s reference to Anderson’s “breaking point” in his military history when his corporal was killed while trying to retrieve him from a “shellhole” in Korea amidst waves of enemy fire, the resolution to Anderson’s psychosis occurred when he was able to admit
the repressed childhood hostility he felt towards his both of his parents. One of the last few scenes depicts a therapeutic interaction between the doctor and Anderson where he tells the doctor about his childhood, specifically how he felt compassion and anger towards his mother for working so hard and suffering, and expressed contempt towards his father for abandoning the family in favor of his alcohol and sexual activities, stating that “I wanted to kill him” and an unintelligible, “almost” utterance about his mother that the doctor was unable to evoke from him. The dramatic relief to Anderson’s psychosis culminated into a final scene where he has locked himself in the dirty “linen closet” with a pair of scissors, prompting the patients and the doctor talk to him through the door, coax him out, while displaying the patients, in chorus-like formation, supportively affirming to him that “we are all in the same boat” and that he is real man and a real officer.

In this scene, elements of Freud’s Oedipus complex emerge as the basis of Anderson’s fundamental psychosis and psychological conflict, that once realized and released, relieved Anderson’s “pathogenic secret” and guilt through his confession of the latent anger towards his mother and father in the presence of supportive others. The classic Freudian psychoanalytic storyline ultimately diffracted attention towards the patient’s childhood histories and inner aggression, and consequently, away from the more immediate and concrete sources of the patient’s military conflicts and traumas. Although the “quasi-rational” Freudian interpretation is less stigmatizing than many of explanations that came before it used to account for military psychiatric casualties, however, as a primary framework, the discourse displaces social and political aspects of the patients’ disorders in favor of a predisposed anger, aggression, and repressed desire to kill. Even in the discursive context of a family produced pathology, unresolved childhood issues provided the audience with the “answer” to the question of the
origin of the patients’ “homicidal, suicidal, and violent impulses”. According to the story told in
the film, Anderson’s problems were reduced to the Oedipus Complex, and exaggerated by, as
well as, reduced through the consolidation of the multiple patients’ delusions into one character’s
psychosis, thus diverting attention away from the patient’s military traumas and distorted the lens
by hyper-focusing on their childhood authority issues.

I am not claiming that Oedipal impulses were not mentioned in Wilmer’s “real” texts. However, they were referenced more generally in the sense of life and death impulses or to explain patient regressive stages related to psychosexual development while being punished in the Quiet Room. When such connections were made, Wilmer generally integrated these interpretations back into the framework of larger social and political narrative. For example, Wilmer referenced a group of four patients whose communication in the community meetings expressed themes of “death, suicide, and murder”, and highlighted that that their histories shared certain similarities, stating that “All of these patients were to some degree homeless. All were trying to run away from their unhappy childhood conflicts and had attempted to find refuge in the service. All had gotten into difficulty in the service. All were intent on self-destruction and had unconscious death-wishes toward a parent, as was manifested in their stories. Death was the theme which brought them all together for the attempted resolution of conflict” (1958a, p. 244). While this is clearly a psychoanalytic interpretation, it also touches upon issues of class and the latent reasons for the patients’ choosing military service that does not abstract their problems from their military experience, but attempts to fit the two together into an immediate conflict that is capable of resolution on both fronts. In fact, many of the excerpts and interpretations in the monograph address issues of social class in the patients’ histories that Wilmer interpreted in conjunction with, as opposed to dismissive of, their military experience and conflict.
While divergences between Wilmer’s “real” and “reel” texts are hardly surprising in the context of a Hollywood produced docu-drama, the differences nonetheless reveal the power of discourses to distort and overdetermine interpretations in a manner that displays a significant contradiction to Wilmer’s patterned regularities in how the patients, the experiment, and the institutional problems were represented. This intense focus of the film on the patients’ hallucinations reduced the problems to the metonymical displacement of simplified Oedipal impulses is a way of “reducing the concrete to the abstract” in a contradictory logic through reducing differences to a set of underlying laws according to an overarching deterministic paradigm (Laclau & Mouffe, 1985, p. 21). This contradiction is evidenced through comparing the display of the political symbols and environmental contexts in the opening scene of the film with the paradoxical resolution and internalized placement of the political that was diffused by the time of its de-politicized conclusion. The combination of associative symbols remained a fragmented aspect of the story that did not once make its way back into the accessible content of the drama. The extreme divergence in the film, from a narrative that foregrounded the scene and the purpose of the experiment to one that shifted to the patient’s temporally removed histories constituted a red flag in suggesting a dissociation between context and content, and a symbol split from and diverted by the reductionist narrative. Perhaps the contradiction indicated a political and creative suggestive influence to symbolically and politically conceal what Wilmer was otherwise censored to reveal.

On the one hand, the film’s reductionist discourse posed a contradiction in Wilmer’s discourses in that it diverged from the regularity of his integrationist “style” of extensive data collection and expansive method of processing of information, as generally hermeneutical (in the sense of oscillating between the part and the whole in interpretation) and, oriented towards
processes of accidental discovery through the “process of serendipity” (1958a, p. 48). On the other hand, the meta-communicative function of the symbol, without the accompaniment of the words to interpret or narrate, was utilized with regularity and creativity in the experiment and throughout Wilmer’s symbolic practices: the military uniform instead of the doctor’s coat; the graphs, maps, and visual data in Wilmer’s scientific texts, referring to the concrete, material that lack an interpretation or even reference in the monograph; the symbolic placement of video cameras in the middle of the community meetings; metaphors of gaging and self-abnegation; and, emphasis on military symbols and rituals with a military patient population that generally expressed intense fear, pain, distrust, anger, rage, and grief about their military experience and/or their institutionalized care while serving in the armed forces.

Given Wilmer’s training as a psychoanalyst in association with his use of the metaphors, allegories, narrative arguments, literary references, his texts display the author as the epitome of man as a “symbol using animal through repetitive display and patterned regularity in the system of his discursive and symbolic formation. The question remains, however, how did this style of discourse, symbolic communication, and pronounced objects thereof position the patients and the staff as symbol perceiving and using animals. In this context, the next section discusses his techne of interpretive cartography used in the staff meetings.

8.4 Insertion in the Map: A Room with a View of the Chairs and Visual Frames of Understanding

A unique feature and technic of the Therapeutic Community experiment was the daily staff meeting custom of opening the staff meeting by “charting on the blackboard the seating positions in the community meeting that had just ended” (1958a, p. 45). The map of the meeting provided the subject matter for analyzing patient-staff-doctor interaction, patient progress and distress, and group dynamics in the community meeting. Wilmer prefaced the technic as the
designed to stimulate staff analytic observations, as well as, a method for understanding of the patients’ interactions and movements in relation to others, levels of tension on the ward, and visually created a frame a reference for the consideration of the group as a dynamic interaction (1958a). Centering conversation on participant interactions as guided by its visual representation offered by the map of the group meeting, the staff meeting was described as the “major device” for the “continuing study of staff attitudes and their influence on staff-patient relationships” that allows for the review of “actions of the staff, their inter-relationships, their counter relations to the patients, and their direct relationships with each other and patients” (1958b, p. 892; 1958a, p. 45). Wilmer explained the group review process as facilitating community membership and understanding among the staff of interrelation dynamics, explaining that the staff “must see themselves as part of the community, influenced by and influencing it” (1958a, p. 45). Because their own seating presence was included on the map, they were literally enabled to see their positional presence as part of the community meeting. The display of the map positioned the staff not only as members in the therapeutic community, but moreover as integral to its health as a system of communication, meaning that their presence and acts of communication are not benign or without impact in the lives of the patients. In comparison to the traditional model of the staff-patient divisions characterizing totalizing organizational cultures, the patients and staff are positioned as significant social and relational agents.

The landmarks and actions drawn on the blackboard map included all the participants, their physical seating position, directions of the movements and communication, the “emergent” labels of the chair positions, the solarium, the “head”, the courtyard, the door to the offices, and the camera if applicable (See Figure 1, 1958a). Over a relatively short amount of time, the chair positions were named according to recurring symbolic subject positions displayed by the
patients’ demeanor in the group as corresponding with these behaviors which represented the “stances that the patients would take and how the topics would be handled in the meeting” (Briggs, 2001, p. 15). According to Wilmer, the staff discovered these metaphorical positions inductively through patterns of patient behavior and communication, as well as, the naming of group and sub-group formations, also claimed to display a pattern of regularity that was used to interpret and analyze the group communication and patients’ intersubjectivity within this conceptual framework. The chair positions were demarcated as: the “Speaker of the house chair” or the witness or counsel chair, the “Preacher’s chair”, the “Snipers chair, the “Guest of honor chair”, the “Right hand of God” chair, the “Chair of the Departed”, the “Coroner’s Chair”, the “Invisible Chair”.

A few themes in the chair positions immediately stand out according to metaphysical themes of death and God in the chairs of the departed, coroner, preacher, and Right hand of God. Also emerging are the elevated status chair positions of the speaker of the hour, the guest of honor, right hand of God. The invisible and sniper chairs stand out as related to combat scenarios. According to Wilmer, The ‘preacher’s chair”, located in the south end of the room, was named because he notes, “quite commonly, we observed, it was taken by patients who had intense religious preoccupations as a part of their psychosis and who wanted to talk or “preach” to the community” (1958a, p. 181). The position of the right hand of god chair in the community meeting was designated as the chair to the immediate right of Dr. Wilmer’s chair position said to correspond with patients’ positions of grandeur, power, and seeking safety. In addition to the grandiosity of the chair positions, themes associated with positions of witnessing and experiencing death, and knowing God are significant symbolic reflections and metaphorical constructions of the patients’ past and ongoing traumatic experience. The chair positions as a
primary object of discourse can also be viewed as a method of situating the patients’ extreme subject positions within a “normalizing” abstraction, and at times, with a sense of humor, that simply accepted the patients’ disorders in relation to the metaphorical and experiential themes, without judgment or discursively produced stigma that is potentially constructed through more literal discussions of the patients’ delusional formations.\textsuperscript{181}

In addition to naming the chairs, the staff noticed patterns in the group formation of the chairs during the meeting, also referred to as “universes”, neighborhoods, and maneuvers that were named according to their graphic distribution and interpreted in relation to the tension and topic of the meeting (Wilmer, 1958b). For instance, some of the formations were named “the dilemma of the porcupine”, the “fire escape”, “desertion of the doctor”, and the “Football team line up” (1958b, see figures 31, 33, 34, 35). These formations were respectively interpreted as expressing “balance of not too close and not too far”, “high group tension, escape mode”, “distrust and father issues”, “friends and enemies between staff and patients” (1958a, 1958b). Wilmer writes, “the position a man takes is determined not only by how he perceives the universe immediately surrounding him, but also by how he imagines that the universe perceives and reacts to him. By analogy, these ‘areas’ are the ‘universes’ in which he moves, “are represented in the diagram as an extension of himself” (1958b, p. 925). The graphic technique of mapping the physical movements of the patients’ underscored an operant principle in Wilmer’s analysis, simply stated, “All motion is relative” (p. 924). If, as Wilmer and Briggs claim, the patients’ behavior corresponded with the metaphorical position implied in the name of the chair and the patients’ changed their position during the meetings in relation to their ‘stance’ or level of tension about the topic being discussed, then this movement is significant for revealing how subject positionalities change in relation to time, space, and other bodies in motion.
These technics of configurational understanding intervened in old screens of division. From a narrative rationality perspective, the patients became characters for the staff in the continuity of the positions, which created an on-going suspenseful drama to follow from day to day, that facilitated observation of subtle changes in patient positionalites, communication, and therapeutic progress. In consideration of the logics and strategies of visual-discursive formations, the elements, named objects of analysis, news of difference, and symbolic logics of their division constructed a new story and narrative in which the staff were actually agents, with agency, empowered to act, reflect, and apprehend the world according to dynamic interaction. Although “mapping” interaction was not a new technology of group analysis, the map of the community meeting is nonetheless notable as an innovative tool for expanding attention beyond individuals out into the social field and displaying the interconnectedness of the moving landmarks in a social field that intervened the field of sight and the frame through which staff can generate new understanding and dynamic interpretation.

In Burke’s terms, Wilmer’s maps intervened in old screens, replaced them with different divisions and dimensions as a method of reorienting what people see, thus providing a perspective that illuminates “relationships between objects which our customary rational vocabulary has ignored” (1984, p. 90). The role of the map intervening in ways of seeing and talking highlights its role as tool for fostering discursive reflexivity and a practical wisdom about their own role in the ward world, as well as, about the patients’ interaction, disorders’, and character. Discursive reflexivity and phronesis are both theorized as forms of knowing cultivated within particular kinds of communication and understanding of the world produced through direct experience and reflection on experience with others (Carbaugh et.al, 2013, Flyvbjerg, 2001, Deetz, 1990). Discursive reflexivity is theorized as a process of meta-communication or
the “reflexive of using discourse at one level to discuss discourse on another” (Carbaugh et al., 2013). In this case, the map facilitated metaphorical, symbolic, and visual reflexivity through what Briggs (2001) referred to as the “visual question”, as guided by the map of a room with a view of the chairs that, literally and metaphorical, redirected the field and variables used to interpret pathology and health.

Within this framework of analyzing change and continuity of theories of practice, Wilmer’s Therapeutic Community experiment is a case of an intervention in conventional and normative logics through divided patient pathology according to social and metaphorical terms of demarcation. The patient subject positioning corresponded with their military and on-going trauma that Wilmer and the staff created new ways of identifying and understanding the patients through discursive and symbolic, literal and metaphorical, shifts in the objects of sight. In contrast to the “pigeonholing” discourse and practices that identify and categorize the patients according to conventional stereotypes and unchallenged assumptions of their incivility and demeanor, Wilmer’s techne expanded, multi-dimensionally, the divisions and configurations used in comparison, contrast, and differences that make it on the map. Through the simple practice of mapping chair positions, interaction, metaphorical as well as literal positions, and clusters of movements, the map decentered the staff’s perspective from a pinpointed focus on the pathology of the individual to the interactional patterns of the entire community. Therefore, the social field was put into symbolic perspective leveled through its mapped abstractions, a process referred to as “abduction” that describes the “lateral extension of abstract components” which functions as an interpretive process capable of shifting patterns of sight (Bateson, 1979, p. 157). Through redirecting, or perhaps more accurately, subverting the staff’s attention from the
patient's individualized diagnosis or “sickness” towards a room with a view of objects and subjects in formation, movement, and in real time.

We are familiar with the statement that “the map is not the territory”, coined by Korzybski (1931), used to denote the relationship between a geographical territory and its representation (Bateson, 1972). This line of thought highlights that a map of a territory is an abstraction, not a mirror, of an environment, whose representation involves cartographic and selection processes of inclusion and exclusion of landmarks, objects, and scales of measurement specific to the particular map (Robinson & Petchenik, 1976). Geography scholars emphasize that “cartography as a form of communication” and that “maps are really symbolic abstractions—or representations—of real world phenomena” (Craft, 2000). “Cartographic persuasion”, or the intentional use of maps as a method of shifting, constructing, and superimposing frames, screens, and elements of reality, has been studied as rhetorical interventions in commonplace worldviews and perspectives (see Wood, 1992, Monmonier, 1996, Tyler, 1982, Prelli, 2006). Maps have relatedly been theorized as a representation able to add clarity to problematic or misunderstood situation, capable of “guiding behavior and simultaneously transforming undifferentiated space into configured—that is, known, apprehended, understood----space” (Carey, 1989, p. 27).

The technics of mapping interaction, movement, and relationships in the group provided a concrete and visual subject matter for the staff that shifted the discussions towards a holistic perspective of social positionalities. More specifically, the methods Wilmer employed subverted the material and symbolic field of sight and sound through visual, metaphorical, and spatial ‘technics” according to multiple dimensions and scales of measurement. The technics altered the terrain of analysis through literally and metaphorically intervening in traditional ways of talking about and mapping psychiatric subjects and their disorders. In a direct sense the map was used
as a redirection and reclamation of the subject matter which allowed the staff to have an altered experience of themselves and others through the exploratory process of symbolic engagement with a map that facilitated an ontology of understanding through a genuine and knowledge generative conversation (see Deetz, 1990). As a meta-communicative framework, the map intervened in the staff’s literal and individualized interpretations through screening and directing their sight, and therefore the field of the understanding to more abstract and sophisticated levels of interpretation.

Philosophically, conversations about map-territory relations invoke questions about the relationship between epistemology and ontology, representation and knowledge, and how changes in maps might intervene not only in how reality comes to be known through epistemological frameworks, but also as constitutive ways of demarcating and classifying human differences (Bateson, 1972, Foucault, 1972, Taylor et al., 2007, Martin, 2002). Along this lineage briefly touched upon in the last chapter invoked Goffman’s (1975) construct of primary frameworks and Kenneth Burke’s (1966) theoretical analogy of terministic screens speak to map-territory relations or the “grid of intelligibility” and interpretation of the territory. When understood through this conceptual linkage, the metaphors of displays, frames, and screens also enable and highlight meanings as they function to direct attention, filter understanding, and affect our observations (Burke, 1965). Theoretically, these conceptualizations are a part of larger meta-theoretical tradition organized around logics which assume that ways of seeing and knowing are connected symbolically, discursively, and visually in a form of demonstrative epistemic discourse which is intricately involved in the social construction of practical and scientific knowledge (Burke, 1965, Foucault, 1972, Prelli, 2006).

8.5 Conclusions
At almost every turn, in various ways, Wilmer not only told a story, but also re-positioned the audiences in that story. I argue that this regularity of practice not only characterizes the “system of formation” of his discourse, but also his primary strategy as a therapeutic technique for the patients, the staff, the cultural public, the military public, and the scientific public for intervening in their own systematic distortions of communication and perception. The regularity and extent to which Wilmer’s style of discourse as a textual practice and social action used non-verbal, visual symbols to communicate to the patient, to the staff, the audiences of his texts.

His social science experiment shares the interest of understanding, emancipation, and public, concrete intervention with a critical social science and intervention in public understanding and public discourse, albeit through affective, subversive, and symbolic strategies of revealing domination and enticing the audience into an experience of injustice and compassionate reaction. Wilmer’s discourses positions the patients’ problems as problems of institutional domination revealed not only through the style and order of his presentation of the problem, but also through the visual and aesthetic means used to represent the patients’ through performing a “symbolic intervention” not only on public audiences, but also by creating a new lens for the ward’s organizational culture to interpret and understand.

I however want to draw attention to more to the general associative and connecting work of symbols for communicating on the basis of conceptual associations that by-pass explicit claims in language that may otherwise invoke defensiveness or resistance. We know that Wilmer was trained in Freudian psychoanalysis, so the implication of an orientation to symbols as a medium is hardly surprising. One of the governing and recurrently occurring “rules”, strategies, and regularity of practice is evidenced in Wilmer’s consistent use of metaphorical and
symbolic communication to communicate what may otherwise be met with resistance (on an individual, cultural, and public level) if stated explicitly. This can be seen across the genres of his texts, in the design of the mapping, ritual, and realism-symbolism technics of interventions aimed towards facilitating a shift in staff, patient, and public understandings of “reality” that oscillates between a raw realism style display of the problems simultaneously balanced with an attempt to communicate to others through the sublime world of symbols in hopes of making discursive associations. When Wilmer's protocol is understood as a rhetorical-symbolic intervention in institutional doxa, primary frameworks, and the previous hegemonic discursive formation, the maps, photographs, and other graphic displays take center stage in his methods or technics, as literally and metaphorically, shifting the territory.
Chapter 9: Conclusions

Overview

On a broad scale, this research has sought to understand change and continuity in public and scientific discourses implicative of social and communication processes resulting in stigmatizing attitudes towards survivors of psychological trauma. A broad survey of the surface of emerging trends in academic, military, and cultural discourse indicates that the stigma-trauma configuration is receiving more concerted attention as a public health problem as it relates to veteran post-combat treatment and social readjustment complications. The conceptual and practical problem calls forth questions which have turned the investigative gaze towards institutional practices, the politics of psychiatric-medical diagnosis, the role of cultural discourses and media representations, and well as, the basis upon which both psychological trauma and stigmatization have come to be theorized and understood.

This research focuses specifically upon the lineage of psychological trauma as a controversial concept with a complex history and a theoretical discourse in order to trace the social-historical contexts that have come to define the contours of its scientific and socially stigmatized attributions. Because of trauma’s concrete position in discursive contexts, yet enigmatic position as a stable, locatable, and differential injury, research attention has therefore focused on the contexts and concepts involved in the social and theoretical constructions of psychological trauma’s past and current articulations. Guided by cumulating evidence that implicate psychological trauma and PTSD are increasingly intertwined in the politics of psychiatric diagnoses, legal responsibility, monetary compensation, and medical treatment, this inquiry has sought to recover the conditions under which the credibility of survivors of
psychological trauma has come to occupy a subsidiary and central position in the social and discursive formation of PTSD in therapeutic, cultural, and political texts and contexts.

The following overarching and open ended research question guides this inquiry:

1. How have post-traumatic reactions come to be constructed and understood in its current form and in association with social and self-stigma?

   The first set of subsidiary questions are designed to explore significant trends, shifts, and controversies in the history of trauma-linked diagnosis and treatment over the course of its psychiatric articulation.

2. What are predominant disciplinary controversies in the history of psychiatric science over the etiology, diagnosis, and treatment of conditions conceptually and diagnostically associated with psychological trauma? What are the main points of consensus and dissensus?

3. How have scientific controversies influenced dynamics and components of stigmatization in the context of PTSD and trauma-related mental disorders in military populations?

4. How have shifts and changes in psychiatric-medical science constructed the character and status of the subject of psychological trauma at significant moments in time?

5. What practices and theories are useful for understanding and correcting practices involved in stigmatization of traumatized populations?

   The second dimension of the inquiry addresses the role of historical and social-political-cultural contexts and discourses in shifting understandings and impacting dynamics of stigmatization of conditions and subjects related to PTSD.

6. How have significant social and political controversies invoked questions of stigmatization in relation to post-traumatic symptomology?
7. How have cultural attitudes and opinions around survivors of trauma changed over time and in relation to changes in survivors’ voices, socio-political trends, and in psychiatric science?

8. How does the interaction between communication around, about, and of psychological trauma demonstrate changes, contingencies, and stability in epistemologies and trauma-related diagnosis over time?

9.2 Research Findings

*Stigmatizing Configurations*

One of the primary tasks of the research inquiry was to follow the historical lineage of named formations that have been discursively and conceptually associated with PTSD in psychiatric and social scientific literature. In order to investigate Herman’s (1992) claims that the history of the study of psychological trauma is characterized by an “underground history” and that survivors of trauma have historically been subject to questions regarding the credibility of their claims, the researcher followed this guidance, beginning by tracing the history of *hysteria*. Because of hysteria’s pivotal placement in between pre-scientific, neurological, psychoanalytic theories of human mental disorder and divergence from “normality”, its history as a stigmatizing “etiology” provided a primary signpost from which to begin. As a shifting signifier, hysteria’s etiology has signified a wandering uterus, demonic possession, genetic degeneration, deceitful malingering, a disease that simulates culture, a disease is simulated, the product of human suggestion, pathological susceptibility to human suggestions, a WW-I post-combat medical diagnosis, and in 1952 a conversion disorder.

In the investigation of hysteria’s history as an explanation of elusive symptoms and abnormal behavior, the times when the condition came under the most scrutiny and as a
source of stigma were during times when institutional dogmatism was most prevalent, particularly in cases of religious or scientific assertions of truth and moral judgment. In both cases, hysteria as associated with authoritative claims of demonic possession or as a condition that the women imitated at every stage of its phases, the moral character of women were consistently invoked as susceptible and predisposed to evil and deceitful transgressions. In cases of historical stigmatization of hysteria in women, the etiology of the condition was inextricably linked to the moral status of the women as a primary object of the degrading discourses. The expositions of Mary Glover, the Loudun possessions, and the Hospital Salpetriere hysteria experiments displayed the women and the questionable status of their condition in the public sphere of opinion and spectacle, and consequently provided sources of cultural fascination whereby their character was subject to public debate and moral judgment.

The role that the public occupied as witnesses, spectators, and stakeholders in the unfolding drama of persecuting “hysteria” was monumental in perpetuating moral stigma in service of the interests of securing religious dominance and in Charcot’s iconic founding of modern neurology and the medical model of disease. On the other hand, however, both of these dominant formations resulted in counter-interpretations that led to seeds of new theories which would eventually call into question orthodox hegemonic understandings and beliefs. Elements of the hysteria formation became recycled and dislodged, in small increments and fragments, from its prior articulations once new positivities formed into groups that challenged the accepted canon of knowledge at the time, giving rise to new set of objects, subject positions, and concepts to be studied that formed into alternative explanations. During the early Enlightenment period, discourses about the passions, humors, and melancholy intervened in the stigmatization of hysteria through a systemic, ecological model of disease and imbalance that was connected to a
cultural-political movement in the struggle to divorce the quest for knowledge expansion from religious authority. This inventive interpretation of hysteria briefly dissociated its symptoms from the character of the individual and displaced the imbalances to interactions in the system of the organism.

Scientific and cultural controversies defined hysteria’s contours perhaps more than its shifting signification. What is learned from the configuration that diverged from the stigmatizing norm lies in its holistic articulation in association with the interactions of emotions, the body, and imbalances in relation to changes in the environment. This configuration of health and illness was not specific to hysteria, but was reflective of prevalent objects of social, literary, and medical discourses, as well as, cultural and philosophical inquiries exhibiting epistemological leanings that articulated human nature as creatures of passionate movements. Prior to Charcot, the emerging field of medicine and inquiring doctors sought to understand hysteria according to theories which briefly provided relief and understanding to previously de-moralized interpretations. New configurations of elements associated with ancient theories came together to produce a quasi de-stigmatizing articulation of hysteria which placed hysteria front and center in the battle of pre-science and religious interpretations.

Charcot’s conversion of hysteria into a medical diagnosis reified and re-instantiated its stigmatized status that drew upon historical images and insinuations of demonic and sexual possession, as well as, implications of a deceitful character. Once it was discovered that men could display “hysterical” symptomology, their human status was inferiorized, however, on the basis of a physically stigmatizing explanation of “neurological” susceptibility and genetic weakness, thus contributing to a chain of discourses already in place that positioned the field of traumatology to be suspect of post-traumatic injuries and elusive symptomologies. This analysis
suggests that Charcot’s construction of hysteria as based in discourses of deceit and susceptibility contributed to the instantiation of a suspicious predisposition in the field of medical psychopathology to theorize, seek, and find deficiencies in neurological, cognitive, genetic, and moral capacities of the patients according to a reductionist logic that subverted attention away from the concrete conditions and consequences of human action, domination, and physical injury.

Hysteria’s history has almost always depended on a political or ideological fixation on the hysteric’s demoralized character as the central and privileged signifier or nodal point in its many discursive formations, its scientized version notwithstanding. The hysterical subject evolved alongside the drama invoked by their analogous representation. The epistemic space from which the discursive formation of hysteria emerged displays the degree to which cultural communication, iconic characterization, and institutional arrangements exert a strong influence on the social construction of what counts as knowledge in their apparent legitimating and objectifying function.

Analysis suggests an overlap between discourses about hysteria as a simulated, malingered, and suspect condition with the continuation of these discussions in Great Britain during WW-I. A recurrent discourse invoking neurological pre-dispositions as a source of ontological inferiority or weaker genetic heredity enters into the constellation of discourses justifying excessive and stigmatizing diagnostic evaluations at the expense of immediate and effective treatment. Despite substantial disagreement and scientific controversy, the discursive suspicion of malingering was an ever-present element in post-combat diagnoses that invariably predisposed the soldiers to the popularized and political interpretations implicating a deceitful and cowardice character. Politically, the discourse of susceptibility subverts and diffracts
attention away from the event, cultural conditions, or relational contexts that caused the injury and instead positions the subject as preemptively degenerate, inferior, and flawed.

Similar to Charcot’s relative monopoly on media communication as an advancement of his views, the British military controlled the range of discourses available for public consumption through media control of the objects of discourse in preference of theories of “malingering”, while silencing the circulation of topic of “shell shock”. Medical and cultural commentators, as suggested by Herman (1992), enthusiastically consumed and circulated the deterministic discourses of heredity and suspicious discourses of malingering, both of which deemed the individual a subject of an inferior genetic-neurology or moral character.

The subjects of these investigations become discursively inscribed in diagnostic forms of recognition that pre-emptively tarnish their social body, their neurological body, and their character, which has enduring implications for how patients and their injuries have come to be recognized and known. Tragic differentiations conceptually functioned to establish a hierarchy of superior positions from which to judge others according to discourses proliferating gendered, moralized, genetic, and/or neurological susceptibility and promulgating human inferiority is highlighted as a discursive trend in social dynamics of stigmatizing individuals suffering from debilitating traumatic and stressful injuries.

As malingering emerged as the proliferated topic of print media and medical discourses in WW-I Great Britain, suspicion of deceitful character would become epistemologically instantiated in post-combat traumatology and its diagnosis when “malingering” entered into the formal diagnostic division of possible expert assessments that not only became subdivided into gradients (full, quasi, partial) as determined through a batteries of diagnostic tests, but would also result in the mishandling of many genuinely wounded soldiers (see Whiteley, 2004). This
diagnostic arrangement directs attention to the asymmetrical positions of the doctor and the patient in the context of treatment and the physical capturing of the physical and ‘neurological body’.

A discursive suspicion regarding individuals displaying traumatic symptomology has since become formalized in the diagnostic criterion assessment of PTSD that requires that “malingering” be eliminated as an explanation for making claims of disabling trauma. In this sense, suspicion of fraud, lying, simulating post-traumatic symptoms, and neurological predisposition, as sources of potential social and medical stigma, have become institutionalized in the PTSD diagnosis itself. I have argue that the sticking point or continuity among hysteria’s stigmatized articulations has been bound by discourses of “susceptibility” (uterine, demonic, and nervous) that eventually split into a discourse of predisposition (constitutional-neuro-biological) and a discourse of suspicion (deceit and malingering) around what came to be known as hysteria in both men and women. I have also suggested that this lineage overlaps with the lineage of PTSD and provides a historical argument in consideration of the enduring institutionalized stigma or discursive suspicion of claims to trauma. As touched upon in Chapter 2, psychiatric diagnostic procedures are under external pressure to empirically validate a diagnosis of PTSD diagnosis; therefore a portion of PTSD research is directed towards defining not only what constitutes a stressful and/or traumatic event, but also the criteria for diagnosing and documenting the events for confirmation (VA presentation, citation, 2006).

As the tone of suspicion is further formalized in institutionalized diagnostic procedures and categorical divisions that specify the range of possibilities for how post-combat reactions are apprehended, we see the emergence of this “grid of specification”, to borrow Foucault’s (1971) term for such epistemological and material divisions. Scientific and cultural interests converged
around neurological, heredity, and malingering discourses about the individuals, while theories of shell shock, precipitating trauma, and human instincts of flight, cooperation, and suppression of pain were empirically and politically excluded from the dominant discursive constellation.

Destigmatizing Configurations

While the counter-discourses of psychological trauma did little to intervene in the dominance of Charcot’s articulation at the time, I suggest that they planted discursive seeds integral to later theoretical trajectories and developments in psychiatry, post-combat traumatology, and communication theories of psychopathology and its treatment. This analysis additionally suggests an enduring tension between medicalized psychopathology and psychoanalytic thought as based in political implications of claims inciting psychological trauma. The research inquiry identified de-stigmatizing discourses as in an antagonistic relation with discourses of character indictment and suspicion of deceit. The humanist threads of psychoanalysis and social psychiatry reared in Freud’s early theories of psychological trauma in direct connected with episodes of sexual violence and rape implicated the discourse of trauma as counter to neurological, malingering, and genetic discourses that degraded the body or the character of the victim.

In terms of how discursive formations of psychopathology change over time, retrospective comparative analysis of Freud’s theory that hysterical symptoms were related to physical and psychological imbalances was radical in its time in the manner that a theory of the passions and grief was in the context of demonic interpretation. Sixty years after Freud’s “discovery” of the unconscious and development of foundational concepts of psychotherapy, this configuration would come to provide a primary argument in social psychiatric research that countered stigmatizing institutional arrangements grounded in theoretical arguments of human
inter-subjectivity, transference communication, and damage to the ego. Prior to however, British psychiatrists, such as H.R. Rivers and Charles Meyers as associated with humanist psychoanalysis and modified versions of Freud’s psychological trauma aligned with combat veterans and developed not only new theories, but new models of treating post-combat psychiatric casualties.

As discussed in Chapter 6, the therapeutic community model as a named formation was developed as a direct response to the institutional treatment and stigmatizing conditions in WW-I British military hospitals that was later implemented during WW-II to repatriate and treat returning British POW’s (Whiteley, 2004, Wilson, Trist, & Curle, 1952). Psychiatrists such as Bion, Tom Main, Maxwell Jones, Tom Rees were not only a part of the humanization of institutional treatment, but moreover envisioned the hospitals according to democratic and egalitarian ideals, which is quite the contrast from WW-I. The discourse of democracy in relation to those persons who risked their lives and their sanity to fight for it started to connect previous dissociated institutional and democratic contexts. As the wars over democracy continued to strengthen democratic discourses of human and civil rights, a dialectical reaction to domination shifted towards movements towards humanism, and resulted in efforts to democratize dominating institutions.

Another factor in this shift is evidence in observing that the move to humanize or democratize psychiatric institutions did not begin until they were exposed and publicly criticized in a related magnet of converging discourses sensitive to problems of totalizing domination and supposed civil rights in democratic institutions. In country still fragile from the residual threats to democracy lingering from WW-II and still present in Cold War American culture, it was on the basis of identification with democratic subjectivities endowed with rights to humane and just
treatment in democratic institutions that these conceptual, political, and social scientific
discourse intersected to produce grounds from which de-stigmatizing articulations of human
subjectivity would emerge and began to include institutionalized psychiatric populations. After
conscientious objectors brought the horrific state of institutionalized psychiatric treatment into
public and media awareness, the privatized state of affairs came into public view and in a
humanizing discourse that struck a chord in a post-WW-II U.S that was “hyper-aware” of threats
to democratic rights as well as in response to fears of domination of human life and dignity in
totalitarian governments. This started a chain of discursive events that would not necessarily
change the conditions immediately, but would provide government funding for change and open
the doors to public research, which offered new categories from which to think about the human
subject.

When viewed from the question of how concepts and theories change over time, the place
of hysteria, shell-shock, and normalized human domination in psychiatric institutions illustrates
not only the role of public and scientific controversy in bringing previously “undebatable”
epistemologies into the discursive terrain, but also the gradual trajectory, which transformations
of ideology and doxa, can be set in motion, once the conflict is elevated to the realm of public
discourse in a democracy. In terms of the Hauser’s (1999) theory of reticulate public spheres as
displaying multiple, local, and interactive webs of meaning and opinion is relevant for framing
how discursive formations are products of rhetorical phenomenon as demonstrated in the
interconnectivity across and between overlapping political, vernacular, and institutional domains
of discourse, but discourses that also span across time periods as Foucault (1972) has suggested.

Recurring Threads of Counter Discourses: Destigmatizing Seeds and Social Configurations
Two relevant patterns emerge as performing interventions in stigmatizing institutional and discursive configurations. First, the importance of theoretical and political “counter-discourses” that emerged in opposition to discourses of silencing and suspicion that, it is important to note, were relatively rejected and dismissed in dominant scientific orthodoxy. The threads of “rejected” explanations or counter-discourses, which were not part of the orthodox or doxa of epistemological leanings at the time, re-appear in relation to new discursive constellations at later times and become integrated and reconfigured to form new discursive formations. Interesting to highlight here is the initial rejection of the shell shock diagnosis that ended in developments in scientific articulation, counter-discourses, and politicized interpretations contributing to the its eventual reuptake in the U.S. during WW-II. Threads of the humanist and psychoanalytic traditions are one such alternative counter discourse to those engendered by discourses of neurological and moral inferiority.

Secondly, these discourses were also counter to the impacts that the hegemonic formations had on silencing the voices of the patients. Most simply stated, humanist and psychoanalytic discursive formations understood and operated from a discourse about how the repression of communication of trauma was in fact part of the trauma and the domination that led to the original and enduring trauma. These counter-discourse and their advocates therefore aligned with the patients and gave them a voice. In drawing upon Herman’s claim that there were three moments in psychiatric history that such political alignments occurred between doctors, patients, and publics, this research suggests that these alignments were on going throughout the major wars over democracy, but also interconnected with participatory public and political spheres growing and aligning with democratic interests, rights, and threats to freedom.
that aligned to produce new sensibilities and grounds for intervention on the basis of retrospective civil awareness that gross violations of human rights had occurred.

Similarly, in Post-WW-II U.S., social and political controversy facilitated by C.O.’s alliance with news media raised institutional mistreatment of military and civilian psychiatric treatments into public awareness leading to changes in social science, especially social psychiatry indicted institutions and their practices as violators of rights to humane treatment under the umbrella of rights in the institution of democracy. This political-intellectual reform movement in the 1950’s demonstrates Gadamer’s (1989) notion of critical hermeneutics that alludes to how “social frames of reference influence researchers questions, which in turn shape the nature of the interpretation itself” (Kincheloe & McLaren, 2002, p. 101). The influence of the scope of the horizon of the inquiry, or the world affiliations of researchers, and the social world of discursive resources of interpretation, come together in what Gadamer termed the “fusions of horizons” or the “hermeneutical act of interpretation” intended to demonstrate how social, public, private, and intellectual interpretations are always, already situated in the social field where these horizons converge.

Within this frame, what also comes into view is the degree to which trends in social science, in this case study, social psychiatry demonstrated and reflected prevalent public sensitivities and social understandings of human behavior more generally. Although not resulting in decreased social stigma in relation to psychiatric populations, Weinstein (1982) claims that in the late 1950’s-early 1960’s, public opinion surveys of the mentally ill indicated a majority of Americans believed in environmental etiology of mental illness. This view is clearly reflected in trend in social psychiatry, prior to the re-emergence of neurological discourses and pharmaceutical treatment. Concurrently, the therapeutic community model emerged within a
unique time in psychiatric history as rooted in a distinctly “social view of psychological disturbance, and a social view of personal change” (Manning, 1989, p. 69)

Discourses in social psychiatry displayed these threads of sociality that were developed into group, social, and communication theories of individual and collective mental health, human deviance, and psychiatric distress emerged as more the norm than the exception. In this sense, these views operated as social logics utilized to articulate and explain problems such as transient psychiatric breakdown in combat and/or captivity, group and individual schizophrenic reactions, group brainwashing, cultural coercion, and human domination through interpreting individual disturbances and transgressions according to democratic logic implicating social and environmental responsibilities.

Destigmatizing Elements of the Therapeutic Community Experiment: Intervening in Patient, Public, Organizational, and Double-Bind Communication

One of the aspects of social stigma and psychological trauma that has been only minimally researched in psychiatric or social science is how the traumatized subjects’ abnormalities in communication play a role in their social stigmatization. As touched upon in chapter one, researchers have found that traumatized subjects show extreme dialectical oscillations in their communication in revealing (communication overwhelming in quantity and emotion) and concealing (withdrawn and contrained), as well as, demonstrating fragments in temporal and coherent narrativity (Herman, 1992, Yehunda, 2005). In Wilmer’s Therapeutic Community experiment, the patients’ communication patterns were underscored as following similar patterns, with the added element of persistent delusions, which appeared to represent elements of their past traumatic experiences, but that had not been integrated into a retrospective narrative. One of the “de-stigmatizing” elements of Wilmer’s therapeutic approach was to immerse the patients in a culture of communication where they would not be judged for their
abnormalities and to use normative measures to basically train the patients to communicate civilly and according to social norms. Even among patients who did not speak, the exposure to group communication and the ongoing narrative was believed to impact the patients’ inner dialogue and means to think with words other than their own as indicative of dialogic view of inner speech (Wilmer, 1958a).

The community meetings provided the communication techne for allowing the patients to talk and listen, as well as, empathetically communicated a sense of acceptance in the exhibition of their traumas, social disabilities, and delusional formations. Equally as important, was the normative intolerance for patients’ communication of their “crystalized delusions”, upon which Bateson (1958) observes that Wilmer would change the subject and/or challenge the patient as to the non-reality of their communication, as a therapeutic type of “discursive closure” (see Deetz, 1992). Thus, through re-training the patients’ to speak according to conversation and social norms, this communication techne was intervening in potential sources of social stigmatization through intervening the patients’ distorted communication. From a theory of the “split-off symbol” theory of traumatized communication, Freud employed the concept of the “speech apparatus” to account for how psychical or physical injury, pain specifically, disrupts spoken and/or written communication, reading, understanding, expression, and/or interpreting meaning (Ferber, 2010). Psychological trauma has been further theorized to impacts the symbol system of representation, expression, and understanding in a manner believed to produce distortions in private and public communication and consequently, disturbances in self-knowledge whereby the “symptom” manifests in the alteration of the function of the symbol is represented in the subjects’ “symptomatically publicly distorted communication” (Habermas, 1971, p. 257).
Within this theory, the action of language, and reflection thereof, serves the purpose of bridging associations through procedurally encouraging new ways of talking about and interpreting the past, the present, and the connection between the two. In service of the patients’ recovery and readjustment to civilian life, symbolic interventions in communicative action through talk and listening therapy is an active restoration of the split off symbol that connects the split and helps the patient reclaim the fragmented narrative of their experience.

With a patient population who did not trust explicit human communication given their traumatic experiences, Wilmer’s experimental techniques relied heavily upon meta-communicative strategies that lessoned resistance, and communicated consistency in orders of command of genuineness matched by aligning actions (Bateson, 1958). Hence, the meta-communicative techne of displaying military symbols and enacting familiar military and group rituals functioned as a therapeutic and corrective technique that served to rearticulate the dissociated meanings of authority and humanity as able to exist together as a corrective emotional experience in healing persisting wounds.

As analyzed in chapter 7, the public communicative context of the Therapeutic Community model was implemented as a therapeutic techne in the community meeting that was attended by outside visitors and recorded with photography, videography, and conversational technologies. As a dialectical technique that created the opposite condition from which the patients’ had recently been exposed and were still haunted by fears of isolation and seclusion, the public nature of the meeting and communication also served as a meta-communicative techne for intervening in the silencing element both the trauma and the stigma of social isolation that communicated on the level of therapeutic public recognition and as strategy for affirming and developing self-identity believed to have been severely damaged and destructed. The public
“reality principle” and public military context benefitted the patients therapeutically, socially, and normatively through being recognized, known, and seen in a corrective manner that exhibited the opposite characteristics of the recent military context to which they had been exposed and in conflict.

On the level of institutional communication pathology, for the visiting and working members of the ward, the public exposure to both the patients and the community experiment facilitated a first-hand experience of the patients and their problems, which contradicted conventional opinions and started to form a “new story” that would, no doubt, be communicated to publics exterior to the ward as news of difference. Chapter 7 also discussed this strategy as a publicly reflective intervention for healing institutional traumas through exposing decision makers and previously abusive staff members to patients in a humanized and civilized environment that facilitated a way of seeing that witnessed the patients in their vulnerability and humanity, that was therapeutic for both parties. This witnessing technology was also utilized in Wilmer’s texts about the experiment in a manner that positioned the audiences to experience the same double bind as the patient.

Presented as one the more pressing and obvious, yet overlooked aspects of the stigmatizing elements of institutional discourses, Wilmer’s experiment illustrated the importance of the organizational culture of the psychiatric institution for creating a therapeutic environment through intervening in reifying logics that maintain and sustain patient traumatic pathology. As a techne designed to facilitate the social integration and epistemological assumptions among staff members of the ward, an innovative organizational culture intervention displayed the degree to which the staff’s fixed and determinate understanding of the patients’ problems, first maintained the pathological culture, and secondly were amenable to change. Stigmatization was found to be
produced through staff attitudes and norms in the ward culture that reified the institutional doxa through everyday vernacular discourse which transmitted and reproduced negative attitudes towards the patients. In this sense, culture as a metaphor or a lens of seeing and knowing served as a ‘terministic screen’ in selection and deflection that held the cultural formation in place (Martin, 2001, Burke, 1966). As a strategy for correcting this lens, Wilmer also understood the Ward “culture as a variable” in his intervention and quite literally intervened in the metaphorical screens through literally replacing them with a different lens of the patients’ that de-centered their disorders through expanding the horizons of pathology to include the social field of interaction and implicit logics of their movements.

Mapping technics that displayed relational patterns in the social field of the patients’ behavior laterally expanded the terrain of disorder that de-centered the patients’ pathology through shifted the logics of practical understanding according to communicative-centered reason as opposed to subject-centered reason (Habermas, 1987). Through displaying the patients in their social environment and allowing the staff to observe changes in the patients according to their movements in relation to others, group tension, and their own tension, Wilmer allowed for a new rationality and social understanding of patients’ problems that de-stigmatized through de-centering the nature of their disorder from the individuals’ character. As a technique capable of facilitating phronesis and practical knowledge, technics of mapping operate according to an abductive, double-description of map and territory induces a way of knowing based in what Shotter refers to as “relational or orientational way of knowing” requiring participation and embodiment of understanding (2009, p. 225).183

During this process, the patients’ and staff self-formative processes and their communication patterns emerge as the object of the therapeutic meta-discourse assumed to
intervene in “meta-communicative habits”, which are theorized to function as a mechanism of learning, self-knowledge, and a higher level of abstracted reflection (Bateson, 1972, Habermas, 1971). Meta-communication, in this sense, emerged as a communication techne for intervening in split-off symbolic dissociations through engaging the speech apparatus at the level of communicative reflection once communication becomes the object of analysis. Mapping as a meta-communicative technology guided the staff to see their place in the organization as a participatory and creative member which proved to be integral to increasing the health of the communication system and that their acts of communication are not benign or without impact in the lives of the patients. In comparison to the traditional model of the staff-patient divisions characterizing totalizing organizational cultures, the patients and staff are positioned in a dynamic inter-subjective between human subjects as social agents.

Facing both the need to and danger of fostering compassion among the staff, the strategies designed to facilitate communication in the staff meetings allowed for tension release or catharsis, as well as, a subverted distance through the abductive technique of the meeting map that allowed for an abstracted theoretical distance from the patients. Staff communication and reflective emerged as an integral technology for managing counter-transference reactions and the dynamic of secondary trauma that has been found to cause “compassionate fatigue” or a kind burnout that impacts mental health professionals through emotional exposure to the victims’ trauma (Figley, 1983). Theoretically, the contagion of psychological trauma is linked to the notion of transference/counter-transference as a phenomenon of identification between the caregivers and survivors of trauma (see Freud, 1950, Burke, 1969, Pettigrew, 1977).

*The Role of Communication Techne for Destigmatizing and Treating Post-Traumatic Disabilily*
The Therapeutic Community experiment was revealed to be a critical social science inquiry and intervention in conventional and normative logics through divided patient pathology according to social and relational terms of demarcation. The intervention demonstrated new ways of identifying and understanding the patients through discursive and symbolic, literal and metaphorical, shifts in the objects of sight and most importantly, new methods of understanding and talking about the patients’ problems. In contrast to the “pigeonholing” discourse and practices that identify and categorize the patients according to conventional stereotypes and unchallenged assumptions of their incivility and demeanor, Wilmer’s techne expanded, multidimensionally, the divisions and configurations used in comparison, contrast, and differences that made it on the map of pathology and recovery from traumatic psychopathology.

Theoretically, Wilmer’s intervention stands out as an application Freud’s communication insights as a means of intervening in the meaning and interpretation of haunting (dis)associations and distorted interpretations of reality by relying upon engaging the speech apparatus to construct not only new objects of discourse, but also a transformed subject through the act of discursive reflection. Based on this claim, the theoretical consideration of the role of communication in the psychiatric enterprise should be considered more in-depthly. As argued by Pettigrew (1977), “psychoanalysis is itself a rhetorical venture” which he claims has been neglected by rhetorical, and if I may suggest, communication scholars more generally (p. 46). A Freudian extension of discursive and narrative theories of identity provide a theory of subjectivity that does not collapse the self into metaphysical theories of consciousness, but rather as capable of demonstrating that the self is a history, a career, and a narrated entity embedded in, impacted by, and constructed through interaction with social and relational environments.

9.3 Recommendations
In terms of psychiatric diagnostic policy concerning PTSD, naming psychological trauma according to Herman’s (1992) diagnostic proposal of “Complex PTSD” is to argue on the basis of damage to the human “self” as constructed in socially, narratively, epistemological, and discursively mediated contexts of human interaction. Within this proposed diagnosis, the first criterion is defined as “A history of subjection to totalitarian control over a prolonged period (months to years)” (p. 121). The proposal of Complex PTSD as a diagnosis differentiated from PTSD implicates the role of a human perpetrator in contributing to the etiology of the trauma can be defined more concretely through descriptions of coercive control, conditions of captivity/restrictions to human freedom, denial of human rights, deceptive communication, double-bind relational configurations, and totalizing institutional forms.

Sustained efforts to include arguments and evidence of the long lasting effects of psychological trauma on the quality of human life and costs to society should enter in the realm of political debate the next time the U.S. decides to enter in a war. While the problems with veterans receiving treatment at the VA could be attributed to numerous factors with its organizational culture and structure, the larger problem concerns the degree to which empirical and theoretical research from decades of research on psychological combat trauma was largely ignored until the crisis overwhelmed the VA system. How the organizational culture of the VA contributes to stigmatization through systematic misrecognition and dismissal of the patients through long waiting times, diagnostic assessments, and adherence to policy at the expense of treatment is another implication and avenue of future research.

An increasingly prevalent scientific discourse concerned with veterans suffering from PTSD in public discourse articulates the experience of war as producing a “moral injury” defined as “transgressions arising from individual acts of commission or omission, the behavior of
others, or by bearing witness to intense human suffering or the grotesque aftermath of a battle” (Ptsd.va.gov, Litz & Maguen, 2012). The concept is further supplemented with the experience of losing comrades, guilt over aggressive acts not immediately associated with combat, violation of their moral code, a torturing of conscience, deep shame, guilt, and rage (Jelinek, Feb. 2013).

However, the reception of the attempt to distinguish the “moral” aspect of psychological trauma is at risk of being reduced to the logic of medical diagnosis that strictly distinguishes between neurological and human concerns. The theoretical intent of this work is valuable and highlights a missing component in PTSD in its medical diagnosis, but in its reduction to a transgression of moral codes and moral (e.g. inner) injury, much of the value of this perspective is once again reduced to individual transgressions and does not speak to the complexity of the injury, damage, or the crime. Until it is supplemented with a social and cultural theory of the self and an understanding of the experience as relational, the concept of moral injury will continue to reduce the phenomenon to an “individual transgression” the evokes simpleton answers and one act solutions such as “forgiveness” and fails to acknowledge the complex political relationships that constitute the “moral” piece of the injury. As a useful for future research, Janoff-Bulman’s (1992) theory of psychological trauma as a theory of shattered assumptions that causes as a crisis in meaning could be further developed in terms of theories of habitus, destruction of epistemological foundations of self, and interruptions of doxa. The post trauma experience is argued to display its impacts at the level of basic assumptions related to one’s identity and place in world and the sense of continuity that comprise the foundations of practical knowledge and trust in the order of things (Janoff-Bulman, 1992).
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Chapter 1


2 The report stated that in 2012, there were 154 suicides for active-duty troops in the first 155 days of the year far outdistance the U.S. forces killed in action in Afghanistan — about 50 percent more — according to Pentagon statistics obtained by The Associated Press.

3 In a 2009 interview about the study, Stahl also found that the “base’s program for soldiers returning from war simply lacked the staff it needed”, noting that there were 15 psychiatrists on staff to treat hundreds of inpatients and outpatients and that psychiatrists primary prescribed medication without any other form of therapy” (Carey, Cave, Alvarez, AP). Military base Ft. Hood is where military psychiatrist Hasan killed 13 people on the base, including 5 other therapists.

4 Citation

5 According to records retrieved from the Defense Logistics Agency showed that 1.1 billion dollars was spent on psychiatric and pain medications for service members between 2001 and 2009. Estimates on the administration of psychotropic drugs among troops while deployed indicate that 1 out of 6 service members were taking a psychiatric drug, many of whom were taking a combination or “cocktail” of medications to treat depression, anxiety, and stress related conditions (armytimes.com). However, I cannot verify these numbers at this point or find the record.

6 The World Health Organization claims that in industrialized nations, mental illness exceeds physical diseases such as cancer and heart disease in functional and life disability (who.org). Research released by the Center for Disease Control (CDC) emphasize that mental illness is an important public health problem in itself because it is associated with chronic medical diseases such as cardiovascular disease, diabetes, and obesity. The CDC estimates that mental illness related costs exceeded 300 billion dollars in 2003 causing concern that Americans’ reluctance to seek help for mental health disturbances will interfere with employability, disrupt families and relationships, increased risk of suicide, increase the severity mental illness, and physical illness and disease (CDC.org).

7 Weinstein offers two research examples from 1947 and 1951 which I read as suggesting an understanding as opposed to negative attitude.

8 Some examples include: National Mental Health Awareness Campaign, a National Anti-Stigma Campaign, an Elimination of Barriers Initiative, a National Stigma Clearinghouse, National Alliance on Mental Illness Campaign to End Discrimination and StigmaBusters, Glenn Close’s recent BringChange2-Mind campaign (Torrey, 2011).

9 See McNamee (2002) for further discussion of deficit discourse embedded in psychological frameworks of mental disorder.

10 The documentary was nominated in 1962 for 5 Emmy Awards and viewed by 2 million people in US and on the BBC in Great Britain, reviewed by the Lancet as “the most remarkable psychiatric film shown on any screen in this
country. It showed with singular effect and accuracy the group rehabilitation of psychotics in the USA by Dr. Harry Wilmer."

11 Wilmer’s diaries consist of full summaries of every community and staff meeting, daily entries and analysis of the events of the ward, which alone consisted of 4000 typewritten pages in addition to the 3000 pages of patient case histories (1985, p. xiv). He also collected: seating charts of the meetings, all notices posted on the bulletin board in the ward, all lists of requests for interviews, photocopies of patient suicidal notes, and scraps of paper he found that pertain to the experiment. According to Wilmer, all of these records formed “the documentary basis for the observations and conclusions which the book presents”. For 30 consecutive days out of the ten month time period, all of the group and staff meetings were filmed by a naval helicopter crew who subsequently produced 133,000 feet of sound-motion film and tape recordings. However, this film was retained by the Navy and supposedly destroyed except for one reel of film used in the making of “People Need People”.

Chapter 2

12 Terror’s Wake: Trauma and its subjects is an article by Michael Lambek (2009) in The Trauma Controversy.

13 In retro-active studies that compared psychiatric casualties in the US military according to wars, the rate of breakdown among Vietnam veterans was 12 per 1000 men compared to 37 per 1000 during the Korean War and between 28-101 out of 1000 during WWI (Dean, 1997, p. 40). In one retroactive study of WWII vets, Zeiss & Dickman (1989) estimates that 56% of WWII veterans still suffered PTSD symptoms twenty years later. While the point here is that statistical analysis offer a wide range of findings that speak to the persistence of post-trauma symptoms, difficulties in calculation, evaluation, measurement, and sample size impact the variability of findings.

14 Research suggests that that the development of PTSD correlated with the length and severity of the traumatic event, being taken by surprise, pushed to the point of exhaustion, being physical injured or violated, or witnessing grotesque death (Herman, 1992). The role of social support and rebuilding social connections post-trauma are among the more important factors in recovery (Egendorf et al., 1981, Herman, 1992, Rand, 2008). Some researchers have noted the impact of political conflict and public ambivalence have had on soldiers returning from war that exacerbated attempts at resolution and finding meaning (Lifton, 1973, Figley, 1980, Herman, 1992, Janoff-Bulman, 1979).

15 The phrase “a new frontier of explanation” was used by A. Stone in reference to PTSD.

16 This term was coined by critical theorists Adorno and Horkheimer.


18 Films depicting war trauma such as Apocalypse Now (1979), Deer Hunter (1979), Taxi Driver (1976), Born on the Fourth of July (1989), Murder in the First (1995), have been well received among audiences. Other popular films such as The Colour Purple (1985), Sleeping with the Enemy (1991), The Accused (1998), Enough (2002), The Girl with the Dragon Tattoo (2011) depicting sexual and domestic violence have also been well received by the audiences, suggesting an cultural interest in how people experience, suffer, and recover from traumatizing experiences. Just a few examples of these include: Green Zone (2010), Restrepo (2010), The Hurt Locker (2009), No End in Sight (2007), Lions for Lambs (2007), In the Valley of Elah (2007) and Battle Scarred (2007). The recent
debut of the documentary film at the Sundance film festival, *The Invisible War* (2011) depicts the intersection of war and sexual trauma by demonstrating the “epidemic” of rape, repeated sexual abuse, and gross military cover-up, specifically among female service members during the Wars in Iraq and Afghanistan. In the musical world, Eminem’s *8-mile*, Pink Floyd’s *The Wall*, The Doors in general, Rage Against the Machine, Metalica’s *Justice for All*, Pearl Jam’s *Ten*.

Wilber Scott’s *The Politics of Readjustment* (1993) documents the arduous efforts, extensive banter and collaboration between veterans, congress, psychiatrists, and the APA to achieve the institutionalization and formal recognition of distress directly related to combat experience. Another social worker who worked at the Brentwood hospital reported, “Most Brentwood psychiatrists I met during this period had not the slightest clue how to deal with Veterans....they didn’t know to treat combat-related stress. Nor could they provide any guidance to the kind of total reintegration into society that we knew was necessary.” (Mahedy, 1986, p. 56).

Robert J. Lifton worked as an Air force psychiatrist during the Korean War and spent much time listening to and studying the narratives of survivors or war atrocities, from the perspectives of the victims, the veterans, and perpetrators who committed “war crimes” Two of his most notable works include *Death in Life: Survivors of Hiroshima* (1969) and *Home from war: Vietnam veterans---Neither victims or executioners* (1973).

While some of the working group was in favor of the name “catastrophic stress disorder”, PTSD was favored by the APA’s Committee on Reactive Disorders and was published in the DSM-III as the group had recommended. This criteria is proposed to be removed from the DSM-V on the basis of evidence of delayed reaction.

The ‘globalization of PTSD” and its extension into countries with little or no a-priori psychological framework of human behavior highlights “how social agents... make use of the category of trauma and the notion of post-traumatic stress disorder, appropriating, reformulating or even twisting them” (Fassin & Rechtman, 2009, p. 12).


In the aftermath of the Wars in Iraq and Afghanistan, the costs of post-war disability compensation, both physical and psychological, estimates VA treatment costs between $208 and $600 billion and disability payments projected between $68 and $127 billion (Bilmes, 2007). The Rand study was based on the 1.6 millions of troops at the time of their data collection in 2007, estimated that two year costs from Post-traumatic stress disorder, alone ranges from 4 to 6.2 billion dollars in treatment, cost of lives lost to suicide, costs due to lost production (Tanielian & Jaycox, 2008).

The costs of the war on terror are difficult to calculate and have yielded conflicting and controversial results. According to the most comprehensive and recent calculations, the total costs of war and trauma are estimated to fall between 2.4 and thirteen trillion dollars if counting the costs of the aftermath of war in the costs of compensation, treating and rehabilitating the physical and psychical injuries (Stiglitz & Bilmes, 2008; Brown University Study, 2008). Eibner et al. (2008) estimated total costs of deployment related Traumatic Brain Injury ranges from 590-910 million.

See Rose (1998) for his classification of “psy” appropriations.

For example, Dana Cloud (1997) in *Control and Consolation in American Politics* argues that therapeutic discourse is a persuasive rhetoric for diffusing potential collective, political action and energy by disciplining the
individual and private realms in a manner that conceals and contributes to the hegemonic interests of late-modern Capitalism.

32 Lifton is noted as a key figure organizing the movement for the formal recognition of PTSD as diagnosis and setting up groups between veterans and mental health practitioners who organized previously disparate positions into productive alliances that resulted in alterations public, cultural, institutional attitudes, understandings through challenged and altered old psychiatric interpretations through creating contexts of understanding and offering alternative perspectives from his research that altered the status of Vietnam veterans and engenders cultural and political empathetic understanding that was eventually translated into policy.

33 One dimension would be contrasting “situated/emergent” with “a priori/elite” in determining ‘whose’ concepts are used in determining what is problematic, secondly, contrasting the distinctions between theoretical and practical knowledge and the demonstrations of politics and political alliances involved research and theory (i.e. the politics of knowledge production) (Deetz, 2001).

34 In alignment with evidence supporting communication symptomology regarding the disruption of the narrative is a contested theory in neuroscience regarding a correlation between PTSD and the hippocampus. Significant atrophy to the hippocampus has been found in sufferers of PTSD and other disorders such as schizophrenia, severe depression, alzheimers, cushings disease, and seizure disorders (Horowitz). Hippocampus is made of cells called place cells and is associated with mental maps that aid in navigation and orientation, spatial memory, and “connector hub” through which new experiences are encoded,. It is a complex network in the temporal lobe of the brain connected to speech, vision, verbal memory, naming, classifying, and comprehending incoming information (Yehunda, 2001, 2005, van der Kolk, Horowitz, 1997).

35 In traditional therapeutic context, such abnormalities are considered symptoms rather than clues that such discontinuities should be embraced in their dialectical movements in that “survivors challenge us to reconnect fragments, to reconstruct history, to make meaning of their present symptoms in the light of current events” (1992, p. 3).

36 While Herman does not offer an explicit theory of subjectivity in support how identity is altered, the implications of the dialectical movements, relational configurations, and able to be altered through experience suggests a social interaction perspective.

37 Two of the core group of researchers associated with the development of this theoretical approach, Jurgen Ruesch and Gregory Bateson, were the psychiatrist and ethnologist chosen by Dr. Wilmer to consult on the project. They were also instrumental in developing a communication theory of schizophrenia contingent upon a formation of “double-binds” believed to result in that are characteristic of a particular group formation, sequential pattern of communicative exchanges, and material conditions of dependence. The next section will explore the role and significance of metaphors and the role of metacommunication in the technologies of subjectivity and the new objects of their formation.

38 Schizophrenia’s status at this as a psychiatric diagnosis is explained by the following explanation in 1968: “Consider for example, the mental disorder labeled in this manual as “schizophrenia”, which in the first edition was labeled ‘schizophrenia reaction”. This change of label has not changed the nature of the disorder, nor will it discourage continuing debate about its nature or its causes. Even if it had tried, the committee could not establish agreement about what this disorder is; it could only agree on what to call it (Forward to the DSM-II, 1968).

39 In contrast to a contradictory injunction, one can still logically choose, whereas in a paradoxical injunction, no choice is possible and the effect is similar to paralysis into a self-perpetuating series (Watzlawick, et al., 1967, p. 217).

Chapter 3
Articulation theory as a method and theory is congruent with the principles related to the “institutional logic theory” of institutional stability and change as displaying the socially constructed historically contingent characteristics of institutional logics that change over time (See Thornton & Ocasio, 2008). Jorgensen & Phillips (2002) identify Laclau & Mouffe’s (1985) use of articulation as a way to reveal “the ideological content of other theories” that is in line with its broader philosophy focused of “understanding (of) the social as a discursive construction” (p. 35). As a method of excavating theoretical and practical assumptions embedded in scientific theories and we could say, as a meta-discourse, articulation theory is useful for deconstructing theoretical elements through mapping linkages between theories, practices, and other bodies of knowledge.

“Hegemony” is a political theory credited to Italian political philosopher and social theorist Antonio Gramsci (1971) who was concerned with the complicity of lower classes and workers to act on behalf of their own interests and realize the conditions of their oppression, described in terms of hegemonic processes. Hegemony came to describe a political formation and theory of the ‘development of a ‘collective will’ through ‘intellectual and moral reform’ exercised in the ability of one class to articulate the interests of other social groups to its own” through the colonization of popular consciousness” (Grossberg, 1984, p 412) (Quoted from Mumby, 2001, p 597). Put more simply, according to Mumby’s summary of Gramsci’s concept, hegemony refers to “the ability of one class or group to link the interest and worldviews of other groups with its own. Hegemony does not refer to simple domination, but rather involves attempts by various groups to articulate meaning systems that are actively taken up by other groups” (2001, p 587).

To perform this task, Laclau & Mouffe (1985) describe this ‘detour’ as entailing two additional steps: first, they had to figure out how to “specify(ing) the elements that enter into the articulatory relations”, and secondly, to figure out how to more specifically describe the “relational moment comprising this articulation” (p. 96).

In reviewing this chapter, I cannot be certain that these are my original words or that I did not read a sentence in another text that very much resembles this idea. I have searched in my refere

This abstract in particular, especially the first two claims demonstrate a misappropriation, perhaps through dissolution of distinctions and lack of understanding of the lineage between the theorists mentioned: “A comprehensive look at the evolution of ideas on hysteria in the followers of Charcot shows that ...the modernity of several of his concepts remains remarkable, including: (1) his traumatic theory, which encompassed sexual factors nearly 20 years before Freud; (2) his evolution towards psychological and emotional issues, which opened the way for Janet and Freud, but unfortunately was largely ignored by Babinski; (3) his strong claim against Bernheim of the similarity of mental states in hypnotism and hysteria, which has recently been confirmed by functional magnetic resonance imaging; (4) his 'dynamic lesion' hypothesis, which now correlates well with neurophysiological mechanisms also demonstrated by functional imaging.” (Bogousslavsky J. (2011). Hysteria after Charcot: back to the future. From Neurological Neurosci. 2011;29:137-61. doi: 10.1159/000321783. Epub 2010 Oct 7).

The questions that guided my approach to reading the texts about and from the experts on this piece of psychiatric history concern how the historical-cultural context around theorizing psychological trauma has contributed to its linkage to social stigmatization, and second, how have theories of trauma, in the form of concepts, themes, and objects of research contributed to how survivors of trauma have come to be known as a marginalized population.
Chapter 4

As argued in Chapter 3 Articulation theory (1985) can be read as an application and conceptual extension of Foucault’s Archaeological Method as read in Laclau & Mouffe (1985) which is amenable to analyzing changing discursive formations as new articulations based on shifts in objects, concepts, subjects, and discourse.

I draw here upon Taylor’s (2002) punctuation of critical postmodern theory as an intellectual resource for qualitative research that problematizes social problems in part by examining and excavating their historical and cultural contexts in order to demonstrate the ways in which discursive practices are assumed to be intricately connected to knowledge generation, the politics of scientific representation, and social construction of identity.

As a conceptual and methodological tools of analysis, Foucault identifies four elements of a discursive formation that constitute the formation of objects, subject positions (enunciative modalities), concepts, and strategies (themes and theories) in a discourse that occur with regularity in a set of statements that are not necessarily unified or coherent in temporality, geography, or proximity of sequence.

King (1998) challenges Veith’s claim as to whether the term hysteria or hysterika was actually used, or if it was applied retrospectively to describe associated behaviors attributed to the wandering uterus.

The only mention of “hysteria” or “hysteric” in the Malleus Maleficarum is in the introduction to the 1928 translation, and not in the text of the treatise itself.

His official treatise or scientific opinion was prefaced with the argument, “that divers strange actions and passions of the body of man, which in the common opinion, are imputed to the Divell, have their true natuall cause, and do accompany this disease” (MacDonald, 1991).

Asmodeus, Zabulon, Isacaraon, Astaroth, Gresil, Amand, Leviatom, Behemot, Beherie, Easas, Celsus, Acaos, Cedon, Alex, Naphthalim, Cham, Ureil, and Achas (Wikipedia.com)

Dictionnaire infernal ou Bibliothèque universelle. Collin de Plancy (1826).

Over three hundred years later, the story was transmuted into the self-proclaimed non-fiction novel The Devils of Loudun, by Aldous Huxley (1952), a stage play in 1960, an opera in 1969, and a feature film by Ken Russell entitled The Devils in 1971. Huxley’s (1952) version of the story highlights seduction, repression, female conniving, and demonic possession in its connection with what is now referred to as schizophrenia or multiple personality disorder (Cioffe, 2003, p. 709).

17th century Europe was very much dominated by the Catholic church. Thus, it is necessary note that Galileo was sentenced to life house arrest by the Inquisition in 1633 for “vehement suspect of heresy” for providing evidence that the Aristotelian, geo-centric “Copernican” philosophy of the cosmic movements, whereby all of the objects in the night sky revolved around the earth, was in fact wrong. This Copernican Revolution, as it came to known, also challenged beliefs originating in the “holy scripture”, which became the basis for Galileo’s court ordered exile of communication and forbiddance of publication of his work (Finocchiaro, 1989).

While I am not directly challenging the claim that a theory of sexual and cultural trauma was developed by Freud sparked by his work and observations with female patients believed to be exhibiting symptoms of hysteria in the late 19th century and later with men suffering from post-combat disturbances, but rather that trauma as a predominant concept, object, or theory in the discursive formation of the scientized version of hysteria was simply (not present) discursively, conceptually, or as an object of inquiry. In other words, the status of psychological trauma as a discursive formation during this time was pre-conceptual and pre-discursive.

Lerner focused specifically upon German psychiatry.

Chapter 5
Railway accident survivors were also recognized and observed by Erichsen and Page in 1860. The survivors exhibited mysterious physical symptoms, delayed emotional reactions and problems with remembering and their spinal cord which was aptly referred to as railway spine (Young, 1995). Railway spine was based in a notion of the force of a shock believed to damage neural tissue or from intense fear or shock (Erichsen, 1860).

(Quoted by Foucault, 2006, p 308).

In Foucault’s explanation of the sources of a “discursive constellation” he states, “A discursive formation does not occupy therefore all the possible volume that is opened up to it of right by the systems of formation of its objects, its enunciations, and its concepts; it is essentially incomplete, owing to the system of formation of its strategic choices. Hence the fact that, taken up again, placed, and interpreted in a new constellation, a given discursive formation may reveal new possibilities. We are not dealing with a silent content that has remained implicit, that has been said and not said, and which constitutes beneath manifest statements a sort of sub-discourse that is more fundamental, and which is not emerged at last into the light of day; what we are dealing with is a modification in the principle of exclusion and the principle of the possibility of choices; a modification that is due to the insertion in a new discursive constellation.” (1972, p. 67).

Micale (2001) distinguishes between nervous degeneration and nervous disorder, with the ladder to believed to be a ‘disease of civilization’ and the ‘civilized’, like the “hypochondriac melancholia in Renaissance, the enlightenment vapors, or the Victorian neuroasthenia – were believed to be the province of the affluent, educated, and sophisticated. The lower social orders, it was tacitly believed, were too primitive in their emotional and nervous apparatus to suffer from the diseases of civilization” (p 117).

Prior to 1840’s, there was not a theory of pathological heredity and nervous degeneration, but if it was discovered that the patient’s ancestors had suffered from a particular condition, then it was assumed that such a family connection constituted a viable explanation for the problems at hand (Foucault, 2006, p 271).

Experts on Charcot’s experimental research document the central position that sexuality assumed in the voices and bodies of the hysteria subjects and simultaneously note the absence of any mention of sexuality or a theory thereof in his research (Goetz, et al., 1995, Foucault, 2006). According to Foucault, Charcot simply did not speak of it, nor did Freud until years after his six month stay at the research institute. Perhaps this is the silence, or the “pathogenic secret” in this story.

Although Hauser’s argument was established in relation to a critique of Foucault’s discourse on power, Foucault’s work and lectures from 1974 where he theorized the resistance of the hysteria patients were not published in English until 2006.

Sigmund Freud almost relieved hysteria from its degenerative and demoralizing interpretation when he proclaimed, “I therefore put forward the thesis that at the bottom of the every case of hysteria there are one or more occurrences of premature sexual experience, occurrences which belong to the earliest years of childhood” (1893) only to retract this proclamation four years later and incite the patient in a discourse of deceit when he claimed, “I was obliged to recognize that these scenes of seduction had never taken place, and that these were only fantasies which my patients had made up.” (1897).

Using hypnosis to limit and contain the symptoms of hysteria and trigger them at will was eventually used to detect malingers, as a point of comparison to the real traumatized...functional mannequins (2006, p. 316). However, the construction of the hysterical subject and enduring images of hysterical subjects positioned them as “functional mannequins” (p. 331), “sexual pantomimes (p. 322), deceptive and pathetic that may have in fact elevated her relational and institutional status, however, did very little for the moral assessment and public perception of hysterical illness or the hysterical subject.

Depicted as the “true militants of antipsychiatry”, the patients complied with the commands of the doctor on their own behalf and in their conditions of captivity were positioned in an important social role and relationship with an
important man, which paradoxically produced a sense of integrity that they were acknowledged and given a high profile role to play (Foucault, 2006).

70 Published in Boston Medical and Surgical Journal, 1890, pg. 89, (as cited in Goetz et al., 1995, p. 211).

71 Szasz is referring specifically here to Guillian’s (1959) biographical account of Charcot.


73 Gabrielle, however, was pardoned in 1903 after Jules Liégeois hypnotized her again in order to testify that she revealed verbally and performatively that she was literally tortured, coerced, and almost strangled by Eyraud to influence her to participate in the crime. The news of her pardoning was published in Australian, British, and American newspapers.

74 Dissociation is still used as an explanatory principle for trauma related reactions in contemporary times (Herman, 1992).

75 Rizzuto (1997) underscores that Freud’s speech apparatus refers to the “intentional and spontaneous component of normal speech in ordinary circumstances” (p. 3).

76 The following diagram is from Freud's model of the word organization (1891 [1953], p. 77, in Rizzuto, 1997)

78 See Deetz, 1992 on distinctions between these models of communication; see Craig, 2006 on the connection between communication theories, discourse, and commonplace assumption.


80 Great Britain lost 2% of its population with 887,000 military deaths and 100,000 civilian deaths (due to related famine or disease), and another 1.6 million wounded, France lost 4% of their population with 1.4 military deaths, lost 300,000 civilians to military/famine, and 4.2 million wounded. Italy lost 3.48% of their population, 651,000 military deaths, 585,000 civilian/famine deaths.
In France, for instance, the percentage of patients admitted to hospitals for “hysterical, hysteron-traumatic, or functional symptoms exceeded ten percent in every region of France and in some areas rose to fifty and sixty percent” (see Roudebush, 2001, p. 254).

These include: In Great Britain and the United States: Erichsen, Page, Paget, Putnam, Beard, Dana, Hammond, Mitchell, Rivers, Southard, Kardiner; In France and Belgium (Suisse Romande): Charcot, Ribot, Binet, Guinon, Bernheim, Janet, Delboeuf, Babinski, dubois, and Dumas; And in German speaking countries: Oppenheim, Bruns, Thompsen, Gaupp, Freud, somner, Hoche, Hallpach, Bonhoeffer, Binswanger, Nonne, Simmel, and Ferenczi.

According to Mendelson & Mendelson (1993) the idea of malingering has been traced back to Galen in his treatise entitled “On Feigned Diseases and the Detection of Them” and has remained a prevalent suspicion about men feigning diseases to avoid or withdraw from military service. The term malingerer is of French origin and was first introduced in the publication of slang words and terms in the “Dictionary of the Vulgar Tongue” in 1785 by Francois Gross in France (published in English in 1811). In the publication, the entry of “malingerer” states: “a military term for one who, under pretence of sickness, evades his duty”.


In a book review published in a British newspaper of Jones & Llewelyn’s book (1917) Malingering: or, the Simulation of Disease, the reviewer writes: “Malingerer’s parasitic art has progressed with the times; nowadays, he does not hesitate to attempt a counterfeit of the symptoms of diabetes, jaundice, cardiac and pulmonary disorders….It is often difficult to say whether hysterical mimicry is at work---the epigram of the authors that hysteria gives a parody, malingering a caricature, of a disease or disability, supplies the basis of discrimination….Nothing has done more to sap the moral of the nation than the creation of a privileged class of cowards.” (ibid)

Neurasthenia originates from a theory based in ‘nerve exhaustion’ that resulted from prolonged exposure to mentally and physically taxing events or series thereof developed by George Beard (1880, 1881) (Young, 1995, p. 52)

An entire chapter on “Malingering in Relation to the Eye” by W.M. Beaumont is included in Bassett & Jones’ text.

Rivers is noted for his close work with Poet Robert Graves and “Mad Jack” (Siegfried Sassoon) a veteran who denounced the war, yet returned to duty in WWI out of loyalty and later described his experiences in semi-autobiographical war memoirs and poetry.

Rivers divided suggestion into three elements: mimesis or unwitting imitation, sympathy or the spontaneous and reciprocal responses between individuals, and intuition or the cognitive element that allows someone to apprehend what someone else is thinking or feeling (Young, 1995, p. 47-48).

This quote was retrieved from an excerpt from his book “Instincts and the Unconscious” published online at: http://psychcentral.com/classics/Rivers/appendix1.htm The piece concludes with the statement “If this value of Freud's theory were only a probability, or even only a possibility, are we justified in ignoring it as an instrument for the better understanding of disorders of which at present we know so little? Are we to reject a helping hand with contumely because it sometimes leads us to discover unpleasant aspects of human nature and because it comes from Vienna?”.

This thread of thought is evident in Burke’s theory and motive of persuasion (1969) postulating cooperation as the ultimate motive for movements of identification as well as the therapeutic panacea for divisions created through war, which he understood as “disease of cooperation” (1950, p. 22).
For instance, Appel and Beebe (1946) found that 200-240 days in combat was sufficient as they explain, “There is no such thing as ‘getting used to combat…Each moment of combat imposed a strain so great that men will break down in direct relation to the intensity and duration of their exposure. Thus psychiatric casualties are as inevitable as gunshot and shrapnel wounds in warfare.” (cited in Herman, 1992).

Similar in reference to Da Costa syndrome or soldier’s heart, which was observed in U.S. Civil War soldiers (1861-1865).

Pilowsky (1985) refers to this tendency as “malingeringophobia” as exhibited in doctors’ fear of missing the malingerers.


There were understood to be “more or less transient in character and which appear to be an acute symptom response without apparent personality disturbance” (DSM, 1952, p. 40). Symptoms were understood as similar to the notion of defense mechanisms, formally articulated as “the immediate means used by the individual in his struggle to adjust to an overwhelming situation in the presence of good adaptive capacity, recession of symptoms generally occur when the situational stress diminishes.

Chapter 6

Gross Stress Reactions were explained as “Under conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear. The patterns of such reactions differ from those of neurosis or psychosis chiefly with respect to clinical history, reversibility of reaction, and its transient character. When promptly and adequately treated, the condition may clear rapidly. It is also possible that the condition may progress to one of the neurotic reactions. If the reaction persists, this term is to be regarded as a temporary diagnosis to be used only until a more definitive diagnosis is established. This diagnosis is justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress, such as in combat or in civilian catastrophe (fire, earthquake, explosion, etc.). In many instances this diagnosis applies to previously more or less "normal" persons who have experienced intolerable stress. The particular stress involved will be specified as (1) combat or (2) civilian catastrophe” (DSM, 1952, p. 40).

This is a contestable claim. Briggs (2001) claims this, but I think the "of its kind" qualifies its validity. Cummings & Cummings (1956), Greenblatt, Brown, & York (1957) published studies about planned therapeutic communities in large state psychiatric hospitals. Ward 55 could very well be the first use of the therapeutic community model in a military psychiatric hospital in the U.S. and is especially noted for its radical, albeit small scale, changes (Manning 1989, p. 25).

The general atmosphere of Ward 55 before the experiment and in military psychiatric wards during this is described in narratives by psychologists Dennie Briggs and Rodney Odgers, both of whom worked on the Ward before and during Wilmer’s tenure. Odgers reports that the hospital staff referred to the atmosphere of the psychiatric service as "the funny Farm," "silly hill," "squirrel canyon," "mockingbird Hill", and "the squirrel cake" (1956, p. 249-251).

The servicemen were received from West Coast military dispensaries and hospitals, or directly off the SF fleet coming from Navy hospitals in Japan, the Philippines, and Hawaii, who had been transported by ship, helicopter, airplanes, and/or buses (1958, p. 23, 1957, p. 360).

Wilmer notes that he disregarded the hospital order of writing “suicide orders” for the staff to read because he thought it led to an overuse of the quiet room. He informed Captain Gaede, Chief Psychiatrist of the hospital that he would not be doing this and was not ordered to do so but was told that “if there was a suicide he would not remember what I had told him and I might be court marshalled” (Wilmer, 2004).

26.6% psychoneurotics, 28.3% character and personality disorders; 0.7% acute situational maladjustment.
Tuke, Pinel, and Esquiral are included in Wilmer’s secondary bibliography. Both Pinel and Esquirol conducted their work at Hospital Salpetriere in France. The lineage of Milieu therapy served as the backbone of Samuel Tuke’s institutional reform research near York, England which documented its moral therapy conducted at the “Retreat” in the book *Insane Persons of the Society of Friends* (1813) “The Retreat” as linked to 19th century asylum reform movement based in a philosophy of the patients’ moral agency, self-worth, and esteem as the primary therapeutic influence. It has has relatedly been linked to Esquiral and Pinel’s institutional reform therapies in France in the early 19th century (Foucault, 1965, Raad & Makari, 2010). Milieu therapy is anecdotally claimed to have been found in Ancient Greece as a “rest”, a retreat until you did not need rest anymore.

In reviewing this chapter, I cannot be certain that these are my original words or that I did not read a sentence in another text that very much resembles this idea. I have searched in my references for the author, but have not found the statement. If this is a recurring statement, it is unintentional.

In working from methodological orientation of Foucault’s (1972) archaeological analysis, four interconnected principles or analytic tools are implicated in the analysis of episteme more broadly or through analyzing a specific contained text. The first tool pertains to analytically reading a collection of texts or book as a “node within a network” stating that “the frontiers of a book are never clear cut: beyond the title, the first lines, and the last full stop, beyond its internal configuration and its autonomous forms, it is caught up in a system of references to other books, other texts, other sentences (Foucault, 1972, p. 24). The second principle assumes that “one cannot speak of anything at any time; it is not easy to say something new; it is not enough for us to open our eyes, to pay attention or to be aware, for new objects suddenly to light up and emerge out the ground” (p. 44-45). The third principle builds on the new objects of discourse through identifying elements of a discursive formation according to a “complex group of relations” at the level of positivity of interconnected discourses (e.g. institutional, economic, social, modes of classification, etc.) (p. 45). A final useful analytic is offered by Laclau & Mouffe’s (1985) guidance for analyzing the “discursive conditions” which gave rise to collective action and new nodal points from which to construct relations of subordination into domination and thus on the basis of democratic discourses was able to intervene in politically dominant discursive formations which have come to be analogous to “hegemony” and “ideology”.

In the introduction to Wilmer’s monograph, he qualifies the experiment’s innovation and techniques “have been borrowing from many people” (1958a, p. xiv).

Dennie Briggs (2001) descriptive article and tribute is the only detailed and comprehensive account of which I am aware.


The 1957 Symposium on Preventive and Social Psychiatry, hosted by the Walter Reed Army Institute of Research, convened precisely to survey recent trends and developments in military psychiatry. In the preface to the published research report of the symposium, the research themes and trends are explained “emphasiz(ing) the roles of group and of social communication in mental health and of social isolation as a combined result and determining agent in mental illness” and a research focus upon “social factors” and “modifications of the external (social) milieu to influence favorably the mental health of member of organized group (Rioch, WRAI, 1958, iii). The Therapeutic Community model, referred to in the Symposium as a “therapeutic milieu” is consistent with disciplinary shifts and trends of its era.

Cited in Wilmer, 1958, p. 3.

Amitai Etzioni wrote this article as a graduate student and research assistant in Sociology at the University of California at Berkeley. He has since been associated with a socio-political stance that emphasizes the importance of community in political life referred to as “communitarianism” and has been named one of the most important public intellectuals of the 21st century in Posner’s book, “Public Intellectuals: A Study of Decline (2001).
Etzioni argues that the Human Relations Approach’s emphasis on communication is trivial and overemphasized at best, perhaps even Utopian in believing that increased communication can solve the complex problems arising between economic and practical obstacles, thus further oversimplifying such challenges. Interesting to note that Sociologist Etzioni stresses the importance of structural factors over communication factors, concluding that the “human relations” approach to studying mental hospitals, “overemphasize (1) the importance of communication, (2) the totality of institutions and (3) the benefits of participation in decision-making conferences (1960, p.22). Etzioni, however, was onto something that will be more in-depthly explored in the upcoming section as an emerging school of thought in mental health research and organizational intervention whereby problems of power, communication, and institutional authority intersect. While Etzioni’s analysis does not attempt to cover is the role of communication in mental health treatment, for instance the theorized role of communication in psychoanalysis, he does accurately observe the growing presence of both mental health organization and communication as growing positivities and new objects of social science inquiries.

For example, in response to Soloman Asch’s paper “Experimental Investigation of Group Influence”, a study on group influence on conformity, Captain Hilmer from the Office of the Surgeon General, Department of the Army, commented on the ethics of the study, stating that, “it seems to me that this is a substantially cruel way of getting this material. I don’t know if this could have been avoided, but it seems to me that your naive subjects were, in a sense, stripped of their integrity in the presence of their peers….is there a way we could minimize the effect on the tender egos of these young subjects and still get at the phenomenon that you are rightfully exploring?” (1958, p. 86). Asch’s experiments are linked to Stanley Milgram’s (1961) experiments that addressed the problem of obedience, specifically in relation to how Hitler was able to gain so many accomplices during the accomplices. Milgram’s research experiment attracted ethical controversy due the stress experienced afterwards by the participants.

At first, I found the lack of reaction to Goffman’s critical claims surprising. In fact, I expected that the question and answer session would have been characterized by criticism or resistance given the implications, but that was not the case. Numerous question and answer sessions from separate panels referenced his works as a jumping off point from which to expand upon or connect ideas.

Stryker, a journalist presenter from Fortune magazine, responded to Fiedler’s comment, confirming that “A good many of the public pronouncements of top executives stress the democratic ideal pf business and try to give the impression that businesses are democratic…Group management is very popular, participation in management---there’s a whole school following that now….The teaching about democratic ideals and so forth have unquestionable affected people’s outer opinions of what should go on in a company.” (1958, p. 279).

Quoted in Wilmer,1958a, p. vii.


Granquist (2010) reports that two of the CO’s were disbanded after they complained to the superintendent, who eventually resigned, but continued their mission of contacting those in journalist positions with newspapers and leaders of religious organizations, for example Rev. Dores Sharpe, the executive director of the Cleveland Baptist Association.

The low budget horror film, Bedlam, was a fictionalized tale of the Bethlehem Asylum in 1761 in London and an unsuccessful attempt to reform it.

CO Frank L. Wright wrote Out of Sight, Out of Mind in 1948. Albert Deutsch, a journalist contacted by the CO’s, wrote articles for PM, a New York newspaper and a book-length description The Shame of the States about the state hospitals in 1948, which is reported to have prompted some changes which Maisel attempted to capture in a follow up article for Life in 1951 in Scandal Results in Real Reforms (Granquist, 2010).

Etzioni claims, this field began with Rowland in 1938, but with the bigger wave appearing after Lewin (1946) and Elton Mayo, in the early to mid 1950’s, for instance, in the research of Caudill (1954, 1956), Stanton & Schwartz (1954), Arensberg, 1957, Maxwell Jones (1954), Belknap (1956), Smith & Levinson (1957), Harry Stack Sullivan (1953), and Goffman (1958), to name some of the key figures.
The pattern describes the building of “pathological excitement” in the patients believed to be connected to “hidden staff disagreements” that go through predictable cycles of staff and patient withdrawal and excitation that eventually results in crisis-like episodes of “collective disturbances”, generally with one disruptive patient “acting as the spark plug” (Stanton & Schwartz, 1954, in Manning, 1989).


Sociologist Raymond Weinstein critiques Goffman’s characterization of mental hospitals as total institutions that have self-mortifications effects on the basis of findings from studies in the 50’s, 60’s, 70’s which refute his claims. Weinstein concludes: “Empirical results from various investigations designed to test the mortification of self have all disproved Goffman’s thesis.....It is difficult to assess exactly why Goffman completely misinterpreted the meaning of mental hospitalization from the patients’ view (1982, p. 272-273).

The split is theorized to be maintained in and produced by the negative stereotypes and problematic understandings each group holds of the other where the staff typically see and respond to the inmates as “bitter, secretive and untrustworthy” while the inmates tend to see the staff as “condescending, high handed and mean” (1958, p. 46).

In his later work, he articulates these interactions in terms of ceremonial and patterned ritualistic interactions involving processes of self-mortifications produced in relational practices of coercion and constraint in some psychiatric wards (1967, p. 89). More specifically, these ceremonial transgressions involve face to face ritual encounters, normatively labeled as “aggressions” or “hostile outbursts” (p. 88-90). These rituals, for Goffman were connected to how the patients’ moral career is altered in these encounters in lost time, connections, and self-other images.

He further states that, “By implication we can obtain information from this history about the conditions that must be satisfied if individuals are to have selves.....It is therefore important to see that the self is in part a ceremonial thing, a sacred object which must be treated with proper ritual care and in turn must be presented in a proper light to others” (Goffman, 1967, p. 92-93).

Goffman offers a concrete example of an institutional misunderstanding through highlighting the patients’ perceptions of inmate culture that their time is wasted and “must be written off”, which when combined with the institutional norm of the patients’ not knowing or having a sense of control over the duration of their sentence produces an underexplored source of tension among patients that contributes to the patients’ experience that “he has been totally exiled from living” (Goffman, 1958, p. 63). Footnoting this claim with a reference to Freud’s description of this “feeling of non-living” in “Mourning and Melancholia” as the result of losing a loved object, Goffman explains how the influence of an indefinite or very long sentence as demoralizing and conceptually connected to the degrading alteration on the patients’ moral career in terms of loss of social connections during exiled times constitutes a form of unnecessary time domination that inhibits the patient from gaining any value from the wasting of their time.

This statement is Kemmis’s excavation of the role of critique in critical theory as related to how these elements reproduce social injustices.

Chapter 7

From all available accounts, the ten month Therapeutic Community model experiment in Oakland was considered a “success” for radically intervening in military psychiatric administration and conventional treatment methods during its ten month instantiation. At the conclusion of experiment, Dr. Francis Braceland, President of the American Psychiatric Association (1956-1957), stated: “I believe that the therapeutic community mode of treatment as presently practiced by Doctor Wilmer is one of the most hopeful developments in psychiatry from both the administrative and psychotherapeutic points of view.... If it were possible, Doctor Wilmer should be endowed and sent throughout the nation as a teacher and as a catalyst....A community should be started in every admission ward
of every mental hospital in the country” (1956, ix). For this reason alone, this case is striking for its value as a humane, radical, and localized episode of an organized intervention in psychiatric practice and treatment. Although the therapeutic community model has been linked socially and politically to psychiatric institutional reform on a broader level, it has not been explored in any substantial manner beyond its own articulation of itself and by a handful of dedicated researchers and participants (Manning, 1989, Briggs, 2001, Wilmer, 1958).

Prior to Dr. Wilmer’s Naval Duty, he had trained as a psychiatrist and psychoanalyst and interned at the Mayo clinic for four years before becoming the first psychiatrist at the Palo Alto Clinic while teaching psychiatry at Stanford University (Briggs, 2001).

Not only did he produce multiple articles for medical and psychiatric journals, but also produced texts for professional practitioners and cultural audiences. In addition to publishing two papers in the U.S. Armed Forces Medical Journal and at least thirteen in psychiatric and medical journals about the experiment, Wilmer wrote and funded the publication of a 383 page monograph entitled, Social Psychiatry in Action, for a wider professional and interested public audience which described the experimental protocol, its rationale, the patients’ histories, and details of the community, staff, and patient meetings in great depth and complexity. According to Wilmer (2004), a psychiatrist in the Los Angeles area contacted him, after reading the monograph, about making the case into a TV docudrama, People Need People, which was broadcasted in 1961. Using the only reel of film of the experiment that the military would allow him to keep because of the other reels’ “poor quality”, he edited the video and audio recordings to provide material for the screenwriting and personally collaborated and consulted on the set during the production of the cultural text (Wilmer, 2004).

One of the first reports Wilmer published about the experiment was entitled, “A photographic report on a therapeutic community at the U.S. Naval Hospital Oakland California” and was published in 1956. It is simply missing. An archivist at the University of Colorado at Boulder Library Department of Government Documents Division searched for me and was unable to find any trace of the document. The docudrama was archived in the University of California Los Angeles film archive and is, to my knowledge, the only public copy available, despite the fact that other shows that aired on the Fred Astaire Alcoa series on ABC in 1961 are available on VHS, DVD, and Internet archives.

“...What will come of this work in the long run is for the psychiatric historian to report, but in the meanwhile I am proud that the Navy Medical Corps had an important part in its launching and pleased to note that this dedicated and humane effort by Doctor Wilmer and his associates is in the great tradition of the Corps.” (Surgeon General, Rear Admiral Bartholomew Hogan (Preface to “Social Psychiatry in Action”, Wilmer, 1958, p. xiii).

The link between ideology, domination, and systematic distorted communication is explained by Deetz (1992) as “communication is considered pathologically systematically distorted to the extent to which communication maintains ideological domination when the norms (usually latent) prohibit open questioning and formation of one’s interests, maintain a certain degree of self and other deception, and most importantly maintains a communication system (relational, organization, etc.) which “endangers the survival of the human and other species by limiting important adaptation to a changing environment, violates normative standards already freely shared by members of a community, and poses arbitrary limits on the development of individualization and the realization of the collective good” (p. 177).

One particular exception is found in Deetz’s description of the outcomes of systematic distortions in terms of limiting adaptation and responsiveness, violating normative standards of a community, and imposing unnecessary and “arbitrary limits” on individual and collective goods that “reproduce” self and experience (1992, p. 177).

He highlights that insufficient public and private funding resulting in a quantitatively notable deficit in trained practitioners compromises the quality of mental health treatment (Wilmer, 1958a, 1958b). The civilian and military mental health care system was estimated to be drastically understaffed by 40% in doctors, 66% in nurses, 28% in attendants, 75% in social workers, and 76% in clinical psychologists (Wilmer, 1958a, 1958b).

At the time of its development in British military hospitals, it was considered a major innovation in the treatment of shell-shocked soldiers, returning prisoners of war, and dependent patients in the great ‘bins’ of the post-war period (Sedgwick, 1982, p. 206).
Wilmer’s mapping techniques are discussed in an upcoming section. However, it is important to note that the maps of the meetings played a central role in analyzing seating patterns, social interaction, as well as group and nonverbal communication in the community meetings. The meeting maps were used as the primary subject matter for the staff meetings to discuss the patients in the group. Consecutive, daily maps of the group meetings were analyzed over time in relation to changes in seating patterns and presented at the WRAI 1957 as a study in nonverbal group communication (Wilmer, 1985c).

A useful comparison to the Therapeutic Community Experiment, both methodologically and analytically, is Lewin, Lippett & White’s (1939) “experimentally created social climate”, which tested changes in group life, patterns of aggression and cooperation according to authoritative, democratic, and laissez-faire group and leadership structures, and was later given the name “Action Research”.

This is evidenced in action research’s association with organizational interventions and experimental studies of social organizing according to differing modes of governance (democratic, autocratic, and laissez-faire).

These cyclical elements of Lewin’s formulation of the activities of action research are summarized in Sanford, N. (1970). Whatever happened to action research? Journal of Social Issues, p. 3-23.

Connected to this framework of the holding tank is a less articulated, but no less an important variable in the state of the ward before the experiment that is clearly related to, but not explicitly associated with, seclusion and sedation is/as? the element of time. Prior to his protocol, Wilmer noted that the unit lacked any kind of definitive time period for the patients’ stay in the ward, claiming it ranged anywhere between “a day to 3 or 4 weeks”, attributed to the lack of any systemic plan of transfer”. Goffman reports that in his studies of mental hospitals, patients consistently point out that in jail “at least you know when you are getting out. Insofar as we know about things, I think the feeling is that the indefinite sentence is one of the disorganizing or disorienting processes of an institution” (1958, p. 91). This absence of time frame “aroused considerable anxiety and jealousy” among the patients (p. 28). According to both Briggs and Wilmer, the patients’ extreme concerns with their disposition status, compensation and benefit status, and fate of their next transfer were understood as causing unnecessary tension and disorientation. This notion of “domination of time” is a point amenable to future examination.

Their previous institutionalized treatment was included in the monograph and in later accounts by the resident psychologist Briggs, who explains that, “We heard endless accounts of the cruelties inflicted by the staff on patients as they passed through the Naval hospital in Yokosuka, Japan” and “there were accounts of mistreatment at other hospitals, prisons, or duty stations. Sometimes patients remembered horrific events from earlier years in the form of punishment, deprivation, or confinement” (Wilmer, 1958, Briggs, 2001, p. 3, 8, 12-13). Woven intermittently throughout Wilmer’s texts are references to the emotional content of the patients’ conversations expressing confusion, anger, and humiliation over the terms and conditions of their prior hospitalization or incarceration.

The correspondence between his explication of the suggested association between external dominant restraints on communication and physical movements with the description of the patients’ disturbance of communication is interesting in light of Sydenham’s (1681) insight that “hysterical symptoms exhibited the conditions of the cultural injury”. (as cited in ?)

The sedative effects of barbiturates were reported to have “long been scientifically understood” as a central nervous system depressant (Wilmer, 1958, p. 92). In the 30’s and 40’s, barbiturates were developed into methods of “deep sleep therapy” or “sleep cures” that would render the patients unconscious for days or weeks on end with no conscious memory of how long they had been asleep (Lopez-Minoz, et al., 2005, Shorter, 1997).

The barbiturate class of drugs include amytal, sodium amytal (truth serum), nembutal, and seconal. The ataractic class of drugs, for instance, Chlopromazine and Reserpine, Wilmer explained as “unlike those of the barbiturates, are not fully understood” (p. 98). Wilmer mostly reserved the use of ataractic drugs for patients’ displaying aggressive, violent, and hyperactive behavior. According to his qualitative observations, the ataractics were helpful for aggressive and hyperactive schizophrenics, manic-depressives in the manic stage, and patients in acute states of delirium. They were observed to have no benefit for non-psychotic or depressed patients (1958, p. 101).
In 1949, there was an emerging neurological theory concerning cycles of wakefulness and alertness known as the Reticular Activating System (RAS) which was later correlated in its dysfunction with schizophrenia, PTSD, Parkinson’s Disease and disruptions of arousal and alterations of sleep-wake cycles (see Magoun, H. (1952). An ascending reticular activating system. *Science*, 272, p. 225-226). This theory was not present in Wilmer’s texts, however, his metaphors of sleep stand out as a regularity in describing the problems with medication.

In addition to attempting to expose the workings of the circular logic of ideological justification, Wilmer also kept meticulous records of drugs that were administered in order to provide an data for testing their effects, thus teasing out the normative claim and making them amenable to empirical testing. An important tenet of a critical social science inquiry is the ability to evaluate and contest validity claims at the level of argumentation through conducting “research into their own practices not just to “perfect” or improve themselves as individuals, but also in the interests of acting rightly in terms of the historical consequences of their action” (Kemmis, 2007, p. 6). In this case, Wilmer’s research on the effects of drugs contradicted the growing belief in the efficacy of pharmaceutical therapy and was thus entering into the arena of public argumentation. The standards used to evaluate their effectiveness were based in empirical observations that contradicted their long term or sustainable calming effects, their relationship to other therapeutic practices, and the practical-normative question of whether or not they are in the best interests of the patient. Accordingly, the criteria for the use of drugs is stated simply as, “When drugs facilitate this process or reinforce its effects, they are a valuable adjunct to therapy; when they have the opposite result, they are worse than useless.” (1958a, p. 91). As a practical research question, he asked only if they helped facilitate socializing processes.

Acknowledging that sometimes patients requested to retreat to the quiet room to withdraw and relieve their own anxiety, he claimed that its use was only truly therapeutic in “rare exceptions”, notably in instances of sanctioned mourning when men needed a place and time to mourn and perform a proper tribute for the loss of friends who died in battle (Wilmer, 1958, p. 120, footnote 2).

For instance, Black’s interactional view of metaphor understands commonplace associations as functioning to organize perceptions of man comparable to a screen (Can’t project a screen) that is “projected upon the field of the subsidiary subject” through implying associations from the principle subject to the subsidiary (1954, p. 288-292).

That the patients in psychiatric wards were literally and figuratively articulated as animals, dangerous, unpredictable creatures, out to kill, in an atmosphere that operates according to “jungle law” is more than merely metaphorically significant. More interesting are reports that claim the patients and the staff came to expect and even enjoy a sense of release after the fight. In an ironic manner, the evidence suggests that collective disturbances were anticipated and expected, perhaps even a ritualistic part of life characteristic of psychiatric wards, furthering implying that these interactions were an integral pattern in the milieu down to symbolic and metaphorical frameworks of jungles, farms, and other comparisons to collectives sites for animals.

On this point, Habermas comments, “It is only under the pressure of approaching problems that relevant components of such background knowledge are torn out of the unquestioned familiarity and brought to consciousness as something in need of being ascertained. It takes an earthquake to make us aware that we had regarded the ground on which we stand as unshakeable” (1987, p. 400).

Intermittent attendees at the meetings included: psychiatric doctors in training, psychiatric technicians conducting field work, Chief of nursing service, the nurse in charge of its in-service training, ethnologist Dr. Gregory Bateson, Dr. William Barrett, President of the American Psychoanalytic Association, Professors from Stanford, such as Jurgen Ruesch, Karl Bowman, and Fleet Admiral Nimitz, retired.

Wilmer writes that the patients “could see from the operations of the ward what was never put into words to them: Patients had a right to dignity and self-respect, and that this right would never be violated in patient-staff relationships on this ward. Their welfare was the paramount consideration” (1958a, p. 21).
Wilmer explains that the community meeting was designed to help the patients’ “solve problems in terms of interpersonal relationships by helping the patient identify himself with a social group and, through identification, to modify his social attitudes because of his growing awareness of his role in relationship to other people” (1958b, p. 880).

Because the interactions in the community meeting were mapped and recorded for the purpose of reflection and analysis in the staff meetings to follow, which were attended by all meeting participants except the patients, then everyone was made aware that they were a part of the observations, recordings, and conversation to follow.


See Habermas, 1999, p. 98.

Chapter 8

As a related intellectual inquiry during this time concerned with related dehumanizing practices, Garfinkel (1956) frames these exclusionary interactions in terms of the impacts of public denunciation result in “the behavior of self-abnegation—disgust, the rejection of further contact with or withdrawal from, and the bodily and symbolic expulsion of the foreign body, as when we cough, blow, gag, vomit, spit, etc.” (p. 421). Articulating that the “paradigm of indignation is a public denunciation”, the degradation of identity is further explained as performed through ritualistic patterns of interaction and exclusive material conditions that involve active processes of social exclusion and alliances (Garfinkel, 1956, p. 420). The shaming element of what he phrased ceremonials mortifications are “found in the withdrawal and covering of the portion of the body that socially defines one’s public appearance” in the “removal of the self from public view” (1956, p. 421). In other words, the public absence simultaneous reveals a shamed presence.

See Julia Kristeva for further explication of the state of “abjection” as life infused with death. “According to Kristeva, the best modern literature (Dostoevsky, Proust, Artaud, Céline, Kafka, etc.) explores the place of the abject, a place where boundaries begin to breakdown, where we are confronted with an archaic space before such linguistic binaries as self/other or subject/object. The transcendent or sublime, for Kristeva, is really our effort to cover over the breakdowns (and subsequent reassertion of boundaries) associated with the abject; and literature is the privileged space for both the sublime and abject: "On close inspection, all literature is probably a version of the apocalypse that seems to me rooted, no matter what its sociohistorical conditions might be, on the fragile border (borderline cases) where identities (subject/object, etc.) do not exist or only barely so—double, fuzzy, heterogeneous, animal, metamorphosed, altered, abject". (1982, p. 207). (Kristeva, J. (1982). Powers of Horror: An Essay on Abjection. Trans. by L. Roudiez. Columbia University Press: NY).

The allegorical form of this story highlights Wilmer’s role as author of the text as well as the allegory as a “representation that ‘interprets’ itself” (Clifford, 1986, p. 99). In contrast to methods of “representing” or “symbolizing” this or that, Clifford identifies the allegory as “a (morally charged) story about that” (p. 100). Associated with the rhetoric of temporality, the allegorical representation according to de Man (1983) highlights allegory as situated within the dialectic of the self and the non-self, subject-object, and shifting of temporal links in meaning (Mirabile, 2012).

Mirabile (2012) contrasts de Man’s allegory with Benjamin’s “baroque allegory” as a form of mourning whose central rhetorical element is a dark pathos. Both of these perspectives, however, shed light on Wilmer’s moral realist discourse about the dark and abjected existence of the institutionalized patient, interpreted as temporally connected to the absence of care or concern.

He adds that the attendants in particular were “still hired without any preliminary training, and without meeting the requirements established by state regulation to ensure maximum fitness... and that they were no more a part of the patient’s day than was John Allen (p. 4).

From Clifford, 1986.
Foucault’s explanation of enunciative modalities asks the question of how the discourse “positions of the subject are also defined by the situation that is possible for him to occupy in relation to the various domain or groups of objects” (1972, p. 52). Foucault uses the examples of what kind of subject is the subject positioned to “be” in relation to the type of information presented. For instance, “according to a certain grid of explicit or implicit interrogations, he is the questioning subject; according to a certain programme of information, he is the listening subject; according to a descriptive type, he is the observing subject” (1972, p. 52).

See Leys (2010) on Freud’s “pathogenic secret” in *Trauma: A Genealogy*.

Referring staff meeting conversations, Wilmer states, “We all learned so much by the process of serendipity—the process of fortunately discovering things that we were not seeking” (1958a, p. 48).

The staff meeting as a “training device” was explained as bringing “order, form, and deeper meaning out of community meeting and gave staff insight into the behavior and the communication of the patients”, which was said to have led to an increase in the “staff’s interest in their work” and a “sense of partnership” with Dr. Wilmer (1958, p. 48).

This term refers to the restroom.

Once the seating arrangement was charted on the blackboard, the meeting was analyzing in “detail, step by step, from the first silence and to the first communication to the closing summary and the ward situation at the close of the meeting” (1958a, p. 47). The subjects and objects on the map were supplemented with almost a complete verbal transcription of the community meeting that then provided the contents of the discussion to follow in sequence, content of spoken messages, who spoke to who (origin and destination). This was recorded by the intern psychologist on the Ward, Dennie Briggs, video, and audio recordings. Some of the meetings were audio and visually taped which were also used in the staff meeting. The chair positions and respective patient positioning were understood as “nonverbal communication”.

Wilmer and Briggs claim this analytic theme emerged organically through observation stating, “In group after group the same type of patient chose the same position so frequently that the staff were soon able predict with considerable accuracy how a new patient would behave by the place which he took in the community meeting” (p. 922). Wilmer recounts that the staff began to name the chair positions according to the patterns of patient behavior who “almost unerringly gravitated towards these particular positions” (p. 922, maybe more).

It was noted that the patients frequently changed positions during the meeting, providing an additional factor in Wilmer’s analysis and interpretation for the patients’ frequency of movement in a meeting and then how other patients altered their movement in relation to others’ movements.

What is notable about the names themselves in association with the act of naming is first the metaphorical themes of death and religious connotations in most of the titles and secondly, the anthropomorphic process of naming an object in light of such “dramatic” and deeply metaphorical symbols. The “Right hand of God”, in addition to its biblical reference, is noted for as a metaphor for the omnipotence of God. In literary theory, the “Right hand of God” is an anthropomorphic expression of exaltation, prestige, power, and honor, through personification of nonhuman entities. Given what I know from my review and reading of Wilmer’s reports, patient case histories, analysis of community meetings, and graphic data, the chair names correspond to some of the episodes in community meetings reported in Wilmer’s of patient behavior described as hallucinations, delusions, rants, and performances of the patients. Many of the names bear an uncanny resemblance to the images and the implied roles. Some of the chair positions, for instance the right hand of god chair and the guest of honor chair were named in relationship to the Dr.’s Chair, respectively to the right and directly facing.

In the case of the preacher’s chair, the position assumed its name from a specific patient, referred to as King, whose talk was characterized as “an irrational, bizarre dissertation on justice and God and evangelical preaching” about things the Secret Police had done. The other patients recognizing the delusional and religious character of King’s speeches commented in response, “He doesn’t make sense” and after the meeting had closed, “Tune in tomorrow and hear Reverand Billy Graham” (p. 182).
An understanding of the “delusional formation” supports this view of schizophrenic imagery. Freud (1911) theorized that “the paranoic builds it again, not more splendid, it is true, but at least so that he can once more live in it. He builds it up by the work of his delusions. The delusional formation, which we take to be the pathological product, is in reality an attempt at recovery, a process of reconstruction. Such a reconstruction after the catastrophe is successful to a greater or lesser extent, but never wholly so; in Schreber's words, there has been a ‘profound internal change’ in the world. But the human subject has recaptured a relation, and often a very intense one, to the people and things in the world, even though the relation is a hostile one now, where formerly it was hopefully affectionate.”

A related methodological and theoretical posturing in the discipline of Communication, identified as “Rhetorics of Display”, specifically focuses inquiry towards how visual, graphic, and symbolic forms of communication intervene in mental maps, patterns in perception, and audience attitudes and dispositions (Prelli, 2006). Central to this rhetorical tradition is the idea that visual communication through the “verbally generated image” is a “culmination of selective processes that constrain the range of possible meaning available to those who encounter them”, furthering explained in terms of how images and maps are used strategically to alter opinions and perception (Prelli, 2006, p. 1-2).

Chapter 12

Shotter describes this epistemology as “a way of knowing which brings to our attention the possible relations—what we might call the “relational dimensions”—existing as a dynamical outcome of the inter-acting of objectively observable phenomenon of which are not in themselves objectively observable...out grasp of such dimensions is only available to use to subjectivity when we appropriately oriented, bodily, toward the phenomenon in question.” (2009, p. 225).