The capture, framing and reframing of trauma

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How we name what is unbearable. Intolerable.
How we name it together.
How we name breadth and curiosity.
How we hear each other.
How we make connections.
Not self-doubting our reactions. Not just the I me.
Not internalised…
What we might stand strong in refusing together.
What we might stand strong in demanding together.

(Fannen, 2021, p. 64-65)

The conversation around trauma has exponentially expounded in modern society. It is a term defined as, “The lasting emotional response that often results from living through a distressing event.” (Camh, 2023) Mainstream mental health research has spoken of increasingly recognising the severity and impact of trauma, and, as such, the popularity of terms such as ‘trauma-informed,’ have become widespread.

Initially, this may be construed as a predominantly positive development. Kathryn. A. Becker-Blease (2017) states that as so many trauma victims and survivors have had their experiences denied in various settings, trauma-informed models carry incredible potential for good. However, she also stresses the need to stay vigilant of what “trauma-informed” resembles as its popularity escalates, who continues to define it, and how this definition impacts survivors today. Trauma is inexplicably connected with not only mental illness, but with power and systemic inequities. Its effects and cause for consequent behaviours and coping mechanisms have been repeatedly weaponised by psychiatry to diagnose, medicate and retraumatise individuals.

Additionally, the widespread conceptual capture and conversation on trauma within a neoliberal hegemony has remained very individualistic. Lisa Fannen contends, “There can be a strong focus on ‘transforming your life’ and ‘healing from trauma’ which does not tend to come overtly interlinked with how we also need to transform and heal the relational world we live in.” (2021, p.132) Neoliberal governments have situated trauma as personal strife to overcome instead of acknowledging social and collective trauma as symptomatic of

systemic and structural inequities and failures which must be challenged and dismantled.

Consequently, many trauma-informed models have been increasingly co-opted and commodified to maintain a paternalistic and capitalist agenda. I hope to focus and cast light upon what I call the practice of insidious omission and manipulation apparent in the widespread framing of trauma, where systemic and social injustices fail to be fully acknowledged or addressed both within the neoliberal government and psychiatry. The necessary reframing of trauma must acknowledge these power discrepancies and the insidiousness of neoliberalism's choice to turn a blind eye. I believe it is worthwhile for the Mad Movement to be conscious of how trauma-informed narratives operate and consider how we may be empowered to reframe the trauma discourse and collectively mobilise for active and radical societal change and betterment.

In the last two years, the Scottish government (Scottish Government, 2021) has developed their own trauma-informed toolkit which outlines five key principles designed to aid all workforce sectors with developing trauma-informed services: Safety, Trustworthiness, Choice, Collaboration and Empowerment. Within the toolkit we can identify an emphasis on what Becker-Blease (2017) calls "individual pathology" whereby efforts by those in power are made to try to contain an individual's trauma symptoms rather than attempt to address steadily preserved systemic injustices and inequities which are catalysts for trauma. We can see the insidious omission of acknowledging the connections between the wider context and the service user and therefore, the toolkit's focus is to ensure individuals stay adapted within the current system.

For example, one of the government's key principles discusses the importance of service users having "meaningful choice" which can address "power imbalances" and give people, "a voice in the decision making." These choices are mostly concerned with the physical environment of organisations (decor, colour scheme, furnishings etc.) and communication and protocol with staff, which gives service users a sort of oxymoronic stringent autonomy. Their choices can influence these spaces but there is no chance to engage with policy makers and those in power to address wider societal discrepancies and inequities. In this way, the service users' input remains incredibly surface level.

The toolkit aims to control trauma symptoms, and normal responses of distress to adversity have been consequently pathologised and individuals are led to believe that the problem is located in their minds instead of a broken and sick system. A system which does nothing to acknowledge or unpack the trauma which exists due to wider societal prejudices and inequalities; the racism that persists, oppression of women, mistreatment of minority groups, poverty, homelessness, class warfare etc. The trauma endured can lead to individuals feeling as if they have no choice but to seek a diagnosis and medication to help them cope.

However, as psychiatric survivor Beth Filson states, “The thorough medicalisation of distress that has taken place since the 60’s, along with the emergence of psychopharmaceuticals, has resulted in severing people in extreme distress from the social, political and interpersonal contexts that so profoundly shape who we are.” (2016, p. 21) It is in the neoliberal government and capitalism’s favour that a focus on the idea of individual ‘recovery’ from mental illness and trauma take the forefront, as this can ensure the continuation of a productive society and one that continues to exist within the hegemonic power structure without complaint.

Services designed to aid survivors can also result in retraumatising practices. Zofia Rubinsztajn discusses anti-violence projects using psychiatric material in order to “gain greater professional competence in dealing with ‘difficult’ women.” (2016, p.130) However this results in a loss of understanding and an approach which signposts to a disorder, rather than recognising the social contexts of these women and the violence they have endured which has shaped their perception of the world. She warns of the rigid strictness and rules implemented in some of these spaces, how they are reminiscent of psychiatric services, and how there is a risk of enacting the same harm on these service users under the guise of another name.

Similarly, trauma-informed prisons have also emerged, however, there have been concerns that once again these hone in on individual vulnerabilities within the lives of those within the prison system as opposed to exploring and challenging vulnerabilities which have emerged out of systemic injustices (Malloch, 2017). Thus, such trauma-informed practices initially appear helpful but can be seen to just be another means to label and diagnose people and do

nothing to change or better the situations of the people within these spaces. Once again, we notice this paradigm of individualistic discourse and a refusal to actively engage with and encourage societal change.

We can identify insidious omission in mainstream mental health narratives on trauma through the ACE study (1998), which focuses on childhood trauma but neglects acknowledging structural traumas, such as racism. Morag Treanor, (2019) who has conducted extensive equalities research to explore socioeconomic inequalities, critiques the ACE framework and what aspects it leaves out. She provides a non-exhaustive list of adversities not acknowledged, including homelessness, loss of benefits, racism and refugee and asylum-seeking children, whilst noting that many of the ACEs not included could be aided by government intervention.

She also discusses the fact that the original ACE study fails to acknowledge societal disadvantages and cultural differences as the study focused on a group of white and middle-class people. Despite the fact that children and families living in poverty experience trauma and strife, ACE maintains that adversity in a child's younger years will go on to cause poverty. They fail to analyse the far-reaching implications of socioeconomic inequity and instead there is an emphasis on parents raising their children to navigate these failing contexts instead of calling upon the state to address the systemic failings which have led to such trauma.

Again, we see the individualising paradigm of trauma where individuals are encouraged to adapt around and accept the systemic inequities which characterise their existences. By positing that ACEs "lead to poverty, rather than be a consequence or manifestation of it," (2019, no pagination) pressure is put back onto families, parents and individuals to mitigate the effects of an unjust system. Furthermore, the popularity of the study in politics is not surprising as it offers a conception of trauma which does not hold governments accountable, but rather those who are floundering within the system.

The Power Threat Meaning framework emerged as an alternative theory towards mental suffering and trauma (2018). Developed with the help of psychiatric survivors, its intention is to pay attention to how people can experience power in various forms, how this power can be construed as a threat,

and how individuals try to make sense of these discrepancies. Fannen (2021) details what the PTMF offers and acknowledges its intentions and method. It is difficult to determine where she stands on the merits of the framework as she does not discuss any concerns over its method and seems to find it favourable but concurrently, she does not explicitly endorse it. I feel that her lack of evident opinion on the framework is confusing given her extensive coverage on trauma within *Warp & Weft*, which focuses on psycho-emotional health.

Conversely, Diana Rose voices her concerns by stating that despite the input of survivor knowledge into the framework's formulation, "all those involved were white." (2022, p. 291) and she points to the paradigm of white professionals once more dictating the program. Additionally, she points out that issues such as structural racism are not discussed and the emphasis on child sexual abuse leads some survivors to feel ostracised when they have discussed different but comparatively severe traumas. I would agree that the framework can provide an advantageous alternative to psychiatric discourse and its social justice slant and conception with the aid of survivors is important and useful.

However, as Rose highlights, there are limitations to its formulation and it should not be viewed as the panacea for discussing trauma. By utilising new methodologies to collate survivor input and continuously and robustly analysing the scope of what such frameworks represent, this could ensure that the PTMF, ACE study and other similar models remain malleable and adaptable to evolve with collective voices.

Within neoliberal society's approach to trauma-informed services, there has been an increase in privatisation and services which are inaccessible to many. Waiting lists for free treatment can leave people without support for months to well over a year, as I have experienced myself. Therapy and counselling is commonly recommended, however, these can be very costly and many simply do not have the finances to afford such aid. As Fannen asserts, "A lot of the current information and/or therapeutic support also costs money; trauma in that sense has been commodified. You could say that there is now a kind of trauma-industrial-complex." (2021, p.132)

As for the services available to those who eventually reach the top of the waiting list, there is an individualistic emphasis. I attended one such course

named ‘Decider Skills’ which had a particular focus on the increasingly popular concepts of “resilience” and “self-regulation.” However, both these terms place responsibility within the individual and advocate a need for the individual to control themselves enough to stay adapted within the current system.

Fannen (2021) goes on to discuss how the idea of regulating oneself can feel like the system demanding that you maintain enough of a sense of control so that you can continue to exist within a productive capitalist society as well as behave in a manner deemed ‘socially fit’. She also notes that a lot of trauma-informed care focuses on trauma symptoms and so cognitive behaviour therapy practices are adopted. My issue with Decider Skills was that the method utilised was to teach people ways to adapt and mould themselves to continue coping within society instead of questioning their social contexts and the systemic injustices interlinked with their trauma. In this sense, the resilience that is advocated becomes a strategy to numb individuals to societal injustices. For many, this approach to trauma is not tenable, however, if one is to reject the service on offer then they can be made to feel ungrateful to not comply with this approach, especially as waiting lists are so incredibly long. Thus, traumatised individuals increasingly feel pathologised, disconnected and helpless.

We can further identify the compulsion of individualisation within other veins of healthcare; concepts of person-centred practice have increased in popularity. However, there is a concern that once again the individualised approach lacks ability to address wider reaching societal issues which impact individuals. Pulvirenti, McMillan and Lawn state, “PCC approaches are, not surprisingly, focussed on the individual, whereas empowerment, especially within the context of health promotion, gives centrality to the social environment the individual lives within it.” (2014, no pagination) The article addresses concerns that PCC approaches have limitations for empowering tangible social change. By focusing predominantly on the individual and lacking insight into their social context and its hindering factors, the approach can arguably once again be seen as a practice in guiding the individual to adapt themselves to the systemic injustices which characterise their lives. However, by reconfiguring such practices within a social justice and human rights-based approach, and looking to the wider community as opposed to just the individual, there would be the ability to address structural barriers and social inequities.

The article, ‘A paradigm shift: relationships in trauma-informed mental health services,’ (Sweeney et al, 2018) is authored by trauma survivors and service providers and provides research and testimony from service users. The authors speak of the risk of over- medicalising natural human distress to high adversity. Factors such as racism, political turmoil and poverty can lead to immense distress. Indeed, the articles cites that the latest UK Adult Psychiatric Morbidity Survey (NHS, 2016) found that, among people receiving Employment and Support Allowance, nearly half had attempted suicide. The authors offer their own view of how the current mental health system acknowledges trauma and speak of how it can conceptualise behaviours and distress as symptoms of mental disorders, rather than view them as coping mechanisms utilised as a response to trauma, and, “as a consequence, responses to people in extreme distress can be unhelpful and even (re)traumatising.” (2018, no pagination)

The article includes testimony from survivors which illuminates the pervading feeling of formal and insidious coercion” powerlessness and distress felt when using mental health services, which in turn can lead to people feeling fearful and reluctant to seek help. The article concludes with discussing how the current mental health system can adopt improved models to acknowledge and tackle trauma, and furthermore, “Recognise and address power imbalances that prevent mutuality, collaboration and choice, and consequently prevent survivors from engaging with services.” (2018, no pagination)

As we move forward with our reframing of trauma, there is the vital importance of including the voices of those who are survivors of the mainstream mental health system. Consumer academic Cath Roper states, “Consumers often bring the knowledge and expertise they have acquired from their experiences to inform their work- experiences that are often underlaid by a significant trauma background. Many consumers also experience ‘sanctuary harm’ - that is, trauma that has been induced by iatrogenic service use.” (Roper, p.204) The collaboration of voices and shared experiences can find paradigms and commonalities which, in turn, can indicate the challenging, dismantling and reconfiguring needed in society.

Miranda Fricker defines hermeneutical injustice like so: “The injustice of having some significant area of one's social experience obscured from collective understanding owing to persistent and wide-ranging hermeneutical

marginalization." (Fricker, 2007) I believe hermeneutical injustice is prevalent in psychiatry and can lead to the retraumatisation of individuals. This speaks to my own experience of being diagnosed with Borderline Personality Disorder when I was in the process of trying to make sense of why sometimes an acute avalanche of pain and fear would overcome me to such an extent that it would leave me mentally paralysed. Instead of having the resources to interpret that these episodes were borne from a previous past of abuse and terror within my social context, I was informed that I was "disordered" and, in my mind, that only allowed me to interpret my inexperience in a way which concluded that not only was my personality, the very fibre of my essence, faulty, but also that I was inherently broken. It was up to me to put back the pieces together privately instead of realising that my experience had shared commonalities and patterns with so many other individuals. There was no counternarrative to suggest that our distress was actually a natural response to our experiences, and it was not pharmaceutical drugs and labelling which were needed, but a model which listened, acknowledged, reframed and looked for new ways to aid and remedy our distress.

Additionally, one which acknowledged that my situation was just one of many casualties caused by a larger epidemic of abuse. Instead, our states were pathologised and we fell prey to the narrative of hermeneutical injustice and psychiatry's dominant framing of our trauma.

The conversation and scope of trauma and analysis of trauma-informed services demands far more exploration than this paper offers, however, I hope to have scrutinised an example of the capture and framing of trauma within the neoliberal government and psychiatry and the insidious omission prevalent within dominant narratives. The necessity to be vigilant over what 'trauma-informed' constitutes is evident and there is a need to recalibrate the mainstream's framing of trauma and the services available. On trauma-informed approaches, Sweeney et al (2018) remark that these should be "a process of organisational change" which seeks to foster healthy relationships through creating supportive and healing environments.

Furthermore, staff should be mindful of intersectionalities and the inequities of social contexts when operating under a trauma-informed lens. We can also draw from researcher T.S. Goetze's (2018) concept of hermeneutical dissent to find

new means to interpret and acknowledge the distress we feel. He acknowledges that despite the dominant hegemony of mainstream interpretations, groups do look for alternative ways to build knowledge and interpret experiences. Unfortunately, these alternatives may be rejected by others who fail to grasp our interpretations but mobilising for radical change must be a collective activity and there is the need to fight "hermeneutical marginalisation through activism and advocacy." (2018, p.14)

Of course, there are many questions to consider: how can we individually and collectively recover from a sick society? Does the idea of 'resilience' spoon fed by the neoliberal government mean to accept the status quo and doom ourselves to infinitely pick our way through a thicket of thorns? Or can we mobilise together to build the hatchet which can begin to cut down those suffocating stalks? Can we create a long-lasting shift away from the biomedical hegemony's framing of trauma and practice of insidious omission? Lastly, who are our true allies in this battle, and can we find methods to ensure survivor-led grassroots movements are not co-opted and commodified by those who claim to help our cause?

Reframing trauma will take shape in many spaces and the models and narratives we utilise should not be homogenous, nor ossified. I believe that by mobilising collectively and developing spaces to nurture these complex conversations, we will be increasingly able to identify and communicate shared injustices and evolve strategies to dismantle the dominant paradigms which oppress our humanity.

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