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Review Article

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Containing Trauma: Protecting a Vital Construct from Overuse and Isolation

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Abstract

Trauma has become a central concern in therapeutic and mental health practice. Using Australia as a specific site, this paper examines complications that are emerging in relation to this status. Initially, two general concerns are detailed: first, that trauma presents a changing phenomenology across time and place, and, second, that expansive diagnostic practices may be leading to excessive case-finding. Three major risks are then identified: (i) in certain circumstances a diagnosis of trauma can be disabling; (ii) narrowly technical approaches to treatment can discount the ethical context of trauma, and (iii) the importance of building the client's capacity for trust and connectedness can be mislaid if an overly individualistic vision of treatment and recovery is adopted. Unless an exclusive focus on 'the individual' is contested, and ethical and contextual dimensions are acknowledged, it is argued the above difficulties will tend to compromise how trauma is theorized and treated.

Introduction

Trauma has a central position in current therapeutic and mental health practice. This clinical status finds its echo in the recognition accorded to trauma by host organizations and governance structures – bodies that, in turn, play a key role in determining what takes place in consulting room. For example, to be eligible for state funding, practitioners in non-government organizations (NGOs) in at least one Australian state must demonstrate they provide 'trauma informed' services. A similar situation is present at the federal level where the Australian government mandates that eligibility for refugee status depends on the applicant's capacity to prove that they have experienced trauma. Interestingly, an increasing focus on trauma is also present in public media – in talk shows, news accounts, fiction and biography. Beyond professional and official accounts, it seems trauma has a kind of pivot status in popular culture.

In the professional domain the status of trauma rests on a substantial research base and a compelling clinical relevance. Beyond the knowledge that a history of childhood trauma has a cart-wheeling neuro-biological impact, a range of broader applications testify to the scale of this contribution. Three specific contributions are:

(i) Trans-generational trauma: this concept possesses considerable explanatory power for understanding the experience of first-nations people such as Aboriginal Australians [1].
(ii) Complex post-traumatic stress disorder: by re-framing borderline personality disorder as 'complex post-traumatic stress disorder' a previously castigated clinical sub-group have been de-stigmatized whilst a constructive space has been opened for more empathic forms of understanding and treatment [2-4].
(iii) Broader than the single diagnosis of borderline personality disorder, a 'trauma model of mental disorders' has the potential to theorize a range of presentations, including the psychoses, and to contest the formulation of mental illnesses as narrowly biological in their aetiology [5,6].

Mindful the above is only a small sample of its contribution, in what follows it is argued there is a shadow side to the rise of trauma as a stand-alone focus for analysis and response.

This paper proceeds in four sections. The first section establishes a general critique by summarizing two key points of contention. The paper's second section examines the relationship between a diagnosis of trauma and the possibility this diagnosis may entrain a process that might infirm the trauma sufferer. A third discussion section raises a larger consideration: might particular social and cultural conditions, particularly a narrow conception of the individual, establish a context within which 'trauma talk' is overly promoted? A concluding section argues the importance of belonging and social inclusion in the trauma recovery process. This emphasis was present in early accounts of recovery from, for example, sexual abuse and refugee displacement, but have tended to fall away as a narrower, more technical and individualistic discourse has been emphasized.

The purpose of the current contribution is to complement the well-deserved status accorded to trauma by asking: what social, cultural and personal contexts best support recovery and healing from an experience of trauma? In what follows the intention is to insert a social dimension into the consideration of recovery and healing. The first focus in this four part review is to question the popularity of trauma as both concept and concern.

The general critique

Trauma is a tremendously useful construct, as it also has limits and a potential for misuse. As a beginning point in a general critique,

two themes are developed. The first is not, in itself, a criticism but concerns a particular qualification: it is impossible to describe the phenomenology of trauma prescriptively. A second theme raises the possibility that the diagnosis of trauma is over-generalized as it has been subject to what has been termed 'concept creep' [7,8].

The changing phenomenology of trauma

It is generally contended post-traumatic stress disorder (PTSD) was termed 'shell shock' during and after the First World War. In this example the terminology has obviously changed, but has the experience of PTSD / shell-shock been consistent for, say, Australian soldiers deployed to Iraq and Afghanistan early in the twenty-first century compared to those who served in WW1?

An analogue report offers a suggestive finding. In a high profile project, former president of the U.K.'s Royal College of Psychiatrists, and senior consultant psychiatrist to the British army, examined the case records of 300 First World War veterans who had a recorded diagnosis of shell-shock [9]. In the case notes of those with this diagnosis the researchers noted there was an almost universal record of these men experiencing profound somatic symptoms, e.g. physical shaking, an inability to talk, difficulties with mobility and balance. The researchers also stated that they found only one report of someone who experienced flashbacks. Today, the experience of flashbacks is common (almost ubiquitous) for those with the diagnosis of trauma.

In relation to these findings it would be unreasonable to assume that, out of three hundred, only one individual actually experienced flashbacks. By necessity, case records reflect the interests and prejudices of the interviewer. More, interviewees would be most unlikely to admit to 'going back in time' unless such apparently crazy-talk had been convincingly normalized (which it certainly was not at that time). Nonetheless, that only one out of three hundred files made mention of the experience of flashbacks seems striking. Most likely, as Wessely & Edgar (2005) argue, the internal experience of trauma qualitatively shifted across time and culture.

If the idea is entertained that the lived experience of trauma has shifted – that flashbacks have become more prominent and somatic presentations less so – what might have has caused this change in inner experience? According to Wessely & Edgar a significant influence was the rise of cinema in the post-first world war period where '… many directors used the flashback technique where every day sounds or settings … transport the protagonist back to their time at war.' As McLaughlin argues: '… This cinematic shortcut is now embodied in the lived experience of PTSD sufferers' [10].

Shifting across time and culture, it seems the experience of war takes many forms: in the language of the social sciences, experience is a subject that is said to be 'fungible.' A range of disciplines have investigated this phenomenon:

… medieval historian Kathryn Hurlock notes, while people have returned from war in severe distress throughout history, the development of PTSD, far from being universal, is heavily influenced by culture. She argues that the ancient soldier was a product of his time. He was conditioned to fight with a clearly defined role in a society that deemed killing enemies to be a glorious thing. He was, therefore, better able to cope with the experience of war (ibid: 2018).

In this regard the shape and meaning of experience is not static. Very likely, inner subjectivity is a dynamic product co-constructed between event and context in that a person's experience may be uniquely their own, but how this realm is narrated, interpreted and conducted will vary between cultures, as it also changes within the same culture over time. Humans, it would seem, are indeterminate in how trauma (grief, illness, distress, and so forth) is experienced.

Concept creep

Until recently, trauma was a medical term that pertained to accidental violence (e.g. road trauma), violence that had been deliberately inflicted (e.g. injuries sustained due to 'battlefield trauma') and to the impact of pathogenic physical processes, for example, a non-normative, (that is, misshapen) root may lead to 'dental trauma.' The term was also used as a referent to describe particular roles, such as 'trauma physician', and the specialized field within which such professionals practiced ('trauma medicine'). This genealogy endows the term with substantial dignity and authority.

Today, the term is used more frequently and encountered very broadly. Didn't get that job, relationship breakdown, bad loss in the semi-final? These kinds of everyday losses are now colloquially described using the 'T' word, and no one appears disconcerted if this occurs. There is no surprize here. It is well understood that language is creative and that the practices of social exchange are fluid. Trauma has also become a prominent theme in fiction, non-fiction and the popular media. In these developments it could be said that trauma has found a broadened constituency.

Might the same evolution be occurring in diagnostic practices and, more broadly, in the conceptual vocabulary utilized in health and human services? This is obviously a large question, one that could potentially be addressed empirically. What can be stated is that a number of mainstream researchers claim that the practice definition of trauma has been subject to a process of 'concept creep' [7,8]. Mindful this claim remains unproven, it is to a degree persuasive given a range of drivers – the criteria for service eligibility; agency funding; practitioner focus; client awareness, if not always explicit demand – cohere to place trauma as a key theme in the dialogues that occur in and around practice [11].

This issue is broader than the possibility there might be a degree of professional over-generalization. For example, some expert spokespersons are literally prescribing trauma as a universal diagnosis: 'We all have them (traumatic memories) tucked away in the lower part of our brain, in the cerebellum' as a leading clinical psychologist told his Australia-wide listeners [12]. How do you know you have these past's dark parts? The listener was told that the evidence is in: each time you over-react, or act out of character, this tells you that you have embedded trauma.

As noted earlier, 'trauma' was initially a medical term. This etymology lent the term weight and dignity. This seriousness has, to a significant degree, been retained as the term has been applied beyond its original provenance. If this important legacy is to be preserved beyond the medical sphere the construct has to be protected from over-generalization. If 'trauma talk' becomes faddish, if its use expands into a contagion, much that is of value will be jeopardized. When a potential client meets with you and you ask 'what brings you here?' and this person says 'I am not sure. Maybe, I have got a history of trauma' it is therefore important to tease out the distinctions

between the colloquial, faux-technical and formally diagnostic meanings of the term trauma. Over-reach, over-inclusivity, conflation – these are now everyday risks. The point is this: in so much as there is diagnostic over-generalization, this process will tend to de-vitalize trauma as a viable concept.

A diagnosis of trauma can invalidate

Being given a diagnosis can have a progressive and regressive moment. For example, it can be enormously reassuring to be told 'you have depression' when you had been thinking 'I am just such a useless no-hoper.' Notwithstanding this advantage, 'the diagnosis, the assessment, (can) … become the cornerstone of an emergent identity' [13]. Might this latter idea be relevant to those with a diagnosis of trauma?

In a recent book Tanveer Ahmed, a Bangladeshi-born, western Sydney-based psychiatrist presented details of his work with a re-settled Afghani migrant. This man had experienced multiple traumas during the 50 year-long tragedy that is the immediate history of his country. According to Ahmed, this man had coped remarkably well until he internalised his PTSD diagnosis, a turn that occurred while he was being therapeutically socialised to become more reflective and emotionally literate. Ahmed concluded that the '(PTSD) diagnosis became his identity and rendered him psychologically disabled [14].'

Rather than the therapeutic process providing relief and greater options, in this (and other cases) Ahmed describes an inadvertent process where persons can be infirmed by their diagnosis. This process of invalidation is familiar to anyone who has witnessed the existential struggle many young people experience when told 'you have schizophrenia' by an authority. Such events are powerful ceremonies, rituals of transformation, which can inadvertently disrupt and engulf – mindful that being given a diagnosis can also have a helpful impact: I don't need to blame myself anymore. *I have PTSD: that's why I struggle with my emotions and behaviour*.

When it comes to diagnoses there is almost always an unstable relationship between advantages and disadvantages. Nikolas Rose put it this way:
(*T*)*he psychotherapies embody … a whole way of seeing and understanding ourselves in modern societies. The words of the psychotherapies, their explanations, their types of judgment, their categories of pathology and normality, actually shape, have a proactive role in shaping, the subjectivity of those who would be their consumers [15]*.

Like mental health practice, the psychotherapies are not neutral. As Rose argues, a program of psycho-education involves a process of re-socialization and, to a degree, identity re-definition. In recognizing this effect it is possible to know there is an inevitably an unstable relationship between 'case finding' and what the philosopher Ian Hacking has termed 'people-making' [16].

Even for the so-called worried well, this process can be subtle, albeit implicitly powerful. For example, if a patient has been convinced by their practitioner (and/or by the media) that when they become upset, when they act 'out of character' to use the words of the public expert referred to earlier, this points to the presence of embedded trauma this has the potential to alter how everyday events are interpreted. *Hey, I over-reacted because I suffer from de-regulation*. Rather than stress the importance of perseverance, context or ethical responsibility, a different kind of theme is placed at the centre of awareness.

Ahmet offered the following summary:
PTSD is increasingly a synonym for experiencing adversity, measured subjectively, whereas the original meaning of trauma referred to unexpected, life threatening circumstances that overwhelmed our coping response. … PTSD is now an important cultural narrative to process suffering [14].

To those who are very seriously struggling, to those with histories that have wounded and maimed, much is offered by a diagnosis of trauma. And, there are risks if this marker of identity comes to inadvertently totalise subjectivity in ways that discount the person's prospective, as well as here-and-now, sense of agency.

For example, a street outreach program might make contact with Brodie, a 40 year old with a long history of institutions and primary homelessness. If this man comes to understand that a history of multiple trauma leaves the sufferer with a chromic impairment, there is the risk that Brodie might think the problem is – to use his colloquial expression – 'brainal': *Hey, not only am I a junked-up prison loser, these know-alls are telling me that my wiring has been screwed up. Wow, I guess that makes me a chronic certified neuro*.' However well-intentioned, programs that, and practitioners who, are geared to be trauma-centred have the potential to leave unwanted, as well as preferred, legacies.

The ethical and ideological context of trauma

Martin Seligman, ex-president of the American Psychological Association, informed Australia's Radio National listeners that his research has proven U.S. military drill sergeants are wonderfully adept at inculcating new recruits into the constructive mindset that is positive psychology. If these junior soldiers internalize the correct system of thinking, Professor Seligman assured *Breakfast's* Fran Kelly, this course of instruction minimizes the risk of these soldiers returning home to the USA traumatized from their placements in Iraq and Afghanistan. Further, if these recruits are able to master the right regime of thought it follows that a good proportion of these young fighters will be able to thrive, to actually benefit from, the difficult experiences that are encountered in these dangerously challenging places [17].

In Seligman's opinion it is a technical matter if soldiers fighting in foreign wars suffer, or do not suffer, PTSD. Given this disposition, the issue needs to be dispassionately approached without questions of ethics encroaching on, and therefore clouding, practicl thought. This position can be contrasted with the view put forward by Michael White, an Australian narrative therapist, when he was asked to comment on the effect on Western soldiers of fighting in wars beyond their own borders in circumstances where these soldiers were seen by locals as outsiders, even invaders, who did not understand, or have the right to participate in, local conflicts.

Western soldiers in this position, White contended, witnessed horrors in relation to which there was an inevitable moral dimension. Rather than filleting these encounters of their moral quality, White contended these soldiers tended to experience what he termed 'violated compassion' [18]. Given this view, it would be anathema to seek to do what Seligman wants to achieve: to inoculate those who are sent to wars where they witness, and engage in, violent acts as if these wars had no conflictual ethical or ideological dimensions.

Separate to Seligman's assertion that effective technical support is available to allied troops to prevent post-traumatic stress disorder (PSTD) – a contention that can be used to maintain the view that 'our' involvement in these difficult wars is tenable – there is also the possibility that PTSD itself is *not* best understood as a private dysfunction. For example, an ethically charged dimension is introduced if it is acknowledged that troops are being sent to undertake a contentious purpose. In this event PTSD needs to be understood as a mediated phenomenon – as a phenomenon that emerged within a particular, and highly contentious, context of meaning. According to leading researcher and practitioner Bruce Perry, the circumstances within which an event occurs can make a crucial difference in that this setting prescribes a context of meaning [19]. Childhood traumas where trust has been violated, for example, offer a different context of meaning to, say, that of a lightning strike or a natural disaster like a tsunami. Other variables, such as age and previous experience of trauma, the degree of social connectedness and personal disposition, are also important to the prospects of trauma and recovery.

The premise that de-politicized, de-contextualized notions of trauma need to be questioned is entirely consistent with the history of the concept. According to a prominent trauma researcher one of the important early descriptions of PTSD was published in *The New York Times* by a psychoanalyst – Dr. Chaim Shatan – in 1972. His argument was that Vietnam veterans were disturbed, at least in part, because they believed they had been

"*deceived, used and betrayed" by a combination of the military, the government and society at large. Shatan alluded to the veterans rage but did not suggest this was a particular reaction to life-threatening battlefield encounters, He described it as what "follows naturally from the awareness of being ... duped and manipulated*"[as quoted by Ahmed 14].

At a second level, there was a progressive aspect to the idea that war veterans might experience PTSD beyond the question of feelings of manipulation and official betrayal. This aspect concerned the shift from questioning the soldier's moral worth to a focus on the disturbing character of combat itself [20]. This revision was progressive with respect to the traditional military attitude of regarding soldiers reporting 'nervous symptoms' as evidence of transgression – that these people lacked character and were behaving in a cowardly, even insubordinate, manner: see Dean [21].

For good and bad, with respect to military settings a technical understanding of trauma has tended to prevail. This ascendancy can be critiqued in terms of cultural imperialism. For example, in a review of *Crazy like us*: *The globalization of the American psyche* the following is put forward as a concluding comment [22].

… the pervasive influence of American psychiatric thinking is easily regarded as pernicious—in particular if it is a poor fit with the experiential world of non-American patients [23].

A strong case can be made that PTSD should not be represented as a straightforward private dysfunction. At the least, PTSD needs to be recognized as a meaning-laden, mediated phenomena. This is easier to recognize where, for example, troops are despatched to a foreign country to execute a dangerous mission for a purpose that is politically and morally contested, mindful this nature is also present to a degree in some examples of 'everyday' trauma.

If, as Perry contends, the circumstances within which a traumatic event occur are crucial in how this experience is embedded, this has implications for how it might be resolved. These circumstances, he argues, prescribe a context of meaning that conditions interpretation, effects and future possibilities. For example, in infant experiences of trauma where trust has been traduced, this dictates a framework of meaning which fundamentally differs from, say, that of a natural event such as an earthquake or a flood. Additional variables, such as temperament and previous experience of trauma, are also relevant. These and other differences acknowledged, it is the complex matrix of meanings within which trauma is embedded that constitute its ethical and ideological context. This context retreats, even disappears, from view in approaches that simply psychologize.

To psychologize is 'to explain or interpret in psychological terms.' Such explanations attribute primacy to the psychological in preference to, say, the contextual and the ethical. Mindful it is more complex than it seems – 'the psychological' can be defined in more than a dozen mutually incompatible ways: the behavioural; the intra-psychic; the transpersonal; the neuro-biological, etc. - it is problematic if the psychological perspective is accorded dominance. Suffice to say, if justice, the external environment, and more, is excluded from consideration the tendency will be to expect there can be private, technical and a-contextual solutions to whatever is presented [24].

An allegoric vignette illustrates this point. Franz Fanon, a psychotherapist working in Algeria during this country's violent war of independence, is said to have become so frustrated with his lack of progress with a patient who experienced panic, suicidal thoughts and what we now refer to as flashbacks that he felt compelled to break with psychoanalytic protocol. *He has attended regularly for a long period; my technique is sound, my knowledge too*, Fanon fumed. Aware it was technically incorrect, Fanon asked his patient what he did for a living. The man replied: 'I am a torturer' [25]. As noted earlier, trauma always has a context.

The role of connectedness in the recovery process

Trauma currently attracts significant interest across disparate fields of practice. For example, in the field of homelessness there is considerable interest in the fact that many who experience long-term homelessness have had histories of disrupted connection that were characterized by neglect and/or abuse from those who were their assigned guardians. Far worse than primary relationships that failed to be 'good enough', to recycle Donald Winnicott's famous phrase, many of these people are also understood to have had violated backgrounds in institutions and have pathogenic leaving care histories.

Narrowly read, this formulation incites a particular kind of query: for those who have experienced trauma is there a class of intervention that has a practical claim to effectiveness? In this consideration a suite of solutions have been presented. These methods claim to be effective in re-adjusting individuals who are deemed to have faults in self-regulation, hyper-arousal, and so forth. Amongst a larger group, EMDR (Eye movement desensitization and reprocessing), 'tapping' / EFT (Emotional Freedom Techniques), 'havening' or, slightly broader in their provenance, cognitive behavioural therapy, mindfulness and positive psychology have been presented as candidate prescriptions. Such 'therapo-centric' interventions have a siren-like appeal [24]. Mindful of this charm, in so much as the

aim is recovery and healing – rather than symptom minimization or control – it is likely that technique plays a significant role without this input being sufficient. This is especially the case if the understanding of recovery is one that embraces the importance of context and belonging. Simply put, there is a degree of tension between more collectivist and more individualistic visons of recovery.

Initially, recovery was understood as a significantly interpersonal project. For example, Patricia Deegan, a foundational thinker in the recovery movement, stated:
… the aspiration to live, work and love in a community in which one makes a significant contribution' is inherent to the possibility of recovery [as quoted in 26].

Another early contributor argued that a pre-condition for recovery was 'the creation of new connections' – 'capacities for trust … and intimacy' that those who have suffered abuse require in order to complement the 'autonomy, initiative, competence (and) identity' dimensions that also have to be re-forged [27].

This principle transcends boundaries between practice fields, for example between intellectual disability and practice with asylum seekers [28, 29]. Commenting on those who have suffered severe dislocation and deprivation, violence and anxiety, as refugees Van der Veer argues that these 'traumatized people are those who don't have a social network and … the primary objective (of recovery work) should be to build up social connections.' Reciprocal attachments and a sense of belonging are central to the prospects for people successfully achieving recovery and social inclusion [30].

How recovery is conceptualized determines how practice is conducted. How might this issue be investigated? In a meta-analysis Burgess et al. identified and reviewed a total of twenty-two recovery measures. In a detailed assessment of these measures eight were singled out as illustrative of 'best practice.' Forty-eight 'domains' / 'areas' were then isolated as key categories in these measures. For the current purpose, it is especially noteworthy that only three from this group of forty-eight presented a focus on any aspect related to belonging and social connectedness. What is even more striking is that Burgess and his associates did not find this was a noteworthy finding even though they had earlier quoted Deegan as saying 'the aspiration to live, work and love in a community in which one makes a significant contribution' is inherent to the possibility of recovery' (Deegan, op. cit.).

It is not far-fetched to suggest that, in effect, these researchers are unconsciously biased. That is, in not dignifying the primacy of belonging and connection, their work is typical of a practice and research milieu that reproduces the individualizing culture their thinking inadvertently represents. It is a stubborn fact that the quality of a client's relational base is a variable that is often marginalized, or completely falls off the radar, for researchers despite an occasional espousal of its importance and the value that is placed on intimate social connection by consumers. More recently, there are signs that a more social and collectivist approach to recovery might be emerging: see, for example, Price-Robertson, Obradovic & Morgan's emblematic contribution *Relational recovery: beyond individualism in the recovery approach* [31].

If the focus is shifted from the field of mental health to that of sexual abuse the same pattern emerges. More broadly still, irrespective of whether the client is a refugee or a drug using person experiencing homelessness, someone who is elderly and ill or able-bodied but unemployed, Deegan's lived experience resonates. As Sandra Pankhurst, the multi-traumatized woman who is the central character of Sarah Krasnostein's *The trauma cleaner* says: 'the opposite of trauma is belonging.' (Pankhurst is also quoted as having said 'the opposite of trauma is order' which is also a powerful idea). The importance of belonging, meaning and history can be glimpsed if one considers the appropriateness of imposing psychologizing forms of treatment on aboriginal people suffering 'trans-generational trauma' [1]. Dispossession and colonization have deeply meaningful, cart-wheeling effects. To frame these effects as symptoms-to-be-treated is violent given this imposition reproduces similar injustices to those that caused the initial harm.

Personal relationships have, until recently, been accorded a marginal status in the thinking that fundamentally informs health and welfare practice. This is worrying, but it is not unexpected given the power that the process of individualization possesses in so-called developed nations [32-34]. In a context where isolation and loneliness are on the rise, it behoves practitioners to prompt connection and accountability rather than self-preoccupation [35,36]. Several schematic suggestions that oppose the tendency to atomize are set out below.

In so much as the practitioner is committed to supporting the client's '… aspiration to live, work and love in a community in which one makes a significant contribution' (Deegan, op cit.) many possibilities arise. In the present paper it is not possible to concretize these options, mindful one important contribution deserves particular mention.

McIlwaine & O'Sullivan offer an analysis, and a number of poignant vignettes that illustrate, the importance of establishing connectedness between participants in work in and around trauma [37]. Building connection, these authors contend, is not work which is achievable if it centres on the primary client alone. One may be able to work systemically with individuals, but it is likely that the skills to, and motivation for, creatively convening meetings between significant-others, and being able to conjointly conduct such sessions, will also be important.

That the agenda involves trust-building, rather than the passive receipt of expert technique, imposes an interest in relationships – past, present and those that might develop in the future. Graduated progress can be made by setting goals that are designed to focus on, and build, trust in so much as the practitioner has a positive disposition towards the possibilities that might exist in one, or more, of these classes of relationship. Clearly, if expectations around safety have been curdled by past experiences this process is, at best, steeply challenging. Asking the right kind of field-opening questions is one way of expressing this kind of creativity: 'Jess. can you think of one person you know you might say "can I sit next to you?" on the bus after school today? What about that girl you said smiled at you last week, what did you say her name was?' Keeping an eye open for exceptions to a negative generalization, like timing and persistence, is always useful.

Getting a rolling dialogue going about relationships is also likely to be advantageous. For example, feeling free to introduce, and to engage in some back-and-forth, with questions such as:

- can you trust people who don't have similar life experiences to yourself?
- if someone reminds you of someone you don't like, how might you try and get over that prejudice?
- done thoughtfully, is it OK to give another person feedback about how their actions affected you?
- Are you 'thingy' about friendships and romance? For example, do tend to 'get out first' so you can't be rejected?

Themes can be built up, experiments trailed and touchy situations, as well as progress, plotted: see, for example, the broad list of ideas and practical exercises in Furlong. Broadly, the commitment involves seeking to resolve trauma and its sequaelae in such a way as to build the client's relational base [35]. 'Attitudes determine practice,'so remaining reflectively positive about the prospects that are inherent in good quality relationships is a pre-condition [38].

Discussion: From the margin to the mainstream

Humans are porous. We do not stop at our skin or talk in a private language. In this condition our thoughts are not ours alone. This means that our iinner life is both elemental and mediated. Each human's experience may be uniquely their own, but how this realm is narrated, interpreted and conducted – how grief, illness, distress or isolation is lived – varies between cultures, as it also changes within the same culture over time.

Currently, the vocabulary of mental health is increasingly used to name, make sense of, and guide inner life in the so-called first-world settings:

I don't feel good. It just feels so hard. Could be I am not well, kind of out-of-order. Hey, X (social media; television; VicHealth, etc.) is saying to everybody that 1-in-4 people have, or will have, a mental health issue. Could be I've got depression? What about OCD, or burn-out, or anxiety, or some kind of phobia? I find I get out-of-it sometimes, and I do like a drink. Could be I'm brewing an addiction, or maybe I'm in denial about having an eating disorder. Come to think of it, I don't get relationships, so maybe I am on the spectrum. Hang on, what about trauma? Just everybody is talking about it.

This kind of reverie would have been uncommon a generation ago. Two generations ago it would have been, and it would have been regarded as, highly irregular. Today, such a dialogue is a normalized occurrence. Rather than personal discomfort being understood as the result of the everyday problems of living – the age-old idea that life has its ups-and-downs – we are now prone to privatize our troubles and accord them a medical provenance [39].

If a person looks over their own test reports – for example, if you see your own MMPI results – it is unlikely you will find no indications of pathology. Suffice to say, there are advantages and disadvantages in using a conceptual vocabulary that is medicalized to interpret human experience and conduct. A person's subjectivity may be highly troubled, but identity and experience risk being colonized in so much as a medical vocabulary is employed to navigate and moor inner life. It follows that the powerful advantages conferred if practitioners are trauma-informed can be acknowledged without a trauma-lens pre-occupying policy and practice thinking. In so much as such a colonization might occur, discontinuities will arise between person and context. This may be a particular risk if too great an attention is given to the person as a stand-alone entity. Analogously put, this might be likened to providing swimming lessons when the river has run dry.

Conclusion

A focus on trauma is increasingly present in popular culture and the media. For example, readers of a high quality Australian newspaper were recently presented with featured reviews of two works whose key theme was trauma. The first review in this double-page spread – of A. S. Patric's *Atlantic black* – was commended as a fictionalized account of 'the impact of trauma'; the second feature – a review of Sarah Krasnostein's *The trauma cleaner* – was held to be a moving, and highly graphic, account of a woman whose inspiring life reflected the book's title (The Age Spectrum, 28.10.17: 18-19).

More generally, trauma is a construct that is now frequently cited in Australia's everyday media. Two recent examples were:

A mother says she and her young daughter are traumatized after opening a packet of Sponge Bob Square Pants biscuits … and finding a dead mouse inside (The Age, 20.07.2017: 8).

Mr (James) Packer, who is known to have suffered from depression and anxiety for many years has just emerged from a particularly traumatic (business) patch (The Age, 26.03.2018: 9)

Given this kind of media usage it is no surprise that trauma-talk has gone beyond professional and official accounts and has entered the subjective experience of normal citizens. That this trend may be inclining citizens to frame their difficulties and disappointments, travails and challenges, with reference to trauma is a troubling possibility. This possibility is the more worrying in so much as trauma is universalized as a condition of human life. As Bourdieu observed many years ago 'it is all too easy to slip from your model of reality into the reality of your model' [38]. A degree of distress and disturbance is part of life. It follows that the notations of trauma do not necessarily offer an appropriate register for narrating inner experience.

A second level of concern is present with respect to the growing interest in techniques for treating trauma as a circumscribed personal problem. To a striking degree, this interest is an epi-phenomena as it represents a deeper formulation: the premise that it is 'the individual' (and their defects) that is at issue. Expressed as an abstract proposition, this premise holds that the individual is an isolated locus of concern – a stand-alone atom within which problems develop, and the location where defects are to be resolved. Unfortunately, the consequence of this view is that 'the social' tends to disappear as the capacity to recognize the influence of this realm is inversely proportional to the priority given to individualistic explanations.

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