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The Untenable Subjectivity of PTSD: A Foucauldian Analysis

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Abstract of the Dissertation

The Untenable Subjectivity of PTSD: A Foucauldian Analysis

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The field of problems that comprise Post-Traumatic Stress Disorder (PTSD) here in the early 21st Century may best be described as a maelstrom, one that implicates public health policy, the epistemological status of mental illness, and the way Western subjects constitute themselves in and through these discourses and practices. Juxtaposing discursive examples from each of these three domains reveals several conceptual irresolvabilities that permeate this tri-partite structure, such that it *produces* an untenable subjectivity of PTSD. Upon closer examination, this untenability reflects and exemplifies a much broader set of problems within our practices for studying, treating, and managing mental illness. By delving into the intellectual history of this maelstrom—using primarily Foucault's *The Birth of the Clinic*—I argue that many of its terms were determined by a similar scientific, institutional, and intrapsychic crisis roughly 200 years ago, at a time when pathological anatomy became the basis of medical experience in the West, irrevocably altering the meaning of death, the organization of space, and the philosophical relationship between universal and individual. This analysis of what Foucault would call "the historical a priori" of the PTSD crisis forms the basis for my argument that (a) the crisis is reaching fever pitch and thus cannot go on indefinitely (b) its fallout will not turn on finally discovering the "truth" of PTSD but rather on constructing a coherent pathological framework for psychiatric practice (in particular, vis-à-vis general medical practice), and (c) these new practices will have a profound, global impact on the social, the scientific, and the role of the state in managing the public (mental) health, and therefore, on the way *all* human subjects mediate their concrete existence in both public and private spaces. In brief, PTSD stands as both exemplar and catalyst for propelling the West across the philosophical threshold at which it now stands. While I do maintain the profound ethical importance of this historical moment, I do not offer the standard normative conclusion. Rather, I examine shame as an old philosophical nemesis that has transferred its potency to mental illness and follow Nietzsche in experimenting with ways of cutting off this artery, which feeds the storm.

In memoriam

For Sgt. Bryan Hoyt Benson,
and all the others

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Prologue: Invitation into a Maelstrom

1.1 The US Department of Defense and the Purple Heart

On May the 2nd, 2008, United States Secretary of Defense Robert Gates toured a Veterans Hospital in Fort Bliss, Texas.[1] In the press conference following this visit, Gates was asked by a reporter whether those veterans diagnosed with Post-Traumatic Stress Disorder (PTSD) could qualify for the Purple Heart, a mark of honor in military service, which also entitles the recipient to increased Veteran's benefits. Secretary Gates responded that it was an "interesting idea" and that it was "clearly something that needs to be looked at" (Miles 2008, 1). Shortly after this press conference, Secretary Gates did indeed direct the Pentagon Awards Advisory Group to study the issue and offer recommendations (Schogol 2008, 1).[2]

This was not a new idea, however. In 1980, the Pentagon had examined precisely this issue, and the official exclusion of PTSD from Purple Heart eligibility was entered in the Code of Federal Regulations (McMichael 2009, 1).[3] In the thirty or so years since that denial, various veterans advocacy groups have lobbied to have this decision overturned or

[1] There are currently 238 such hospitals in the country (United States Department of Veterans Affairs 2010, 1).

[2] Gates delegated responsibility for this inquiry to David S. C. Chu, Undersecretary of Defense for Personnel and Readiness (Schogol 2008, 1).

[3] PTSD is specifically listed as an injury not eligible for the Purple Heart in Title 32 of the Code of Federal Regulations (McMichael 2009, 1).

even officially re-examined, to no avail, until last May after Secretary Gates found himself at Fort Bliss.

Given the clearly codified precedent and the failure of these advocacy groups to successfully change it for several years, one can assume that something has recently raised the political, medical, and/or military stakes around PTSD sufficiently to compel the Secretary of Defense to re-examine the question.

Speaking to precisely this issue in an interview on October 22, 2008, Defense Secretary Gates emphasized the challenges of the "stigma" attached to mental illness or psychological symptoms. He argued that "this is another area where we have a strong culture to overcome, where people basically say, 'Suck it up and get on with the job,' and so on, without realizing that people who have PTSD have suffered a wound just like they've been shot and need to be treated" (Gilmore 2008, 1).

Nonetheless, just ten days later, on November 3, 2008, the Pentagon Awards Advisory Group (comprised of awards experts from the Office of the Secretary of Defense, the Joint Chiefs of Staff, the military departments, the Institute of Heraldry, and the Center for Military History) recommended that Gates uphold the longstanding policy, which denies PTSD as a Purple Heart qualifying wound (McMichael 2009). Gates accepted the recommendation. Curiously, this decision was not released until two months later, on January 6, 2009, at a press conference held by Pentagon spokeswoman, Elaine Lainez (ibid.). She explained:

> The Defense Department has determined that based on current Purple Heart criteria, PTSD is not a qualifying Purple Heart wound. The Purple Heart recognizes those individuals wounded to a degree that requires treatment by a medical officer in action with the enemy or as the result of enemy action where the intended effect of a specific enemy action is to kill or injure the servicemember. (ibid.)

She continued,

> PTSD is an anxiety disorder caused by witnessing or experiencing a traumatic event. . . [and is thus] not a wound intentionally caused by the enemy from an outside force or agent. Based on the definition of a wound – 'an injury to any part of the body from an outside force or agent' – other Purple Heart award criteria, and 76 years of precedent, the Purple Heart has been limited to physical, not psychological, wounds. – The requirement that a qualifying Purple Heart wound be caused by 'an outside force or agent' provides a fairly objective assessment standard that minimizes disparate treatment between servicemembers. Several members could witness the same traumatic event, for instance, but only those who suffer from PTSD would receive the Purple Heart. (ibid.)

Lainez went on to mention that PTSD is specifically denied Purple Heart eligibility in Title 32 of the Code of Federal Regulations and reiterated that historically, the Purple Heart has never been awarded for mental disorders or psychological conditions resulting from witnessing or experiencing traumatic combat events (ibid.)—for example, combat stress reaction, "shell-shock" (a term used after WWI), combat stress fatigue (a Vietnam-era term), acute stress disorder, or PTSD.

Finally, she stated that "current medical knowledge and technologies do not establish PTSD as objectively and routinely as would be required for this award at this time," and suggested that, should that change, the issue could perhaps be re-examined in the future. This suggested, contrary to many of her other points, that the problem is merely one of awaiting scientific advance (ibid.).

1.2 The Anonymous Poet

I can't sleep, can't feel
Anything.
Time passes in chunks now --
A month passes for me
Like someone else's day.

Zombies don't have rhythms;
I go wherever my trance
Takes me.
Today I panic in a store,
Where danger doesn't lurk.

Maybe if I stay awake, there
Won't be any nightmares tonight.
But I can't go without rest forever.
It's over, finished. So why am I
Sweating? Why am I still afraid?

Today I saw most of my family
For the first time in a year.
Nothing felt real; everybody was a
Stranger I am supposed to know.
"Dissociation," I think a doctor said.

No bumps, no bruises. No broken limbs.
But my mind is shattered, along with my
Soul.
I don't know how to tell you that, don't

Know how to put the genie back in the bottle.

When my emotions got shut off, I didn't get to
choose which ones I wanted to keep;
They all left; they are all gone.
And it feels like there is an invisible hand
Keeping me frozen on my bed.

I used to care about how I looked, but now
All I can think about is what I saw, what I
Experienced; nothing seems to matter beyond
That. I will do anything – anything at all –
To keep from repeating that time.

I think more now, talk less. Months of numbness
Are followed by a week of depression and tears.
I am weak, frail, imperfect.
Broken.
My identity then irrevocably altered.

Do I want help, you ask.
How are you going to help me?
You weren't there; you don't know
What I saw, what I did.
What was done to me.

How does one 'undo' a scorched mind?
Deep within me a voice mumbles 'help;'
But you'll never hear that. All you will
See is my distant, fixed stare and my
Clenched jaw. I can't take the chance.

How long will it be before you
Give up on me? I know it's coming;
I'm resigned to my fate. Resigned to a
Lot of things, actually. Here, in my bunker,
In Hell.

1.3 The Initial Juxtaposition

I am undertaking an experiment with this juxtaposition. At first glance, it is a curious methodological move to begin with a Department of Defense policy inquiry and an anonymous poem posted on the Internet. For one thing, there is clearly no means of verifying any of the poem's content or even the identity of its author. But I am not attempting to establish the veracity of any data given in it, nor to cite its author as an expert, nor to decipher what "is really going on" in the mind of someone else. There are a number of reasons to begin with this contrast, perhaps most importantly, to demonstrate the chasm that separates a first-person account of an experience from a policy discourse meant to locate and contain it. On the one hand, they operate on utterly different logics; on the other, there is a palpable excess or remainder of the narrative account. This hardly a new philosophical point, and I do not intend to claim it here as my own. I do, however, mean to let that unending transgression of the narrative claim you, the reader.

Secondly, this juxtaposition is intended to demonstrate that both the policy discourse and the poem are mediated through a third type of discourse, namely, medico-psychiatric discourse. In order to continue mining the breadth of issues brought out in my

initial comparison, I must identify this third major artery feeding into the vortex. In other words, I must introduce the current, mainstream medico-psychiatric understanding of PTSD. To this end, I will utilize the poem to illustrate the technical terminology associated with contemporary discussions of PTSD. My intention is not to perform some kind of pseudo-diagnosis of an anonymous poet; I simply want to introduce the medical vocabulary while also demonstrating that access to these concepts is made vastly easier and more ethically and socially compelling with a narrative account. Once the third leg of this tri-partite structure is in place, the stage will be set for identifying some of the irresolvabilities at the heart of the maelstrom of PTSD, here and now, a decade into the 21st century.

1.4 The Third Leg: Technical Medico-Psychiatric Terminology

In moving into this third leg of medico-psychiatric terminology, I will deliberately avoid overly technical jargon. Doing so would (a) cloud the purely introductory function of this Prologue and (b) place undue emphasis on the current medical(ized) understanding of the thoughts, behaviors, etc. associated with PTSD and thus compromise my critical distance as a philosopher. A much more involved discussion of these definitions and their evolution will follow later in the project.

I begin with the distinction between traumatic memory and PTSD. It is important to understand that within most mainstream medical *and* military/public policy discourses, PTSD is treated as a clinically distinct disorder, meaning it has criteria that differentiate it from other specific disorders (e.g., Major Depressive Disorder or Generalized Anxiety

Disorder). As a clinically distinct disorder, PTSD is also distinct from the more general concept of traumatic memory, whose definition I will borrow from Allan Young: "memories caused by some intensely frightening or disturbing experiences. . . that are concealed in automatic behaviors, repetitive acts over which the affected person exercise[s] no conscious control" (Young 1995, 4).[4]

While *traumatic memory* has been a widely available trope at least since the popularization of Freudian psychoanalysis in the late 19th century, 'PTSD' is a far more recent term, being officially coined for the Third Edition of the *Diagnostic and Statistical Manual of Mental Disorders* in 1980 (*DSM-III*). Although it is not uncommon for the two terms to be used interchangeably in everyday language, it is, for the moment, important to understand that within the medico-psychiatric community, as well as in the public policy domain, 'PTSD' is a technical term with specific diagnostic criteria that differentiate it from other mental disorders that must be met to qualify for treatment, benefits, etc. As a point of reference, current estimates of PTSD for US soldiers returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF, referring to the US military campaign in Afghanistan) typically fall between 20% and 30% (Science Daily 2008; Swords to Plowshares 2009; Leopold 2008). These estimates are controversial and deserve extensive analysis in their own right, since differences in prevalence, especially across cultures, has been a point of contention and, more importantly, deliberate intervention. I will discuss this latter point again shortly, but first,

[4] It should be noted that Young's book, *The Harmony of Illusions*, from which this definition is drawn, traces a genealogy of the concept of traumatic memory, arguing that it, too, was essentially assembled over the course of the 19th century. His view is consistent with those I will be presenting in this entire project. It is also perhaps prudent to mention at this early moment, however, that the idea of an event leaving an indelible mark on—or even damaging—a person is to be found in very early accounts of recorded history.

I will introduce the specific PTSD criteria listed in *DSM-IV-TR*, the current edition in use since 1995.

1.4.1 (A) The Stressor Criterion

Currently, in the United States,[5] a PTSD diagnosis requires (A) "Exposure to a traumatic event in which the person (1) experienced, witnessed, or was confronted by death or serious injury to self or others **AND (**2) responded with intense fear, helplessness, or horror" (American Psychiatric Association 2000, §309.81; emphasis mine).[6]

Symptoms resulting from exposure to such an event that produce the requisite emotional response are then divided into three clusters: (B) Intrusion, (C) Avoidance/Numbing, and (D) Hyperarousal. According to diagnostic protocol, these symptoms must last longer than one month and cause clinically significant "distress" or "impairment" in functioning (ibid).

The anonymous poem expresses examples of each of the three symptom clusters.

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[5] *DSM-IV-TR* was released in 1995. The *International Classification of Diseases* (*ICD*), which is the diagnostic code used by the WHO, varies slightly (Practice Management Information Corporation 2005, §F43.1). Indeed, cross-cultural and international differences are far from a minor point, both for the purposes of my thesis, but also within the scientific and public health discourse. Thus I do not mean to indicate a lack of importance by relegating it to a footnote. However, for the sake of clarity, I am beginning with the currently used diagnostic criteria in the country whose public policies and medical definitions are most influential, i.e., the US. These technical differences from the *ICD*, as well as several of the most pressing concerns about cross-cultural use of these definitions, will be given due measure once I have introduced the reader to enough of the terminology, but, more importantly, once I have developed the philosophical tools adequate to discuss them.

[6] The specific difference in the *ICD* is that it does not include (A2), i.e., the requirement that the individual in question felt intense fear, horror, or helplessness (Practice Management Information Corporation 2005, §F43.1). See Section 1.6.2 below as well as Chapter Three.

1.4.2 (B) Intrusion

Re-experiencing the traumatic event in the form of flashbacks or nightmares is perhaps the most widely known type of intrusive symptom of PTSD. It is typically described as re-living, either while awake or asleep, something that happened in the past and presenting physical, as well as psychological, responses as if the event is recurring now. Other types of intrusion also fall under this umbrella, however. For example, in children, nightmares may display no overt reference to the content of an "actual" event. In any case, the example from our poet above:

> Maybe if I stay awake, there
> Won't be any nightmares tonight.

1.4.3 (C) Numbing/Avoidance

These two types of symptoms are conceptually distinct, but they are grouped together because they are (currently) conceptualized as ways to minimize symptoms of intrusion (B).

"Numbing" has two senses in the field of psychiatry: first, lack of emotional connection and, second, not feeling real or visible, a symptom also known as "irreality." Numbing symptoms may also be referred to as "dissociation," although there are some reasons for avoiding this latter term, since "Dissociative Disorders" comprise one of thirteen general categories of disorder in the *DSM-IV-TR*. PTSD, moreover, is not even

within this general category (it falls, rather, within Anxiety Disorders, as Lainez mentioned in her press conference). In any case, our poetic example:

> When my emotions got shut off, I didn't get to
> choose which ones I wanted to keep;
> They all left; they are all gone.

Or another:

> Today I saw most of my family
> For the first time in a year.
> Nothing felt real; everybody was a
> Stranger I am supposed to know.
> "Dissociation," I think a doctor said.

"Avoidance," on the other hand, entails any type of behavior that is consciously or unconsciously undertaken to minimize exposure to stimuli that trigger symptoms of intrusion. Some common avoidance techniques include substance abuse, self-isolation, or not going into certain types of environments (e.g., amusement parks). The line from the poem:

> All I can think about is what I saw, what I
> Experienced; nothing seems to matter beyond
> That. I will do anything -- anything at all --
> To keep from repeating that time.

1.4.4 (D) Hyperarousal

This symptom cluster is understood as the physiological component of PTSD and is typically characterized as an elevation of the autonomic nervous system (the part of our nervous system responsible for non-conscious responses, e.g., telling the heart to beat). Because it is outside of one's conscious control, it makes one jumpy or easily startled by quick movements or loud noises. Our anonymous poet says it thus:

> Today I panic in a store,
> Where danger doesn't lurk.

Or another:

> It's over, finished. So why am I
> Sweating? Why am I still afraid?

To recap, according to *DSM-IV-TR*, a PTSD diagnosis requires that a person must have undergone some kind of qualifying event (A1), responded with a certain kind of feeling (A2), and then displayed symptoms from each of the three symptom clusters (B, C, and D) for at least one month. Finally, the symptoms must have caused significant distress or functional impairment. (The latter is a general requirement for any type of diagnosis based on the *DSM-IV-TR*).

1.5 A Caveat

Before moving on, I wish to emphasize that neither the precision, nor the universality, nor the timeless nature of these diagnostic criteria is presumed here (and indeed, my critical stance will receive much greater treatment later in my dissertation). However, it is important to note that within *much* of the discourse I will examine—including the press statements made by officials with the Department of Defense quoted above[7]—it is assumed to exist as just such a universal, timeless, and distinct disorder. These discourses treat PTSD as a disorder that, *in principle*, consists of a limited set of identifiable symptoms, etiology (causal mechanism and course of development), and prognosis (likely outcome), even if many of these same discourses acknowledge that we do not yet have all the components to complete such an account.

Nonetheless, although diagnostic practices currently operate upon the assumption of clinically distinct disorders, there are also many divergent voices within the medico-psychiatric community, as well as many others outside this community who are highly critical. For example, Derek Summerfield of the Institute of Psychiatry in London was recently quoted in *The New York Times*, stating, "Western mental-health discourse introduces core components of Western culture, including a theory of human nature, a definition of personhood, a sense of time and memory and a source of moral authority. None of this is universal" (Watters 2010, 1).

[7] This is evidenced, for example, when Lainez states, "current medical knowledge and technologies do not establish PTSD as objectively and routinely as would be required for this award at this time" (McMichael 2009, 1).

1.6 The Irresolvabilities that Cut *Across* the Tri-Partite Structure

With this baseline understanding of the medico-psychiatric terms in place, I want to take a step back again and consider the juxtaposition of all three discourses (the Pentagon press conferences, the poem, and the *DSM* criteria). In doing so, several conceptual incoherencies appear. Crucially, however, these incoherencies or, as I will refer to them most often, irresolvabilities, do not separate the discourses *from* one another—rather, they cut across all of them. Since I am gathering some rather disparate points under this term *irresolvability,* it's not a technical term *per se*. Thus, in lieu of a definition, I offer here an overview of each of the five points I'll be covering. It also seems prudent to point out that this list is not meant to be exhaustive, if such a goal were even theoretically possible.

(1) The discrepancy between conceptualizing PTSD as a wound or injury versus a mental disorder or illness.

(2) The chasm between seeing/witnessing an event and experiencing it, often referred to as the objective vs. subjective content of the event.

(3) Malingering on the one hand (faking a disorder for the purpose of receiving compensation) versus the fear/shame/stigma that prevents people from seeking or continuing treatment.

(4) The resultant intersocial difficulties in spontaneous or deliberate forms of acknowledgement and interaction for those diagnosed or diagnosable with

PTSD. (This applies across an astonishing breadth of social relations, including familial, employer/employee, governmental, as well as the more obvious patient/physician).

(5) The intrapsychic untenability that results from and reciprocally reinforces the above four irresolvabilities. I often use the term "untenable subjectivity" to denote this element.

Taken together, the elaboration of these irresolvabilities comprises my initial outline of the field of problematization surrounding PTSD.[8] It is also intended to reveal how deeply these irresolvabilities permeate each type of discourse: whereas both the policy and psychiatric discourse examples reflect a mastery over them, the poet seems to go one step further. What at first glance might seem to be an expression of the most private pain reveals that the poet has literally in-corporated the irresolvabilities.

1.6.1 Wound or Injury vs. Illness or Disorder

After reading the *DSM-IV-TR* criteria for PTSD, it is a likely impulse to want to understand all the pain and dysfunction of our anonymous poet as solely the result of the terrible thing he or she went through. Arguably, I've encouraged this response. Within such a framework, we are well on our way to understanding it as an injury. Almost immediately, however, we run into the problem of why the "same" terrible event does not necessarily produce the "same" response in everyone, in the way that a bullet hitting

[8] "Field of problematization" is a Foucauldian term. He uses it, for example, in his *Psychiatric Power: Lectures at the Collège de France, 1973-1974*.

anyone's chest would rip it apart. We also run into the problem that these very criteria, which suggest the injury model, are codified in *The Diagnostic and Statistical Manual of Mental Disorders*, which is published, maintained, and promoted by the American Psychiatric Association (APA), which claims to represent "over 38,000 physician leaders in mental health" (American Psychiatric Association 2010e, 1). In other words, it is inscribed in the domain of mental illness, in which no other disorder is treated as an injury.

Perhaps, then, we feel compelled to switch tactics, to think of it as a psychological disorder, an illness. Conceived thus, a different host of problems emerge, all related to the role of the event (codified in Criterion A). Epistemologically, the event itself is not a symptom, and in this way, Criterion A has a fundamentally different function than Criteria B-D. Criterion A's role is, in fact, largely unique within the *DSM*, as it is seen to both cause and determine the meaning of all other symptoms (e.g., the images are conceived as flashbacks of the event rather than as merely nightmares). As I will elaborate later in this dissertation, Criterion A implies an entire theoretical structure of psychodynamics despite the fact that the *DSM*—at least in the current edition—is conceived of as atheoretical.[9]

The epistemological ambiguity between a wound and an illness is only amplified when we highlight its connection to public policy. If PTSD is conceptualized as an injury, then a whole set of implications for public responsibility follows. There would normally be a moral responsibility on the part of those who put the individual in harm's way, for example. The military case is exemplary here, due to the severity of combat scenarios

[9] See Section 5.5 of Chapter Three for an expanded discussion of this idea.

but, most of all, because exposure to such an event is so clearly the result of military orders. I've cited Defense Secretary Gates above ("people who have PTSD have suffered a wound just like they've been shot and need to be treated"), but contemporary discourse is littered with references of this sort regarding the responsibility of the US government to take care of the psychological wounds of the troops as much as the physical wounds.[10] However, even in the somewhat contained example of the US military, contemporary discourse is equally littered with references to PTSD as a disorder or illness. Again, I've used one concrete example above, namely, Department of Defense spokesperson Lainez ("PTSD is an anxiety disorder caused by witnessing or experiencing a traumatic event"). She cites the "fact" that PTSD is a "secondary effect" as one of the many justifications for denying eligibility for the Purple Heart, because it is an award specifically given to soldiers *wounded* in combat (McMichael 2009, 1).

The poet, too, expresses this ambiguity, at least in such a way that reflects the problem with conceiving of it as a wound:

> No bumps, no bruises. No broken limbs.
> But my mind is shattered, along with my
> Soul.

And the invisibility—that is to say, the difference of this kind of wound from an obviously physical wound—folds into the poet's experience of the impossibility for cure,

[10] To cite one more example, just two days after Lainez's press conference that announced the denial of Purple Heart eligibility for PTSD, a reporter asked Press Secretary for the Department of Defense, Geoff Morrell, whether "this [denial] will just increase the stigma that the department has been trying to decrease or eliminate about post-traumatic stress patients." Morrell responded, "just because an awards committee believes this particular *injury* does not qualify for this award, does not in any way reflect that we don't take this problem seriously and aren't committed to doing everything we possibly can towards preventing it, towards treating it, towards taking care of those who are suffering with it" (Morrell 2009, 1; my emphasis).

for treatment, for help (above all, help from someone who was not there, which relates to my fourth point below regarding intersocial codes of acknowledgement and interaction):

> Do I want help, you ask.
> How are you going to help me?
> You weren't there…

Or:

> How does one 'undo' a scorched mind?
> Deep within me a voice mumbles 'help;'
> But you'll never hear that.

As the discursive examples quoted here show, PTSD is currently conceptualized alternately and confusedly as both injury and mental illness. But this is not merely a discursive point: our policies and practices are equally heterogeneous, even incoherent. I am not calling for a unification of discourse or practices per se and certainly not at this early juncture. I am rather hinting at the fifth and final point in this section: that the subject position of those diagnosed or diagnosable with PTSD, which has been created through the convergence of a slough of policy and research and culture and historical contingency, is utterly untenable. As I work through each of the remaining four points, I intend to only strengthen this preliminary case and thereby invite the reader into this vortex with some footholds on the terrain.

1.6.2 Seeing or witnessing vs. experiencing

Our poet most pointedly expresses this tightrope:

> All I can think about is what I saw,
> what I Experienced;

Remarkably, the revised edition of the *DSM-IV-TR* (issued in 2000) encodes this ambiguity in its first criterion: (A) "Exposure to a traumatic event in which the person (1) experienced, witnessed, or was confronted by death or serious injury to self or others **AND (**2) responded with intense fear, helplessness, or horror" (American Psychiatric Association 2000, §309.81; emphasis mine).[11]

The same problem is at work in the Pentagon press conference:

> The requirement that a qualifying Purple Heart wound be caused by 'an outside force or agent' provides a fairly objective assessment standard that minimizes disparate treatment between service members. Several members could witness the same traumatic event, for instance, but only those who suffer from PTSD would receive the Purple Heart. (McMichael 2009, 1)

The poet, the Pentagon, and the APA struggle in the same morass: the ambiguity between the difficult to define "objective" content of the event and the "subjective" way it was "experienced."

Finally, here, I am able to properly introduce the difference between the *DSM* criteria and those listed in the *International Classification of Diseases* (*ICD*), the

[11] See below for a discussion of the difference here in the current version of the *International Classification of Diseases, ICD-X*.

document endorsed by the World Health Organization, currently in its tenth edition with the eleventh due out in 2012. Let me preface the comparison in the PTSD criteria by pointing out that *ICD-X* was the first edition to use the *DSM* structure of listing explicit diagnostic criteria. Dr. Darrel A. Regier (chair of the task force for the upcoming fifth edition of the *DSM*, due out in 2013) was asked in a 2007 interview with Norman Sussman: "Is there any liaison process taking place with the authors of the *International Classification of Diseases* (*ICD*) to create more consistency between the *ICD* and *DSM*?" He responded:

> One of the major accomplishments of the *DSM-IV* and the *ICD-X* [released in 1994 and 1993, respectively] was to achieve almost 90% congruence between the two reference manuals. This was the result of a conscious effort. . . to link the *DSM* process with the World Health Organization (WHO) *ICD* process. The result was that the *ICD* completely changed the orientation of their nomenclature, added explicit diagnostic criteria for the first time, and adopted virtually the same names for illnesses that were used in the *DSM-IV*. That was a tremendous advance. There still are perhaps as many as 10% of diagnoses where there are slight differences in the two systems. For example. . . [t]here are. . . some differences in the eligibility criteria for posttraumatic stress disorder. (Sussman 2007, 1)

Cited in a different context, I would dwell on how this passage so clearly demonstrates the power the US has in driving global mental health practice. For my purposes her, however, I am focusing on the irresolvability between seeing/witnessing an event and experiencing it and how this impasse is reflected in the different codification of Criterion A within *DSM-IV-TR* as opposed to *ICD-X*. Specifically, the *ICD-X* differs in its definition of the stressor criterion in that it does not include (A2)—i.e., the part of the criterion that specifies the "subjective" emotional response to the event (Practice Management Information Corporation 2005, §F43.1). Again, at this point, I am not arguing which version is preferable; it's the ubiquity of the impasse I want to highlight,

as well as some of the consequences of such an impasse. In the same interview, Dr. Regier summarizes these consequences quite concisely. Addressing the roughly 10% of disorders that do not have identical diagnostic criteria in the *ICD-X* and the *DSM-IV*, he states:

> There are numerous diagnoses scattered across the diagnostic spectrum that result in actual differences in prevalence rates when these criteria are applied in epidemiologic studies.[12] As part of our extensive collaboration with the WHO, we have established a harmonization group that will monitor and attempt to correct any discordances between the *ICD-XI* chapter on "Mental and Behavioural Disorders" and the DSM-V. (ibid.)

Regier here makes it plain that the epidemiological data is decidedly different depending on how the diagnostic criteria are codified.

When Lainez claims that PTSD is not established as "objectively and routinely" as would be required for the Purple Heart award (McMichael 2009, 1), she is referring to varying epidemiological data on its prevalence. She is not simply being callous or thrifty in the doling out of scarce resources (which is by no means denying that the scarcity of resources and shirking responsibility are at play here). Whether or not Criterion A2 is included, and whether it makes any difference in prevalence rates, has been hotly debated among researchers in anticipation of *DSM-V*. If the recommendations of the PTSD work group prevail, Criterion A2 will be dropped from *DSM-V*. On its official website maintained by the American Psychiatric Association, the rationale cited for dropping A2 is surprisingly pithy: "*DSM-IV* A2 Criterion has no utility" (American Psychiatric Association 2010c, 1). Nonetheless, as both the Department of Defense press conference and the poem reveal, there is a strongly felt distinction between the so-called "objective" content of A1 and the "subjective" content of A2.

[12] Epidemiologic studies track the statistical prevalence of various diseases and disorders.

1.6.3 Malingering vs. Difficulties in Getting Service Members to Seek and/or Remain in Treatment Because of Fear/Shame/Stigma

There is nothing profound or original in noting that, once compensation is in question, there is a structural incentive in place for qualifying for a diagnosis. Recall that, along with the honor of the Purple Heart, the award also entitles its bearer to priority treatment in Department of Defense and Department of Veterans' Affairs healthcare facilities as well as increased monetary compensation. When Lainez speaks about concern over minimizing the "disparate treatment of service members" who "witness the same traumatic event" (McMichael 2009, 1), it is precisely this issue she is addressing. The structural incentive makes malingering an inevitable risk, and this has been true since the earliest examples of psychological trauma were deemed medical conditions *and* economic liability was legally codified.[13]

In theory, an independent, objective measure of whether or not someone without a doubt "has" PTSD could be discovered; philosopher of science, Ian Hacking (among others), refers to such a measure as an "independent validator" and constructs something of an epistemological hierarchy of sciences based on whether or not they have achieved such validators (Hacking 1995; Hacking 1998). The weight such an external validator would carry—essentially, the possibility that it could eliminate the problem of

[13] I am referring here to the condition known as "railway spine," the name given to a condition "characterized by the manifestation of a variety of physical disorders in otherwise healthy and apparently uninjured railway accident victims" (Micale and Lerner 2001, 32). When, in 1864—some twenty years after railway travel and therefore railway accidents became commonplace—"parliamentary legislation made British railway companies legally liable for the health and safety of their passengers, doctors, lawyers, and insurance experts began a contentious debate over the nature, cause, and prognosis of these new conditions" (ibid., 12).

malingering—compels Lainez to leave the door open on the question of Purple Heart eligibility. Not surprisingly, then, the search for such a "biomarker" has recently picked up steam, both as a research objective and as a policy objective for the US Department of Defense.[14] Millions, perhaps even billions, of dollars turn on this issue of verification, which is one of several things that set PTSD apart from other disorders. Fame and fortune awaits the "specific intellectual"[15] who can guarantee an individual "has" this illness—or injury.

Lacking such a "biomarker," however, concern rages over the possibility of fraudulent claims of PTSD. In the midst of this turmoil of science and policy, the poet strikes us with his or her counter-force:

> Deep within me a voice mumbles 'help;'
> But you'll never hear that. All you will
> See is my distant, fixed stare and my
> Clenched jaw. I can't take the chance.

First, let me point out that I have chosen an *anonymous* poet (as opposed to a memoir of a known patient, for example) for a reason—namely, in order to highlight the willful self-concealment and withdrawal from any help, particularly professional help. Clearly, the poem's author is not unfamiliar with psychiatric help, as evidenced by the line

[14] A leader in this search is Dr. Charles Marmar, Chair of Psychiatry at NYU Medical School, who has recently been named head of a massive Department of Defense project to find biomarkers of PTSD "risk and resilience" (Marmar 2010, 1).

[15] I am once again referencing Foucault here. As I will outline further in the Introduction of this dissertation, the role of a "universal intellectual," who stands outside the ebb and flow of history and drives the direction it ought to go, is dead. Instead, Foucault claims, history will be driven by those operating in specific disciplines, which, though specific, affect the philosophical status of human being. His paradigmatic example is Oppenheimer, "who acted as the point of transition between the universal and the specific intellectual" (Chomsky and Foucault 2006, 163-164).

"'Dissociation' I think a doctor said." It is noteworthy, in fact, that even while refusing professional help, the author is mediating his or her experience through medico-psychiatric terminology. My main point here, however, is that the author chooses anonymity. What seemed an utterly compelling problem of malingering nearly evaporates in the face of this self-silencing.

Lest this seem to be merely anecdotal evidence, however, consider the following: in 2007, the Department of Defense founded the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE). On its website, the DCoE refers to itself as "the open front door of the Department of Defense for warriors and their families needing help with PH and TBI issues, promoting the resilience, recovery and reintegration of warriors and their families" (Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury 2010, 1). One component of the DCoE mission involves "working to tear down the stigma that still deters some from seeking treatment for problems such as post-traumatic stress disorder and TBI with our Real Warriors Campaign" (ibid.). The literature of the Real Warriors Campaign cites the Mental Health Advisory Team (MHAT), established by the Office of the U.S. Army Surgeon General, regarding "some of the factors that discourage members of the military from seeking psychological health services" (ibid.). These include:

- It would be too embarrassing.
- It would harm my career.
- Members of my unit might have less confidence in me.
- My unit membership might treat me differently.

- My leaders would blame me for the problem.
- I would be seen as weak (Real Warriors 2010).

To sum up, despite the obvious concern over the risk of malingering, at least in the case of the military example,[16] in practice, the focus has shifted to the flip side of the coin, namely, on how to get someone to come to treatment and stay.

I'd like to pause for a moment to draw out the connection of this conflict to the problem the first point (1.6.1) above, that of whether PTSD is a wound or an illness. The reason Defense Secretary Gates (along with many other Department of Defense and Department of Veterans' Affairs personnel) so often insist that PTSD is an injury is precisely because there is much less shame associated with an injury than a mental illness. Moreover, this conflict between shame over seeking treatment, on the one hand, and malingering, on the other, devolves into a quagmire once we consider its implications beyond the military healthcare system. For example, consider the role of the following two contingent historical facts in the United States: (1) the very large number of Americans without any health insurance, who would be excluded from this structural incentive to malinger and yet left with the fear/shame element; (2) the inconsistency in mental health parity laws, which means that even if a person has health insurance and receives an official diagnosis of a mental disorder by a qualified professional, their insurance may not cover any treatment. Moreover, because insurance companies are still permitted to exclude coverage for "pre-existing conditions," an official diagnosis can carry serious implications for coverage of any medical issues that could be blamed on the

[16] And all others where compensation is in question; this issue does apply, for example, to cases of PTSD linked to the childhood sexual abuse scandal of the Catholic Church, because, there again, compensation is in question.

patient “having” PTSD. Not surprisingly, the American Psychiatric Association recognized the importance of these parity issues during the healthcare reform debates between 2008 and 2010. Speaking in June of 2008, newly elected APA President Stotland stated,

> The November elections offer us a major opportunity to shape our future. We spend more per capita on health care than any other country in the world, without producing more health. What are we doing wrong? Health care costs go up, increasing the number of uninsured who don't seek care until their problems are catastrophic. Our emergency rooms are clogged with patients for whom there are no resources. Our jails and prisons hold more people with mental illnesses than our hospitals. We have to fill Congress and the White House with people who will do something about that. . . . I know what it's like to feel intimidated about speaking to legislators and the public. But if we don't provide mental health information, somebody else will. (Moran 2008, 1)

I’ve only begun to hint at the important role of shame and fear in this field of problematization surrounding PTSD, and yet, in many ways, I believe it carries more philosophical weight than the others. For one thing, comments like those of Stotland, as well as the Real Warriors Campaign, cast shame as merely an issue of ignorance. In developing the Foucauldian resources in the remainder of this project (along with my Hegelian and Nietzschean affinities), I hope to reveal that the shame at play here draws its force from a well much deeper and older than ignorance. Suffice it for now to say that shame constitutes a formidable maelstrom of its own, which is acting as a major fuel-line feeding the PTSD storm. I will return to this thematic in the Conclusion of this dissertation. For the time being, however, the theme of shame brings me to the fourth irresolvability that defines the field of problematization.

1.6.4 Conflicting Social Codes of Acknowledgment and Interaction

Imagine for a moment, as much as it might be possible, that the three irresolvabilities I've just outlined were resolved. It does not matter so much which way you imagine the pendulum swinging, only that you imagine each is resolved in a relatively stable way. Say you opt for the injury/wound model. In such a state of affairs, whenever someone presented the types of symptoms outlined above, everyone around him or her would assume he or she had been injured by an event (and never that he or she is 'ill'). In order to imagine this, it is probably easiest to imagine PTSD no longer named within *DSM*; assume, rather, that it is inscribed within the sphere of general physical medicine, that its difference from the "bullet wound" has vanished. In this hypothetical order of things, there would be some obvious reason why someone else who witnessed the "same" event did not "experience" the same thing—in other words, epistemologically, the event would no longer be the "same." The problem of malingering would in turn disappear, and it would be much easier to persuade those who are so clearly injured—as the direct result of an easily identifiable (causal) traumatic event—to accept treatment. To tack on a few points that I've not yet explicitly discussed: treatments administered would be conceptually consistent with the underlying medical theory regarding what distinguishes an event as traumatic, *and* it would be consistent with prevalent political and ethical views on who ought to be responsible for the treatment. For example, it would be clear what type of qualified expert (or healer) ought to administer treatment, and it would be clear who ought to pay for this medical care.

Finally, this political, ethical, and scientific unity would dictate whether any other compensation ought to be given.

A similar set of coherent practices could be imagined for the alternate "illness" model.

In either hypothetical, there is one particular set of consequences I would like to draw out here: the fact that, *utterly contrary to what is the case now*, codes of social behavior would become clear. Obviously, protocol for the physician/patient interaction would be specified, but it's the other relationships I am highlighting here. To name just a few, family members, spouses, and friends would quickly come to understand what is needed from them (in the same way, for example, that nearly all parents understand their child needs a doctor when they have a high fever); within the military, decisions for all kinds of resource allocation, treatments, and awards would be clear (for example, regarding decisions on re-deployment, fitness for promotion, or awards of service such as the Purple Heart). And these codes would extend to other, non-military examples of (potentially) traumatic events (e.g., sexual abuse, rape, natural disasters, terrorist attacks).

Crucially, co-extensive with all these questions of social codes are questions of space, and this is dramatically illustrated in several popular culture examples: where should those who are diagnosed with PTSD be? Integrated in home environments with their families and given outpatient care? Institutionalized? Brought together in circles of those who have been through something similar or kept apart? Allowed to work? Encouraged to work? Given special types of work? Even within one of my hypothetical scenarios, where one imagines that PTSD is clearly conceptualized as either an illness or as an injury (rather than the way it is now), etc., these questions are difficult, for each one

carries complex implications about who has the authority to answer them and why. Is it based on an expertise of knowledge? A privileged role of statesmanship? A gift in compassion and empathy? Filial responsibility? The fact that all of us mediate our lives through these practices, not just those who "have" or may have PTSD, means that their heterogeneity, ad hoc application, and conceptual incoherence is profoundly disruptive, both socially and spatially.

1.6.4.1 *Popular Culture, News and Literacy Representations*

A few media representations of trauma and PTSD further emphasize the point that social codes are extremely unclear; these media representations, I will suggest, are both players within the field of problematization surrounding PTSD and a reflection of it. Consider first these more general references to traumatic memories that do not specifically address PTSD:

- the FX network began a series in 2004 entitled *Rescue Me* that follows the lives of firefighters struggling with the events of September 11, 2001.
- *Stop Loss*, a film released in 2008, explores the fractured lives and psyches of returning Iraq veterans who are called back to duty after their official tours have expired.
- Israeli film *Waltz with Bashir*, which met with international critical acclaim,[17] treats the subject of delayed onset of traumatic memory when its Israeli protagonist begins having flashbacks 20 years after the 1982 invasion of Lebanon. It also treats the theme of whether art can serve a therapeutic function in the face

[17] It was nominated for an Academy Award for Best Foreign Language Film in the US and for the Palm d'Or at the Festival de Cannes.

of this experience.

More and more, however, popular culture has begun including specific references to PTSD.[18] Again, I offer a few examples:

- MTV's long-running series *True Life* devoted its December 6, 2008 episode to three veterans diagnosed with PTSD (*True Life: I Have Post-Traumatic Stress Disorder*).

- In the 2008-2009 season of *Grey's Anatomy*, a new character—Dr. Owen Hunt—is introduced, a surgeon who has recently returned from serving in Operation Iraqi Freedom. Plagued by nightmares and erratic self-isolating behavior, he is beseeched by the show's neurosurgeon, Dr. Shepherd, to have a CT scan of his brain. Dr. Shepherd tells him: "The technology on PTSD has come a long way in the past few years. I can help you" (Grey's Anatomy 2009).

In the non-fiction world:

- On January 26th, 2009, just two weeks after the Pentagon press conference discussed above, *The New York Times* included two lengthy editorials on the decision to deny Purple Heart eligibility to PTSD. One writer was in favor of the denial, one was against it. Not surprisingly, the former focused on the "injury/wound" narrative and the latter on the risk of malingering and the unfair disparity among soldiers who had "seen the same thing" (Boudreau 2009; Wein 2009, 1).

- On March 3, 2009, a book was released entitled *Soft Spots: A Marine's Memoir of Combat and Post Traumatic Stress Disorder.* (The title term 'soft spots' is military shorthand for mistakenly stepping on the remains of a fellow marine killed in combat). A quote from the dust jacket: "Diagnosed with post-traumatic stress disorder, [author Clint Van Winkle] sought help at a Veterans

[18] Among the many reasons for this shift, I'd like to draw attention to a committee within the International Society for Traumatic Stress Studies (ISTSS), whose role is to guide all types of media (television, news, etc.) toward what they consider more accurate and socially responsible representations.

> Administration hospital, where he received a cursory examination, a few pills, and a pat on the back. As Van Winkle sought to suppress the horrid images, he also struggled to find a place in an indifferent society that had little sympathy for the war he'd fought, the friends he'd lost, or the duty he'd served" (Van Winkle 2009).

Though this point about popular culture is not one I will dwell upon in this project, I want to acknowledge three points here:

- Media representations are deeply entwined with the tri-partite structure I have outlined thus far.
- Once a subject matter infiltrates this far into public consciousness—becoming a household word—our social codes typically enter a phase of rapid evolution.
- This wrangling within both fictional and news media may in the end become as important as any scientific discovery.

1.6.4.2 *Globalization*

To broach yet another complex and ethically loaded topic under this heading of social (and spatial) codes, I want to introduce very briefly a point about the globalization of the Western conception of mental illness. I say *briefly* introduce because even one of these collisions could comprise an entire dissertation. Even from my position of considerable ignorance, I can think of several gut-wrenching examples when Western (mental) health workers have attempted, with the best of intentions, to provide help

within communities that do not generally view madness as mental illness or trauma as an agent of individual pathology. In his recent book, *Crazy Like Us: The Globalization of the American Psyche*, Ethan Watters has drawn attention to one particular example involving schizophrenia. It is currently causing quite a controversy in psychiatry/mental health circles. The crux of the issue is that what we in the West would call a schizophrenic often function much better—even without any psychotropic medication—within cultures which view their attacks not as a mental illness, but rather, for example, as the result of spiritual affliction. The reasons, Watters suggests, include that other members of the social circle of the afflicted individual accept certain responsibility for appeasing the spirit, and, importantly, place no blame or stigma on the individual themselves nor any kind of isolating label like 'schizophrenic' (Watters 2010b).

Similar collisions are happening more and more frequently within cultures that do not view "trauma" as an agent of individual psychopathology. Perhaps some of the most visible examples here in the 21st century have happened in the wake of natural disasters, such as the tsunami in Thailand in 2004.[19] But there are also examples that would more readily apply to what I have made my paradigmatic case of combat-related PTSD. There is growing research on various cultures or sub-cultures with a traditional warrior class, who conceive of any "distress or impairment" following battle to be a communal disruption. Their responses to such disruptions thus involve communal rituals of expurgation or healing.

[19] In the wake of the current oil spill in The Gulf of Mexico, the term "Natural Disaster Stress Disorder" has begun popping up, and although, socially and politically speaking, it is easy to understand its distinction from combat-related PTSD, it is important to note that there is no such distinct disorder listed in the *DSM*.

In any of these cross-cultural examples, the reader will note that none of the three points of irresolvability I introduced above (wound vs. illness; seeing vs. experiencing; and malingering vs. shame/stigma) apply, or at least they do not apply in the same way. (The spiritual affliction model does, for example, remove any sense of shame or stigma associated with schizophrenic attacks, but it does not achieve this over and against the problem of malingering; nor is the stigma overcome through scientific understanding as over and against ignorance, which, again, is certainly the mechanism emphasized in all the anti-stigma campaigns with PTSD). As such, the field of problematization in those cultures is decidedly different, and hence, to tie this back to the main theme of this fourth "irresolvability," the codes of social acknowledgement and interaction are different and often, at least before the Westerners arrive, decidedly more stable.

What strikes us here in the early 21st century, however, is not just this disparity, but that our Western (and arguably primarily American) conception of mental illness is following in the footprints of Coca-Cola or Starbucks. It is encroaching; it is seducing; it is undermining and usurping, although rarely if ever maliciously—in fact, usually with a great deal of good intention, even restraint, and always armed with much scientific evidence. There is, moreover, a growing awareness (and a plethora of what Foucault would call "transparent discourses"), which debate the ethical ambiguities involved in sending Western (mental) health workers into such communities to offer services and, what's more, to build the institutional infrastructure to provide ongoing services. The *DSM-V* taskforce has listed sensitivity to cross-cultural issues as one of its top priorities,[20]

[20] From the *DSM-V* website: "Given the vision of a system for classifying mental disorders that will be applicable across geographical and cultural boundaries, the APA/WHO/NIH Executive Steering Committee for the project attached high priority to assuring the participation of investigators from all parts of the world. Toward this end, each conference in the series had two co-chairs, drawn respectively from the U.S.

and this sensitivity extends beyond identifying culturally specific symptom presentations, etc. to the philosophical concepts of human nature contained within the entire model of mental illness.

My main aim in bringing up all these popular culture and global references is, for the moment, simple. I am demonstrating that there is much more at stake here than what to do with the "broken cogs" among us—whether we conceive of them as wounded or ill. There is a trouble *in* all of us. The impasse permeates all our relationships as well as the rituals, language games, and spontaneous expressions we have in place to confront our most fundamental of human conditions and the very concrete organization of our spaces.

1.6.5 The Untenable Subjectivity of PTSD: Tarrying With

Perhaps now, with this brief introduction to the field of problematization surrounding PTSD, the poet's voice claims us more urgently. What I hear, in any case, is a subject struggling to express horrific pain, but also struggling to mediate this pain within a maelstrom of incoherent discourses and practices. It is the combination of these two types of struggle, I am suggesting, that leaves him or her unwilling and unable to ask for help.

> Deep within me a voice mumbles 'help;'
> But you'll never hear that. All you will
> See is my distant, fixed stare and my
> Clenched jaw. I can't take the chance.

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and a country other than the U.S. Approximately half of the experts invited to serve on the work groups were from outside the U.S., and half of the conferences were convened outside the U.S" (American Psychiatric Association 2010d, 1).

I am not in any way claiming that a (traumatic) event itself is incapable of producing disruption, suffering, and behaviors characteristic of the diagnostic criteria in the *DSM*. I am simply saying that the patient/wounded will also suffer, extensively, from the incoherence of the scientific conceptualizations, the public policies, and the social codes. Again, this is not primarily a tension between theory and practice; nor is it reducible to institutional callousness toward those who are suffering.

Without tipping my hand too much, nor introducing too much jargon, perhaps I can say that it is something of a Hegelian point I am making here. If the institutional practices are incoherent themselves, it will follow that, as ordinary consciousness attempts to mediate its existence through such practices, it will suffer on a different level. It is a philosophical kind of suffering, shall we say, when the order of things is out of sorts. It is untenable, and its untenability reaches all of us whether we are fully aware of it or not.

1.7 Conclusion

I have invited you, the reader, into a maelstrom, but quite a sophisticated one. The irresolvabilities made apparent in this tri-partite juxtaposition are reflected not just in elite circles of psychiatrists but across the entire matrix of our social-symbolic (highly spatial) world. Many of these irresolvabilities have been apparent for decades, if not longer. (For example, the problem of malingering for the purposes of receiving compensation has been around since the flurry of scientific and policy debates around a condition known as

"railway spine"[21]). Yet to say we've been circling in this torrent for decades does not amount to the claim that it's all been mere repetition of the same specific set of irreconcilable conflicts. Our discourses reflect a growing trepidation over our institutional failures to manage this thing we call 'PTSD,' which in an exemplary way marks the broader failure to manage this thing we call 'mental illness.' And this scientific and political disunity permeates the intrapsychic world of trauma victims, it is true, but thereby the intrapsychic lives of all Western subjects (and increasingly, global subjects).

As such, it was not clarity I was aiming to offer with this invitation. I rather hope I've brought something of a sense of semi-ordered confusion. In other words, my goal here was, first, to establish the skeleton of the tri-partite structure and five of the irresolvable conflicts that cut *across* and thus destabilize this structure and, second, to marvel at the advanced state of the impasse. The five main conflicts I outlined within this field of problematization probably seem quite familiar, and this is precisely the point. Similarly, all my popular culture references above were meant to show that PTSD has become a household word here in the US and again, increasingly across the globe.

Thirty years after PTSD was codified as a mental disorder in the *DSM*, giant meta-studies are now being carried out in the hope of summarizing the masses of data collected; the US government (as well as most other Western countries and, increasingly, non-Western countries) are erecting enormous facilities for furthering this research, incorporating cutting edge technology; harmonization groups exist to reconcile the codification of the *DSM-V* and the *ICD-XI* so that we can have one globally implemented lingua franca of mental pathology. I could go on and on here, but perhaps I have done enough in order to make this one single point: *despite* the conceptual mastery of the

[21] See footnote 13 above.

irresolvabilities and their incredible reach, they remain irresolvable. The maelstrom is reaching fever pitch.

1.8 An Acknowledgement

I have certainly not attempted yet to make clear all the players on this stage; from the beginning, I must confess that I'm sure I won't. I ask the reader's forgiveness for what I am sure are multiple omissions. The fact that this vortex may yet include more irresolvabilities or wider implications than I've introduced here, I hope, only strengthens my point.

In that vein, I want to end this prologue by acknowledging a fear. I have been alternately terrified that I will not do justice to the depth and breadth of these disruptions, or that if I do, that it will destabilize me too much, because I am not only speaking about some *they*—the "they" who have PTSD or even the "they" who treat it.

In some of the worst moments of confronting this fear, I drew inspiration from Cherríe Moraga's words, written July 20th, 1980, about her dissatisfaction with the feminist movement. "I want a movement," she said, "that helps me make sense of the trip from Watertown to Roxbury, from white to black" (Moraga and Anzuldúa 1983, *xiv*). According to Moraga, this roughly forty-five minute train ride from one end of Boston to the other reveals to her, every time, how the feminist movement as it exists fails to address so much of the experience, the in-the-flesh, lived experience of those around her.

I am drawing my inspiration rather loosely here, for the trip I want to make sense of is decidedly different, though also remarkably contained. My trip begins in the living

room of my uncle's house in a small midwestern town on Christmas Day, 2005. It is the first Christmas after my cousin, Bryan, a Sergeant in the Marine Corps who had served two tours of duty—the first in Afghanistan, the second in Iraq—shot and killed himself on April 27th. On this particular Christmas Day, the air is thick with deafening silence. No one in my family says a word about Bryan, because all our conflicting ideas about what caused his suicide, what his suicide means, and who (if anyone) is to blame, get in the way of us mourning together the absolutely agreed upon facts that he is dead and we miss him. The disruptions, which I now know are also epistemological and political, ripped my family apart that day, held us each in isolation. To echo a point made long ago, the personal is political.

The end of my trip falls twenty-four hours later, somewhere on a highway between Minneapolis and Chicago. It is desolate and freezing outside, and I am crying the tears I held in the day before. Or, at least, I am crying these tears until I am silenced by a cold, angry voice from the driver's seat: "Bryan was either sick or stupid and you need to get over it. Stop crying, or I am leaving you right here on the side of this road." To this day, these words hurt me, not least of all because I am ashamed I had no response to them. This might be a particularly cruel expression of this sentiment, but the sentiment itself is not unusual. The tragedy of suicide haunts this entire topic of PTSD and certainly the project I've written; and with suicide comes multiple issues on age-old philosophical questions of will and choice.

In a way, I am perhaps more distraught than Moraga, because I am not part of a movement to which I can express my dissatisfaction. I am not even entirely clear about my audience. To whom am I speaking? I began with the tri-partite analysis of a policy

maker, a poet, and a psychiatric definition from the *DSM* because, at times, I am writing to each camp. And yet my longest section in the Prologue ended up devoted to the "intersocial codes for acknowledgement and interaction." I write to bridge gaps and somehow imagine that as a philosopher, maybe, *just maybe,* I can hold these utterly varied discourses and struggles in perspective with one another.

One thing is certain: I am not approaching these problems with "the antennae of cold, curious thought"[22] (Nietzsche 1974, 283). I'm not even sure I approached them at all. These questions about PTSD chose me. I have a narrative that cannot be told without it; I move through the world physically altered by it. I seek solace and community in and amongst those who are willing and able to think and talk about all of its ambiguities with me. If things were set up differently for dissertations, I could write one simply describing the breadth and depth of conversations that have resulted from this question alone.

So many of the great thinkers of our Western tradition relate myths of solitude, of removal from society, as the means by which they reached their most profound philosophical insights. On this point, I must indict even my beloved Nietzsche and the ten years his Zarathustra spent up on the mountaintop. My insights have come in a decidedly different setting, nowhere near a mountaintop, a forest, or a cabin. I was working in a restaurant. In the midst of non-philosophers and, by and large, non-intellectuals, I found myself nonetheless surrounded by an eclectic bunch of people remarkably interested in what I was working on. And of those who hadn't thought much about PTSD, almost everyone had personal experiences navigating the morass of mental illness in some form. There was almost always common ground. It was in this setting that I found the courage to begin my dissertation with an invitation into the center of a storm. My experience of

[22] *The Gay Science*, book 5, sec. 345.

needing a community within which to think, I realized much later, is a deeply feminist point. Quite organically, then, I have come to draw more and more inspiration from feminist thinkers and writers, although my bibliography will not reflect it. My knowledge of the content of their work is too rudimentary, and my encounters with their thought came much too late to be properly incorporated. My affinity for their method and spirit, however, could not be more profound or deeply earned.

As I said above, this impasse, these irresolvabilities, permeate all our relationships and space. I have written this project to try and make sense of it, it is true, but also to heal. My invitation thus speaks to any and all others who are driven by these two—at times, seemingly contradictory—needs: to understand and to heal. Everyone is welcome.

Introduction: The Untenable Subjectivity of PTSD

2.1 Introduction

If I come to believe—based on accurate fact or not—that I am under constant threat of attack (which is to say, it gains precedence in my beliefs about the vulnerability of my physical and/or psychic boundaries), then is it not prudent to keep my eye on the horizon at all times? To sleep with one eye open, as the saying goes? Doing so gives me at least a fighting chance to fend off an attack, to have a shot at protecting myself. Indeed, if, as I said, that belief has gained precedence, my very survival seems to depend upon such hyper-vigilance. I must remain at the ready, endlessly folding in new data. I am always vulnerable, and thus everything I do is reactive.

Is this mindset pathological? Does it become pathological if this external force goes away and yet I continue to keep an eye forever on the horizon, in case it should return? Or what if I find myself in a place where this skill (for it is a skill) is once again proportionate to the situation at hand, if, in other words, I find myself in another milieu where my hypervigilance seems warranted, even valuable? Does my "psychological impairment" disappear? Does the pathology cease to exist? Or what if that external force was never "really" after my demise? How does the accuracy of my emotional and rational assessment of a situation matter in deciding whether or not I am ill? Was I predisposed to be vulnerable? Could I have been better prepared to be "mentally resilient" in the face of such stressors, or can I acquire resilience after the fact with proper treatment?

I am not saying anything new here. The plethora of possible reactions to extreme stress and the variations on how to conceptualize them have developed in the messy world of history for millennia.[23] The specific difficulties I've raised here about whether or not many of these reactions to extreme stress constitute a *medical* problem—a pathology requiring treatment by some sort of physician (broadly construed to include any and all certified mental health workers)—are, however, relatively recent. And yet in the two hundred years or so that such difficulties have been on the table, the questions I just posed have by now been distilled, catalogued, and rehashed again and again.

Put differently, the fields of Traumatic Stress Studies and Psychotraumatology are no longer in their nascent stages. Crucially, of course, these two fields are not the same. The former includes an extremely broad methodological repertoire and, more often than not, emphasizes the social and political charge of the events deemed (potentially) "traumatic," whereas the latter assumes certain responses to extreme stress do in fact constitute individual pathology; it has become essentially a clinical specialty. Nonetheless, the objects of analysis for these respective fields have a great deal of overlap, and thus a great deal of discourse aims at distinguishing their methodologies and assumptions.

It is perhaps important to note early on that I am not arguing for or against the psychiatric diagnosis of PTSD, nor about whether it is "real"—except perhaps on the level of saying: of course it's real. Thirty years after PTSD was codified in *DSM-III*,[24] one need only look at its massive effects, effects that both organize and disrupt our entire

[23] In the nascent stages of the contemporary discipline known as Traumatic Stress Studies, it was a favorite activity to mine the Western canon of literature and history in search of early expressions of what we might now call post-traumatic responses. See, for example, Micale and Lerner's introduction to *Traumatic Pasts*, which cites passages from Ovid and Homer (Micale and Lerner 2001).

[24] The third edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

social, political, economic, and scientific orders, to know it is real. PTSD is not merely a timely issue because of a particularly violent and unpredictable century filled with wars (on a world scale or without a traditional frontline) or natural and man-made disasters. Rather, it gathers together in its web several irresolvabilities deeply rooted within our contemporary social-symbolic world. More than just reflecting these conflicts, however, I am claiming that it is provoking a show down, that it has the power to incite a revolution in our epistemological, ontological, and phenomenological order of things.

2.2 My Questions

If I have successfully made the case in the Prologue that the various phenomena surrounding PTSD constitute a maelstrom, my specific questions become relatively simple: How did we get here? What should we expect moving forward? And what, if anything, does it impinge upon philosophically?

2.3 My Method

My method for answering these questions is considerably trickier. The amount of data and approaches to the problem of PTSD are staggering, even if I were to limit myself to the thirty years since this specific term entered the *DSM*, which I won't. The question then becomes how to approach two hundred years of convoluted history and the masses of discourse, studies, denials, work groups, task forces, narratives, refusals, transgressions, and utterly incompatible vectors operating in what is nonetheless the same

field of problematization. How, in other words, can I think through this maelstrom, while also being caught up in it?

My main resource as I dive into this vortex will be the work of Michel Foucault, in particular his text *The Birth of the Clinic*. For those familiar with Foucault's corpus, this may seem a somewhat peculiar choice given that he published several other texts explicitly on madness and mental illness. While I will also draw upon the latter to some extent, *The Birth of the Clinic* has the following two features: first, it offers an account of the historical movement that forms the condition of possibility for a psychiatric *science* and, second, it provides a model of how to diagnose and dissect such a historical movement, to highlight, in effect, a moment in history that constitutes a philosophical threshold.

In discussing that analogous moment of the birth of the modern clinic during the era of the French Revolution, Foucault suggests that, although the most pressing issues seemed to revolve around how the new Republic ought to manage the certification of physicians, these voluminous debates turned out to be irresolvable—and even beside the point—until a much deeper battle could play out on the world stage. He states:

> It seemed quite clear that no reform of medical teaching would be possible until the problem for which it acted as a screen had been solved, namely, the problem of the practice of medicine. . . . The whole problem was caught up in a political and conceptual impasse; but at least all these discussions had had the merit of revealing what the real question was: not the number or the programme of the *Ecoles de Sante*, but the very meaning of the medical profession and the privileged character of the experience it defines. (Foucault 1994, 77-78)

The "political and conceptual impasse" over PTSD was what I undertook to demonstrate in the Prologue, in order to set myself up to make the case that I believe

history will show the late twentieth and early twenty-first century to have constituted a philosophically important threshold. And just as there were particular, historically contingent facts which made it necessary for the conceptual shifts outlined in *The Birth of the Clinic* to occur in France—in brief, the political, cultural, and epistemological upheaval that fomented before, during, and after the French Revolution—similarly, as I already stated in the Prologue, the United States is the primary site for the PTSD maelstrom to provoke its revolution. To name just a few of these contingent yet compelling facts: (1) the US is the only Western country to lack universal healthcare, with the corollary consequence that corporate lobbyists play a heavy role in setting public policy. (2) "Mental health care" in the US is even more volatile, as evidenced in the recent "parity" law passed in January of 2010. (3) The US is currently responsible for the vast majority of troops in two long, unpopular wars, only two generations after the Vietnam War. These three unconventional wars mean the US now has: (A) a vast quantity of suffering veterans (many of whom would have died in previous wars, when acute medical care were less advanced) and thus (B) an undeniable (and escalating) public and political crisis over responsibility for these suffering veterans. These factors have already and will continue to provoke the development of practices and policies that extend far beyond available evidence, despite the recent buzz word that rings throughout all healthcare debates, including those on PTSD: "evidence-based practices."[25]

[25] Evidence-based medicine (EBM) "proposes a 'hierarchy of evidence' in which the best form of evidence is a systematic review or meta-analysis of the best research on a specific clinical question (whether that question focuses on the efficacy of a single treatment or on a range of treatments for a particular condition). The idea is that having these summaries enables physicians to make better treatment recommendations to their patients" (Bluhm 2009, 136). It should be noted that Robyn Bluhm's article, "Evidence-Based Medicine and Patient Autonomy," from which this passage is taken, "draw[s] on work in feminist bioethics to critique EBM's approach to involving patients in decision making, in which patients are asked merely to select their preferences among various possible treatment outcomes but are not encouraged to actively contend with the effects of illness on their lives as a whole" (ibid., 134).

The crisis over PTSD thus exemplifies the contemporary irreconcilability of the scientific, the ideological, and the self-understanding of ordinary consciousness, making it glaringly obvious that our practices are unsustainable.

2.4 On the Role of the Thinker

Unlike Foucault in the passage above, I do not have the historical distance that would allow me to sum up the resolution of the crisis I am diagnosing, nor even to decipher all the key factors of its evolution thus far. I certainly do not have enough foresight to say precisely which elements—discoveries, or events, or practices—will be most decisive in defining a new way to see, nor the new spaces that will need to be arranged to accommodate sustainable practices, nor the new forms of narrative that will develop as Western subjects come to mediate their experience in new ways through these evolving practices. However, by placing myself in Foucault's camp, I am adopting his view that it is not the task of a philosopher to attain these goals of reconciliation, since among other consequences of that threshold crossed two hundred years ago, we left the era of "the universal intellectual," i.e., an age in which it was possible to believe in intellectuals who spoke truth from a position outside the din of history. Thus, although I think it would be disingenuous to suggest I can offer such a reconciliation, I also cannot deny that at times, I feel a compulsion to attempt it: to translate goals among groups or, above all, to point out that many of the irresolvabilities I've introduced simply do not turn on who is "correct."

Well before Foucault's rejection of the universal intellectual, Nietzsche declared such a position outside history forever closed off to the thinker, another casualty of the same forces that killed God. In *The Gay Science* he offers us a different model:

> A thinker is now that being in whom the impulse for truth and those life-preserving errors clash for their first fight, after the impulse for truth has proved to be also a life-preserving power. Compared to the significance of this fight, everything else is a matter of indifference. The ultimate question has been posed here, and we confront the first attempt to answer this question by experiment. To what extent can truth endure incorporation? That is the question; that is the experiment.[26] (Nietzsche 1974, 171)

The thinker herself, Nietzsche says here, which is to say, her very corporal being, has become the battleground over the *value* of truth and error. Over one hundred years after Nietzsche wrote these words, can anyone deny that we live in an era for which the value of truth is deeply troubling even while the quest for it charges ahead? I could not possibly be arguing in this project that we ought to stop trying to advance our knowledge of psychological trauma and its consequences. Such an argument would be futile, naïve, and boring. Yet I believe I can make the case that much of the flurry of discourse being produced is acting as a screen[27] for the real issue, which involves the very practice of medicine. And I can, in turn, attempt to broaden the field of analysis, to frame that field as a battleground between forms of experience—which invariably include hierarchies among voices, groups, institutions, etc.—but which are not, decidedly, a battle between good and evil or even truth and error.

Writing about the "vortex of phenomena" collected under the term "hysteria" in the 19th century, Foucault claims in the lectures published as *Psychiatric Power* that, in the "psychiatric scene" playing out between the hysteric and her physician, we ought to

[26] *The Gay Science*, book 3, sec. 110.

[27] See Foucault passage cited above, page 45.

hear the rumble of "battle" (Foucault 2003, 297-323). When he looked at this vortex, he did not see the march of knowledge, but a fully fleshed out enactment of the matrices of power that constitute our modern, Western way of life: a disciplinary power that is reciprocally entwined with the means and goals of knowledge production. Echoing Nietzsche, then, Foucault repeatedly appeals to the metaphor of war and battle as perhaps the one most pertinent to history. While I won't be adopting this language exactly, the dynamic play of forces and strategies, the import of certain figures being in the right place at the right time (or the wrong ones), and so forth, all add to my Nietzschean sensibility of looking upon the world and hearing cacophony, or "the discordant concord of things"[28] (Nietzsche 1974, 76).

I have gathered this maelstrom together under the heading of "the untenable subjectivity of PTSD." It is a fraught term, since 'subjectivity' comes with a great deal of historical and philosophical baggage. It is likely that both Foucault and Nietzsche would disapprove. However, 'subjectivity' has the distinct advantage of emphasizing those caught in the crossfire of this mess, a mess that is distinctly not of their own making. It furthermore emphasizes the mediated nature of being a subject, even while also being the object of intensive scientific research. By calling attention to this inevitable mediation, I am reminding the reader (and myself) that there are people trying to hang together precisely by *using* this tangled and often flat out incoherent web of practices and concepts. I am also thereby reminded that they do not always make it.

I brought up Nietzsche's new image of the thinker as a battleground to emphasize that I am not immune to these forces. Inevitably, by writing a dissertation, I will try to make the plot hang together, but that's also because I wish to hang together, too. (And

[28] *The Gay Science*, Book 1, sec. 2.

because I like plots). But let the record show: I don't always believe in this tidiness, nor do I long for it all the time. I want the tears in the fabric to show through. And I say this believing that these tears are the source of our despair and also the source of our joy, our joy that falls from the sky.[29]

This is one of my basic philosophical commitments, then: that we are driven by the incompleteness of history and that we yet require respite, moments of relative equilibrium when our eyes do not focus on the tears in the fabric. It is foolish to ask our fellow human beings (or ourselves) not to seek the moments of respite. And it is equal folly to have faith these respites can last.

I assert from the beginning that I cannot make the subjectivity of PTSD more tenable, but I can at least resist the urge to underestimate its reach and its portent.

2.5 A Caveat

Having made a case for the broad reach of this maelstrom, I must confess a somewhat self-imposed, though also historically justified, methodological limitation. Although in theory any number of life-threatening events could qualify as a traumatic event, I have largely limited myself to what is usually considered the paradigmatic case of PTSD: a soldier "in the theater of war" who has witnessed, undergone, or perpetrated one (or a small, limited number) of acute, contained, gruesome events, often informally referred to as "combat PTSD." In his genealogical account of PTSD, Allan Young refers to 1995, the year *DSM-IV* was released, as the "repatriation" of PTSD from Vietnam (Young 1995, 290). The criterial modifications included in the new edition of the *DSM,*

[29] I am here alluding to Rilke's tenth elegy in *The Duino Elegies* (Rilke 1989).

says Young, "brought [PTSD] home," so that it might apply to all sorts of potentially traumatic events. In the final sentence of his text, Young states, "As the veterans of Vietnam age and fade, and their patrons in government adopt new priorities, a chapter in the history of traumatic memory draws to a close" (ibid.).

Limiting myself to combat PTSD now, fifteen years after its repatriation, may seem inappropriately myopic. However, I offer here the following three justifications: (1) With the advent and continuation of the two large US military campaigns, Operation Enduring Freedom and Operation Iraqi Freedom, the figure of the "wounded warrior" has once again become prevalent in public consciousness. (2) The vast majority of research money devoted to PTSD is aimed at this population.[30] (3) The VA is the largest mental health provider in the country and thus carries tremendous sway for general questions regarding what constitutes adequate and responsible mental health care and the public policy passed to implement it. (The VA is a civilian organization, and is one of two primary institutions charged with caring for the needs of active duty and discharged military personnel. The Department of Defense is the second such institution, but as a military institution, it is charged only with active duty personnel.) But perhaps more importantly, if I can demonstrate an utterly untenable subject position even here, where the focus has been for several "chapters" of this unfolding history, it follows that it is only worse for those positions defined over and against this paradigmatic case.

[30] In January 8, 2009 press conference, Geoff Morell, Press Secretary for the Department of Defense, told a reporter, "I think we will have spent about a billion dollars on research, development, treatment, preventative measures [of PTSD]. And I think you will see more and more money being spent to combat this very real problem that we are all terribly concerned with" (Morrell 2009, 1).

2.6 The Promised Plot: Plan for the Dissertation

As mentioned, broadly stated, I am making the case here that the untenable subjectivity of PTSD—with all its implications *as well as historical conditions*—indicates that we stand on a philosophical threshold. I also mentioned that Foucault will be my primary resource for making this case—both as one who has done a great deal of the groundwork for the relevant intellectual history (of medicine, psychiatry, and their interface with forms of governance, including, above all, the place of public health within the deployment of disciplinary power in the modern age) and as one who has developed a method for analyzing a prescient historical evolution in the configuration among the state, medical knowledge, and the individual. I am relying upon him, in other words, for points of content and points of methodology.

Chapter One is a pointed exegesis of *The Birth of the Clinic*, specifically, outlining Foucault's case that, over the course of less than half a century, the form of medical experience was utterly transformed from what he calls a "medicine of spaces" (Foucault 1994, 22) and which I will be referring to as "classical nosology" (which prevailed in the 18th century) to "pathological anatomy" (which dominates the 19th and 20th centuries). This transition, in Foucault's account, had implications far beyond medicine itself; it effected an overcoming of the universal form of science that had prevailed from Aristotle through Hegel. It in turn defined—or rather produced—a brand new object for science: the individual. The modern, centralized state, moreover, claims this new individual as the main target of its role in governing, and the management of the "public health" becomes, henceforth, one of the central pillars of the governance in the West. Pathological anatomy, built, as we will see, upon the new scientific status of death

and its specific technology of the autopsy, signified nothing less than a new ontological and epistemological status of human being.

Chapter Two has three components. The first part of the chapter continues in the vein of providing an intellectual history of the maelstrom, picking up the reins just after the birth of the clinic, when psychiatry is born as one of the "human sciences" built upon the newly minted "individual" (whose objectivity derives from the form of experience in pathological anatomy). The point of Section One is to analyze the evolving structure of psychiatric experience under the legacy of the lesion, as a separate but tenuously linked economy over and against the one evolving within what is variously referred to as "organic" or "physical" or even "general" medicine. Section Two introduces the revolutionary moment of 1980 when *DSM-III* is published as the field's *first* standardized nosology, which, structurally speaking, bears striking resemblance to the "classical nosology" of the 18th century. Taken in the framework I've established up to this point, it becomes clear that already in this first codification of PTSD, we ought to hear the rumble of battle. The third and final part of this chapter, Section Three, enumerates five lessons from *The Birth of the Clinic* regarding *how* these rapid evolutions in the meaning of medical experience happen. This is the methodological instruction I am drawing from Foucault. As mentioned, I am attempting to understand the philosophical import of an historic moment as it transpires; it seems only prudent to have some sort of compass for navigating the storm.

Chapter Three is a deeply epistemological project. There, I examine the details of the last chapter in *The Birth of the Clinic*, entitled "Crisis over Fevers." The crisis over fevers, Foucault tells us, entailed a confrontation between two incompatible forms of

experience whose practices could not sustain themselves side by side (Foucault 1994, 174). The implications of each opposing form of experience were far too different—in terms of the organization of hospital and social space, medical education, public health policy, and intrapsychic self-constitution—for them both to persist. One had to be adopted at the expense of the other. The fallout of this crisis, not surprisingly, both conditions the crisis of PTSD and gives me a guide on how to approach the collisions occurring within it at this late stage in 2010. Not surprisingly, this chapter contains my detailed examination of the *DSM*, most pointedly, with a look at the proposed changes for the upcoming *DSM-V* regarding not only the PTSD diagnostic criteria, but also regarding the definition of mental illness in general.

I conclude by returning to Foucault's claim that pathological anatomy ushered in a new "philosophical status of man" two hundred years ago (Foucault 1994, 198), which I have called "the non-replaceable individual." The crisis over PTSD, I am arguing, has once again put this status in question. If it is the search for sustainable practices that drives history, again, it is hardly my role to offer a set of prescriptions. Instead, I offer a set of brief meditations on the role of shame in this maelstrom and most pointedly, as the element that troubles me still as I try to make sense of a certain trip I took nearly five years ago, and which constitutes the origin of this project.[31]

[31] See Section 1.8 above.

Chapter One: Is There Anything New Under the Sun? The Birth of the Clinic on the Heels of the End of History

3.1 Introduction

The conceptual and political impasse of PTSD, I have argued, is ubiquitous, its field of problematization writ large across the world historical stage. Cast in these terms, i.e., as part of the unfolding history of ideas, this impasse leads us to what is both a historical and a critical question: how did we get here? How is it that PTSD, named and codified thirty years ago, has come to produce such a flurry of debate, the irresolvabilities of which have been absorbed into so many domains: medico-legal, public health, popular culture, social, and intrapsychic? Perhaps more directly: how did it come to pass that the discourses in these manifold domains reflect a conceptual mastery over the untenable dichotomies that make PTSD so difficult to treat, manage, have, or know someone who has and yet, despite this mastery, the impasse persists? Furthermore, what factors will be relevant to resolving this impasse?

While this final query is one of the primary questions I am addressing in this dissertation, we require a better understanding of how we arrived at this state of affairs before I can answer it properly. It also seems appropriate at this juncture to address who the "we" is, as well as locate the "here." With the possible exception of the anonymous poet, whose nationality and location are unknown, my analysis in the previous chapter clearly focuses on the "state of affairs"—practices, terms of debate, and limits—in the

United States. This is not merely an ethnocentric choice on my part. Due to several, largely contingent historical factors that I have already introduced, the maelstrom is reaching fever pitch only here in the US. Coupled with the widely acknowledged fact that the American Psychiatric Association (APA) and American academic psychiatry drive global health policy and research—in a way unparalleled by any other country—the way this perfect storm resolves will be decisive for not only global practices regarding treatment of psychological trauma, but, as I will show, also global practices regarding mental health in general. To cite one timely example, I'll use the case of Iraq. In a January 30th, 2010 article in *The New York Times*, John Leland reports that "by 2006 [three years after the US invasion of Iraq], fewer than 100 psychiatrists remained in a population of about 30 million, and almost no psychologists" (Leland 2010, 1). Today the country has its first multidisciplinary clinic for PTSD, called the Sara Center for Trauma, which opened in December 2009. Prior to its inauguration, with funding provided by Iraq's Ministry of Health and the United States Substance Abuse and Mental Health Services Administration, six teams of Iraqi health care workers came to the US for training in how to provide integrated care for PTSD. Dr. Akeel al-Sabbagh, the Center's attending psychiatrist, was quoted in the same article as saying: "This is the first time we've had anything like this. In Iraq, the psychiatrist is like a dictator. Even my colleagues now, they say, 'Why would you talk to a nurse?' In the U.S.A. we saw the nurse, psychiatrist, psychologist and social worker all talk together about the patient" (ibid., 1).

This is not just a matter of exporting PTSD treatment; it amounts to exporting a definition of mental illness and a basic institutional structure designed to treat it. It is this

undeniable global influence that has grown up alongside the US's own remarkably disparate and heterogeneous practices regarding mental health that makes it the fertile ground for epistemic revolution. Conceptual inconsistencies as well as practical ones become all the more glaring under the eyes of the world, and this attention itself feeds the storm.

In any case, I return now to the question, how did we get here?

Most intellectual histories of PTSD begin their tale in the year 1980—and for good reason, as this is the year the term 'PTSD' is coined for inclusion in psychiatry's *Diagnostic and Statistical Manual of Mental Disorders* (in its third edition, referred to as *DSM-III*). In a tale where the trajectory of PTSD begins with *DSM-III*, the year 1980 marks a triumph of science, the moment when enough knowledge about the consequences of traumatic events has finally been gathered to accurately codify the symptoms of trauma in the psychiatric nosology. It is also typical for these historical accounts to claim something about the era of modern industry and warfare being more "traumatic." More events occurring "outside the range of usual human experience"[32] translates directly (i.e., causes) more stress-induced mental pathology. Crossing this threshold of quantity, in turn, allows these psychogenic disorders to finally be recognized. More traumatic events beget more knowledge about effects of trauma, so the story goes.

Though psychiatrists here claim an important victory for science, the war is far from over, of course, because they still face a formidable villain: ignorance. Since, on this view, ignorance creates (or perpetuates) the monumental stigma associated with mental

[32] Criterion A for PTSD diagnosis in the *DSM* currently in use in 2010 (*DSM-IV-TR*; see the Prologue above).

illness, anti-stigma campaigns all revolve around the goal of disseminating an advancing scientific knowledge. Under this logic, the plight of all those enveloped in this nexus of PTSD requires negotiation between knowledge and ignorance, acceptance and denial, truth and stigma.

As the Prologue was meant to establish, however, the whole maelstrom surrounding this disorder is not this simple. Conceptual and moral irresolvabilities plague the existence, meaning, and subjectivity of PTSD. Thus, the simplistic history of PTSD beginning in 1980 will not do. Of course, not all historians tell this tale of the simple progressive uncovering of truth. Ian Hacking, for example, has devoted two books to what he terms "transient mental illness diagnoses"[33] (Hacking 1995; Hacking 1998). Perhaps even more convincing is the collection of essays entitled *Traumatic Pasts: History, Psychiatry and Trauma in the Modern Age, 1870-1930*. Published in 2001 as the result of a "scholarly conference on the history of medicine and psychological trauma" held in 1996, the editors identify three overlapping but methodologically distinct approaches to trauma studies: intellectual histories of the trauma concept, studies on traumatic suffering in psychiatric settings, and works on trauma and the arts (Micale and Lerner 2001, *xiii*). What is striking to Micale and Lerner, however, is the relationship among these three areas of research:

> For all of their richness, these three categories. . . remain conspicuously disparate and uncoordinated. Thus far their authors have betrayed strikingly little awareness of the work of their professional counterparts in other disciplines and countries and on other historical episodes. . . . We realized the importance and timeliness of such a book after independently coming across bodies of new scholarship that, taken together, seemed to comprise an emerging field of historical studies waiting to be recognized, organized, and developed. We were struck not only by the impressive

[33] Hacking discusses multiple personality disorder and a, now obsolete, diagnosis from the 19th Century, fuguer.

> quality (and prodigious quantity) of this work, but also by its rich national, disciplinary, and methodological diversity. (ibid., 9)

To reiterate, then, a breadth of historical approaches color the field of traumatic stress studies. Even those who study historically located psychiatric diagnoses hold widely divergent views regarding the universality and timelessness of such diagnoses, as well as regarding the importance of history in engendering certain symptom presentations. As such, it is impossible to talk about PTSD without addressing psychiatric diagnosis as such, and, more specifically, the importance of 1980 not as the first moment a disorder was recognized but as a precipitous moment of convergence. Ultimately, I will focus on the episode in this saga that began in 1980, but not because it is where a truth was finally recognized. Rather, it is the moment a trauma disorder finally entered firmly into the economy of public health, only to provoke a crisis in that economy. But I am getting ahead of myself.

It may seem self-evident now that psychiatry is a medical specialty, and that psychiatric illness ought to therefore be treated by physicians (albeit by specialists); it may even seem self-evident that such physicians must begin with a differential diagnosis of a patient. Which psychiatric disorder does a patient have? Is it PTSD, for example, or Major Depressive Disorder, or Generalized Anxiety Disorder or a condition known as Adjustment Disorder?[34] This former "self-evident fact," however, has only been true for about two hundred years, and the latter, for only thirty. Foucault wrote *Madness and Civilization* to address the importance of coming to treat madness as mental illness; however, it is in *The Birth of the Clinic* where he addresses "the great break in the history

[34] I list these three disorders, because each one can prove difficult to distinguish from PTSD.

of Western medicine" (Foucault 1994, 146), namely, the historical transition that *produced the object* a psychiatric medicine could see.

3.2 The Birth of the Clinic as the Death of the Universal

In the preface to *The Birth of the Clinic*, Foucault makes the provocative claim that the birth of the modern clinic "lifted the old Aristotelian prohibition: one could at last hold a scientifically structured discourse around an individual"[35] (Foucault 1994, *xiv*). In other words, a change in the structure of medical perception around the time of the French Revolution made it possible both to see and to describe singular variations between patients in a systematically rational way. And this fundamentally changed a model of science that had dominated since Aristotle, which is to say, virtually since the inception of science itself.[36] This revolutionary account of Foucault's is markedly different from that of most medical historians. The typical history modern medicine gives itself is one of scientific progress: a throwing off of scholastic dogma as well as moral and religious fetters in order to reveal the truth that had simply been obscured by centuries of error and repression.[37]

In Hegelian terms, one could read this myth of modern medicine as an example of the way in which, when a new shape of consciousness comes on the scene, it always

[35] The Aristotelian prohibition to which Foucault is referring is given in chapter 13 of the Metaphysics, where Aristotle plainly states: "there is no science of the individual as such" (1086b 33). I will discuss this prohibition in more detail below, once the aim of this chapter is clearer.

[36] Of course, certain other Aristotelian commitments had already been fatally critiqued by this point, for example, by Galileo's physics and Copernicus' cosmology. However, I am speaking here of this one Aristotelian commitment that hung on much longer: that all science must be of the universal.

[37] This can seem like a tired, old theme but it is still very operative in contemporary psychiatric discourse, including on PTSD.

recasts its new object as an immediacy. Every shape of consciousness, says Hegel, starts in this way, with consciousness telling itself that the previous shape of consciousness was simply wrong, and that now we've got it right (Hegel 1977). Now we are uncovering truth as it is: direct access to the given.

But there is already something problematic in using Hegel's understanding of history to illuminate Foucault's account of the history of medicine. It is a curious coincidence that the revolution in modern medicine that Foucault is describing, and which essentially traces a new shape of consciousness coming on the scene, is occurring at exactly the same time that Hegel is composing *The Phenomenology of Spirit*, which is to say, at exactly the period when, finally, consciousness was supposed to have already lived through every possible shape of consciousness. For Hegel, Absolute Knowing was possible and in fact necessary in the first years of the 19th century because there was no longer anything new under the sun. It had all been done. It had all been lived. Everything to come was to be just a variation on what had already happened.

In fact, what I want to argue is that this is no mere coincidence—this simultaneous transition in medical perception, which creates a new shape of consciousness, and the so-called end of history, which declared that no more were possible. Specifically, I will argue that Foucault's account of the overcoming of Aristotle's prohibition—which stated that there can be no science of the individual—is his way of implicitly arguing that there is something beyond Absolute Knowing in the Hegelian sense. There is something new under the sun, for Foucault as well as for most of his generation.

In short, Foucault's argument is the following: the reason Hegel sees no possibility of anything new is because he was limited by this Aristotelian conception of science. In other words, Hegel's system in the *Phenomenology* is, on Foucault's account, the culmination of an Aristotelian conception of science. Thus, to go beyond Absolute Knowing requires a new conception of science. And, as one might expect if one is Hegelian, this new conception doesn't come from the philosopher sitting in his armchair, but rather from the unstable experience of natural consciousness struggling to organize its world. In this particular case, Foucault argues that it comes out of profound transformations in medical thought that occurred in the midst of the French Revolution, or more specifically, from a transformation in medical perception that is going on at nearly the same moment that Napoleon is conquering Europe and Hegel is proclaiming the end of history.

Just like Hegel, then, Foucault believes that this period of history around the turn of the 19th century *is* a decisive threshold for the modern world, but not in the way that Hegel conceived it—or, at least, Hegel got it only partially right. Something monumental was coming to an end, but something else—something new—was beginning, and this break is what Foucault will call "the great break in the history of Western medicine" (Foucault 1994, 146): the individual is given a new ontological and epistemological grounding through a new spatialization of a disease and a difficult reconceptualization of death that originates in medical thought.

What I wish to do here, then, is to throw some light on this complex account of Foucault's, whereby a certain key commitment of both Aristotle and Hegel is overcome within the few years spanning the French Revolution. I will begin with a brief discussion

of Aristotle's prohibition regarding the universality of science. Then, I'll address the way in which Hegel is clearly Aristotelian on this point. The next section is dedicated to showing the many ways in which *The Birth of the Clinic* is itself Hegelian (and I'll explain when I get there why I've included this section). Fourth, I offer a summary of the main argument of *The Birth of the Clinic,* in order to make it possible to illuminate, in the fifth and final section, precisely where Foucault breaks with Hegel, arguing that there is indeed something beyond Absolute Knowing and that it involves being able to speak rationally about the individual.

3.3 Aristotle

In Chapter XIII of the *Metaphysics*, Aristotle proclaims outright that "there is no science of the individual as such" (1086b 33). This is a structural requirement that Aristotle is formulating, not a normative one. Science by definition deals with the general, with what is common and repeated in individuals. It is true, Aristotle says, that one must always begin with "sense-knowledge" of particulars, because "intellectual knowledge" of universals is attainable only through abstraction (*aphairesis*) or induction (*epagôgê*) (1076a 10-1087a30). Yet despite the fact that intellectual knowledge (of the universal) is dependent upon sense-knowledge (of the particular), the former is nonetheless superior to the latter.

To flesh this out a bit more, it is useful to refer to Aristotle's distinction between matter and form. Matter, for Aristotle, is an undifferentiated substratum, present in all concrete particulars, to be sure, but is not intelligible. Its qualities can be perceived, but it

is intelligible to us only insofar as the mind penetrates beyond the simply perceptible qualities and grasps the form, or organizational structure, which makes a thing what it is. This organizational structure, or form, is by definition, then, universal. It is what is common to all particular concrete instances of a kind of thing. By contrast, trying to make the concrete particular intelligible, that is, trying to structure a rational discourse around a concrete individual, is impossible. Such a task would be interminable, because concrete particulars are constantly changing. In short, there is nothing permanent about the concrete individual other than its form, which is universal, and thus all knowledge (science) must be of the universal.

3.4 Hegel as Aristotelian

In the last section of the Preface *to The Phenomenology of Spirit*, Hegel states that the universality of Spirit has gathered such strength in his time that the individual must become correspondingly less important. "[T]he total work of Spirit which falls to the individual," he states, "can only be very small. Because of this, the individual must all the more forget himself, *as the nature of Science implies and requires*" (Hegel 1977, 45). Similar to Aristotle, Hegel is referring to a structural or definitional requirement of science. He believes he has reached the terminus of philosophy (and hence the terminus of history) precisely because the particular has *become* universal, united in what he terms "the universal individual" (ibid., 16). Hegel proclaims the end of history because he believes the world, by actualizing Enlightenment ideals, has reached the point where every individual falls under the logic of the instance. In other words, the distance between

universal and particular has finally been overcome. To be sure, there are still differences between particular human beings, but those differences no longer matter for world history (and thus no longer matter to science), because the universal has become so strong.

Moreover, with this closing of the gap between universal and particular, all individuals become interchangeable, *replaceable*. It is this particular consequence of the Hegelian system that will get a great deal of attention from various post-World War II French thinkers, including Foucault. In fact, many of Foucault's clearest allusions to the *Phenomenology* in *The Birth of the Clinic* deal with this specific point, which I'll get to in the final section of this Chapter.

Of course, there are also some very marked differences between Hegel and Aristotle. Hegel thought Aristotle was basically right about the logic of instance and form, and hence right that science must always be of the universal. But Hegel believed Aristotle was wrong about that form and about how that form was achieved. Human beings, for Hegel, are not simply rational animals—a substance with a determinate property. Human being, for Hegel, has a narrative form, a history. It is a process of mediation. Science, then, is not the discerning of universal properties as Aristotle believed, but is rather the understanding of this whole process of mediation whereby human beings achieve unity or self-consciousness, in short, a subjectivity.

3.5 Four Reasons to Read *The Birth of the Clinic* as a Hegelian Text

Before presenting my argument that *The Birth of the Clinic* seeks to go beyond Absolute Knowing by overcoming the implicit Aristotelian commitment in the

Phenomenology, I want to briefly make the case that *The Birth of the* Clinic is in many ways a Hegelian text. There are two reasons for this section of the chapter. First, because this text of Foucault's is not very well known, by associating it with the *Phenomenology* I can quickly locate what kind of method Foucault is employing in it and thereby spare us a lot of complex exegesis. Second, showing that *The Birth of the Clinic* is largely Hegelian allows me to highlight the precise point where Foucault attempts to break away from Hegel, as opposed to his text being some kind of simple dismissal of the Hegelian system, which would be far less convincing.

I believe there are many ways in which *The Birth of the Clinic* is Hegelian, but I'm going to limit myself to four of the most fundamental. For Foucault as for Hegel:

- Truth is produced; it is the result of a process in which consciousness is an essential moment.
- It follows from this that what must be analyzed in philosophy is not a subject or an object isolated from each another, but rather experience, which is to say, consciousness in its relationship to an object.
- The criterion for the truth of a form of experience is not something imported from the outside. It is sustainability or equilibrium.
- The progress between these forms or shapes of consciousness is experienced by consciousness itself as a "way of despair." In other words, violence and suffering are necessary conditions of philosophical development.

I'll now develop each of these in detail.

3.5.1 Truth is Produced

I'm going to begin with what was arguably the most profound Hegelian insight for the post-World War II generation of French thinkers, namely, that truth is produced. In section 20 of the Preface to the *Phenomenology*, Hegel writes, "The True is the whole. But the whole is nothing other than the essence consummating itself through its

development. Of the Absolute it must be said that it is essentially a *result*, that only in the end is it what it truly is" (Hegel 1977, 11). It must also be stressed that, for Hegel, Consciousness is an essential moment of this process, even if it is often unaware of its own role.

Many of Foucault's works—*The Birth of the Clinic* included—attempt to debunk the myth of the given, to borrow a phrase from Wilfrid Sellars.[38] In other words, in several of his texts, Foucault seeks to show how truth has been produced within a particular domain of experience and, simultaneously, to show how the typical accounts which suggest a progressive uncovering of truth are naïve and misguided. In *The Birth of the Clinic,* he specifically critiques the typical histories of modern medicine, which interpret the events in and around the French Revolution as a triumph of truth over philosophical dogma, political privilege, and religious repression. In the place of this naïve history, he attempts to offer an account of the complex conceptual, material, and institutional conditions for the emergence of a new shape of medical experience.

3.5.2 Philosophy Must Analyze Experience

A second Hegelian insight, which Foucault adopts in *The Birth of the Clinic* is that, if truth is produced or, put differently, if consciousness is a necessary moment of truth, it follows that one cannot analyze either a subject or an object isolated from one another. Hegel states in section 84 of the *Phenomenology*, "the essential point to bear in mind throughout the whole investigation is that these two moments, 'Concept' and

[38] Influential 20th century philosopher of mind in the Anglo-Saxon tradition. In the Stanford Encyclopedia of philosophy, it states: "Sellars is perhaps best known for his classic 1956 essay 'Empiricism and the Philosophy of Mind,' a comprehensive and sophisticated critique of 'the myth of the given' which played a major role in the postwar deconstruction of Cartesianism" (Stanford Encyclopedia of Philosophy 2009, 1).

'object,' 'being-for-another' and 'being-in-itself,' both fall within that knowledge which we are investigating" (Hegel 1977, 53)

This is another one of Hegel's most fundamental insights in the *Phenomenology*, namely, that the smallest unit of analysis that is philosophically relevant is consciousness in its relationship to an object, or what he calls "Experience," or as shorthand: [consciousness → object]. An analysis of such experience, therefore, entails elucidating the meaning of that arrow: what kind of access does consciousness have to its object at a particular point in history? And how do each of these two terms (consciousness (or subject) and object) change, if they change at all? And, finally, what does that change say about the previous relationship between consciousness and its object (what Hegel would call the previous shape of consciousness)? One could very briefly contrast Hegel's position on this with Kant's. Kant revolutionizes the prevalent epistemology of his day by arguing that consciousness (or in his language, the subject) has an organizational structure, which determines the kind of access it has to objects. This structure, for Kant, is permanent or static. It does not change in the course of history, and hence, history is irrelevant to his critical philosophy. Hegel, on the other hand, argues that consciousness is an act that has a historically contingent relationship to its object. The one described by Kant was, for Hegel, simply one very powerful relationship among many.

The Birth of the Clinic is Hegelian in this respect because, in it, Foucault attempts to show that the meaning of that arrow does indeed change between roughly 1775 and 1816 and thus so do both of the terms. More specifically, he argues that in the field of medicine, the relationship of consciousness to its object underwent a profound change around the turn of the 19th century, and that this change had profound repercussions for

human consciousness in general, inevitably on both the theoretical level and the level of everyday experience. As he states in the chapter entitled "Open Up a Few Corpses,"

> it bears jointly on the type of objects to be known, on the grid that makes it appear, isolates it, and carves up the elements relevant to a possible epistemic knowledge (savoir), on the position that the subject must occupy in order to map them, on the instrumental mediations that enables it to grasp them, on the modalities of registration and memory that it must put into operation, and on the forms of conceptualization that it must practice and that qualify it as a subject of legitimate knowledge. What is modified in giving place to anatomo-clinical medicine is not, therefore, the mere surface of contact between the knowing subject and the known object; it is the more general arrangement of knowledge that determines their reciprocal positions and the connection between the one who must know and that which is to be known. The access of the medical gaze to the sick body was not 'the continuation of a movement of approach that had been developing in a more or less regular fashion since the day when the first doctor cast his somewhat unskilled gaze from afar on the body of the first patient'; it was the result of a recasting at the level of epistemic knowledge (savoir) itself, and not at the level of accumulated, refined, deepened, adjusted knowledge (connaissance). (Foucault 1994, 137)

Foucault goes on to say that the "proof" that this rearrangement happens at the more basic, epistemic level is found in the fact that knowledge (connaissances) in the new form of experience (what he calls "anatomo-clinical experience") "is not formed in the same way and according to the same rules as in the mere clinic," which immediately predates it (ibid.). He concludes, "It is not a matter of the same game, somewhat improved, but of a quite different game" (ibid.).

3.5.3 The Criterion for Truth is Sustainability

The third way in which *The Birth of the Clinic* is Hegelian is that it does not bring in a criterion for judging the truth of a form of experience from the outside. As Hegel says in the Preface to the *Phenomenology*, he does not want to import any "bright ideas"

and, more importantly, doing so is unnecessary (Hegel 1977, 54). The truth of a particular shape of consciousness proves itself by organizing our world in a sustainable way. *Blieben sich erhalten* is the German phrase he uses – to sustain itself. For Hegel, of course, no shape of consciousness can truly sustain itself outside the whole system, but each shape is so chosen *as* a shape precisely because it does manage to achieve a period of relative equilibrium.

This is essentially the kind of movement that Foucault's text traces: he analyzes both historically and structurally the tumultuous emergence of a new shape of consciousness, which, over a period of roughly forty years, reaches a relative state of stability. Appropriately, then, Foucault introduces the last chapter of *Birth of the Clinic* by stating, "In this chapter, we shall examine the final process by which anatomo-clinical perception finds the form of its equilibrium" (Foucault 1994, 174). Equilibrium is the criterion that Foucault uses to decide that his archaeology is complete, and equilibrium is a Hegelian criterion.

3.5.4 The Way of Despair

The final point on which I wish to draw a parallel *between The Phenomenology of Spirit* and *The Birth of the Clinic* regards the necessity of violence to philosophical development. As Hegel puts it in Section 78 of the Introduction, "what is in fact the realization of the Concept, counts for [natural consciousness] rather as the loss of its own self; for it does lose its truth on this path. The road can therefore be regarded as the pathway of doubt, or more precisely as the way of despair" (Hegel 1977, 49). In other

words, the unsustainability of a particular shape of consciousness is not established by a theoretical critique performed by philosophical consciousness. The critique is historically played out as natural consciousness tries to use an increasingly inadequate set of beliefs and concepts to manage real practical affairs, real concrete bodies. Thus, says Hegel, the violence which consciousness suffers is "at its own hands" (ibid., 51)

For Foucault, too, the chaos and desolation surrounding the French Revolution were "structurally necessary" (Foucault 1994, 167) to make the need for a new scientific paradigm felt. It was only because the old paradigm failed to provide a scientific and political unity of medicine—which is to say that it failed to care for the sick and dying while also adhering to the staunch political commitments of the era to abolish privileged loci of knowledge—that it was finally overcome.

3.6 Brief Summary of the Main Argument in *The Birth of the Clinic*

Recall that the subtitle of *The Birth of the Clinic* is "An Archaeology of Medical Perception." Thus, what Foucault is essentially trying to do in this text is trace the historical-conceptual path by which the various elements of a new kind of perception come together to achieve a certain moment of equilibrium.[39] Foucault calls this perception *anatomo-clinical perception* (Foucault 1994, 139), since it is the product of the 'mere' clinical perception—which reaches its very brief and unstable zenith around 1800—and pathological anatomy—which storms onto the scene with the publication of

[39] This moment of equilibrium, according to Foucault, is more or less the entire 19th century and a very good chunk of the 20th. When Foucault writes this book in 1963, he says that we are just beginning to emerge from this form of perception, a point that is deeply relevant to my overall project here.

the French physician, Bichat's, two revolutionary works in 1801 and 1807. As I mentioned, on Foucault's account, this whole process of assembling the various elements of anatomo-clinical perception takes approximately forty years, from roughly 1775 to 1816.

First, let us briefly examine these bookmarks. In 1775, the *Societe Royale de Medicine* is formed, and it quickly becomes an organ to collect and record public health data, and, on the basis of this data, it develops plans of intervention aimed at improving the health of the population. This improvement in health in turn enhances the political power and economic prosperity of the state. In brief, then, it marks the concrete realization that a careful monitoring and control of public health is essential to the destiny of a state. The other bookmark, 1816, is the year in which another French physician, Broussais, publishes his *Examen des Doctrines Medicale*, which ultimately results in the addition of a physiological element to anatomo-clinical perception. As such, Foucault might have more properly called the perception whose emergence he was tracing anatomo-physio-clinical perception, but I think, for one thing, he probably just found this too cumbersome. But more importantly, it is the coming together of anatomy and the clinic that he calls "the great break in Western Medicine" (ibid., 146) for reasons I'll get to shortly. In any case, the final addition of physiology, while important, is secondary to this achievement.[40]

I'm going to sidestep the time-consuming task of reconstructing Foucault's entire archaeology, in order to instead draw out just the parts of his argument that will be essential to the next and final section of this chapter where I deal explicitly with

[40] As a methodological point that determines when the transition to a new shape of consciousness is complete, I am going to borrow much more heavily from this final chapter by Foucault. The details of how and why I do so, however, are the subject matter of Chapter Three of this dissertation.

Foucault's critiques of the *Phenomenology*. This is not merely a scholarly point to distinguish Foucault from Hegel. It is central to Foucault's approach to history as decisively non-dialectical (despite all his Hegelian sympathies).

As is typical with Foucault, throughout *The Birth of the Clinic* he employs a diacritical comparison of two adjacent periods in history in order to draw out their distinguishing features, and, of course, in order to trace the complex transition between them, such that the rules governing what it means to make true and false statements change. The periods here are roughly as follows: Renaissance to the 18th century; the transition (1775 to 1816); and the 19th century along with most of the 20th. While Foucault's account of this transition has many levels, the heart of it involves (A) a change in the spatialization of disease and (B) a change in the conceptualization of death. Let us first look at these two elements in the first period, the Renaissance through the 18th century.

3.6.1 Spatialization and Death from the Renaissance through the 18th Century

To explain the spatialization of disease in the 18th century, we must refer to another Aristotelian idea, in this case, the idea of taxonomy, or the division of things according to the logic of genus and species. The taxonomy of diseases is called "nosology." In the 18th century, disease essences were understood against the broad background of nature, just as was the case with the plant kingdom or the animal kingdom. (Let me be clear: I am not referring to a microbiological conception of *entities which cause* disease; I am talking about a conception of the universe in which diseases were themselves a kind of entity, a category of things.) The essence of a disease, within this

nosological framework, was basically a certain ordering of symptoms, a "constellation," as Foucault calls it (Foucault 1994, 103). In other words, symptoms were the elements of disease, and the particular symptoms which were present, along with their order, constituted the specific differences between various species of disease. What Foucault calls the "primary spatialization" (ibid., 15) of a disease, then, is its place within the nosological table. (Later, in Chapter Three, I will delve a great deal more into the similarities of this 'primary' space of disease by comparing it to various versions of the *DSM*.[41])

Given their primary reality as a disease entity, or "morbid essence" as Foucault calls them (ibid., 101), the fact that a disease unfolded in a human body was a matter of their "secondary spatialization" (ibid., 10) and thus conceived of in terms of an accident in the Aristotelian sense. Correspondingly, the fact that a human body may deviate from its basic nature and become ill was also deemed an accidental feature. In short, within this view, there is nothing essential to either the disease or the human body that links the one with the other. As a result, any individual variation in the way a particular disease develops in me versus how it develops in you are just further accidental features that a good physician must learn to subtract when making their diagnosis. And all potentially true statements about a particular disease can only be inferred, tested, disproved, etc. by abstraction and generalization from a number of individual cases.

There is a great deal more nuance to Foucault's account of the primary and secondary spatialization of disease during the classical period (Renaissance through the 18th century), but, for now, this will suffice for a discussion of the corresponding conception of death that is dominant during this period.

[41] See Sections 5.4 and 5.5.

"An immemorial slope as old as men's fear," Foucault says, "turned the eyes of the doctor toward the elimination of disease, towards cure, towards life" (ibid., 179). For this reason, he often refers to illness as a fundamental human experience (e.g., in Omnes and Singulatum). But up through the end of the 18th century, death was still considered outside the realm of medicine, and more generally, outside the realm of science. It was the point at which medicine no longer served any purpose. If anything, it marked the failure of medicine. Autopsies—in the sense of dissections performed in order to *discover* the cause of death—were rarely if ever performed in the 18th century, but not due to the typical cited reasons of moral or religious prudence. Rather, says Foucault, it was that nobody believed there was anything there to see. The dissections that were performed and for which there was no trouble getting access to corpses by the mid-18th century, were performed for the benefit of students, so that the instructor could show the students what the instructor himself already knew to be there.

The living studied themselves from the point of view of life, and as I said above, this was consistent with a conception of disease entities—essentially a set of symptoms in a particular configuration that accidentally (in the Aristotelian sense) attacked life from the outside. Death, then, too, was conceived of ontologically as an accident to life and epistemologically as a "black hole" or "abyss" lurking beneath disease, unknown and unknowable. Foucault states it thus:

> In eighteenth-century medical thought death was both the absolute fact and the most relative of phenomena. It was the end of life and, if it was in its nature to be fatal, it was also the end of the disease; with death, the limit had been reached and truth fulfilled and by the same breach: in death, disease reached the end of its course, fell silent, and became a thing of memory. . . . Death was that absolute beyond which there was neither life nor disease, but its disorganizations were like all morbid phenomena. (ibid., 140-141)

This conception of death as limit was prevalent up to the very end of the 18th century, even through the period of the proto-clinic, or 'mere' clinic, which as I mentioned above reached its brief zenith around 1800. As such, the transformation in the spatialization of disease and the conceptualization of death that I'm about to summarize happened over the course of less than a decade, and nearly all of it rests on the shoulders of one famous French physician, Marie-Francois-Xavier Bichat.

3.6.2 The Transition to the 19th and 20th Centuries

Bichat's importance in the history of medicine is indisputable. Foucault devotes an entire chapter to recounting the import of his great discovery, *tissue*. Tissues, according to Bichat, are at once constitutive of organs as well as constitutive of the systems within which organs are related. There are various kinds of tissues—twenty-one on Bichat's original count—each with its own proper structure and, as such, each with its own possible kinds of deviation or, to use the parlance of the times, its own possible kinds of lesions.

What differentiates "mere" clinical perception from anatomo-clinical perception, Foucault says, is the conviction that lesions explain symptoms. In other words, it is the belief that there is something *beyond* the ordering of symptoms, which the reader will recall, defines the whole essence of disease (and hence its primary spatialization) within the taxonomical model of the 18th century. For the anatomo-pathologist, then, the task is no longer simply limited to diagnosing the particular species of disease according to its constellation of symptoms, but rather to determine the anatomical seat of disease, i.e., the

lesion which underlies it and which defines the way in which the disease is going to unfold in the three-dimensional space of the body.

It is easy to see why autopsies suddenly become important in pathological anatomy—they now have something to *teach* the physician. While a patient is alive, it is true that, for the most part, the doctor has only symptoms to rely upon. The lesions are for the time being hidden underneath the skin. With only symptoms to rely on, then, a physician can make a more or less likely diagnosis, but the real reckoning comes when the patient dies, and an autopsy can reveal *with certainty* which disease had overtaken the body. Once pathological anatomy is fully adopted, Foucault states, the only way to know whether a patient "has" pulmonary pthysis is to open up the corpse and look for the presence or absence of the lesion.[42]

This all important final reckoning point, I will argue in Chapter Three, is precisely the crux of the matter with mental illness. The lesion is lacking. And psychological trauma disorders are decisive precisely because they become the first diagnoses that propose some kind of analogous seat in the "traumatic memory." First, however, I must complete the exegesis here, because a great deal turns on this new role of autopsy.

In this transition, according to Foucault, death becomes a privileged point of view, which can provide information otherwise unavailable to even the best-trained doctors as they confront a living body. Furthermore, this examination of the corpse in order to uncover the pathways of death and disease simultaneously allows medical science to learn a great deal about general processes of life. Life is no longer opposed to

[42] Of course, this is prior to our advances in x-rays, and various other forms of imaging technology, which, to some degree anyway, allow a physician access to that opaque space inside the body. Foucault's point here can be extended, however. These technologies were developed *precisely because* there was a new felt need to "see" inside the body. And even still, no cutting-edge imaging technology is yet able to trump the certainty of autopsy.

death, Foucault says, but rather, taken together, they constitute the two ends of an utterly natural process. The absolute temporal cut-off that death provides, moreover, allows the gaze unprecedented access to what is happening inside the living body. Elaborating on this epistemological privilege, he states,

> Life, disease, and death now form a technical and conceptual trinity. The continuity of the age-old beliefs that placed the threat of disease in life and of the approaching presence of death in disease is broken; in its place is articulated a triangular figure the summit of which is defined by death. It is from the height of death that one can see and analyze organic dependences and pathological sequences. Instead of being what it had so long been, the night in which life disappeared, in which even the disease becomes blurred, it is now endowed with that great power of elucidation that dominates and reveals both the space of the organism and the time of the disease. The privilege of its intemporality, which is no doubt as old as the consciousness of its imminence, is turned for the first time into a technical instrument that provides a grasp on the truth of life and the nature of its illness. (ibid., 144)

To get back to the issue of spatialization, then, what is so revolutionary about Bichat and pathological anatomy is that morbid essences are no longer conceived of as distinct disease entities, which attack the body and thereby "de-nature" it. Rather, it is the body itself which, by its nature (as comprised of tissues), can become ill. And it becomes ill, moreover, in very specific ways depending on the kind of tissues affected and the ways in which they are connected. The contemporary term was "tissual propogation." The task for the physician, on this model, is radically new: to understand the relationship between spatial lesions and temporal symptoms. In other words, the physician must find a way to correlate spatial phenomena that are buried deep in the body with the surface phenomena of temporally unfolding symptoms. A third dimension that links these two is thus added to medical perception,[43] and this three-dimensional "gaze" is what Foucault

[43] Again, this third dimension gets extensive treatment in Chapter Three of this dissertation.

calls anatomo-clinical perception. Now, perhaps more clearly, appears the need for various forms of imaging technology.

I've already begun to untangle the reconceptualization of death that goes along with this new spatialization of disease in pathological anatomy, but let me try to be more explicit about it now. The death that previously marked the limit of medicine, in the sense of what was both unknowable and unworthy of being known, becomes instead the key to knowledge about life and disease.

In other words, death—specifically through the corpse—is what allows for the third dimension of anatomo-clinical perception, specifically by providing a point of view from which one can study the relationship between physical lesions and temporal symptoms. This is the epistemological point: death becomes a privileged point of view over life and disease. Foucault uses the figure of an isosceles triangle in the passage cited above: death is at the apex, illuminating, on one side, the pathological processes of disease but also, on the other side, the healthy or normal life processes going on inside the solid, enclosed three-dimensional space of the body.

But death is not only a point of view for pathological anatomy. It also becomes something with a positive content, in the sense that it comes to contain something that can be known. Specifically, with Bichat, death comes to be understood as multiple and dispersed in time, i.e., as a process that moves through the body according to its material paths of interconnected tissues, i.e., according to the laws of tissual propogation. For example, one's kidneys may stop functioning and, eventually, the built-up waste products cause the lungs to become congested and cease to function. Deprived of its necessary

oxygen, the heart stops and, finally, the brain is starved of blood, so it, too, dies. Such a dispersed unfolding of "mini-deaths" was inconceivable in the 18th century.

Let me stress here that this transformation in medical perception is fully Hegelian in two important senses; first of all, because it is not simply a theoretical movement. Violence and strife are essential. During the *Ancien Regime*, there were entire teaching institutions, and distributions of funds and authority that were structured to work with the classical nosological conception of disease. And when the *Regime* fell and, shortly after, hospital funds were nationalized and universities closed, a chaotic period of medical free-for-all commenced. Charlatans and quacks scammed the ill or even harmed and killed them with unsafe "cures" until the newly formed Republic accepted that they must adopt some role in managing the practice of medicine. Though I haven't highlighted the specifics of this strife, each stage of conceptual transition is born out in highly dramatic, historical terms. Only by traveling this "way of despair" can consciousness can be made to see the inadequacy of its concepts of life, disease, and death for organizing the world in a sustainable way.

Second, this transformation is Hegelian in the sense that it addresses not just an epistemological refinement but an entire recasting of the terms at both the epistemological and the ontological level. Bichat didn't just peel away layers of ignorance and error to gain a better understanding of what disease *is* (though initially this was his goal). His notion of tissue changed our entire conception of what disease is, *although he did not set out to do so*. No longer was it a distinct morbid essence that may or may not attack a human body; with the discoveries of pathological anatomy, disease becomes what Foucault calls "a mobile dimension constantly operating between a

necessarily linked life and death" (Foucault 1994, 155). And life, too, thus changes shape. It is now that which is constantly exposed to death, or more properly, to little deaths, and it is, moreover, that which must constantly resist these deaths. As Canguilhem, one of Foucault's teachers, said in *The Normal and the Pathological*, life is not indifferent to its conditions (Canguilhelm 1989). Simply by living, we are moving towards death, though we are also constantly resisting it. Or, to put it more concretely, from the moment we are born, our organs, which are comprised of tissues, are being worn down in particular ways that eventually prevent us from being able to resist death, and its chosen instrument, disease. And this is the ontological point: with this transition to the anatomo-clinical gaze, the primary and secondary spatialization of disease *collapse* into one. For the first time, disease is superimposed on the space of the body.

3.7 Foucault's Critique of Absolute Knowing

I hope by now I've set things up well enough so that Foucault's critiques of Hegel are becoming clear. In any case, there are two levels of this critique that I want to discuss here, the first leading directly into the second. The first involves the criterion that Hegel gives us for knowing when we have reached Absolute Knowing. He says in section 80 of the Introduction to the *Phenomenology* that "the goal [of this progress through the complete series of forms] is as necessarily fixed for knowledge as the serial progression; it is the point where knowledge no longer needs to go beyond itself, where knowledge finds itself, where Concept corresponds to object and object corresponds to Concept" (Hegel 1977, 51). In other words, the goal of the process "is the point where knowledge no longer needs to go beyond itself" because nothing is other to it (ibid., 51). There is no

more Kantian distinction between the *in itself* and the *for us*, between what a thing is and what we know it to be.

For Foucault, the problem with history being over, as Hegel claims, is that there was still something 'other' to knowledge, namely, "the whole dark underside of disease," or death (Foucault 1994, 195). Until Bichat, death was an unknown, "an indivisible, decisive, irrecoverable event," as Foucault says (ibid., 144). Death thus had no positive content of its own, either scientific or with respect to everyday, concrete experience (in Hegelian terms, for "natural consciousness" or in my terms from the Prologue, for intrapsychic self-constitution). Unknown, mysterious, and linked with a "metaphysic of evil" (ibid., 196), death escaped Hegel's system insofar as it was pointed to something beyond this world, beyond the Concept. On the one hand, the transformations that Foucault traces in *The Birth of the Clinic* are perfectly in keeping with the Hegelian logic. If death was still an unknown, what was required was that it be recaptured in some new form of experience, and this is precisely what anatomo-clinical perception does. So, it might seem like Foucault's critique is merely that Hegel forgot one last step. There was still one final vestige of the infinite left on earth, but there's no need to worry, because Bichat took care of it.

But—and this brings me to the second level of Foucault's critique—this recapturing of death will, on Foucault's account, undermine an important assumption of the Hegelian system itself. In short, what Foucault is arguing is that, through this new spatialization of disease and this difficult reconceptualization of death, the individual (in the sense of the singular or concrete) is opened up to rational discourse. Specifically, once you move to a material underpinning of disease (namely tissue), the minute

variations between individuals in the texture and so on of tissue become relevant and expressible. And these variations become knowable through the corpse. Each of us thus becomes a case study, insofar as we are a unique meeting point of a nearly infinite number of specifiable factors. Language in turn is given the new task of describing these qualitative differences between individuals that are revealed to the gaze only once a corpse is opened up.

As Foucault states, "The old Aristotelian law, which prohibited the application of scientific discourse to the individual, was lifted when, in language, death found the locus of its concept: space then opened up to the gaze the differentiated form of the individual" (ibid., 170). Or, as he puts it elsewhere, death gives to life "a face that cannot be exchanged" (ibid., 172). Thus, we have here come back to one of the primary consequences of Absolute Knowing, namely that with its attainment, all individuals are simply instances of the universal and can therefore be exchanged without loss. Foucault's text can be read as the attempt to trace a change in medical perception, which gave a hitherto unfathomable philosophical density to the individual.[44]

Indeed, in the final pages of his conclusion to *The Birth of the Clinic*, Foucault's allusions to Hegel on this point could hardly be clearer:

> And, generally speaking, the experience of individuality in modern culture is bound up with that of death: from Holderlin's Empedocles to Nietzsche's Zarathustra, and on to Freudian man, an obstinate relation to death prescribes to the universal its singular face, and lends to each individual the power of being heard forever; the individual owes to death a meaning that does not cease with him. The division that it traces and the finitude whose mark it imposes link, paradoxically, the universality of language and the precarious, irreplaceable form of the individual. The sense-perceptible, which cannot be exhausted by description, and which so many centuries have wished to dissipate, finds at last in death the law of

[44] As a side note, Foucault also provocatively states in his conclusion that a similar movement can be traced in the literary transition from the macabre to the morbid.

> its discourse; it is death that fixes the stone that we can touch, the return of time, the fine, innocent earth beneath the grass of words. (Foucault 1994, 197)

3.8 Conclusion

In conclusion, I've attempted to do two things in this chapter. First, I attempted to show that Foucault's text is Hegelian in at least all of the following ways: it demonstrates that truth is produced, and that this fact requires that all philosophical analysis address not the subject or object isolated from one another, but rather consciousness' experience of its object. *The Birth of the Clinic* is also Hegelian in that it uses sustainability as the criterion for the truth of a particular form of experience, and it follows the search for such a sustainable set of practices by tarrying with ordinary consciousness along the "way of despair" as it attempts to organize its complex world with these concepts.

My second purpose in this chapter was to present Foucault's case that the birth of the modern clinic (over roughly the years 1775-1816) undermines one of the most fundamental assumptions about the power of language and the reach of science—operative from Aristotle to Hegel, and given its ultimate articulation in *The Phenomenology of Spirit*. It is no coincidence that this modern clinic (and its concomitant "way to see") came together at precisely the historical hour when Hegel declared there was nothing new under the sun. If we follow Foucault, the fate of the individual *qua instance of the universal* (replaceable without loss) had in fact reached the end of its history. For that kind of individual, it seems we can agree with Hegel: "less must be demanded of him, just as he in turn can expect less of himself, and may demand less for himself" (Hegel 1977, 45).

Taking a step back for a moment and recalling that my ultimate concern centers on the current state of affairs surrounding the psychiatric diagnosis of PTSD, it may seem bizarre that I've begun with *The Birth of the Clinic* and followed its allusions, no less, into the entrails of Aristotelian form and matter and the Hegelian end of history. However, this was no mere scholarly diversion. Everything to come in my analysis hinges on the importance of medicine in the project of knowledge, in the structure of the relationship between the state and the citizen, and in mediating ourselves, intrapsychically and amongst each other. This is to say, my analysis of PTSD must be understood against this backdrop of the "ineradicable chronological threshold" that was crossed when something new emerged in history (Foucault 1994, 195). There was indeed something new under the sun: the non-replaceable (i.e., non-universal) individual. From this critical moment on, the individual (with its intractable material limit in the corpse) stands as the load-bearing structure for our modern way of life: it is a convergence point for the functioning of the centralized state (henceforth acutely concerned with public health), a new project of knowledge in the human sciences (including psychiatry), and a new way of relating to oneself and to each other.

In the conclusion to *The Birth of the Clinic,* Foucault provocatively summarizes the new status of medicine and the import of its new object:

> At that point, medical gestures, words, gazes took on a philosophical density that had formerly belonged only to mathematical thought. The importance of Bichat, Jackson, and Freud in European culture does not prove that they were philosophers as well as doctors, but that, in this culture, medical thought is fully engaged in the philosophical status of man. (Foucault 1994, 198)

Chapter Two: The Third Moment in the Making

4.1 Introduction

As I outlined in Chapter One, Foucault's *The Birth of the Clinic: An Archaeology of Medical Perception* traces a monumental shift from one historical configuration of the relationship among medicine, the individual, and the state, to another, dramatically different configuration. In my exegesis of Foucault's text, I emphasized the epistemological element of this transition, which is to say, the transition *away from* a descriptively based nosology—what Foucault calls "traditional nosology" (Foucault 1994, 130)—and *toward* pathological anatomy. In pathological anatomy, the space of disease becomes one and the same as the space of the body—"superimposed," as Foucault says (ibid., 176)—so that henceforth, when the body appears as an immediately causal space. Foucault names the corresponding new r*egard,* or "way to see," "the anatomo-clinical gaze" (ibid., 134). It is a gaze trained to look within something that was, just a few years before, considered impenetrably opaque—the three-dimensional space of the body—and for the markers of disease that lie within it, i.e., lesions. These localized lesions, moreover, ultimately determine whether or not one *has* a given disease, which in turn means that death takes on a primacy it never had before. Whereas autopsies were virtually irrelevant within the earlier form of medical experience defined by classical nosology (at best used demonstrably), in the new medical experience defined by

pathological anatomy, the corpse holds the final word. Only it can provide the anatomo-clinical gaze with unlimited, uncompromised access to the dark, enclosed space where lesions lurk.

Although Chapter One emphasizes the epistemological element of the transformation traced in *The Birth of the Clinic*, Foucault, in fact, locates these moments of epistemological crystallization across forty years of tumultuous social, political, and intrapsychic turmoil. (Perhaps to emphasize this point, he discusses all events according to the multiple calendars used during the French Revolution, which makes the text maddening to read and perhaps contributes to its undervaluation within both Foucault scholarship and philosophy of medicine). As I mentioned in Chapter One, Foucault demarcates these two historical moments (traditional nosology, on the one hand, and pathological anatomy on the other) according to the Hegelian criterion of "equilibrium." The transition he elucidates between them is also quite Hegelian in form in that it is constructed as a narrative, a story tracing the "way of despair" experienced by natural consciousness when the practices through which it mediates its experience are incoherent. The equilibrium which tells him the narrative is over is established as the outcome of a "crisis over fevers," a crisis which fixes the "final element of the way to see" (ibid., 192)—i.e., the final element of the anatomo-clinical gaze. The process by which this crisis is resolved, says Foucault, establishes once and for all that pathological anatomy will become *the* form of medical experience in the modern era of the West. This crisis, in other words, was both the *product of* the "conceptual and political impasse" over medicine that had been plaguing France for the roughly thirty years since the fall of the *Ancien Regime*, and also necessary for *resolving* that impasse.

In the next two chapters I will present my case that the crisis over PTSD indicates the dawn of a third moment[45] or, rather, the darkest hour before the dawn. To use my language from the Prologue, the fact that the PTSD maelstrom is reaching fever pitch, even when the discourses reflect conceptual mastery of its irresolvabilities, suggests something is about to give. Put in the language of a narrative, this is the climax scene. It is a phase akin in many ways to—though of course also different from—the crisis over fevers of which Foucault wrote. These two chapter, in other words, constitute an extension of the project begun by Foucault in *The Birth of the Clinic*, and will also be informed by his approach to the history of ideas utilized in that text, as well as others he wrote both before and after.

There are three components of the present Chapter. Part I draws out some counter-intuitive "compass" points from *The Birth of the Clinic* that will help me navigate the current maelstrom—or "density of discourses" (ibid., *xix*)—as I move into Part II, which continues with a Foucauldian-inspired intellectual history given in the previous chapter. More specifically, I locate the inception of psychiatry as a human science that stands on the shoulders of the new (non-replaceable) individual that co-originates with the modern episteme Foucault refers to as the "clinic". This story will be abbreviated or, rather, highly selective. Drawing on Foucault's work on mental illness and psychiatric power, I argue that psychiatric medicine developed as a separate but linked economy vis-à-vis organic medicine, beginning around 1810, which is to say, during the same exact years of the crisis over fevers.

[45] The first "moment" refers to the "traditional nosology" of the 18th Century, and the second to Pathological Anatomy.

Having set up the tenuous distinction between these economies, Part III of this chapter presents a counter-narrative for this same historical period. While I do not disagree with Foucault that the economies of psychiatric and organic medicine developed throughout the 19th and 20th centuries according to quite different logics, I mean to emphasize here that "psychological trauma" disorders have always haunted this border, breaking down what was already a tenuous distinction, in large part because these traumatic events create scenes of encounter alongside the scenes of physical wounds or injuries.

All this sets the stage for Chapter Three of this dissertation, which begins with the monumental event that was the publication of *DSM-III*. I've already hinted at the beginning of Chapter One that the publication of *DSM-III* was a radical moment in the history of psychiatry, but not for the reasons often assumed. Here, finally, I can more fully flesh out why it inaugurates not a big step in a cumulatively progressing science but, rather, another "hastening of evolution" (Chomsky and Foucault 2006, 144) in many ways parallel to the one that occurred from 1775-1816. With all this in place, I will be able to make the case that the crisis over PTSD amounts to a collision between two incompatible "ways to see," an incompatibility that will be played out along the way of despair. I certainly do not have the ability nor the arrogance needed to say what the fallout of this collision might be, but I can use Foucault's analysis in *The Birth of the Clinic* of the crisis over fevers in the early 19th century as a guideline for what requirements it might take to achieve sustainable practices. These insights can in turn give me some good critical purchase on the structural changes of the soon-to-be released

DSM-V and its implication for the "philosophical status" of the human being (Foucault 1994, 198). Might it be that there is once again something new under the sun?

4.2: Part I: Methodological Lessons from Foucault

Foucault provides a concise summary of his aim in *The Birth of the Clinic* ten years after its publication in an interview conducted by Dutch philosopher Fons Elders:

> My problem [in *The Birth of the Clinic*] was. . . to pose the question 'How is it that at certain moments and in certain orders of knowledge, there are these sudden take-offs, these hastenings of evolution, these transformations which fail to correspond to the calm, continuist image that is normally accredited?'. . . At this level, it's not so much a matter of knowing what external power imposes itself on science as of what effects of power circulate among scientific statements, what constitutes, as it were, their internal regime of power, and how and why at certain moments that regime undergoes a global modification. (Chomsky and Foucault 2006, 144-145)

Unlike Foucault in *The Birth of the Clinic*, I have chosen to write about what I believe to be another "hastened evolution" or "global modification" *as it is occurring*. As I attempt to hold in view policy evolution, epistemological reorganization, and the (reciprocally evolving) intrapsychic mediating practices of everyday experience (that is, a shift in the tri-partite structure presented in the Prologue), it will therefore be helpful to have some guidelines as to what merits attention.

It is important to recall that the transition from classical nosology to pathological anatomy, on Foucault's reckoning, took less than half a century. The parallels between that transformation and the period between 1980 and 2010 are striking. The year 1980 marks the publication of the first standardized psychiatric *nosology* (which also just

happened to be the one that first codified PTSD), whose form is essentially identical to the classical nosology of the eighteenth century. As I just mentioned, the second bookend of that forty-year period centered around the crisis over fevers, which brought two incompatible ways of seeing into a head-on collision.

I am looking upon these methodological points from *The Birth of the Clinic*, then, as something like a compass within the storm, a source of orientation in the contemporary maelstrom of PTSD. There is nothing static about such a process and, thus, I'm afraid I cannot present a cookie cutter paragraph or two on method. When Foucault wrote *The Birth of the Clinic*, he commented on his atypical approach, saying the text was "an attempt to apply a method in the confused, under-structured, and ill-structured domain of the history of ideas" (Foucault 1994, 195). As the reader might imagine, drawing methodological direction from what was an experiment is far from tidy. Nonetheless, these key points from *The Birth of the Clinic* will be very useful. They are, as it were, the cardinal directions I will use to help me navigate today's PTSD maelstrom and predict a course the storm could take. For the sake of simplicity, I include the entire list of those compass points here at the beginning. I then expound upon each in turn, and as I move through the project, I will reference them according to the numbers provided here.

4.2.1 The Compass Points

(1) A proper intellectual history involves seeking the historical or concrete a priori of a "hastened evolution."
(2) The hastened evolution traced in *The Birth of the Clinic* was set off on a point of "tertiary spatialization," not a scientific discovery. This is crucial for understanding the importance of the public health component of the crisis, as

well as the importance of the spaces of encounter (hospital, mental health clinic, on the frontline, etc.).

(3) The "free field" of unregulated practices during the early years of the French Revolution *prevented* the attainment of sustainable practices, rather than fostering the growth of knowledge untainted by political ends.

(4) Several key moments in the development of the new configuration consisted of a convergence of interests and functions, often anonymously and without moral significance.

(5) Relative equilibrium (i.e., the new configuration) was finally achieved following a crisis over a particular kind of disorder, which exemplified the conflict between two incompatible forms of experience. (Because I am making a case for a strong parallel in the crisis over fevers and the crisis over PTSD, this final point will constitute its own chapter (Chapter Three)).

4.2.2 Seeking the historical or concrete a priori of a "hastened evolution" in medical thought

In the Introduction to *The Birth of the Clinic*, Foucault describes his project thus: to determine, "outside all prescriptive intent," "the conditions of possibility of medical experience in modern times" (ibid. *xix*). His choice of words here makes his affinity for Kant apparent. This is only a "quasi-Kantian" project, however, because, as I treated in the previous chapter, Foucault's critical project is also profoundly historical. Later in his career, he will develop the language of "truth regimes" to emphasize that, though these realms of discourse remain subject to truth-like commitments and rules of engagement, and thus also have truth-like effects, they must be differentiated from any kind of unchanging structure of Truth (see, for example, Foucault 1980). He, therefore, emphatically rejects the model of a cumulatively maturing science, particularly in any human science, as is clearly stated in the passage above.

It was in order to emphasize this historical conception of truth within Foucault's critical project that I placed *The Birth of the Clinic* under a Hegelian slant in Chapter One, but I now wish to complicate that picture further. Though in some sense the historical transition of the type examined in *The Birth of the Clinic* does resemble a Hegelian shift between shapes of consciousness (certainly more than it resembles the maturing science), for Foucault the mechanism is decidedly different from dialectic. For Hegel, the kernel of each shape of consciousness contains within it the seed of its own undoing. Foucault's analysis pointedly approaches history in a different, much more Nietzschean way. He does not look back and find an internal contradiction within the prior form of medical experience. Rejecting dialectic on the one hand and progressive, cumulative discovery on the other, he instead embraces "war and battle" (Foucault 1980, 114) as a metaphor far more "pertinent to history" (ibid., 112). This metaphor emphasizes concretely played out competing strategies and tactics that can, at times, and often under the influence of utterly contingent factors, bring disparate aims in line with one another (See section 4.2.4 below). How these strategies and tactics play out can perhaps be made more comprehensible by understanding Foucault's notion of tertiary spatialization, the topic of the next compass point.

In any case, we can now see that the hastened evolution from classical nosology to pathological anatomy (the subject matter of *The Birth of the Clinic* and my previous chapter) forms an important part of the historical a priori of our entire contemporary organization of medico-psychiatric thought and practice, arguably the most important part.

4.2.3 The revolution in the lines of visibility (i.e., the birth of a new way to see) was set off historically on a point of "tertiary spatialization"

In order to flesh out this crucial point from *The Birth of the Clinic*, I will need to review Foucault's distinction between the "primary" and "secondary" space of disease.[46] The "primary spatialization" of a disease refers to its place within the old paradigm of classificatory thought, its place as a species in the taxonomy of the nosological table. "Secondary spatialization," then, refers to the accidental (in the Aristotelian sense) implantation and development of disease in a human body. According to this view, the implantation of a disease into a body inevitably "denatures" both, which in turn requires a physician was to subtract any denaturing influence of the body in making a diagnosis.

Against this backdrop of the primary and secondary space of disease, tertiary spatialization was of another order entirely. Foucault sums it up thus:

> Let us call tertiary spatialization all the gestures by which, in a given society, a disease is circumscribed, medically invested, isolated, divided up into closed, privileged regions, or distributed throughout cure centers, arranged in the most favorable way. Tertiary is not intended to imply a derivative, less essential structure than the preceding ones; it brings into play a system of options that reveals the way in which a group, in order to protect itself, practices exclusions, establishes the forms of assistance, and reacts to poverty and to the fear of death. But to a greater extent than the other forms of spatialization, it is the locus of various dialectics: heterogeneous figures, time lags, political struggles, demands and utopias, economic constraints, social confrontations. In it, a whole corpus of medical practices and institutions confronts the primary and secondary spatializations with forms of a social space whose genesis, structure, and laws are of a different nature. And yet, or rather, for this very reason, *it is the point of origin of the most radical questionings*. (Foucault 1994, 16; my emphasis)

What Foucault is saying here seems to be the following: each era and society will confront a certain basic fear of poverty, disease, and death. Inevitably, they will develop

[46] For a fuller discussion, please refer back to Chapter One.

practices to contain those fearful elements. According to the myth of a cumulatively maturing science (which, recall, Foucault explicitly rejects in the interview with Fons Elders cited above), these tertiary factors would always *result from* sound knowledge about what disease is, about its primary and secondary spatialization. Knowledge about the nature and cause of disease would inform practices aimed at containing these fearful elements.

But as Foucault argues in *The Birth of the Clinic*, what actually occurred was entirely different. He states, "It so happened that it was on the basis of this tertiary spatialization that the whole of medical experience was overturned and defined for its most concrete perceptions, new dimensions, and a new foundation" (ibid.). That is to say, it was *on the basis* of a point of tertiary spatialization that the primary and secondary space of disease collapsed together in a way that reorganized the visible and the invisible. Two hundred years later, we take it as self-evident that the space of disease is one and the same as the space of the body (superimposed), because the entire practice and governmental regulation of medicine (as well as its role in intrapsychic and social mediation) takes it as self-evident.

The "compass" point I am drawing from Foucault here is that questions of tertiary spatializations are not derivative. These "various dialectics"—with their "heterogeneous figures, time lags, political struggles, demands and utopias, economic constraints, social confrontations" (ibid.)—may in the end, resolve the irresolvabilities of PTSD, even though most histories will be rewritten according to the myth of the march of knowledge and the overcoming of prejudices.

Lest this all seem far too vague, I offer here a more detailed exegesis of Foucault's claim that it was a point of "tertiary spatialization" that overturned classical nosology two hundred years ago. At the time, it was seen as a minor change in practice, designed to improve the efficiency of treating the sick: keep them in their homes. The argument was that, in the home, the disease would be de-natured as little as possible, allowed to develop in its purest form. A disease could therefore run its "natural" course (recall the concerns about all secondary factors which could "denature" the true expression of a disease). Moreover, the family could benefit from many of the resources accorded to the patients (e.g. heat, food, etc.). Finally, no one could possibly be more invested in caring for a sick patient than his or her family, so the cost of labor would be drastically reduced, absorbed by the care of family members who gave their labor freely, spontaneously.

This change in the space defining the relationship between patient, physician, and all others responsible for the manual labor of caring for the sick involved, at least on the surface, no new scientific discovery. Even less does it seem to impinge in any significant way on the operative episteme regarding what a disease *is* and where it resides in the order of things (the nosological table). However, according to Foucault, the consequences of this new spatial arrangement were so enormous that it did precipitate just such an epistemic overhaul.

Briefly, caring for the sick at home required a certain generalized flexible system of assistance based around the family, constant vigilance by those who are most concerned and those who can also benefit from the assistance given (ibid., 18-19). It thus also entailed a new role for the state, namely, to determine how and when to distribute

funds to individual families as well as an elaborate system of certifying physicians to distribute such funds. “The medicine of individual perception,” says Foucault, “of family assistance, of home care can be based only on a collectively controlled structure, or on one that is integrated into the social space in its entirety. At this point, a quite new form, virtually unknown in the eighteenth century, of institutional spatialization of disease, makes its appearance” (ibid., 20). In this moment, he continues, “medicine becomes a task of the nation,” (ibid., 19; emphasis mine).

Very quickly, this bureaucratic apparatus came to require a robust system of data collection, sorted by province, by disease, etc. To incorporate some of Foucault’s later language, this is the birth of “population”: a body politic with statistical regularity to its illnesses, births, deaths, and so forth. It is also the genesis of the state’s vital concern with the “health of its population” and the public’s sense that the management of health falls under the province of the state, yet is redistributed throughout the familial and community space (Foucault 1990; Foucault 2007). In other words, *it is the origin of public health as a central component of modern Western governance.* Initially, however, the radicality of these new policies remains on the tertiary level: the concept of what disease *is* and how it affects what the body *is* have not been challenged.

Crucially, however, implementing this new policy of home treatment could only be partial. Inevitably, there were patients who had no such home or family to rely upon, and then there were the extreme cases, for which most families were ill equipped. For these disparate types of cases, it was deemed necessary to maintain a (vastly diminished) hospital system. However, debate immediately erupted regarding how such hospitals should be funded, given that hospitals had all but been abolished and their funds

nationalized as part of the ideological commitments that brought down the *Ancien Regime*.

After a very short time lag indeed, the new Republic discovered that it needed well-trained physicians as well as a system of regulating their practice if it was to ensure the public health and the prosperity of the state. Enter the idea of a teaching hospital, or what is translated as "the clinic". The educational function was to justify the expenditure, and as such, its structure was to provide exemplary cases of each disease for the purposes of teaching. In practice, however, very poor people or very sick people do not always amount to pure, exemplary cases ideally suited for the purposes of education.

It was here, then, in the teaching clinic, that the stage was unknowingly set for a collision of two incompatible epistemes: traditional nosology versus the newly emerging and, as yet, small discoveries of pathological anatomy. The conceptual incompatibility between them animated the struggle over how to organize the literal space of a hospital and the bodies within it in order to care for the destitute and the grievously ill, all the while also seeking exemplary cases with which to teach new physicians. In Chapter 5 of *The Birth of the Clinic*, "The Lesson of the Hospitals," Foucault provides an analysis of the hospital at Montpellier, which most dramatically enacted the epistemic confrontation (a matter of the primary space of disease), masked behind a flurry of debates about policy, space, and structure, i.e., matters of tertiary spatialization.

Thus, what began as concerns of tertiary spatialization, whose "genus, structure, and laws are of a different nature" than the primary or secondary space of disease (Foucault 1994, 16), nonetheless quickly raised the incompatibility between pathological anatomy and the old classificatory thought (i.e. nosological thought). Leaving several

details aside, the key point is this: the irresolvability was not settled because of either purely economic or humanitarian reasons. Rather, through a series of discursive revisions—"transparent" discourses, as Foucault likes to say (ibid., 165)—the conceptual irresolvability was re-hashed over and over again until a new scientific and political unity of medicine was achieved. In this brief historical episode, Foucault emphasizes the metaphor of war and battle, because various political, economic, and social interests (i.e. elements grouped under matters of "tertiary spatialization") converged, often without even hinting that it was a moral battle (see point 4.2.5 below).

It's unfortunate that this rich concept of tertiary spatialization is so hard to adopt as a technical term, because the triumph of pathological anatomy over classical nosology amounted to a collapse of the primary and secondary "space" of disease into one. In fact, the collapse of the primary and secondary space of disease—i.e., the superposition of the space of disease onto the space of the body—precisely constitutes, according to Foucault, "the great break in the history of Western medicine" (ibid., 146). (Incidentally, throughout his career, he constantly reiterates the monumental importance of this threshold for nearly every aspect of the modern, Western way of life.) In any case, with primary and secondary reduced to one, *tertiary* seems quite misleading. But, for lack of a better term and with this caveat firmly articulated, I'm going to use it here.

4.2.4 Convergence of Interests and Functions, often anonymously and without moral significance, even coincidentally

A historically contingent outbreak of epidemics, both among citizens and livestock, also constitutes an important part of the historical a priori of the transition from

classical nosology to pathological anatomy. Epistemologically speaking, these epidemics were, Foucault argues, of "marginal importance" (ibid., 22), since they were thought to be different from the sporadic case only in *degree*, a crossing of a quantitative threshold. However, the practices to address its phenomena differed dramatically, requiring mass corpse disposal, curfew enforcement, etc. In point of fact, epidemic and epizootic phenomena incited the *Ancien Regime* to found *The Societe Royale*, but although it begins "as a control body for epidemics, it gradually became a point for the centralization of knowledge, an authority for the registration and judgment of all medical activity" (ibid., 28).

And although, as Foucault states, the medicine of classes and a medicine of epidemics are opposed on every point of primary spatialization,

> when it is a question of these tertiary figures that must distribute the disease, medical experience and the doctor's supervision of social structures, the pathology of epidemics and that of species are confronted by the same requirements: the definition of a political status for medicine and the constitution, at the state level, of a medical consciousness whose constant task would be to provide information, supervision, and constraint, all of which 'relate as much to the police as to the field of medicine proper.' (ibid., 26)

Within Foucault's archaeology of the new medical perception, then, this "policing" function constitutes an important element of the new gaze, which was solidified in an anonymous and amoral convergence of the state's concern with regulating the practice of physicians, on the one hand, and managing epidemic and epizootic outbreaks on the other.

To thread these first three compass points together a bit (and therefore make clearer my use of *The Birth of the Clinic* as a compass), if we examine the epistemic shift from classical nosology to pathological anatomy in terms of it historical a priori, we

quickly discover that it did not occur as a progressing science. Rather, it was set off on a point of tertiary spatialization, a seemingly minor shift in policy to keep patients at home as much as possible (as opposed to being treated in the hospital). This in turn precipitated a collision between the relatively new insights of pathological anatomy and the entrenched, a collision which played out in debates over the organization of the literal space of the teaching hospital (or clinic). Moreover, the emerging concern of the central state to regulate the practice of physicians and the distribution of funds (among families who were caring for their members at home and also among the limited new hospital system) found its mediating institution in the Societe Royale, whose original function was quite limited and nonetheless, quickly expanded. In any case, these historically contingent collisions and convergences brought about a whole new understanding of the being of disease and its relationship to the human body, i.e., a collapsing of the primary and secondary space of disease, which amounted to a revolution in the epistemological rules of medicine and ontological status of human being (and disease).

What is so fascinating to Foucault is that history was quickly rewritten to claim that the epistemic shift—the new scientific discoveries of pathological anatomy—preceded the changes in practice and hospital organization, and in fact justified them. Nietzsche expresses this all-too-human folly most eloquently:

> Is the 'goal,' the 'purpose' not often enough a beautifying pretext, a self-deception of vanity after the event that does not want to acknowledge that the ship is *following* the current into which it has entered accidentally? that it 'wills' to go that way *because it—must?* that it has a direction, to be sure, but—no helmsman at all?[47] (Nietzsche 1974, 316)

[47] *The Gay Science*, book 5, sec. 360.

Importantly, this kind of historical revision belies the underlying nature of or, rather, mechanism, of power. In this mythical tale, scientific advance appears like a hero on a quest toward truth, subjected only to the obstacles of repressive forms of power—be they religious or political or even ignorance. Again, Foucault has another story.

4.2.5 The Free Field (of practice) did not set knowledge free; on the contrary, it hindered the consolidation of a politically and scientifically compatible form of medical experience

The ideology of the French Revolution called for a "free field" of knowledge (Foucault 1994, *xv*). Freed for observation from both theoretical prejudices and the morally and politically entrenched elite, the medical gaze (it was believed) could finally discover the truth of a disease. One of Foucault's most counter-intuitive points in *The Birth of the Clinic* is that this free field—which concretely entailed the abolition of guilds, universities, and hospitals; in short, any privileged loci of knowledge—precisely *inhibited* any kind of scientific advance or, rather (since he is critical of the notion of "advance"), it inhibited the epistemic transition that had already begun from classical nosology to pathological anatomy.

Foucault is unequivocal here: it was the commitment to scientific, political, and economic liberalism that for years *prevented* the organization of clinical medicine (understood quite literally as the organization of hospitals according to the new precepts of pathological anatomy). Stated in more Hegelian terms, without consistent mediating institutions in place, the epistemic transition could not be completed.

If it seems odd to bring this point up here since no one is attempting to abolish privileged loci of knowledge, we need only focus our lens a bit more on the US institutions and policies in place for managing mental health. Compared to most other western nations, the mental healthcare practices in the US appear like the wild, wild west. I could offer numerous examples. The US Department of Defense explicitly states that they do not have a unified mental health policy but rather a piecemeal strategy, and yet this is our most highly regulated site of intervention. It is a widely known fact that US prisons hold a disproportionately high number of mentally ill inmates. A minor scandal broke recently in New York State when it was revealed that, although many children held in juvenile detention facilities are on psychiatric medications, the state does not employ even one full-time psychiatrist. I could go on and on, but perhaps I've made my point: the US has an astonishing array of ad hoc and unevenly applied practices for dealing with mental illness.

4.2.6 Much of the Discourse Acts as a Screen for the Real Issue

As I've outlined, within Foucault's account, new public health practices (elements of tertiary spatialization) at the turn of the 19th century eventually created the conditions of possibility for new "elements" of the gaze (*regard*) until, finally, there was a widely felt unsustainable state of affairs. The much re-hashed debates of the era, says Foucault, "acted as a screen. . . for the real question" (Foucault 1994, 77-78) which was a confrontation between two conflicting "form[s] of experience" (ibid., 51) or epistemes if you will. This confrontation had to be resolved before there could be a political and

scientific unification of medical practice, but this was no abstract confrontation. The new form of medical gaze (the *regard* of pathological anatomy) came to fisticuffs with the previous form of the gaze (which saw only the nosological constellation of symptoms) in the crisis over fevers, the unfolding of which is included in the next chapter.

Again, it is not my aim to reconstruct Foucault's entire archaeology from *The Birth of the Clinic*, nor to offer some kind of cookie cutter map of what is currently happening in the vortex of phenomena surrounding PTSD. Rather I am attempting to give some depth to his methodology in order that it might serve as a lens of sorts, to help account for the role of the public element (fraught with historical contingency) in what seems to be the birth of a new *savoir*, i.e., an entirely different set of rules for forming objects, concepts and statements.

4.3 Part II: A Foucauldian Account of Psychiatric Experience from 1816-1980

4.3.1 Psychiatry as a "Human Science"

In the conclusion to *The Birth of the Clinic,* Foucault provocatively summarizes the foundational place of (modern) medicine (i.e., in the form of pathological anatomy) vis-à-vis all the human sciences, or rather, as a condition for even conceiving of the human sciences:

> It is understandable, then, that medicine should have had such importance in the constitution of the sciences of man—an importance that is not only methodological, but ontological, in that it concerns man's being as object of positive knowledge. . . . Hence the fundamental place of medicine in the over-all architecture of the human sciences: it is closer than any of

> them to the anthropological structure that sustains them all. (Foucault 1994, 197-198)

"The anthropological structure" that sustains all the human sciences, of course, is the newly defined individual, which is no longer an interchangeable instance of the universal as it had been from Aristotle through Hegel (see Chapter One). The exemplary role of medicine in the history of ideas hinges on its delivery of the corpse as an epistemological point of access and an ontological point of differentiation. "It will no doubt remain," says Foucault, "a decisive fact about our culture that its first scientific discourse concerning the individual had to pass through this first stage of death" (ibid., 197). Psychiatry must be understood as an offspring of this stage of death, a scientific pursuit to know the singular; a "science," as Freud called it, of the individual human psyche (Freud 1999).

4.3.2 The Legacy of the Lesion

Although psychiatry, as a human science, relies upon organic medicine and its exemplary relationship to the material objectivity of the corpse (with its corollary practice of autopsy) for its very structure and aim, it also inevitably suffers from an epistemological inferiority in comparison to medicine. I refer to this as the Legacy of the Lesion.

Foucault began his intellectual career troubled by exactly this problematic legacy, essentially claiming that psychiatry can only be an unruly descendent of the "great break

in western medicine" (Foucault 1994, 146). In his earliest published book,[48] translated as *Mental Illness and Psychology*, Foucault asks in what way we could possibly understand the relationship between mental illness and organic illness as anything more than a deception of language. He concludes with the verve appropriate to his youth, "The coherence of psychological life seems, in effect, to be assured in some way other than the cohesion of an organism" (Foucault 1987, 10). In my paraphrase, he is saying, *look all you'd like at the corpse. What we call mental illness or mental health will never reveal itself therein, because it is not distributed spatially, anatomically.*

In the first edition of this early text, Foucault concludes that psychiatry, conceived of as a branch or specialty of medicine, is doomed to fail. Instead, he argues, we ought to be pursuing an existentially based psychology, using, for example, the Heideggarian starting point of being-in-the-world (Foucault's model here is the work of Binswanger). In the second edition of *Mental Illness and Psychology*, Foucault abandons this prognosis of doom and thus also his prescriptive intent. Instead, he poses an entirely different question about the cultural meaning of attempting to inscribe psychiatry within medicine, given that it lacks any ground comparable to the "organic unity" of the corpse.

Later in his career, Foucault distances himself from this early text completely, saying it was alternately too caught up in neo-Marxist theory and structuralist concerns—the debates which defined his intellectual milieu in France at the time. By the time he writes *The Birth of the Clinic* several years later, he emphasizes that he has abandoned the role of prescription. He states in the Preface,

> I should like to make it plain once and for all that this book has not been written in favour of one kind of medicine as against another kind of medicine, or against medicine and in favour of an absence of medicine. It

[48] Published in 1954, nine years before *The Birth of the Clinic*.

> is a structural study that sets out to disentangle the conditions of its history from the density of discourse, as do others of my works. (Foucault 1994, *xix*)

However, psychiatry's place as a specialty within medicine—coupled of course with the problematic distinction between "organic" illness and "mental" illness—continues to vex him. He returns to these themes ten years after the publication of *The Birth of the Clinic* in his lectures at the College de France between 1973 and 1974—published as *Psychiatric Power.*[49] By this point, he has had a revelation in his own thought that leads him to abandon his former view of power as primarily repressive, and to formulate explicitly his now famous account of its productivity. (As I've already argued in Chapter One, of course, though Foucault never mentions 'power' in The Birth of the Clinic, he does adopt a view of truth as produced). In these lectures on psychiatric power, then, he is certainly no longer interested in whether an epistemologically based[50] psychiatry (as opposed to an existentially based one like that of Binswanger) is doomed to fail. Rather, he starts from the obvious fact that psychiatry and its practices occupy a formidable position of mediating force for modern Western subjects, because they *produce* truth-like effects, and he undertakes an analysis of its practices and the form of power they enact in the physician-patient encounter. Nonetheless, he again frames his inquiries on psychiatric power with an observation about its incongruence with the practices of (general or organic) medicine. He states:

> Leaving aside for the moment the problem of why in fact such a practice [of psychiatry] could be seen as a medical practice, and why the people who carried out these operations had to be doctors, it seems to me that, in

[49] Delivered in 1973-74 but not published in French until 2003 (and in English translation in 2006).

[50] The phrase "epistemologically based psychiatry" was inspired by Hubert Dreyfus's introduction to *Mental Illness and Psychology*. Specifically, it refers to a model in which there are discernible species of psychiatric disorders, i.e., natural kinds, as a philosopher of science might say (Foucault 1987, vii-*xliii*).

> its morphology, in its general deployment, the medical operation of the cure performed by those whom we think of as the founders of psychiatry has practically nothing to do with what was then becoming the experience, observation, diagnostic activity, and therapeutic process of medicine. At this level of the cure, of this event, the psychiatric scene and procedure are, I believe, from that moment, absolutely irreducible to what was taking place in medicine in the same period. (Foucault 2006, 11-12)

Foucault's claim in this passage (and also consistent with the passage above from *The Birth of the Clinic*) is that, although the new field of psychiatry depended on organic (or general) medicine for its legitimacy, "the psychiatric scene" in fact had very little to do with the new organization of clinical medicine, the latter being organized according to the precepts of pathological anatomy. Rather, he says, it entailed the highly ritualized organization of spaces and bodies based primarily on power differentials: a "disciplinary structure" between patients, supervisors, servants, doctors, etc. that involved, above all, a battle of wills.[51] In other words, Foucault is claiming that, from its very inception, the practices of psychiatry look remarkably different from those of organic medicine.

4.3.3 The Psychiatric Scene Epitomized in the Hysteria Vortex of the 19th Century

In *Psychiatric Power* Foucault goes into great detail on the encounter between the hysteric and her physician, and he relies upon the multiple accounts of Charcot's "treatment" scene, as recorded primarily by his students. These scenes are so instructive

[51] Foucault here cites texts from the era 1810-1830, which describe the "ideal physique" and even hair color of an asylum physician. In these ideal accounts, he shows, "there is no application of a technical medical formula to something seen as a pathological process of behavior. What is involved is the confrontation of two wills, that of the doctor and those who represent him on the one hand, and then that of the patient. What is established, therefore, is a battle, a relationship of force" (Foucault 2006, 10).

because they highlight that the practice of psychiatry for so long had nothing whatsoever to do with lesions or corpses.

Charcot famously argues that it is dogmatic to assume there must be any link whatsoever between organic illness and mental illness, proposing that it is entirely possible to have a purely psychogenic cause of hysteria. He further states that the "traumatic neuroses"—which seem to emerge following real, catastrophic events (e.g., those following serious railway accidents so prevalent in the era)—are in no relevant way different from the symptoms of the hysteric (Micale 1995).

On Foucault's account, Charcot takes the possibility of a purely psychogenic cause to its logical end. Not only diagnosis but also the very existence of the disorder depends upon the eliciting power of the physician. On Foucault's analysis of this scene, Charcot must rely exclusively on a clinical encounter of wills, a spectacle thoroughly imbued with humiliation and shame. And, as Foucault so eloquently points out, the physician's power, or will, is limited by the moment if and when the hysteric can turn this shame back upon the physician, by exceeding what he attempts to elicit. That is to say, when the hysteric's words and behavior become so grotesque (usually hyper-sexual) that they exceed what the physician is trained to see, he must *turn away*, though ostensibly he will pass this off as an act of propriety. For Foucault, this movement of turning away is akin to tossing out corpses during the 18th century, when medical experience was organized around classical nosology. Once a patient was dead, the physician looked away without performing an autopsy, because, I repeat, he believed there was nothing to see.

To return to the question of the basic structure of psychiatric experience, Foucault's point in analyzing these opposing scenes is to illustrate that since its inception,

psychiatry had virtually nothing to do with the structure of medical experience, despite its ostensible place as specialty. As such, for decades, the practices remained largely isolated in separate economies.

Moreover, Foucault says that, without the objective limits drawn by the corpse, the disciplinary structures put in place during the inception of psychiatric practice persist in a way very different from organic medicine, at least up until the late 20th century. To put it differently, whereas organic medicine has been able to attain a degree of relative objectivity, akin to the likes of biology for example, psychiatric medicine as the science of mental illness has been able to attain no such comparable objectivity. (Arguably, the structure of *DSM-III*, which I will discuss in detail in Chapter Three, finally at least makes an experimentally based science of psychiatry structurally *possible*. Whether it can attain objectivity, of course, is perhaps the question of our day.)

4.3.4 New Lines between the Visible and Invisible vs. The Myth of a Maturing Science

My aim here is not to focus on Foucault's intellectual trajectory. I do, however, believe he makes a convincing case that psychiatry has always inhabited a peculiar position under medicine's wide umbrella. Its undeniable mediating force depends, by and large, on it being a *medical* specialty, replete with doctors and scenes of encounter based in a clinical setting of sorts. Moreover, although for most of its first two hundred years psychiatric practice bears little resemblance to general medical practice, it is by and large careful never to appear at odds with it. (Freud, for example, always maintained that a biological cause would eventually be found for the neuroses). Yet with nothing to *see* at

autopsy (or at least the long-operative belief that there is nothing to see), mental illness and its associated science of psychiatry has languished under the weight of its bastardized epistemological position vis-à-vis organic medicine, as a science of so many "invisible" disorders.

The "invisibility" of mental illness, however, demands a closer look. The entire point of Foucault writing *The Birth of the Clinic* was to reveal the historical production of a gaze able to see lesions, what he calls the anatomo-clinical gaze. (This productive process, moreover, must be seen as the historical *condition* for any and all technological advance we've since undertaken to identify the lesions that remain hidden under the skin until a person actually dies, e.g., x-ray or MRI). So although it seems self-evident to us now, we need only recall that the lesion carried no such importance even in the mid-eighteenth century, and autopsies were scarcely ever performed, though corpses were readily available. Foucault uses this easily demonstrable fact—that no one wanted the corpses—to demonstrate that it was actually the lines of visibility that were being re-drawn, even though most medical histories have been (falsely) re-written to comply with the myth of scientific advance. Writing about the seductiveness of this myth in the conclusion of *The Birth of the Clinic*, Foucault states:

> [It seems that what] was fundamentally invisible is suddenly offered to the brightness of the gaze, in a movement of appearance so simple, so immediate that is seems to be the natural consequence of a more highly developed experience. It is as if for the first time for thousands of years, doctors, free at last of theories and chimeras, agreed to approach the object of their experience with the purity of an unprejudiced gaze. But the analysis must be turned around: it is the forms of visibility that have changed; the new medical spirit. . . cannot be ascribed to an act of psychological and epistemological purification; it is nothing more than a syntactical reorganization of disease in which the limits of the visible and invisible follow a new pattern. (Foucault 1994, 195)

Debunking false histories is certainly a Foucauldian hallmark, since he believes we are easily seduced by tales of cumulatively building knowledge as the overcoming of ignorance and especially, the overcoming of repressive forms of power, be they state or religious.[52] But one ought to remember that he does not debunk such myths simply for the sake of exposing bad historians. He finds it revealing that history can so quickly and unabashedly be rewritten, oftentimes in the face of very obvious counterevidence. Specifically, such ad hoc revisions reveal that something much bigger and deeper is going on—as he might say, at the level of *savoir* rather than *connaissance*—but that natural (or ordinary) consciousness requires a more coherent story. In Hegelian terms, this is natural consciousness recasting its object as an immediacy.

Thus, as I attempt to argue that what is at stake in PTSD is the organization of a new way to see, which is to say, new limits of the visible and the invisible, I also must contend with similarly seductive false histories and, since it is happening here and now, false projections regarding "what is needed"—for example, Lainez's claim that some future scientific advance might clarify the etiology of PTSD and thus re-open the question of Purple Heart eligibility (McMichael 2009).

4.3.5 Separate but Equal? Are Psychiatric Disorders Real?

To sum up, the vexing problem of the "invisibility" of mental illness co-originates with the science of psychiatric medicine, almost by definition. Psychiatry, in effect, is a

[52] Reflective of his intellectual context among the French Left in the 50s and early 60s, Foucault devotes time to debunking other methods of history, for example, Marxian or those of the transcendental phenomenologists. However, I restrict myself here to his critiques of the refinement models of knowledge, because these are certainly the most operative in the discourse surrounding PTSD and psychiatry in general.

discipline developed to treat what were referred to as "the nervous disorders," in other words, those apparently "without organic lesion" (Foucault 1994, 178). After nearly two hundred years, we face the exact same problematic with PTSD. For example, the 453-page report released by the Rand Corporation in 2008 is titled "The Invisible Wounds of War" (Tanielian and Jaycox 2008). It provides a cost-benefit analysis to argue in favor of extensive federal government funding to treat these "invisible" wounds of Operation Enduring Freedom and Operation Iraqi Freedom, in particular, its "signature wounds": PTSD and Traumatic Brain Injury (TBI) (ibid., 4). The durability of this problematic speaks to the simultaneous stability—or sustainability—of the practices, built upon the basic structure of the "anatomo-clinical gaze," which *sees* lesions, that Foucault provides in *The Birth of the Clinic*.

This material limit of the corpse and the type of experience defined by it has allowed organic medicine to adhere at least more closely to the mythic metaphor of a cumulatively maturing tree of knowledge. In more straightforward scientific terms, as I said above, it has achieved a degree of objectivity. Even those disorders, which for brief moments might be horribly stigmatized, like AIDS, eventually lose their moral stigma in the face of the scientific objectivity that the afflicted is not to blame for his or her sickness.[53]

Suspicion over whether or not the suffering is "real" has haunted nearly every one of the rotating cast of what Ian Hacking calls "transient mental illnesses" over the past two hundred years.

> What counts as evidence that a psychiatric disorder is legitimate, natural, real, an entity in its own right? . . .

[53] I am alluding here to the position Susan Sontag maintains in *Illness and Its Metaphors* and *AIDS and its Metaphors*.

> Perhaps all [these] problems will be erased when we have enough objective scientific knowledge. I have another view. We do have a limitless reservoir of ignorance but we also have conceptual confusions that new knowledge seldom helps relieve. There are a number of reasons for this, but I am especially impressed by the way that scientific knowledge about ourselves—the mere belief system—changes how we think of ourselves, the possibilities that are open to us, the kinds of people that we take ourselves and our fellows to be. . . .
>
> We often express our malaise about this phenomenon, which we do not correctly identify, by asking whether certain disorders or their manifestations are real. The first chapter of my recent book about multiple personality disorder was titled 'Is it real?' 'I am not going to answer that question,' I wrote; 'I hope that no one who reads this book will end up wanting to ask that question.' Vain hope! Time and again people have taken me aside and quietly asked what I actually believe: is multiple personality real or not? (Hacking 1998, 9-10)

Put in terms of the stages of a science as described by Hacking, most psychiatric disorders are not diagnosed with any kind of independent validator. Lack of such a validator perpetuates the recurring irresolvability between malingering and shame/stigma that plagues the field of mental illness. I would suggest, however, that it is acting as a "screen" for the real issue: the source of this "reality" conundrum is largely the legacy of the lesion I have just outlined.

However, that is not to say I mean to dismiss the ethical element. We feel so uneasy in the face of the "reality" of mental illness because it raises disquieting questions about responsibility, and that can destroy even well-established social rituals and practices, as it did for my family when my cousin committed suicide. The mask this problematic wears, in other words, may change. And even if we are in a historical epoch that will re-draw the lines of visibility, i.e., structure a new episteme or *savior*, it will carry profound moral implications. The Hacking passage above rings almost Hegelian: since we mediate our entire intrapsychic and intersocial lives through the concepts and

practices of medicine (including its unruly offspring like psychiatry), when we find that mediation to be untenable, we feel a deep malaise, although we may "mis-name" it as a problem of "reality." Moreover, despite what the anti-stigma campaigns might suggest, this confusion over codes of social responsibility and acknowledgement do not turn simply on ignorance. "Mental illness" does indeed continue to shudder under the legacy of the lesion, but simply more knowledge will not solve the problem.

At this point, I can perhaps finally explicitly reject the model of psychiatric disorders as timeless and universal "natural kinds" that were simply unrecognized in previous times or remain so in other cultures. As a corollary to this historical a priori approach, I am rejecting any view that scientific progress would advance uninhibited were it not for external, repressive forms of power (be they state, religious, etc.), a point that will be more fully developed in Point (3) below.

4.4 Part III: The Counter-Narrative—The Special place of Trauma Disorders

As I just reviewed, with his analysis of 19th century insane asylums in the *Psychiatric Power* lectures, Foucault claims that since the inception of psychiatry, the psychiatric illness has operated within an economy different from—though tenuously linked to—that of organic illness: separate in the form of power it enacts and in terms of what the psychiatric gaze *sees*.

And yet, although Foucault devotes little attention to them, psychological trauma disorders began almost immediately to haunt the boundary between these separately

developing economies. As such, they occupy a peculiar position in this unfolding history. They are exceptional for at least all the following reasons, many of which are *tertiary*:

(1) They almost always produce physical as well as mental or emotional disturbance.

(2) Their connection to politically and socially charged events—paradigmatically wars, but also, e.g., railway accidents of the 19th century or terrorist attacks and natural disasters in the 20th and 21st centuries.

(3) These events produce spaces and scenes where psychological casualties are confronted right alongside physical casualties, i.e., absolutely not an entirely separate scene of the sort analyzed in Foucault's accounts of the asylums.

(4) The sheer quantity of suffering has necessitated intervention even when unified political will or unified medical evidence were lacking, or certainly, where there was lacking any convergence of political will/ideology with medical evidence. Without such unified political will or medical evidence, these practices have inevitably been designed and applied in quite an ad hoc manner.

(5) The fact that they seem to affect even "the best and the brightest" and thus prompt a need to "rehabilitate" or "cure" certain populations at certain moments (e.g., distinguished military officers).

Because of their frequent relation to (often manmade) catastrophic events, trauma disorders were some of the first to be regularly treated in the same facilities and by the

same physicians as traditionally "organic" disorders (and they remain so, primarily in the military context but also in immediate responses to other events such as natural disasters or terrorist attacks). Moreover, the distribution of symptoms following such large-scale events has repeatedly destroyed all classist, sexist, and racist biases that are more easily maintained in other non-event related "disorders," even those with a similar symptom profile such as hysteria.

4.4.1 Railway Spine

These peculiar features first hit the world stage with a condition known at the time as "railway spine" (see page 35 in the Prologue). The temporal line drawn by the railway crash—the event—becomes something like a pseudo-lesion. It is "pseudo" because although it is theorized as the seat of the disease—or to use Young's term, as the "most typical feature" (Young 1995, 124)—it is still invisible at autopsy. By comparison, the less "typical" features, like nightmares, lethargy, racing heart, or outbursts of anger, seem far more visible, but again, not at the all-important moment of autopsy. Railway spine is also important because it is the first disorder "without organic lesion" for which economic responsibility becomes a widespread issue. Nearly all Western countries whose passenger travel was revolutionized by rail travel were plagued, within a few years, with copious litigation over the reality and ultimate financial culpability for what seems to be a psychogenic disorder that produced physical symptoms.

I am not going to delve into the details of each trauma-related disorder coined since the early 1800s, but I do want to briefly address two more, first WWI and its associated psychological disorder known as "shell shock" and second, Vietnam.

4.4.2 WWI and Shell Shock

Because of the debates that arose around Railway Spine and other similar conditions sparked by the Industrial Revolution, by the time of WWI, "traumatic injury" had taken on the two distinct meanings: physical trauma (including physiological shock following gross injury) and psychic trauma. The relationship between the two, however, was far from clear.

What WWI added was a hitherto unseen *quantity*; critical mass was quickly reached and surpassed. It is by this point a banal historical fact that WWI provided physicians with an incomparable natural laboratory, and that the science of organic medicine—particularly in the domain of acute physical trauma—advanced dramatically during these brief years. It is an equally banal fact that The Great War provided physicians with an abundance of psychological wounds, but as Young concisely points out, there was no kind of comparable advance: "In the case of the psychogenic traumas, there was no accumulation of knowledge, development of new treatments, or revision of established theories to parallel the changes that occurred in biological medicine" (Young 1995, 85).

The heterogeneity of practices adopted in the aftermath of WWI reflects this utter lack of unity in understanding the causes or effective treatments for the psychological

wounds/illnesses as well as the inevitable tangle with all the issues of public health and scientific "reality" outlined above.

There certainly exist opposing viewpoints to Young on whether WWI provided scientific advance in the field of psychological trauma. In any case, one thing is clear: each country implicated in WWI was confronted with what it understood as a traumatized population. There was an undeniable need to *do something*, and all the institutional structures in place for addressing what was seen as a public health concern (because—crucially—psychiatry is a medical specialty), required some kind of theoretical basis for intervention. This is a prime example of what Foucault would call power/knowledge. Enter the rising popularity of Freudian psychodynamics and, in the US, *DSM-I*.

Putting aside the question of whether or not the psychological suffering of WWI veterans verifies Freud's science of the individual psyche, it is worth pointing out that the war neuroses utterly baffled Freud. The fact that returning soldiers repeatedly reported dreaming about horrific events contradicted his theory that dreams serve as wish fulfillments. Noting that reliving terrible events seemed to be anything but a fulfilling of wishes, Freud states dramatically in *Beyond the Pleasure Principle*, "This astonishes people far too little" (Freud 1999; Volume XVII, page 13). (Arguably, it was this "astonishment" that led Freud to first posit a second drive, a death drive.)

By now it should be clear why I don't want to enter into the volumes of debate about whether Freud or any other particular intellectual figure (Janet, Crile, etc.) was "correct" about the etiology, prognosis, or treatment of psychological trauma. Instead, I would like to mention one more well accepted historical fact, namely that the millions of psychological casualties of WWI, a scale absolutely unmatched hitherto, unquestionably

catapulted a more or less Freudian account of the psychodynamics of the human mind, including its pathologies, onto center stage in mainstream psychiatric practice. Freud himself claimed as much when he declared war conditions had "an important influence on the spread of psycho-analysis" (quoted in Kaplan 2009, 29). By the time *DSM-I* is published in the US in 1952, following yet another World War, these psychodynamic principles of psychiatric practice are deeply entrenched and form the intellectual basis of this first psychiatric nosology.

Instead of comparing the relative merits of these giants of psychiatric thought, I want to evaluate the practices according to the Hegelian criterion of sustainability or equilibrium. *If* the natural laboratory of WWI had in fact verified Freud's (or anyone else's) theoretical account of the cause and mechanisms of psychological trauma, we could expect there to be a more unified set of practices implemented to "manage" the disruption. Of course, at the time, biases and prejudices may have prevented the immediate implementation of adequate and fair practices, but eventually, these disparities would have collapsed under the weight of irrefutable scientific evidence (as was the case with AIDS), for example), which would have permitted a more efficient public health management of a severely disruptive set of phenomena. But this is far from what occurred. The disparate responses to the psychological casualties in the era spanning the two World Wars is remarkable, and its lack of effectiveness even more so.

To recap, trauma disorders have always been a curious exception to this division between organic and psychiatric medicine, due to the material exigency of the events seen to cause them (natural disasters, wars, and the like) which place the bodies of the psychologically wounded right along side the physically wounded and, perhaps more

importantly, face to face with physicians who see differently when they look at an "ill" or "wounded" patient. (A second dissertation on PTSD could be written, it seems to me, on the troubled communication among these various types of experts who find themselves forced together: social workers, psychologists, psychiatrists, etc.).

In any case, each disorder in the long litany of psychological trauma disorders coined since the inception of psychiatry, provoked a flurry of discourse, from medico-scientific to policy to narrative to familial, all of which implicated again and again these intertwined and *irresolvable* problems of scientific reality, social stigma, economic responsibility, and shame.

By the time the Vietnam War occurred—the US's least popular war to date—the view that Freudian psychoanalysis was ineffective for the treatment of psychological trauma was gaining ground. American psychiatric practice was ripe for a coup, and that is exactly what *DSM-III* effected, a revolution, moreover, that constitutes an important element of the historical a priori in the crisis over PTSD.

Chapter Three: The Crisis over PTSD

5.1 Introduction

In the second part of Chapter Two, I argued (following Foucault) that the practices put in place by the founding figures of psychiatry in the early 19th century had little or nothing to do with the clinical scene established as the basis of general medicine since the turn of the 19th century. During the era, which runs through the 19th and most of the 20th centuries, these practices operate according to a different logic of power (evidenced in the different structure of the "scene of encounter"). As a corollary, the relative stability achieved in general (organic) medicine has not been paralleled in the medical specialty aimed at "mental" illness, which I have been calling, for the sake of simplicity, psychiatric experience. In point of fact, there is remarkable breadth among those labeled as 'mental health workers'—above all, in terms of their approach, or in other words, in what it is they purport to see. While I have thus far not explored this breadth and heterogeneity, I will come back to it shortly as crucial to both fueling the maelstrom and to anticipating what might come out of it. In any case, in Chapter Two, I grouped these varied approaches under the term 'psychiatric experience' in order to make the point that as a set of practices that all fall under the rubric of an ostensible medical specialty, they remain simultaneously justified by this link to general medicine and yet are continually relegated to an inferior epistemological position. As such, psychiatric

experience, as a petulant off-spring of the medical revolution that occurred during the French Revolution, creates an inescapable yet destabilizing role in the intrapsychic constitution of Western subjects, *whether they are the ones deemed mentally ill or not*.

After presenting Foucault's case for this separate logic of power and thus separate economy of psychiatric practice, I then diverged somewhat from his narrative by arguing, in the second part of Chapter Two, that psychological trauma disorders (of which there have been several over the past two hundred years) have always problematized this already tenuous distinction between organic and mental illness. The *way* in which they problematize the border, however, is crucial. Above, I enumerated five reasons trauma disorders differ from other psychological disorders;[54] the first of these—that there seem to be both physical and mental symptoms—pertains to Foucault might call the primary space of disease, i.e., its anatomical seat (if it has one), its etiology, and so forth. Points (2) through (5), however, all raise questions of tertiary spatialization. The reader may recall that the second "compass point" I outlined in Part I of Chapter Two dealt with the concept of tertiary spatialization employed in *The Birth of the Clinic*. And, in the current chapter, I will be invoking Foucault's claim cited there that because the "genesis, structure, and laws [of this social space] are of a different nature. . . it is the point of origin of the most radical questionings" (Foucault 1994, 16).

I have argued that each successive psychological trauma disorder, beginning with railway spine and proceeding through shell shock, soldier's heart, gross stress reaction, and so forth, has raised again and again the irresolvabilities outlined in the Prologue. The year 1980, however, the year 'PTSD' is codified within the newly released *DSM-III*,

[54] See page 114.

marks an important turning point in this saga because it defined, for the first time in psychiatry's history, a nosological table of disorders distinguished according to the Aristotelian taxonomical principles of specific difference. Interestingly, then, its structure parallels the "traditional nosology" that dominated all of medical experience in the 18th century, as I examined in my detailed exegesis of *The Birth of the Clinic* in Chapter One.

The reader may also recall that there was one final "compass point" I did not elaborate upon in the previous chapter. It is now time to do so, because that fifth point details a remarkably similar crisis *at the end* of the hastened evolution two hundred years ago. The first half of the current chapter, therefore, closely examines the *form* its resolution took, in the hopes it can be instructive for predicting, to at least some extent, what we might expect in the crisis over PTSD.

After this elaboration of the fifth compass point, I will discuss in much greater detail the importance of *DSM-III*, including the fact that PTSD was included for largely tertiary reasons and, in fact, violated the principles of the taxonomy. By following the dual evolution of (A) the successive revisions of the diagnostic criteria in the *DSM* up through and including the proposed revisions for *DSM-V*[55] and (B) the heterogeneous practices for managing it—i.e., matters of tertiary spatialization—I will be able to disentangle what is historically at stake from the density of discourse.[56]

In epistemological terms, the evolution of the PTSD diagnosis in the *DSM* over the past thirty years will reveal that it codifies two incompatible forms of medico-psychiatric experience. One is structured around a psychodynamic theory of how the

[55] Due out in 2013, available now for public review at the APA's *DSM-V* website: DSM-V.org.

[56] Foucault claimed, as we also discussed in Chapter Two (page 91), that in *The Birth of the Clinic* he was undertaking a "structural study that sets out to disentangle the conditions of its history from the density of discourse" (Foucault 1994, *xix*).

mind works; the other purportedly only *describes* readily observable traits of the disorder (a-theoretically) in the hope of engendering experimental research that might one day develop into some kind of cohesive underlying theory. If the *DSM-V* rhetoric is any indication, the hope is far more speculative and specific: namely that one day a comprehensive theory of pathophysiology will be able to account for all physical, cognitive, and emotional symptoms. The vision of this latter form of medical experience, which is, as I said, embraced by the planning committee for *DSM-V*, would mean the two largely separate economies of practices that have built up over the past two hundred years ("organic" or "physical" or "general" medicine, on the one hand, and "psychological" or "mental" or, the term I have primarily used in this dissertation, "psychiatric") must collide. Should the overarching pathophysiological account eventually prevail, it will have drastic implications for the structure of medical education; for parity in mental healthcare; and, in general, for the role of the state in implementing and maintaining "public health," not to mention for the way that Western subjects mediate their intrapsychic and intersocial lives. But in point of fact, even if it does not prevail, its failure will matter, too.

Once and for all, then, let me emphasize that the crisis over PTSD is not upon us because of more "trauma," but because we lack a scientifically and politically unified medico-psychiatric experience. Put in different terms, the PTSD maelstrom exemplifies the breakdown—which was a long time coming—of the tenuous link between the economies of psychiatric medicine and organic medicine. As I stated in the Introduction, this is the darkest hour before the dawn, but I am not speaking of the dawn of a truth emerging from behind the veil of ignorance (and its partner, stigma), but rather, the dawn

of a new configuration, one that—if history is any indication—ought to bring a relative equilibrium that ordinary consciousness (and many historians) will mistake for scientific progress. In Hegelian terms, the longer a set of phenomena remain *in principle* invisible, particularly if they become especially disruptive to everyday existence (i.e., become a "way of despair"), indicates that a transformation is nearing on the level of *savoir* and not mere *connaissance*. This Hegelian framework would suggest that consciousness will soon re-cast its new object as an immediacy and what now seems hidden or invisible will suddenly seem available to exhaustible epistemological access,.

The hunt for a "biomarker," which would serve as an independent validator that a person "truly has" PTSD, is on. In fact, the hunt for all kinds of biomarkers is on: one that might indicate a "predisposition" to develop PTSD, for example, or one that might indicate who will be most resilient in the face of extreme stressors. The myth of the maturing science portrays this search as a way to finally verify the existence of the hidden wound; the Foucault-inspired reading would instead have it that the structure of how to see is changing, i.e., that the lines between the visible and the invisible are being redrawn in the messy world of history.

It's the witching hour, and I do not pretend to sketch here for you the, as yet, unrisen sun. I can make the case, however, that whatever new form of medico-psychiatric experience this crisis provokes, it will certainly impinge upon the "philosophical status" of the human being, which for so long has been structured around the objective, material limit of the corpse. In the Conclusion of this dissertation, I will offer my case for the profound philosophical import of PTSD, more specifically, suggesting it portends that, once again, there may be something new under the sun.

5.2 The Fifth Compass Point from *The Birth of the Clinic*: How a Crisis is Resolved

On Foucault's account, the "hastened evolution," which occurred between roughly 1775 and 1816 and which resulted in the adoption of pathological anatomy as *the* form of medical experience, was brought to a close through a crisis over a specific class of disorders, namely, what were known as "essential fevers" (Foucault 1994, 174). The crisis over fevers, Foucault tells us in the final chapter of *The Birth of the Clinic*, provides "the final process by which anatomo-clinical perception finds the form of its equilibrium" (ibid.). Again, I emphasize that equilibrium is a Hegelian criterion, a matter of achieving a way to see (an episteme that encompasses the entire unit of [Consciousness → Object]) that can inform sustainable practices.

In the Introduction, I quoted Foucault's eloquent assessment of the situation at the turn of the 19th century in France, as the various factions within the new Republic vigorously debated what the government's role ought to be in regulating the practice of physicians. These debates, Foucault says, "acted as a screen" for the real issue (ibid., 77). That is to say, these factions did not understand they were enveloped in the collision between two incompatible forms of medical experience, "traditional nosology" and pathological anatomy. The pathological anatomists did have this advantage, however: a teaching clinic, structured such that anyone—rich or poor—could in theory be shown how to open up a corpse and find the lesions within. It seemed decidedly democratic, and hence far more compatible with the ideological commitments of the Revolution.

There was a hitch for the pathological anatomists, however. Two classes of disorders seemed to lack a lesion and therefore to fall outside its principles. First, there were the "nervous disorders." I have already treated the fate of this class at length in Chapter Two: they were given, as Foucault says, "a sufficiently special status" (ibid., 178)to warrant their own specialty—namely psychiatry—with separate clinics, universities, and basic structure of those experts qualified to see. Second, however, was a certain type of fever denoted as "essential." Most fevers were deemed "non-essential," that is, they represented merely one symptom among several in what was clearly an "organic" disorder (i.e., had a seat in some sort of lesion) (ibid., 189). These non-essential fevers posed no real problem to the pathological anatomists. *Essential* fevers, on the other hand, seemed to occur independently of any other symptoms and, above all, without leaving any sort of lesion. This apparent lack of organic underpinning threatened to undermine the entire theoretical system of the new episteme and therefore to threaten its ability to become the chosen model for the new Republic. What was at stake in this crisis over fevers, then, included how hospitals ought to be laid out, how physicians ought to be certified, and even how true and false statements were to be made within the domain of medicine.

The crisis over fevers spanned roughly 15 years in the early 19th century. At its center were two conceptual difficulties within early articulations of pathological anatomy: first, whether the lesion (access to which, you will recall from the previous chapter, is precisely what the autopsy is able to deliver) *is* the disease or merely a correlate of it (i.e. some accidental feature) and, second, depending upon the answer to the first, whether there might be non-lesional disorders—i.e. whether medical nosology

ought to begin with one primary distinction between disorders with a traceable (visible) organic seat and those without (the "invisible" disorders). Since the physician's authority as an expert depends heavily on his ability to achieve a differential diagnosis, the question over disorders without lesion is paramount. If lesions are the ultimate criterion of differential diagnosis, what authority can a physician have when there is none? Or, rather, what else can constitute the basis of his or her authority in such cases?

On Foucault's account, it was this crisis in the underlying structure of the medical gaze that provoked a flurry of discourse about essential fevers, which continued for several years and which acted as a screen for the real issue, namely, a syntactical reorganization of the lines between what counts as visible and invisible (ibid., 167). He is able to tell this story over one hundred years later because, in retrospect, he can examine all the re-written histories, which propound a cumulatively maturing science, but which, for example, incorrectly report that corpses were hard to come by due to religious repression. It is these false histories that indicate something much deeper was going on. What truly resolves the crisis over fevers, says Foucault, is the physiological medicine of François-Joseph-Victor Broussais. Broussais' texts, published between 1804 and 1816 "[fix] for [this] period the final element of *the way to see*" (Foucault 1994, 192). As preliminary justification for rather lengthy detour into just how Broussais' physiological medicine resolved an old crisis, consider the following:

(1) Although there were two prominent types of disorders "apparently without lesion," only the fevers problematized pathological anatomy as *the* new basis for medicine. I, of course, am primarily interested in the "nervous

disorders," which includes all the precursors of PTSD. Juxtaposing the different role and fate of the essential fevers, however, will be telling.

(2) As I mentioned earlier, the new proposed definition of mental illness in the electronic draft of *DSM-V* currently available for public review suggests the term "psychobiological," although up until recently, co-task force chair Regier described the new basis of the taxonomy as "pathophysiological" (Norman 2007, 1). Delving into the details of just what Broussais' physiological medicine provided to pathological anatomy will allow me to analyze the importance of it being abandoned here on the eve of the publication of *DSM-V*. Should the *DSM* eventually achieve this "pathophysiological" account, it would signify the end of a certain epistemic era. Similar to the crisis over fevers, then, the highway of despair lived out across these irresolvabilities (of PTSD as well as other psychiatric diagnoses) would appear philosophically necessary for this epistemic evolution.

Returning to the crisis in fevers, Foucault tells us that it entailed "an essential confrontation, the last (and the most violent, most complex) of the conflicts between two incompatible types of medical experience," namely the medicine of spaces (or classical nosology) outlined in Chapter One of *The Birth of the Clinic*, in which diseases had their own being that preceded their deployment on a body (Foucault 1994, 174), and the medicine of pathological anatomy, whose archaeology he traces in chapters 2-7. In other words (to recap the compass points from Chapter Two), the elements of this "new way to

see" were accumulated over 30 some odd years, tipped off on a point of tertiary spatialization, converging anonymously and often without moral significance with a number of other historically contingent forces, once there was again some sort of governmental structure in place to mediate the production of knowledge and the implementation of practices (i.e., once the "free field" became far less free—see section 4.2.5 in the preceding chapter).

5.2.1 What Physiology Gave to Pathological Anatomy

In his early text, *Mental Illness and Psychology,* Foucault rather concisely, if implicitly, states what physiology did for modern medicine. In a contrast that will be useful for my purposes later, he compares it to what psychology did *not* provide:

> psychology has never been able to offer psychiatry what physiology gave to medicine: a tool of analysis that, in delimiting the disorder, makes it possible to envisage the functional relationship of this damage to the personality as a whole. The coherence of a psychological life seems, in effect, to be assured in some way other than the cohesion of an organism; the integration of its segments tends toward a unity that makes each possible, that that is compressed and gathered together in each. (Foucault 1987, 10)

I will return later to Foucault's claim about psychology's failure. For the moment, I want to remain with his implication that physiology gave medicine "a tool of analysis" that made it possible to envisage the functional relationship of a given kind of damage (lesion) to the (health of the) body as a whole. Returning to *The Birth of the Clinic* and extrapolating a bit: it is this possibility of "envisaging" the process that linked the lesion to the overall health or illness of the body that finally provides pathological anatomy with

"the form of its equilibrium" (Foucault 1994, 174). In other words, once Broussais' physiological medicine is incorporated into pathological anatomy, the construction of a coherent medical perception (*regard*[57]) is complete: "Since 1816 [when Broussais published his *Examen de la doctrine médicale généralement adopte*], the doctor's eye has been able to confront a sick organism. The historical and concrete a priori of the modern medical gaze was finally constituted" (ibid., 192). Since physiology constitutes this final element of the medical gaze (*regard*), we can infer that mere pathological anatomy, *without the physiological element*, was not able to provide an account of this functional relationship between the damage and the whole body. It was precisely this lack that was brought to the fore in the virulent debates surrounding the "fievres dites essentielle," the fevers said to be essential.

5.2.2 The Troublesome Essential Fevers

The conceptual trouble that forms the basis of the crisis over fevers is fairly simple: any nosology based on mere pathological anatomy requires a lesion as the principle of differential diagnosis. If there is no lesion with these fevers, it suggests that pathological anatomy cannot account for all types of illness. In other words, it suggests that there is some fundamental distinction between the organic and non-organic disorders and, therefore, that pathological anatomy is only a specialty within some more general kind of medical experience. *If* this were to be the case, a whole host of questions arise:

[57] In Chapter One, I mentioned that Foucault names this regard "the anatomo-clinical gaze" even though it would be more accurately named "the anatomo-physiological-clinical gaze."

how will these two separate species of disorder relate to one another? How will they be diagnosed? How must doctors be trained to diagnose and treat these non-organic disorders? And will the same physicians be trained to treat both types? How shall the government regulate the medical field for these two different types of disorder?

Thus, despite the fact that pathological anatomy originated and developed as a replacement for classificatory thought (i.e., classical nosology), the concern here of the pathological-anatomists regarding fevers (and, to a lesser extent, the nervous disorders) "paradoxically. . . revitalized the classificatory idea" (ibid., 176). This conflict should not be understated, because it ultimately raises the question of whether the lesion leads to the disease or the disease leads to the lesion. As Young pointedly states, the highest form of validity in any science is achieved when it can account, coherently, for a causal mechanism and thereby achieve predictive power—in the case of medicine, when it enables the physician to have some success with prognosis (Young 1995, 104-105).

To reiterate, this was a *crisis* over fevers precisely because it brought to the fore the incompatibility of two forms of medical experience, which means it was not merely a scientific dilemma. There were profound public health implications, as well as socio-economic distributions at stake. (And as Foucault or Hegel would tell us: this is *always* the case).

What further complicates matters and yet what will be key in the resolution of all these debates is that a number of these "fievres dites essentielle" seemed to produce localizable symptoms, that is to say, symptoms within specific anatomical regions of the body.

> when it is a question of dividing up this essence, the function of division is operated by a principle that belongs not to the logical configuration of

> species [as it would in "traditional nosology"], but to the organic spatiality of the body: the blood vessels, the stomach, the intestinal mucous membrane, the muscular or nervous system are called upon in turn to serve as a point of coherence for the formless diversity of the symptoms. . . . The principle of the essentiality of the fevers has as its concrete, specified content only the possibility of localizing them. (Foucault 1994, 182)

Foucault emphasizes that, in order to resolve this fundamental problem with essential fevers, Broussais returns to a number of pre-clinical ideas and thus also to largely outdated techniques of treatment. Specifically, he revitalizes the idea that fever and inflammation are part of the same pathological process, which develop according to "sympathies" (ibid., 178) This revitalization allows Broussais to follow Bichat's principle of tissual propogation all the way to its final consequences—which, in turn, resolves the problem of essential fevers quite simply. He states,

> Each tissue has its own mode of alteration: it is therefore, by analysis of the particular forms of inflammation at the level of the areas of the organism that one must begin the study or what are known as the fevers . . . [Once looked at in this way, they] evolve in a convergent manner, according to the logic of tissual propogation." (ibid., 185)

Or in Foucault's words,

> first an attack on the functions, then an attack on the texture. Inflammation has a physiological reality that may anticipate anatomical disorganization [i.e. a lesion], which makes it perceptible to the eyes. . . . In order to detect this primary, fundamental, functional disorder, the gaze must be able to detach itself from the lesional site, for it is not given at the outset, although the disease, in its original source, was always localizable; indeed, it has to locate that organic root before the lesion, by means of the functional disorders and their symptoms. . . . 'To study the altered organs without referring to the symptoms of the diseases is like regarding the stomach independently of digestion,' says Broussais. (ibid., 187)

To summarize Broussais' and Foucault's dense prose, the primary "alteration" that exists anatomically (and therefore, spatially) is not originally visible in a lesion; rather, it is

induced by either some external "irritating agent" or some internal alteration in functioning that occurs "by sympathy" with the originally affected organ/tissue. Eventually, this irritant becomes sufficiently irritating to produce a lesion. Broussais' physiology thus offers a theoretical unity between etiology and prognosis *and* a clear role for symptoms. Foucault states:

> By means of this conception of the external agent or of internal modification, Broussais avoided one of the themes that had dominated medicine, with few exceptions, since Sydenham: the impossibility of defining the cause of diseases. From this point of view, nosology from Sauvages to Pinel had been like a figure confined within this abandonment of causal assignation: the disease set in and flourished in its essential affirmation, and casual series were merely so many elements within a schema in which the nature of the pathological served it as an effective cause. With Broussais—which was not yet the case with Bichat—localization demands an enveloping causal schema: the seat of the disease is merely the link point of the irritating cause, a point that is determined by both the irritability of the tissue and the irritating agent. The local space of the disease is also, immediately, a causal space.[58] (ibid., 188)

The upshot for essential fevers is that they represent merely the early phase of irritation, before there is a lesion. They are nonetheless a localizable phenomenon, which is to say, *les fievres dites essentiel* do not fall outside the principles of the new episteme of pathological anatomy, and that host of questions I raised earlier evaporates. To reiterate the passage from *Mental Illness and Psychology* cited above, Broussais' physiological medicine provided a way to envisage the relationship of the damage to the organism as a whole, although to achieve this integration, Broussais had to ignore several recent discoveries and reinvigorate an old one.

[58] As an aside, it seems worth noting that although this all predates the discovery of microorganisms as the cause of (many) diseases, it is not hard to see that accommodating it entailed relatively minor adjustments in the structure of medical perception. Broussais had already made a place for the external "irritating agent" that disturbed the tissue; the fact that they were microorganisms seems comparatively minor. However, as Foucault notes in his lectures on psychiatric power from 1973-1974, it would take doctors "a long time to forgive" Pasteur for the blow to their authority and ego incurred by the fact that their hands meant to heal were in fact spreading disease (Foucault 2006, 337).

In short, the suffering that resulted from the lack of scientific and political unity to medicine at the time (which translates into a new government unable to decide how to regulate the education and practice of physicians) created the historical conditions for the confusion over fevers to become a crisis over fevers, which in turn, conditioned the re-emergence of long since abandoned theories, *the very opposite of a progressively advancing science*.

Broussais' physiology, then, finishes drawing the new lines, which divide the visible from the invisible. Because it is a shift at the level of *savoir* rather than *connaissance*, it seems that a sudden epistemological purification has happened, which allows the physician to see something behind (or rather before) the lesion: the "irritating agent" and the "irritated tissue" (ibid., 188-189). The anatomo-clinical gaze thus takes on its third and final dimension, which is to say, it becomes equipped to link the two disparate domains of *temporal* (clinically presenting) symptoms with the *spatial* manifestation of lesions. The corpse and the technology of autopsy were crucial to process, because of the absolute "intemporality" of death, meaning that corpses could be opened up at varying stages of illness, thereby allowing for continually refinement of etiology.

On Foucault's account, then, this resolution of the crisis over fevers completes the epistemological and ontological revolution I outlined in Chapter Two. Taken in this light, the "way of despair" lived out by ordinary consciousness, appears necessary to complete the transition to a new epistemic era and to *produce* the non-replaceable individual, which forms its basis[59].

[59] See Section 3.5.4.

The further Hegelian point is that being able to envisage this relationship and thereby create a subject that is also object (the non-replaceable individual), permitted the elaboration of a form of governance built around the design and implementation of "a public health." (In Foucault scholarship, one can see how these studies on medicine and psychiatry led him to an interest in 'governmentality,' 'population,' 'biopolitics,' and so forth. This evolution in Foucault's thought is beyond the scope of my project here; however, the rest of my analysis on the *DSM*, etc. could easily be approached with the rich terminology of Foucault's later work on these themes. The flip side is that anyone who studies these later Foucault texts ought to understand the work he did on medicine and psychiatry, because he never abandons his view regarding the importance of this "stage of death" in conditioning the modern, Western way of life (Foucault 2006, 197).

5.3 What Psychology has Not Given Psychiatry

In contrast to this lengthy exposition on what physiology gave medicine, I can now briefly contrast it to what psychology did not give. For the sake of clarity, I repeat the passage from *Psychology and Mental Illness* already cited above:

> psychology has never been able to offer psychiatry what physiology gave to medicine: a tool of analysis that, in delimiting the disorder, makes it possible to envisage the functional relationship of this damage to the personality as a whole. The coherence of a psychological life seems, in effect, to be assured in some way other than the cohesion of an organism; the integration of its segments tends toward a unity that makes each possible, that that is compressed and gathered together in each. (Foucault 1987, 10).

When Foucault wrote these words, he believed that such an achievement by 'psychology' was impossible. As the second sentence in the passage makes clear, the lack of any appropriately defined material object from which to draw abstractions—such as the corpse—forever doomed psychiatry to be a pseudo-science, determined almost entirely by politics, prestige, and economic power. As I have noted, just as Foucault quickly abandoned this fatal critique, I am also not interested in it. However, I do think he poses a valid historical question in the first sentence above: has psychology been able to provide psychiatric experience with a tool of analysis that allows for an understandable—i.e. in principle, visible or knowable—relationship between the pathological element and the "personality as a whole" (ibid.)?

I am essentially recasting Foucault's question from his early text, *Psychology and Mental Illness*, as an emphatically Hegelian one, which is also more in line with Foucault's own approach in *The Birth of the Clinic*. *If* psychology were to have been able to provide psychiatry with this "tool of analysis" comparable to physiology, one would expect that by now, the separate economy of psychiatry would have settled into a relative equilibrium. Carved off as it was, the "scene" of diagnosis and treatment for *mental* illness, in other words, would have developed over the past two hundred years into a relatively constant force in the organization of social space as well as within intrapsychic and intersocial mediation. It seems to me nothing could be further from the case. The plethora of mental health workers, with all varieties of education and certification (not to mention economic compensation), is astonishing. Add to this some well-established trends, for example, that general physicians prescribe more than 40 percent of anti-depressants (Stagnitti 2008, 1), and that various "alternative" therapies, which almost

universally decry the outmoded and flat-out incorrect mind-body division at the basis of Western medical practice, and the variety among the "scenes" of physician-patient encounter seem to multiply exponentially. Compare this, by contrast, to the regulation of non-mental health professionals. It is unfathomable that a medical school student would not begin with standard courses in anatomy and physiology. Foucault, it seems to me, is correct. Psychology has played no comparable role to physiology.

As I discussed in the previous chapter, moreover, even in moments when either man-made or natural disasters provided a "natural laboratory" of psychological harm (such as WWI), psychiatry has not advanced as a science in any way remotely comparable to the advances made in organic medicine. The transitions between the dominant paradigms of psychology read more like an intrigue novel than like the development of a science. In place of such a stable set of practices, we find a remarkable longevity of the same irresolvabilities that center around the invisibility of its claimed object and multiple competing theories regarding just what kind of training a mental health workers must undergo to learn how to see what is hidden from lay people. Taken in this framework, it is clear that psychology in no way lives up to the role played by physiology. And hence, despite its formidable and undeniable mediating force, psychiatry still lacks a coherent pathological framework for "mental" illness, and in this sense, produces and perpetuates a whole host of untenable subject positions.

I maintain that this last claim is important to emphasize, although it is also a fairly well-acknowledged point within the field itself. It is, in fact, a point frequently cited as grounds for revamping the basis of the *DSM* for its third edition. Before I can get to that

re-working of *DSM-III*, however, I must briefly review the theoretical basis of *DSM-I* and *DSM-II*.

5.4 The Psychodynamic Underpinning of *DSM-I and DSM-II*

The first two *DSM*s—published in 1952 and 1968 respectively—were based on a psychodynamic theory of mind, one that was essentially Freudian. Any psychodynamic framework for mental illness, psychoanalysis included, purports to account for the mechanism (the "dynamic") that links the cause (etiology) with the concrete and clinically identifiable display of symptoms. One of the essential features of any psychodynamic theory, then, is its relative de-emphasis on specific symptoms. Discussing precisely this fact, Young cites the APA on the way symptoms are viewed within the various forms of psychodynamic psychiatry:

> [In the clinical encounter] attention is focused on the particular way the patient molds and distorts the interview situation in order to make it conform to his or her deeply ingrained (usually unconscious) fantasies, attitudes, and expectations about interpersonal relationships. The nature of these transference phenomena will be noted in order to predict future behavior in the treatment setting and to shed light on the patients's early developmental experiences and the conflicts that underlie the current disturbance. (Young 1995, 96)

The psychiatric scene of encounter for psychoanalysis, then, entails that the physician must decipher the real object of interest, the underlying conflict, by using clues from the current disturbance as well as all sorts of molding and distorting behavior undertaken by the patient during the clinical encounter itself. All "neuroses" are seen to be, at bottom, the ineffective navigation of these intrapsychic conflicts. As such,

"[s]ymptoms are not inherently interesting in this context, and the nosological vocabulary of psychodynamic psychiatry is correspondingly simple" (ibid.).

On its own terms, this is a coherent structure of psychiatric experience. That is to say, it is internally consistent. Whether an internally consistent theory can be applied consistently or effectively, however, is a different question. I point this out here, because as I move into the revolution enacted with the publication of *DSM-III*, it is crucial to understand that psychodynamic psychiatry dominated the practice of mental healthcare from World War I up until the 1970s in the US. Commenting on the climate in US by the late 70s, Young states,

> APA Medical Director Melvin Sabshin has recalled….that psychiatry was perceived by the federal government and private insurance companies as a 'bottomless pit'—a voracious consumer of resources and insurance dollars—because its methods of assessment and treatment were too fluid and unstandardized. . . .
>
> Under these unfavorable professional conditions, the psychosocial model, as the dominant organizing model of psychiatric knowledge and the sources of many of these problems, would have to be significantly altered, if not jettisoned altogether. (ibid., 101).

It was these "unfavorable professional conditions" no doubt, that led the American Psychopathological Association (now renamed the American Psychiatric Association) to invite philosopher of science Carl G. Hempel in 1959 to present a paper on how to achieve "a more scientific classification system for mental disorders" (Sadler, Wiggins, and Schwartz 1994, 2). The paper he presented "emphasized many of the innovations to be borne by DSM-III twenty years later [including] the importance of taxonomic description with minimal inference, operational definitions, the minimizing of valuational statements, [and] the requirement of testability" (ibid.).

Young refers to the publication of this third edition of the "psychiatric bible"[60] as "the *DSM-III* Revolution" (Young 1995, 89) for two reasons. First, it is the first version that provides a *standardized* nosology in psychiatry (replete with the institutional requirements that it be used as lingua franca for all scholarly publication, etc.). Second, it is the first *DSM* to be descriptively based, which is to say that its disorders are (purportedly) distinguished according to criterial symptoms only. These criterial symptoms, which delineate affective or behavioral markers (denoted as symptoms of "distress" or "impairment," respectively), are supposed to be independent of any assumptions about "invisible etiologies" (causes) and therefore, amenable to various theoretical orientations. This descriptive format also should make it possible to diagnose consistently across settings, therefore making it possible to collect accurate epidemiological data.[61]

I must emphasize this last point: without a common set of terms—much less universal diagnostic procedures—it was structurally impossible to even begin collecting epidemiological data on mental health in the US until 1980. *In spite of this fact*, there were government-sanctioned policies and even government-run institutions put in place to manage mental health. This is a crucial point: "evidence"—in the rather strict sense of data gathered and analyzed according to the precepts of the scientific method—is in no way necessary for policy to be designed, debated, and implemented. "Evidence" in a

[60] Referring to the *DSM* as the 'psychiatric bible' has become so commonplace now I could cite multiple sources.

[61] There were, of course, separate disorders listed in *DSM-I* and *DSM-II*. And there were trauma diagnoses of a sort in each one. However, as the epistemological basis for these two *DSM*s was of a quite different nature, the descriptions of each disorder were not divided into criterial symptoms that were individually necessary and collectively sufficient for diagnosis, as will be the case with DSM-III. As mentioned above, this is because symptoms are secondary.

much looser sense—some sort of rhetoric presented under the guise of a reason; some account of why we ought to do A rather than B for the good of the public health—has, however, been mandated by our institutional structures since the birth of the centralized state.

In any case, the "revolution" of *DSM-III* without question changed the type of evidence it has been possible to collect and, as such, altered the practices implemented through public policy on the basis of the new form of data. Not surprisingly, then, *DSM-III* had many critics from the beginning, at times for specific disorders it included or how it defined them, but mostly for the overarching understanding of mental illness it reified and the one it precluded. Again, I invoke a point made by Young: although *DSM-III* was meant to be atheoretical—i.e., adaptable to any number of theoretical viewpoint—"[t]aken to their limits, the two languages, psychodynamic and descriptive, are mutually unintelligible" (Young 1995, 97). (To repeat, this is because, on a psychodynamic understanding of mind, symptoms are secondary to the underlying forces causing them). By emphasizing and, in fact, defining an illness according to its criterial symptoms only, as *DSM-III* purports to do, these underlying psychic forces and their interplay become irrelevant at best and speculative and untestable at worst. Momentarily, I'll outline the exception of PTSD.

Thirty years after the "*DSM-III* revolution," it is undeniable that its descriptive format has indeed engendered a formidable amount of data that at least has the semblance of being scientifically analyzable. This data includes both epidemiological studies on prevalence as well as comparisons on the effectiveness of various kinds of treatment. For certain highly visible and/or exceptionally common disorders, enough data has been

generated to call for meta-studies that are justified—conceptually and economically—with the explicit purpose of informing public policy. For example, at least two such meta-studies on PTSD have been carried out in just the past three years. The Institute of Medicine released a report in October of 2007 (Committee on Treatment of Posttraumatic Stress Disorder 2007); the Rand Corporation released one in 2008 (Tanielan and Jaycox 2008)**.** The Department of Veterans Affairs (VA) and the Department of Defense (DoD) have invoked the conclusions of both these reports in various policy decisions.

DSM-III was the harbinger of change *and deliberately so*. In 2010, thirty years after its publication, a new buzz word now permeates all the discourse on public policy pertaining to mental health: "evidence-based practices."[62] Its prevalence indicates that we are far enough along in the fallout of *DSM-III* that psychiatric medicine, which for so long developed in separate scenes of encounter, and according to a different logic of power, now can at least pass for an experimental science comparable to general or organic medicine.

I am by no means claiming that *DSM-III* suddenly elevated psychiatry to a level of objectivity akin to general medicine. I have, in fact, claimed nearly the opposite by assenting to Foucault's assessment that psychology has not provided psychiatry with a mechanism equivalent to physiology. I am claiming, however, that by making epidemiological studies and, in turn, "evidence-based practices," structurally possible, *DSM-III* irrevocably altered psychiatric practice, above all its position vis-à-vis general medicine and its place in public health policy. At the 2007 conference of the International Society for Traumatic Stress Studies, a spokesperson for the National Institute of Mental

[62] See footnote 25.

Health (NIMH) began his power point presentation with the following slide: "Utilized Interventions are under-tested; Tested interventions are under-utilized" (Chambers 2007). He then set about outlining a plan to rectify this disconnect. In the same panel, playing the role of antagonist to our NIMH speaker, a mental health worker lamented: "we all know how this works. To get funding from Congress, we have to show them some study that 'proves' that our intervention works by comparing its effectiveness to 'practice as usual'" (Oliver 2007). These characters are singing their part in the chorus of the buzz that resounds from Capitol Hill to the research lab to the clinic: evidence-based practices.

True to form, then, beginning in the fall of 2007, the US Veterans Administration rolled out two programs for treating PTSD: Prolonged Exposure Therapy and Cognitive Processing Therapy, precisely because they were the only two types of treatment that show any statistically significant effects in the Institute of Medicine meta-study mentioned above (Kelly et al. 2007). At first glance, then, PTSD seems to be a success story of the *DSM-III* revolution. Finally defined according to operational criteria, which allowed for testability, the evidence amassed informed the rollout of two interventions on the part of the VA. A deeper look, however, reveals a wrench in the cogs.

5.5 PTSD's Conceptual Violation of *DSM-III*

Given that the architecture of *DSM-III* is precisely what has allowed for massive data collection on PTSD, it is striking that PTSD's original criteria violated the rules of that architecture. As Young points out, PTSD's "most typical feature"—Criterion A, i.e., the stressor criterion that codifies the traumatic event—in fact posits an etiology (Young

1995, 124). Whereas in the Prologue I provided the current definition of PTSD from *DSM-IV-TR* (whose architecture is still explicitly descriptive like the 1980 edition of *DSM-III*), here I offer the original version from *DSM-III*, in part to highlight how clearly it posits the stressor criterion as a causal mechanism: "Existence of a recognizable stressor that would *evoke* significant symptoms of distress in almost everyone" (American Psychiatric Association 1987, §309.89).[63] 'PTSD' is by no means the first term coined to refer to psychological suffering resulting from a traumatic (usually wartime) event, but it is crucial that only with *DSM-III* is there a codified trauma disorder in a standardized nosology, which is supposed to utilize only operationally defined criteria without postulating on etiology.

Recalling that this intellectual history is squarely situated in 1980, the "recognizable stressor" brings us face to face with millions of veterans of the Vietnam War. That there were millions of "psychological casualties" of Vietnam is a widely accepted fact. As Foucault would say, however, the question is how to provide an analysis of such banal facts. Without question, it is historically significant that the sheer quantity of suffering and its social disruption of the late 1970s in the US garnered enough political will to get PTSD included in the *DSM-III*, despite its conceptual inconsistency with the loudly proclaimed new descriptive architecture, not to mention the politically and morally fraught issues of the Vietnam Veteran in the public consciousness.[64]

To tip my hand a bit, what makes PTSD so philosophically relevant is that it bursts into the economy of public (mental) health policy at precisely the moment

[63] The evolution of Criterion A from 1980 up through the currently proposed revisions for *DSM-V* makes for its own riveting study. Here, however, I limit myself to the proposed architectural revisions.

[64] It is the only diagnosis in the history of the *DSM*, in fact, to have a non-professional assigned to its work group: Veterans advocate and Vietnam veteran, Jack Smith.

psychiatric diagnosis is deliberately attempting to distance itself from claims about etiology (generally) and, in a more covert way, from the underlying psychoanalytic commitments that defined a very different architecture for *DSM-I* and *DSM-II*. Moreover, it is crucial that this unfolding tale of epistemic violation will be told through the lens of the exemplary case of combat PTSD. The epic tale, in other words, has a face: that of the wounded (except also kind of ill) warrior.

Keeping this face in mind, this very poignant figure of the Vietnam vet, I'd like to introduce the second way in which the PTSD diagnostic criteria violated the *DSM-III* architecture. Along with positing a causal event, it implicitly codified an entire psychodynamic theory of the way that event "evokes" the other symptoms. It is in order to avoid "intrusive" flashbacks, for example, that a vet will "avoid" crowded places. Or it's in order to "numb" out the pain that he will take up drinking. All of these implied links between criterion A and criteria B-D violate the purportedly atheoretical structure of *DSM-III*. I suggest, moreover, that it is nearly impossible to conceive of removing these implicit links because we inhabit a place and time ordered according to narrative accounts of trauma.

It is possible, however, that this era is drawing to a close, depending upon whether *DSM-V* can attain its vision.

5.6 *DSM-V*

The crisis over PTSD that began in1980 is, as I have repeated several times, reaching fever pitch. What may happen in this climax scene is as yet unknown, but one

thing is clear, the impending publication of *DSM-V* is going to be a significant player. *DSM-V*—currently under review and due out in 2013—is significant because it purports to abandon the merely descriptive architecture initiated by *DSM-III*. In an interview in 2008, Dr. Darrel A. Regier, vice chair of the *DSM-V* task force, stated, "We are rethinking the fundamental structure of *DSM*, which would be a first since 1980, when *DSM-III* was produced"[65] (Yan 2008, 1). Regier went on to describe this new basis as "pathophysiological" (ibid.), a term that buzzed around among key task force members between 1999 (when work began in earnest on *DSM-V*) and 2009. The electronic prototype currently available online, courtesy of the American Psychiatric Association, proposes a different term, however: "psychobiological" (American Psychiatric Association 2010a).

Recall that *DSM-III* (and all revisions since) explicitly claimed to avoid all questions of the etiology of mental illness (the violations of PTSD notwithstanding). The proposed pathophysiological basis for *DSM-V* was precisely intended to open that door again—widely in fact—which is to say, to pose the question of what causes mental illness. It indicates, moreover, a move toward an integration with "physical" illness. The official *DSM-V* website states it perhaps most clearly. In a section entitled "Classification Issues Under Discussion" it reports,

> A proposed revision for the definition of a mental disorder is being addressed by select members of the Anxiety, Obsessive-Compulsive,

[65] Moreover, the architect of *DSM-III*, Dr. Robert Spitzer, who is portrayed as master of the psychiatric universe in Young's genealogical account (Young 1995), has been ostracized from the process of designing the new edition (Lane 2008). And he has been one of the most vocal critics of that process. The vitriolic, personal nature of these conflicts is by no means unique to psychiatric circles. However, the lack of a final reckoning point, like a lesion in a corpse, makes psychiatry particularly prone to long-standing and, at bottom, *irresolvable* conflicts among the various schools of thought and its proponents. This is why the history of psychiatry reads more like an intrigue novel than anything even resembling a cumulative science.

> Posttraumatic, and Dissociative Disorders Work Group, a member of the Mood Disorders Work Group, and additional individuals. (American Psychiatric Association 2010f, 1)

The current edition of the *DSM*, *DSM-IV-TR*, defines a mental illness as:

> A. A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual. . . .
>
> D. A manifestation of a behavioral, psychological, or biological dysfunction in the individual. (American Psychiatric Association 2000, *xxxi*).

The proposed revisions for *DSM-V* would alter these definitions thus:

> A. A behavioral or psychological syndrome or pattern that occurs in an individual.
>
> B. That reflects an underlying psychobiological dysfunction. (American Psychiatric Association 2010g, 1)

The "rationale" cited for this proposed revision is that "[t]he term psychobiological is used to emphasize the inextricable links between the biological and the behavioral/psychological" (ibid.).

Or again, whereas *DSM-IV-TR* states that, "No definition adequately specifies precise boundaries for the concept of 'mental disorder'" (American Psychiatric Association 2000, *xxxi*), the proposed *DSM-V* becomes far more explicit: "No definition perfectly specifies precise boundaries for the concept of either 'medical disorder' or 'mental/psychiatric disorder'" (American Psychiatric Association 2010g, 1). And the rationale for this proposed revision directly states,

> It may be timely to reconsider the term 'mental disorder,' given our growing knowledge of the psychobiology of these disorders. In considering new disorders for *DSM-V*, we need to consider their relationship with diagnostic "near-neighbors," and the overall benefits vs harms of an addition. (ibid.)

Even if *DSM-V* had held on to the language of physiology, its immediate revolutionary character would always have been muted, since the task force built in safeguards for the purposes of clinical continuity. For example, its thirteen work groups correspond to the same main thirteen divisions used in *DSM-IV*, despite claims by task force leaders that they would not be assured to carry over into the new edition (American Psychiatric Association 2010b, 1).

Regardless of whether *DSM-V* will adopt a pathophysiological basis or a psychobiological one, the direction it is moving is clear. I have already argued that mental illness and its definition, its management in the interests of the public health, and its role in intrapsychic and social mediation is one of the main problems of our day. As such, *DSM-V* is bound to be a fulcrum point, re-defining the direction of the practices of psychiatric diagnosis and practice vis-à-vis "general" medicine.

I have structured this dissertation by arguing that the terms of this confrontation have been in place since the inception of psychiatry itself in the early 19th century. Even the scene for this battle—the dark, enclosed space of the body—was determined two hundred years ago, foreshadowed by a remarkably similar epistemic shift that occurred between roughly 1776 and 1816. I needed Foucault's account of that threshold crossed in order to provide a truly adequate intellectual history of this maelstrom of conceptual, ethical, and intrapsychic untenabilities surrounding PTSD.

Ultimately, I am arguing that, as the only official trauma disorder in the first standardized and descriptive nosology of mental disorders (*DSM-III*, released in 1980)—i.e., as a disorder that codifies a causal event and, implicitly, a theoretical account of the psychodynamics that follow upon such an event *despite* the ostensibly atheoretical basis

of the nosology—PTSD is different from its trauma disorder predecessors in *DSM-I* and *DSM-II*. Like the crisis over fevers, then, the PTSD maelstrom amounts to a confrontation between two incompatible types of medico-psychiatric experience that has been brewing for decades. To reiterate, that kind of confrontation cannot be solved with a scientific advance.

Moreover, the fact that *DSM-V* intimates a shift ever closer to a pathophysiological account of mental illness, it is not overstating it to claim that PTSD portends a general crisis of medical experience—which is to say, a crisis in the interface between "physical" and "mental"—in this country. And as I've already argued, the US is exporting its crisis: the medicalized theory of the traumatic memory/event is proving to be one of the most effective tentacles in this long reach of the West's concept of mental illness, and its flagship disorder is PTSD. As Young so eloquently argues in *The New York Times*, "PTSD has become psychiatric Esperanto. It may turn out to be the greatest success story of globalization" (Watters 2007, 1).

Conclusion

6.1 Summary of Dissertation

In the Prologue, I argued that the maelstrom surrounding PTSD reflects an incompatibility between the scientific aims of research (according to positivistic assumptions regarding the truth of PTSD as a distinct disorder), the structure of our civilian and military institutions for the management of the public (and individual) health, and the intrapsychic constitution of a subject trying to mediate his or her existence through these confused practices and discourses. I then enumerated five "irresolvabilities" that cut across this tri-partite structure. My aim in this "invitation" into a maelstrom was to introduce the complexity of the issues, while also essentially debunking any illusion of simple scientific advance or the equally potent myth that this is merely a moral matter—e.g., a callous, economically-driven state attempting to evade its responsibilities to a veteran population suffering in the wake of war.

Chapter One presented Foucault's case, made in *The Birth of the Clinic*, that at the moment Hegel was declaring the end of history, a new figure was emerging as the construct upon which a new modern, Western way of life would rest: what I have somewhat cumbersomely been referring to as the non-replaceable individual.[66] For

[66] To use the language of Mary Rawlinson, at that historical moment we exited the logic of the universal and entered a logic of the singleton.

approximately two hundred years, a new logic of the non-replaceable individual has ordered our social space, the relationship between state and citizen, and given new form to the mediating practices through which a subject constitutes him or herself.

In a characteristically provocative way, Foucault states in the Preface to *The Birth of the Clinic*:

> Medicine made its appearance as a clinical science in conditions, which define, together with its historical possibility, the domain of its experience and the structure of its rationality. They form its concrete a priori, which it is now possible to uncover, perhaps because a new experience of disease is coming into being that will make possible a historical and critical understanding of the old experience. (Foucault 1994, *xv*)

On the one hand, Foucault is making a point about his methodology here. It is the movement of history and the diacritical perspective it provides that permits him to decipher the domain of medical experience and the structure of its rationality (which, he maintains, is decisive for human existence in general). However, the provocative claim contained within this passage is that an epoch is drawing to a close, and that the West once again stands on the brink of a new experience of disease, which, of course, would carry enormous implications. Clearly, I am simply taking a cue here, since Foucault does not elaborate upon this "new experience" in *The Birth of the Clinic* (although he does provide some clues in others of his texts, as I've shown). In any case, assuming that once again the movement of history—as a way of despair—is producing a fundamentally new experience, all my analysis hitherto would suggest that we have been assembling its elements through disparate, uncoordinated practices that are thoroughly imbued with historical contingency—and which are, above all, spatial. What is on the table is no less than a new episteme, which is never merely "epistemological." It is always also

ontological and ethical, which is, in my view, why Foucault prefers the term "experience." In any case, the point is that if we indeed stand on this threshold, the "philosophical status of man" (ibid., 198) is at stake.

On the basis of Foucault's analysis of the significance of the birth of the clinic, in Chapter Two I undertook a brief intellectual history of psychiatric practice as an off-spring of the medical revolution two hundred years ago—which, again, made "the individual" a viable object of scientific inquiry. Using Foucault's other texts on psychiatry (primarily his lectures published as *Psychiatric Power* and the early text *Mental Illness and Psychology*), I traced his case that, for most of this two hundred year epoch, psychiatry developed into a separate, though tenuously linked economy of practices. I concluded this chapter with my own counter-narrative, however, claiming that, although I believe Foucault makes a compelling case for the separateness of these economies, "psychological trauma" disorders have always haunted this boundary, largely for historically contingent reasons that, above all, bring the scenes of encounter side by side, thereby revealing their epistemic incompatibility.

In Chapter Three, I drew out exactly how the epistemic revolution analyzed by Foucault in *The Birth of the Clinic* drew to a close in a crisis over a certain type of disorder that pitted two incompatible types of medical experience against one another in the space of the hospital. The detailed account of how this crisis "fixed. . . the final element of the new way to see" (ibid., 192), I maintain, can serve as a guideline for what type of factors will matter in the PTSD fallout, particularly if its resolution does suggest that the heretofore separate economies of "mental" and "physical" illness, and their associated practices of "psychiatric" and "general" medicine, can no longer be held

tenably apart. The highly anticipated *DSM-V*, moreover, will clearly be the document through which this confrontation is mediated.

To summarize, then, a decade into the 21st century, this maelstrom of phenomena is at fever pitch. It has been growing long enough for new academic and scientific disciplines to be founded (traumatic stress studies; psychotraumatology, suicidology…), for governmental and non-governmental agencies to be founded, and for umbrella agencies to emerge, which purport to coordinate and translate their various goals and discoveries. This means it has also been around long enough for the phenomenological struggle that swirls within this nexus of issues to have permeated popular culture and our most intimate social relations. Yet, despite the conceptual mastery and the deeply felt (and shared) desire for a coherent system, there is an impasse.

There is a deep recognition across of the impasse across this tri-partite terrain. In November of 2007, I attended the annual conference of ISTSS, attended by more than 2500 participants. The title of the conference was "Preventing Trauma and Its Effects: A Collaborative Agenda for Scientists, Practitioners, Advocates and Policy Makers." I was struck by the vast difference among the ways to see what they somehow imagined to be some unified object: trauma. In any case, the sunny portrayal of harmony and cooperation suggested by its title can be contrasted with the Institute of Medicine[67] Report, which was issued just two weeks before the conference. The report, commissioned by the VA, was a meta-analysis of 90 randomized clinical trials, 37 parmacotherapy studies, and 53 psychotherapy studies done on the various treatments available to treat PTSD.

[67] The Institute of Medicine is a non-profit NGO that conducts independent studies and then makes non-binding recommendations to the NIH and other governmental health organizations.

After pointing out in the introduction to the study that it is (one of the) fastest growing diagnoses in the *DSM*, the report moved on to make several dismal conclusions, among them that there is no consensus (in fact, vast variation) among the studies regarding what constitutes improvement or cure (Committee on Treatment of Posttraumatic Stress Disorder 2007). The philosophical implications of this vast variation are apparent. They are the makings of a Socratic encounter. Can you see him there, addressing the "expert," the one deemed to hold the relevant knowledge, pressing him or her to define the criteria of successful treatment. As I imagine the scene, it would not take long for the elenchus to lead to perhaps the most famous Socratic questions: how ought we best to live? What is the good life? This difficulty is certainly not unique within the field of mental illness, but as I've tried to show, the PTSD vortex exemplifies it.

Put differently, the vortex of issues around this highly visible disorder mark it as an extraordinarily prescient site of philosophical relevance, both in the sense that philosophers can contribute much to the discussion and in the sense that it marks an important site where the philosophical status of being human is being renegotiated. Interestingly, at the ISTSS conference, not one panel included a philosopher. On a more or less Hegelian model, moreover, the philosopher is drawn to the way of despair almost involuntarily, because it will be along these jagged edges where a new experience is forged. To borrow the language of Fons Elders, there are "nodal problems in history," and these nodal problems sometimes appear with such force that their implications seem to infuse nearly every domain of human practice (Chomsky and Foucault 2006, 146).

6.2 Ethical Implications: The Problem of the "Ought"

This would be the classic way to go in an applied philosophy dissertation. Given my new and terribly insightful analysis, what ought we *do*?

Foucault ought to make us at least a little bit nervous in the face of this question, which, incidentally, is often used as a point of critique against him: he doesn't readily offer that the intellectual can intervene and make things "better." To ask the thinker for such a pronouncement, Foucault believes, represents an old bias from the era of the universal intellectual, when any project with ethical relevance had to be normative. We left this era, according to Foucault, when we stepped off the cliff at Hegel's end of history and entered the logic of the non-replaceable individual. No longer may we look toward the sage who sits outside and speaks truth to power. (This view is also what put Foucault and Chomsky at odds in their famous debate in 1971. Chomsky still wishes to maintain that truth can challenge power (Chomsky and Foucault 2006).)

Ever the rhetorical genius and ahead of his time, Nietzsche ridicules this model of the universal intellectual long before Foucault, with each flippant "thou shalt" that peppers his oeuvre. To speak such a phrase, Nietzsche suggests, one must stand on the shoulders of a giant who is dead and in fact, already decaying. I can almost hear the dialogue Nietzsche would construct:

> A: Philosopher, thou shalt have an "ought".
> B: Thou shalt? Thou *shalt*??

In a set of interviews in 1976 with Italian thinkers Alessandro Fontana and Pasquale Pasquino,[68] Foucault calls this "the political question" for the intellectual. He states,

> It's not a matter of emancipating truth from every system of power (which would be a chimera, for truth is already power) but of detaching the power of truth from the forms of hegemony, social, economic, and cultural, within which it operates at the present time.
>
> The political question, to sum up, is not error, illusion, alienated consciousness, or ideology; it is truth itself. Hence the importance of Nietzsche. (Foucault 1980, 133)

Nietzsche's madman in the square perhaps pronounces it most dramatically: holding a lantern in broad daylight, he cries, "*we have killed [God]*—you and I. . . . Is not night continually closing in on us? Do we not need to light lanterns in the morning?"[69] (Nietzsche 1974, 181). A darkness is coming.

With scathing critique for any legitimate claim to a 'thou shalt,' Nietzsche proposes to direct his faith elsewhere: "*In what do you believe*?" he asks himself in a brief passage near the end of Book 3 in *The Gay Science*. "In this," he replies, "that the weights of all things must be determined anew"[70] (ibid., 219).

Intimating the importance of shame in this new weighting of things, Nietzsche continues almost immediately with these three aphorisms that conclude Book 3:

Whom do you call bad?-- Those who always want to put to shame.

What do you consider most humane?-- To spare someone shame.

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[68] Published as "Truth and Power" in *Power/Knowledge*.

[69] *The Gay Science*, Book 3, sec. 125.

[70] *The Gay Science*, Book 3, sec. 269.

> *What is the seal of liberation?*-- No longer being ashamed in front of oneself.[71] (ibid., 220)

Thus, if I have an *ought* in this project it is Nietzschean in form, and therefore at once bigger and smaller than the crisis of PTSD. It is to attack shame as one of the primary arteries feeding the maelstrom, a condition of possibility for the whole nexus and, moreover, for the way its irresolvabilities permeate the entirety of our physical, social, and intrapsychic spaces. The untenable subjectivity of PTSD will remain, I believe, until there is a shift in the economy of shame that is much deeper and broader than understanding the latest discoveries about "normal" human responses to extreme duress or a shift in the military culture.

Truly resolving the crisis of PTSD probably requires nothing less than a new way to see, a way that might enable the neuroscientists to speak cogently to the social worker. It will also require, among other things, integration between military and civilian arms of mental health services (and thus some kind of consistently applied policies on mental health insurance). Is this possible? I cannot say from this position in history.

However, I can say that such a resolution is not possible until a coherent episteme is established, which at the very least minimizes the untenable chasm between mental and physical illness. I can also say that, even without a coherent episteme, policies will continue to be implemented, all ostensibly based on "what we know" (Foucault 1994, 135). This is Foucault's long-standing point that we live in an era of power/knowledge, i.e., an era in which power is always intertwined with knowledge and vice versa. Moreover—and this is the archaelogical point once more—the practices that are being

[71] *The Gay Science*, Book 3, secs. 273-275.

(and will continue to be) implemented will *produce* many elements of the new episteme, often anonymously and without moral motivation. Many histories of this process, however, will be rewritten to suggest it is yet another tale of scientific progress and/or a merely moral problem of living up to economic responsibility.

6.3 Meditations on Shame

If one were firmly entrenched in the discourse of contemporary psychiatry, shame would appear as either a symptom itself, or a factor that prevents a truly sick/wounded patient from getting treatment. Again, within this discourse, the only option is to fight the old paradigm of "ignorance" with knowledge, typically delivered in the mouth of the expert, and with an extensive (and expensive) anti-stigma campaign that must constantly appeal to all "we have learned" about PTSD. Given all the conceptual irresolvabilities that I outlined in the Prologue and have since filled in, this campaign of knowledge versus ignorance is likely to prove unending. And though I've often steeped myself in this messy accumulation of data and theories, I do not wish to enter the maelstrom through the door of knowledge. My affinity always lies first and foremost with the poet.

As a point of methodology, then, my approach is decidedly different from that of Susan Sontag when she critiques the metaphors of illness that have plagued other historically located and morally charged illnesses: tuberculosis, cancer, AIDS. Her critique is essentially that the shaming used against the afflicted was a product of biases—often based on gender or race. According to Sontag, however, these biases are always revealed as such once a true etiology is found. In other words, though certain

diseases carry too much mythical weight for a time, and are in fact distorted by such myths, the truth will set them free.

I contend that the shame over being ill has a more complicated origin than biases perpetuated due to a temporary lack of etiological knowledge. Its basis is more complicated even than the lack of a coherent medical episteme—the issue to which I have devoted most of this project and for which Foucault has been my main resource.

6.3.1 The Implications for the "Concrete Forms of Existence"

While throughout much of this dissertation, I have emphasized the importance of this new individual born at the turn of the 19th century (and hence the importance of medicine) vis-à-vis the project of the human sciences, there is a second level of implication Foucault states in the conclusion of *The Birth of the Clinic*:

> Hence, too, [medicine's] prestige in the concrete forms of existence: health replaces salvation, said Guardia. This is because medicine offers modern man the obstinate, yet reassuring face of his finitude; in it, death is endlessly repeated, but it is also exorcized; and although it ceaselessly reminds man of the limit that he bears within him, it also speaks to him of that technical world that is the armed, positive, full form of his finitude. (Foucault 1994, 198)

Foucault poetically states that the transformation of death into a scientifically knowable phenomenon banished the last vestige "of the infinite on earth" (death), and in the place of this infinity delivered to man "the full form of his finitude" (ibid.).

"Health replaces salvation" (ibid.)—which is to say, medicine absorbs the responsibility and power of giving meaning to death, of giving "man" a new philosophical status as the being who carries his death within him. In a magnificent

sleight of the historical hand, then, the legacy of shame was transferred from original sin to illness. And our responsibility to our everlasting soul was redirected to our health. The weight of this new shame over being ill stands out in glaring relief when our Westernized vision of mental illness collides with other cultures that hold differing views not only of mental affliction but illness in general.

In the Prologue, I focused on only one element of shame: the intrapsychic turmoil resulting from the irresolvabilities that color the whole field of mental illness and especially PTSD. This turmoil is amplified because its paradigmatic victim/patient is the hyper-masculine soldier who feels he has failed in the age-old warrior ethos of courage and bravery. But there are elements of shame, even in this relatively contained example of the solder, such as the shame of survival or shame over what one did in order to survive. And yet, I maintain that all these different levels of shame are conditioned by—among other factors, of course—the historical sleight of hand just outlined, the one in which what used to be shame over being a sinner shifted into shame over being one who falls ill.

It is foolish, then, to believe this shame is merely a product of ignorance about mental illness. Its force cannot be fully accounted for by the lack of a lesion. Shame, too, has a long, dark legacy, and for this, I turn to Nietzsche.

6.3.2 Nietzsche on Shame

Nietzsche tells us that shame is the long-ripening fruit of an entire moral system that has only very recently crumbled yet has not disappeared. He famously claims, in

fact, that for hundreds if not thousands of years, we will yet live in the shadows of God. Any experience of shame, I am claiming, carries with it this uncanny shadowy character.

In Nietzschean terms, the revolution from classical nosology to pathological anatomy shifted the weights of things. It speaks to something like the way human beings understand themselves in the world as those who will die as a part of the order of nature, not as the result of some otherworldly force. It is a corollary to the death of God, i.e., the fact that God has become something unbelievable. The "evolution" I am talking about here, which falls under my term 'intrapsychic,' gave Western subjects a new task, namely, to constitute themselves with respect to a finitude that has depth, to inhabit a body whose constant movement between health and illness is all-too-human. There emerges here, then, a newly perceived need here to tell of the intricacies of one's body. Since Foucault's intellectual trajectory takes him toward the emerging science of sexuality, he points to Sade's confessions on his sexual life as an example. But I would here like to simply indicate this new weighting as part of the historical conditions that have produced an entirely different genre than that of Sade: the medical narrative, a topic Lisa Diedrich has explored in depth in her work *Treatments: Language, Politics, and the Culture of Illness* (2007).

In any case, that death has become a scientific phenomenon, to have become the organic limit that fixes what had been impossible to fix—the here and now—drops us into our skin in a new way. We are both more and less weighty, and for this reason, everything becomes a problem of "specific gravity"[72] (Nietzsche 1974, 343), a Nietzschean question of determining the weights anew.

[72] *The Gay Science*, Book 5, sec. 380.

By and large, Nietzsche embraces this violently acquired finitude. Only if we cease "to *flow out* into a god," he says, can we find a joy and fullness of meaning entirely within the bounds of our own skin[73] (ibid., 230); hence his emphasis on *physis*. Even the seeker of knowledge will find his passion to know limited by physiology, by what he can stand to know: "can truth endure incorporation?" he asks. "That is the question; that is the experiment"[74] (ibid., 171).

6.3.3 The Inescapable Shame

This point, I have made: mental illness and our conflicted, piecemeal institutions designed to deal with it, are inescapably tied up with the problem of shame. Narratives like that of the anonymous poet reflect a volatile course alternating between shame and a desperate desire for help, which is why so many of the public awareness campaigns speak of "reducing stigma" attached to mental illness (Real Warriors 2010, 1).

Hegel said shame is always about the bodily functions. When Sartre wrote about shame in *Being and Nothingness*, he located shame in an awareness that I am being looked *at* (Sartre 2003, 284), that I have a body that can be seen by another. In both models, shame is inescapable, it is true.

When Nietzsche wrote about shame, though, he said something quite different. He tells us we were heirs of a shame forged over millennia, now so deeply incorporated that we believe it must be as old as time itself.

[73] *The Gay Science*, Book 4, sec. 285.

[74] *The Gay Science*, Book 3, sec. 110.

For better or worse, every "philosophical" problem that has ever caught my attention has centered around this insidious ether that steals the air. To Hegel and Sartre, then, I make this Nietzschean point: shame is not *of* bodily things, nor because I *have* a body. It is bodily.

The remainder of this chapter, then, is about shame before oneself—self-silencing, the oppression within.

Book 2 as well as Book 3 (cited above) in *The Gay Science* ends with a cry to defeat the shame in front of oneself. I believe shame to be Nietzsche's "archenemy"[75] (Nietzsche 1982, 268), and that some of the highest splendor of his prose comes out when he faces it down:

> At times we need a rest from ourselves by looking upon, by looking *down* upon, ourselves and, from an artistic distance, laughing *over* ourselves or weeping *over* ourselves. We must discover the *hero* no less than the *fool* in our passion for knowledge; we must occasionally find pleasure in our folly, or we cannot continue to find pleasure in our wisdom. Precisely because we are at bottom grave and serious human beings—really, more weights than human beings—nothing does us as much good as a *fool's cap*; we need it in relation to ourselves—we need all exuberant, floating, dancing, mocking, childish, and blissful art lest we lose the *freedom above things* that our ideal demands of us. It would mean a *relapse* for us, with our irritable honesty, to get involved entirely in morality and, for the sake of the over-severe demands that we make on ourselves in these matters, to become virtuous monsters and scarecrows. We should be *able* also to stand *above* morality—and not only to *stand* with the anxious stiffness of a man who is afraid of slipping and falling any moment, but also to *float* above it and *play*. How then could we possibly dispense with art—and with the fool?—And as long as you are in any way *ashamed* before yourselves, you do not yet belong with us.[76] (Nietzsche 1974, 164)

[75] *Thus Spoke Zarathustra*, Third Part, "On the Vision and the Riddle."

[76] *The Gay Science*, Book 2, sec. 107.

A shift in the economy of shame, a profound shift, would be subversive. If I am putting forth a call, it is to subvert this rootstock of the West.

6.4 On Women and Shame

In that old world order, where shame ripens over millennia as a fruit of the Judeo-Christian worldview, it is not evenly distributed. I cannot think about shame without thinking about women, and thus with very little foresight, certainly without deliberation, I have come to realize my entire project rests on feminist pillars.

I may be a few generations behind, but I feel an affinity for Simone de Beauvoir. Shit, I hear her say, I guess I finally have to write something about being a woman. But everything I think is informed by being a woman—why must I thematize it?

I don't have the theoretical resources of feminism; I've absorbed them a little here and there, but not studied them. I am a prodigal daughter; I renounced it all and came back again and again to the fact that I think always as a woman; I am marked; I am embodied; I think as flesh; I carry scars; I hold pain; I hold so very much pain. And I do not know what to do with the feelings in the face of the thoughts. The feelings will kill me and the thoughts will most likely do nothing at all in the world. C'est drole, non? Where is the place in a dissertation for the inarticulate fear that ripples through my gut, that sends my abdomen into convulsions? Where is the place for that in a dissertation? Can I transform it into a claim I clearly and calmly state and then wait, standing at attention to defend against civilized and measured attack? Where is the place for me to be

okay in all this? Where can I get permission for survival, and then, and then!—I whisper—for joy?

6.5 The Trip to Make Sense Of

But in any case, I have already framed this entire dissertation in terms of a trip I wanted to make sense of. In the end, my 'ought' must come from here.

April 27, 2010 was the fifth anniversary of when my cousin, Sgt. Bryan Hoyt Benson, put a gun in his mouth and pulled the trigger. For a long time, I thought I was writing this dissertation to him. I wanted to tell him it wasn't his fault, that he was caught up in a clusterfuck that may well represent the main question of our day. I was wrong, though. I'm not writing it to him. I'm writing it in his honor, but if I had him before me again, it is not this that I'd want to say to him.

As I said in the Introduction, the trip I write to make sense of ended in a mini-van. Did you imagine yourself there, in the mini-van? Did you silently make your choice whether my cousin was sick or stupid? Even if I add in "wounded" here, does it matter? Was he sick, stupid, or wounded? Can you choose among these untenable distinctions? Or can you abide the overdetermination of these mutually exclusive choices that seem to nonetheless overlap in Bryan's suicide? How shall we judge who is *responsible?* Must we cast our lot?

Down there on the ground, in my skin, those words—*Bryan was either sick or stupid and you need to get over it*—pulled the rug out from under me. They shamed me for my grief and commanded me to cast a verdict. This shame seems curiously to be so

terribly general, in that it's about my being, my "right to exist," as Nietzsche might say[77] (Nietzsche 1974, 232), and so terribly specific: it is activated (actualized) only in the instant of Your command that I choose, and because You matter to me in that moment. Spoken by one without weight in my world, these words might have had little effect. But as it stands, they changed everything. In that instant, the scales fell from my eyes. I was thrown headfirst into the maelstrom without a tether. Again, I did not choose this project; it chose me, and it's taken five years to realize it must finish there, too.

"[A]nd to whom and to whom and to whom," says Moraga (Moraga and Anzaldúa 1983, *xv*).

To my great surprise, those words can hurt me still. I hurt, still. And so it's to You that I write this last chapter. When I say I write to heal, it means I write to render Your specter weightless. I seek the Nietzschean seal of liberation from a nemesis we share.

Having already adopted his cue that shame will not be defeated with serious critique, that I must rather become crafty, jubilant, playful, and above all, irreverent, I take another cue from the following passage:

> And let me say this among ourselves and about my own case: I don't want either my ignorance or the liveliness of my temperament to keep me from being understandable for you, my friends—not the liveliness, however much it compels me to tackle a matter swiftly to tackle it at all. For I approach deep problems like cold baths: quickly into them and quickly out again. That one does not get to the depths that way, not deep enough down, is the superstition of those afraid of the water, the enemies of cold water; they speak without experience. The freezing cold makes one swift.[78] (Nietzsche 1974, 343-344)

[77] *The Gay Science*, Book 4, sec. 289.

[78] *The Gay Science*, Book 5, sec. 381.

Is it too presumptuous on my part, then, to revise history just a little? Reword Your biting turn of phrase that lives in my flesh *still*?

"Bryan was either sick or stupid, and thou shalt get over it."

Strikes an old chord phrased thus, does it not? Carries with it the ease of the terribly familiar and unambiguous? Make your commitment, You say. Declare your allegiance and condemn the fallen to their failure or fate or folly. It matters not which one so long as you condemn and quickly, *cleanly*, move on, for *you* are nothing; *you* are worthless except as my own reflection.

With your charge thus revised, I also find permission to revise my response. This time, I speak:

How fortunate I am to have You behind the proverbial and literal wheel just now! The dead ones are dead, right? It is only about You and I! Will I cross the bridge and come to You? Will I cast aside my questions, my right to ambiguity and fear and grief, in order to bring back the accord? How wise I was to relinquish control over my body and mind, to one like You who can keep things tidy!

Let's get down to it, then. You want to know whether *I think* Bryan was sick or stupid? Well, alas, I cannot oblige. I refuse Your choice. And, finally, I see now that it is You who are afraid, afraid of the unknown forces of this whole thing, its disruptive power. You are afraid of the clusterfuck. You are afraid of the ways I am tossed about in it, because I have become unpredictable to You. And in seeing that, I also allow myself to feel the betrayal in Your command that I choose. If You don't want to see this pain, I'm afraid it will have to be You who turns away. Or even casts me out on the side of the road. You will have to act; you will have to choose.

* * *

I cannot offer the simplistic ought. It would be futile as well as disingenuous. However, Nietzsche tells us over and over again in *The Gay Science* that, cut free from the sun—i.e. our ability to believe in an ultimate sense of the good, the true and the real—we now need a new relationship to the compulsion to know. I write so that one day I might not feel the need to defend my right to exist, so that one day, I might stand here undefended. Silent to Your question because I refuse it and no longer self-silencing because of my fear and shame.

My anti-thesis: let us be done with shame, then. Let us gather all our finest minds, our finest impulses,[79] and direct them toward undermining the foothold of shame. Take it out at the knees if you must. Choose your weapons carefully, though, when you spar with an enemy that lives in your own flesh. Precision is called for, at times even cunning. And ultimately, there is no sustainable way to dismantle the oppression within without simultaneously creating a new way to be.

Will this solve the "problem" of PTSD? How could I offer such a promise? It has too many tentacles, colors too many things. But as I said before, a shift in the economy of shame would be subversive. The poet's voice would claim us differently then, because the same cry made in a chamber whose contours have changed *sounds different*.

* * *

My sweet Bryan, I am not up to the task of your redemption. I cannot solve it though it's all I really want. And yet I feel silly for my grandiosity. I am no different from anyone

[79] Henry Miller wrote: "Every day we slaughter our finest impulses (Miller 1964, 25).

else. In the end, I am impotent and full of grief. I can scarcely bear the weight of all my losses, and so I've mapped this futile course across the ravages of my soul, foolishly wishing I'd be crossing over to you. All I can do is lean in, come close, whisper to you that, though I cannot help you, I can tarry alongside.

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